

SAMA INSIDER

JUNE 2014

SAMA golf day

Interviewing the GS

Protect doctors says WMA



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ALLERGIES

SHORT COURSE IN THE CLINICAL MANAGEMENT OF ALLERGIES

The prevalence of allergy is increasing worldwide, particularly in urbanised communities. Asthma is thought to occur in at least 1 in 10 people, and allergic rhinitis may occur in 1 in 5, irrespective of race or socio-economic status. Therefore, all family practitioners, irrespective of which communities they serve, will probably see patients with hay fever every working day. In many instances the diagnosis is made easily, but sometimes the diagnosis is difficult to make and investigations will help to confirm the diagnosis of allergy and the attendant inflammatory airway disease. The wide range of allergy tests available requires a logical approach to selecting the most cost effective and appropriate test for each individual.

COURSE CONTENT

This course covers the following modules:

- Allergic disease;
- Respiratory allergy;
- Skin allergy;
- Systemic allergy and
- Food allergy and intolerance.

ACCREDITATION

Accredited according to the HPCSA CPD Guidelines for Health Professionals - November 2006, for 30 CEUs on level 2. (Workshop: 12 CEUs, Assessment: 18 CEUs)

COURSE FEE

R 3 400 (Inclusive of all VAT and taxes where applicable)
This amount includes everything except travel and accommodation.

DATE
26 – 27 July 2014

VENUE
Port Elizabeth

REGISTRATION

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DIABETES MELLITUS

SHORT COURSE IN THE CLINICAL MANAGEMENT OF DIABETES MELLITUS

Diabetes Mellitus is rapidly emerging as a major public health problem. Although it is a chronic debilitating disease, early detection and effective management can significantly improve quality of life. Some of the important contributors to the rising prevalence of the disease are for example the effects of urbanisation and the obesity epidemic. Public and professional awareness of the risk factors for and the symptoms of diabetes are an important step towards its prevention and control. The importance of this problem has been acknowledged by the Department of Health with the introduction of a national programme for control and management of type 2 Diabetes Mellitus. Healthcare professionals therefore need the skills to effectively manage the disease. The course will also create a further opportunity for healthcare professionals to differentiate their practice and to respond to a growing consumer demand.

COURSE CONTENT

The following modules will be covered:

- Introduction;
- Clinical features;
- Treatment;
- Optimal control;
- Complications;
- Special situations;
- Diabetes and pregnancy;
- Diabetes and hypertension;
- Diabetes in children and
- Diabetes and surgery.

ACCREDITATION

Accredited according to the HPCSA CPD Guidelines for Health Professionals-November 2006, for 27 CEUs on level 2. (Workshop: 12 CEUs, Assessment: 15 CEUs)

COURSE FEE

R 3420 (Inclusive of all VAT and taxes where applicable)
This amount includes everything except travel and accommodation

DATE
7 – 8 June 2014

VENUE
Pretoria

REGISTRATION

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MEDICAL ETHICS

As the healthcare industry evolves due to global driving forces the doctor will increasingly be challenged with making business decisions without compromising professional ethics. This course is intended to provide participants with an appreciation of the need for continual reflection on the ethical dimension of medicine and how to deal with ethical issues in their practices.

COURSE CONTENT

MODULE 1: Ethics in the healthcare environment
MODULE 2: Healthcare funding and resource allocation
MODULE 3: Relationships in healthcare
MODULE 4: Policy, governance and ethics

COURSE FEE

R 1192 (Inclusive of all VAT and taxes where applicable) the course fee includes all study material, assessment and certification.

REGISTRATION

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Fax: 086 558 5433
Email: melanym@foundation.co.za

DISTANCE COURSE

EARN YOUR CPD POINTS AT
YOUR OWN PACE AND TIME!

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EDITOR'S NOTE JUNE 2014



Conrad Strydom
Editor: *SAMA INSIDER*

Meet the new boss – same as the old boss?

No one was particularly surprised when the African National Congress claimed its fifth consecutive victory at the polls recently, despite growing concerns over its service delivery in key aspects of governance, including healthcare. An organisation with such a near-mythical history is always going to be a force in South African politics, for good or ill. But the face of the government need not really concern us. What matters to doctors is the question: "Where to from here?"

Quite a lot, if the hype is to be believed. The overwhelming support the ruling party got at the polls will be seen as a green light to push some of the government's more ambitious projects through the legislative process and into our daily lives. For doctors, this means only one thing: start reading up about National Health Insurance (NHI). NHI policy is big news and will affect you in a very tangible way, whether you are a private or public practitioner. You can download the green paper from the government website (www.gov.za) and numerous other sites.

When doctors are not busy avoiding the spectre of a looming overhaul to the health system, they can be found on the golf course. See what they got up to on pages 6 and 7 where we feature a lavish selection of images from the recent SAMA Golf Day at Zwartkop Golf Course. We also stop by the General Secretary's office to get an update on the current activities of the SAMA Trade Union, and feature a very enlightening article about the relationship between doctors and the Road Accident Fund on page 18.

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Ethics: Deafening silence on patient responsibilities



Prof. Ames Dhali, President, SAMA

A recent bulletin issued by the Health Professions Council of South Africa (HPCSA) on 30 April 2014 had 'charging for no shows' as one of its points of caution to practitioners. The latter were reminded that it is against Council rules for patients to be charged when they did not show up for appointments. It is interesting to note that the bulletin was silent on the issue of a lack of responsibility on the part of the patient. The reminder was drawn from the 'Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974'. These rules were first published in 2006 and have undergone three revisions thus far, with the latest one being in March 2013.

Section 7 of the rules, entitled 'Fees and commissions' reads as follows:

"(1) A practitioner shall not accept commission or any material consideration (monetary or otherwise) from a person or from another practitioner or institution in return for the purchase, sale or supply of any goods, substances or materials used by him or her in the conduct of his or her professional practice.

(2) A practitioner shall not pay commission or offer any material consideration, (monetary or otherwise) to any person for recommending patients.

(3) A practitioner shall not offer or accept any payment, benefit or material consideration (monetary or otherwise) which is calculated to induce him or her to act or not to act in a particular way not scientifically, professionally or medically indicated or to under-serve, over-serve or over-charge patients.

(4) A practitioner shall not share fees with any person or with another practitioner who has not taken a commensurate part in the services for which such fees are charged.

(5) A practitioner shall not charge or receive fees for services not personally rendered, except for services rendered by another practitioner in his or her employment or with whom he or she is associated as a partner, shareholder or locum tenens."

Finder's fee, under-servicing, over-servicing and over-charging patients is frowned upon in most jurisdictions internationally and understandably so. The bulletin referred the reader to section 7 (5) as justification for the cautionary reminder. While, ethically speaking, section 7 as a whole is reasonable, using section 7 (5) as *raison d'être* for not charging patients who do not show up for their appointments is, in my opinion, open to challenge.

Much is made of practitioner obligations and responsibilities; however, very little consideration is given to patient responsibilities

Can waiting for the patient not be interpreted as a service? It is, after all, utilisation of practitioner time albeit a no-show. What about fairness? In today's lived context one cannot afford to ignore the cost of practitioner time and that of running a practice. Surely this decision by the regulator is indicative of disconnect between the HPCSA determinations and the reality that practitioners face on the ground? In fact, an appraisal of all the rules reveals that, in general, several aspects are outdated and/or impractical when implementation is contemplated.

Much is made of practitioner obligations and responsibilities; however, very little consideration is given to patient responsibilities despite the National Patient's Rights Charter unambiguously detailing ten of these. It is also interesting to note that this Charter has been adopted as Booklet three of the HPCSA's Guidelines for Good Practice in the Healthcare Professions. Patient responsibilities detailed in the Charter are the responsibility to:

- Take care of his or her health.
- Care for and protect the environment.
- Respect the rights of other patients and healthcare practitioners.
- Utilise the healthcare system properly and not abuse it.
- Know his or her local health services and what they offer.
- Provide healthcare practitioners with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.
- Advise healthcare practitioners of his or her wishes with regard to his or her death.
- Comply with the prescribed treatment or rehabilitation procedures.
- Enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.
- Take care of the health records in his or her possession.

It is clear from the above list that patients who do not show up for their appointments are in essence not honouring their responsibilities in terms of their Charter and in doing so they do not respect the rights of other patients (who may have been denied an elective or even an emergency consultation because of a lack of availability of the practitioner); and moreover, they are disrespectful of practitioner rights as well. In addition, this could also be interpreted as an abuse of the healthcare system. While it may be said that the Charter was written in the main to apply to patients in the state sector, the principles espoused in the document can well be extrapolated to apply equally to healthcare services rendered in the private sector.

So, now that we recognise the flaws in the rules, what should we do about this situation? I have written to the HPCSA, as your President, calling for a revision of the rules and have already received a positive response to this request. As practitioners we need to study the document and contribute to this revision process, especially in light of the fact that the determinations have a direct bearing on what we may or may not do in our jobs as healthcare practitioners. The Rules are available at http://www.hpcsa.co.za/downloads/ethical_rules/ethical_rule_gg29079_2006.pdf.

I look forward to your valuable contributions to this process. And let's also remember to remind our patients of their responsibilities whenever we are able to.

SAMAREC/CPD SERVICES AVAILABLE:

- South Africa Medical Association Research and Ethics Committee - SAMAREC
- South African Medical Association Continued Professional Development Accreditation
- Our Mission:
 - o Empowering Doctors to bring health to the nation
 - o Excellent Service
 - o Quick Turnaround
 - o Efficiency



WHAT WE ARE ABOUT

SAMAREC:

Evaluating the ethics of research protocols developed for clinical trials conducted in the private healthcare sector. Ensuring the protection and respect of rights, safety and well-being of participants involved in clinical trials and to provide public assurance of the protection by reviewing, approving and providing comment on clinical trial protocols, the suitability of investigators, facilities, methods and procedures used to obtain informed consent.

CPD:

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.

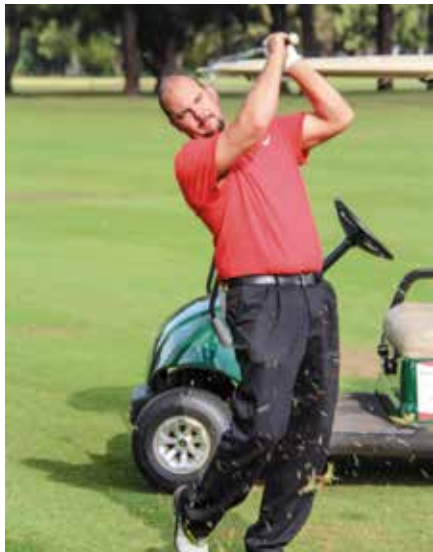
SAMA golf day raises funds for charity

Conrad Strydom

On 16 April, doctors, businessmen and golfing fanatics descended on the idyllic Zwartkop Golf Estate in Centurion for the annual SAMA Golf Day. The event, which was organised by SAMA's Marketing and Communications Department, sought to raise funds for the association's Benevolent Fund, which provides financial assistance to the families of doctors who are

destitute. Not that the participants needed any excuse – the enthusiasm with which the assembled professionals took to hitting balls over great distances was almost touching to behold. The competition took the form of a four-ball alliance with two scores counting. A total of 18 teams, comprising 72 players, competed for top spot over the course of a full 18 holes. After

an exhausting day of non-stop golf, players were treated to a dinner at the Zwartkop club house and a prize-giving function emceed by none other than South African golfing legend Dale Hayes, whose irrepressible brand of humour kept the audience in stitches. Thanks to an impromptu auction, Hayes and the SAMA marketing team managed to raise a total of R12 500 for the SAMA Benevolent Fund.



"I was driving home one day when a beggar accosted me at a stop light. "Please boss, give me some money," he said. "Go away!" I said. "You're just going to buy booze!" "No way boss, I don't drink," he replied. So I said "Yes, because you would rather buy dagga." No, said he, he doesn't smoke that stuff. "Do you play golf?" I asked him. "You must be mad!" he exclaimed. "Who ever heard of a beggar who plays golf?" So I took him home to my wife to show her what happens if you don't drink, smoke or play golf!"

SA golfing legend Dale Hayes at the SAMA Golf Day





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**To the sponsors of the SAMA Golf Day,
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LIBERTY



An interview with the General Secretary

Conrad Strydom

Since its inception, the SAMA Trade Union has been a highly vocal, active body of health professionals that has had an overwhelming effect on the South African public healthcare sector. The *SAMA Insider* sat down with the Trade Union's General Secretary, Dr Mahlane Phalane, to get an update on the organisation's past victories, current battles and future concerns.

There are persistent concerns that the emergence of a SAMA Trade Union has somehow disrupted or changed the direction of the SAMA. How do you respond?

Actually, the official registration of this association as a trade union predates the moment we changed our name to SAMA! We were first registered as a trade union on 11 November 1996, back when we were still the Medical Association of South Africa (MASA). Members who are claiming that we are changing the character of the organisation are therefore somewhat misinformed.

What is the biggest challenge facing the Trade Union currently?

At the moment, our biggest challenge is trying to build strong Trade Union structures on the ground. It is our hope that each hospital in the country should have an active shop steward or representative who can engage with doctors about their issues and bring these to our attention. We are trying to establish a provincial executive council (PEC) in each province as a valuable first step towards maintaining fully functional Trade Union provincial structures responsive to members' needs. So far we have launched PECs in Limpopo, KwaZulu-Natal and Gauteng, with the Western Cape hopefully soon to follow. But those are administrative matters; our main challenges are the issues faced by our members, and those are many.

What difficulties are affecting members the most?

Probably the number one issue currently is the commuted overtime. This year, there have been major issues regarding the payment of commuted overtime in Mpumalanga and the Military Health Service, the latter of which even resulted in the Minister of Defence establishing a special task team to tackle this issue. The establishment of this team was a direct result of

SAMA leadership personally bringing this matter to the attention of the Minister. We also faced a full-blown crisis in Gauteng when public doctors were not paid their commuted overtime for April, due to poor management and systems failure. We are currently making inputs on an updated draft commuted overtime policy that we hope will address this problem.

Renumerative Work Outside the Public Service (RWOPS) continues to be an issue, but we have made lots of progress in this regard. We had an extensive consultation process from members regarding this policy, and while we support it in principle we also acknowledge that individuals could be disadvantaged by the implementation of this policy. Our comments and inputs in the official draft RWOPS policy are currently with the national Minister of Health, Dr Aaron Motsoaledi.

How is the Trade Union handling the implementation (or lack thereof) of Occupation Specific Dispensation (OSD)?

We are gravely concerned and utterly disappointed that provinces have failed to implement OSD. It is now five years since it was supposed to be implemented. Besides pressuring the Department of Health (DoH) to make good on its promises and implement the OSD system as soon as possible, we can ensure that our shop stewards are tasked with overseeing the process of translating members to OSD.

Can you explain how these OSD issues relate to the Performance Management and Development System (PMDS)?

In many of the country's hospitals, hospital supervisors and human resource managers are failing to make sure that doctors' performance appraisals are done on time and that the relevant performance bonuses due to them are paid. Some doctors are also failing to ensure that these appraisals are performed. I want to make this very clear: If you do a performance appraisal, you can't progress on OSD! So make sure your PMDS affairs are in order – it is causing everyone concerned a lot of grief.

What is the Trade Union doing for trainee doctors?

Registrars and intern doctors are disadvantaged in a number of ways and we must attend to



Dr Mahlane Phalane

their issues too. Regarding registrars, we appeal to our higher learning institutions to ensure that specialist training is not taken lightly. Registrars need a conducive, professional environment to study in. Our training standards are internationally renowned – let's keep it that way by making sure that examinations are fair and accurate and that no favouritism is shown. Hospitals that are accredited training institutions for interns must also be reminded that they are bound to the HPCSA's rules and regulations and must adhere to them.

What can we expect from the Trade Union in the near future?

Right now we are excited at the prospect of engaging with the Department of Labour to make sure that we benefit from an envisaged amendment to the Labour Relations Act. This will ensure that we can independently participate in bargaining processes – a real victory for SAMA. We must also try and involve as many of the country's doctors in our activities as possible, simply by showing them how effective we are at fighting their battles for them. We can't scare people to join SAMA – we must show them what we can do for them. When we took up the concerns of the National Health Laboratory Service doctors, those doctors joined us in droves. In the military we had few members until they saw how effective we were at fighting for their rights. This process has to continue so that we can eventually have enough members to unite the medical profession in this country, because that is the moment our health system will finally turn around.

What does the Private Practice department do?

SAMA Private Practice Department

The South African Medical Association (SAMA) is a non-profit, section 21 company that acts as a professional association for both public sector and private practice medical doctors. To this end, SAMA has a dedicated Private Practice Department (PPD), which strives to improve the professional environment of both general practitioners and specialists in private practice. SAMA's PPD champions doctors' rights and causes in its interactions with National and Provincial Governments; the Health Professions Council of South Africa (HPCSA), other regulators and all the major role players within the healthcare funding and administration industry. The PPD constantly focuses on promoting and strengthening private medical practice in order to protect its fundamental characteristics and promote its pivotal role in the private healthcare continuum.

SAMA offers the following services to all members

- Protection of doctors' scope of practice by protecting and updating the SAMA Medical Doctors' Coding Manual (MDCM).
- A full legal services department that reviews all contracts, gives advice pertaining to HPCSA hearings and all other practice-related legal issues.
- A medical coding unit that provides free procedural and diagnostic coding advice to SAMA members and their office staff.
- CME opportunities in conjunction with the Foundation for Professional Development.
- Online training programmes.
- A free medical journal and a doctor's lifestyle magazine every month.

SAMA PPD reports to its members through the respective General Practitioner and Specialist Private Practice Committees. The PPD itself comprises an Acting Head of department, Ms Glenda de Beer; a secretariat for each of its constituent committees and a medical coding unit headed by Ms Glenda de Beer who is ably assisted by Ms Leonie Maritz, Ms Zandile Dube and Ms Salosh Ishwarpesad.

What does SAMA do for private practitioners?

The South African Private Healthcare environment is dominated by massive companies that have almost limitless funds at their disposal to determine their own financial risks and then pay doctors accordingly.

Many of these companies are now so brazen that they have started telling doctors how to treat their patients and how to run their practices. In order to assist doctors to manage the myriad risks inherent in private practice, SAMA has engaged new technology applications, many of which are unique to SAMA and our members.

New projects that will add value to your doctors' practices

- National Health Insurance (NHI) task teams to ensure that doctors influence the eventual design of NHI.
- National projects to assist and address inherent private practice risks.
- Establishing a Designated Service Provider Network.
- New technology interface development.

- Practice management tools.
- Electronic MDCM and Complete CPT® for South Africa (CCSA) with search functions.
- A practice Cost Calculator to determine own tariff.
- Medical scheme rating tool.
- Medical advisor rating system.

Value-added benefits that SAMA offers to members at no cost

- Fully automated CPD risk assessment manager.
- CPD collection and HPCSA submission application.
- Knowledge share database.
- Pharmaceutical database.
- Woundcare and medical technology database.
- Unique, customisable webpage for each member.
- Unique, customisable homepage for each member.
- Locums database.
- An electronic MDCM code search engine.
- Medical scheme tariff comparison tool.
- Medical practice geomapping tool.
- Private Public Partnership Projects (PPPP).
- Exclusive free and discounted services and products from some of the top companies in South Africa.

The function of the PPD is to stand up for doctors, and the more members we have, the stronger our voice. It is only through unity that doctors will be able to reclaim their rightful place as the most important decision maker in the healthcare chain.

WMA holds Tokyo council meeting

The World Medical Association

A World Medical Association (WMA) Council meeting was held in Tokyo, Japan from 24 - 26 April and was attended by delegates from more than 30 national medical associations (NMAs). The WMA was honoured to receive a visit from the Prime Minister of Japan, Mr Shinzō Abe, who spoke to the delegates about the longevity model of healthcare in Japan and the need to enable elderly people to

live at home. He stressed the importance of universal healthcare and highlighted in particular the need for primary care.

Delegates discussed a number of issues, including the following:

Africa Project

Dr Margaret Mungherera, President of the WMA, reported on the African Medical Initiative she has been pursuing since becoming

President. She reminded delegates that Africa was the continent with some of the lowest health indices in the world. This was largely because of weak health systems and poor universal health coverage and access, leading to bad outcomes. She said the initiative was based on the fact that only 20 of the 54 national medical associations in Africa were members of the WMA. She wanted to see not only more African NMAs join the WMA, but also

increased participation by those NMAs that were members. To achieve this it is necessary to strengthen the capacity of African NMAs in medical education, continuing professional education and national health policies.

Databases and clinical trials

The Council agreed that a work group should continue consideration of an updated policy document setting out principles for the ethical use of data in health databases and human biological material in biobanks. Delegates from Europe pointed out that this was particularly urgent in view of the European Union legislation replacing the concept of individual consent by broad consent. After Dr Otmar Kloiber, Secretary General of the WMA, stressed the importance of this issue. The Council agreed that a draft Declaration should be circulated to NMAs for

comment and further consideration at the WMA's General Assembly in Durban, South Africa in October.

Air pollution

Increasing concern about the negative health effects of air pollution around the world prompted the Council to set up a new work group to examine the issue and come up with urgent recommendations. The Council received a request from the Austrian Medical Chamber to issue a new policy on the prevention of air pollution and vehicle emissions on the basis that air pollution reduced life quality for millions of people worldwide, causing a large burden of disease, as well as economic loss and costs in the health systems.

Wellbeing of physicians

Proposals from the WMA's Junior Doctors Network (JDN) for a series of measures

to improve physicians' wellbeing were welcomed and it was agreed to set up a wider group to build on these recommendations and produce a comprehensive policy.

Declaration of Helsinki

It was agreed that the 50th anniversary of the Declaration of Helsinki this year should be celebrated at a special ceremony in Helsinki on 11 November this year. A programme will be announced later.

Junior Doctors Network

Following the meeting, the JDN met to discuss its future strategy. More than 30 junior doctors from 12 countries attended and discussed plans to hold the JDN's first meeting of junior doctors from Africa in Durban during the WMA General Assembly in October.

PHSDSBC concludes agreement on recognition of improved qualifications

SAMA Trade Union Organising and Collective Bargaining Unit

Parties to the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) concluded a collective agreement referred to as Resolution 1 of 2014. This agreement emanates from clause seven of Public Service Coordinating Bargaining Council (PSCBC) Resolution 1 of 2012 which deals with the improvement of salaries and other conditions of service.

PSCBC Resolution 1 of 2012

Clause 4 of the PSCBC Resolution 1 of 2012 provides, among others, that:

- *The employer will recognise the attainment of an improved qualification which is related to the employee's scope of work and enhances the employee's performance and the service delivered by the employee;*
- *Upon attainment of the said qualification, the employee will receive a once-off cash bonus of ten percent (10%) of his or her annual salary notch eight, provided this does not exceed the minimum notch of salary level eight payable with effect from 1 January 2013;*
- *The cash bonus is limited to attainment of one additional qualification;*
- *Employees funded by the State for the attainment of an improved qualification are not eligible for the once-off cash bonus;*

- *Sectors must define the qualifications which are relevant to their respective areas of work and determine the conditions or criteria applicable for recognition of such qualifications.*

PHSDSBC Resolution 1 of 2014

The PHSDSBC Resolution 1 of 2014 provides that:

- *The minimum qualification appointment requirement and recognisable improved qualifications for medical professionals will be MB ChB or equivalent.*
- *For purposes of recognition as an improved qualification, the employer will now recognise any relevant qualifications above the minimum appointment requirements including, a postgraduate diploma, masters degree or a PhD.*
- *International qualifications recognised by SAQA will also be accepted.*

Such a qualification must have been obtained through a recognised institution registered with the Department of Higher Education and must have the necessary credits attached to be recognised, that is:

- National Certificate – 120 credits
- National Diploma – 240 credits

- Degree (including postgraduate) – 360 credits
- B Tech Degree – 480 credits

The listed qualifications must carry a minimum of 120 credits and be of at least 12 months' duration.

Conclusion

- The employer must recognise any qualification that might have been left out at the time of signing the agreement and which complies with the set criteria in respect of improved qualifications.
- Departmental bursary holders whose bursaries are withdrawn and who have repaid the department such amounts in terms of the applicable bursary conditions shall benefit in terms of the Resolution should they acquire an improved qualification through self-funding.
- Employees who acquired improved qualifications after the signing of PSCBC Resolution 1 of 2012, which became effective on 31 July 2012, will benefit from the new dispensation, and those who might have acquired qualifications prior to the signing of the Resolution will benefit as per provisions of the old dispensation. It should be noted, however, that the date of effect of the Resolution is 1 January 2013.



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.

Prof Bavesh Kana
Conference Chair 2014

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.



CONFIRMED SPEAKERS



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.

The Gauteng Provincial Executive Council of the Trade Union at the first meeting on 10 May

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The WMA says governments are not doing enough to protect health personnel

The World Medical Association

A plea for health professionals and medical facilities to be protected in times of armed conflict has been made in Nigeria by Dr Margaret Mungherera, President of the World Medical Association (WMA).

Speaking at the Nigerian Medical Association's annual conference in Benin City, Edo, Dr Mungherera referred to violence in Nigeria, Syria, Ukraine and elsewhere in the world. Physicians and other health professionals have been killed or injured in fighting, and hospitals and other health facilities have been destroyed.

"In many countries experiencing armed conflict, health personnel have been injured or lost their lives. About 70% of these are local health providers. The result is that patient access to healthcare is undermined, not only from the deaths and injuries but when health personnel migrate away from areas of conflict," says Dr Mungherera.

"Governments around the world are simply not doing enough to protect medical

personnel and facilities. They must ensure unobstructed access to medical treatment for the injured."

Dr Mungherera also made it clear that health professionals have a responsibility to protect patients' right to confidentiality, and to do all they could to minimise harm and to make decisions that were in the best interests of their patients.

"This is as equally important in times of peace as it is in situations of armed conflict and other emergencies," she said.

She hoped that draft regulations and guidelines drawn up by the International Committee of the Red Cross (ICRC) emphasised the need for protective measures to cover health training institutions. She wanted to see medical students among the groups specifically mentioned as requiring attention.

"New ICRC guidelines will be important in ensuring safety for health personnel to allow them to fulfil their ethical obligations towards their patients. The WMA is encouraging all national medical associations to lobby their

governments and others to implement these guidelines.

"And the WMA will continue to speak out in support of medical associations in Turkey and elsewhere, which are struggling for the right to exercise clinical independence and professional autonomy."



The World Medical Association is an independent confederation of national medical associations from 106 countries, and represents more than nine million physicians. Acting on behalf of patients and physicians, the WMA endeavours to achieve the highest possible standards of medical care, ethics, education and health-related human rights for all people.

Trade Union holds first Gauteng PEC meeting

Conrad Strydom

The Gauteng Provincial Executive Council of the SAMA Trade Union held its first meeting on Saturday 10 May at the SAMA Head Office in Pretoria. The goal of the meeting was to establish common ground among members regarding the functions of the provincial Trade Union structure and to adopt resolutions that the Trade Union leadership can use to engage with the national Department of Health (DoH). The meeting also saw the election of the provincial structure's first leadership corps, with Dr Mpho Poee of Charlotte Maxeke Hospital appointed as chairperson.

The meeting focused heavily on the appointment and retention of a proper system of shop stewards in the province's hospital complexes, as part of the Trade Union's broader strategy to react to issues that affect doctors as soon as they arise. Dr Poee was especially vocal in calling for a more efficient shop steward system, while Dr

Langanani Mbodi, the Trade Union's national treasurer, noted that the lack of dedicated eyes and ears on the ground in hospitals means that the Trade Union is not informed of important events quickly enough.

Another area of concern was the increasing difficulty that professionals were experiencing with the lack of implementation of the government's Occupation Specific Dispensation (OSD) system. The OSD was designed to attract professionals to the public health sector, but its implementation has so far been a shambles, as was especially apparent when listening to the doctors present. There is a great deal of resentment about the improper application of OSD and salary increments not being applied. The incoming leadership promised to take these matters up with the DoH.

It was not all doom and gloom, however. According to Trade Union President Dr Phalane Mahlani, the adoption of a new

Remunerative Work Outside the Public Service (RWOPS) policy by the DoH is now in its final stages. The new policy, which was heavily influenced by SAMA, will hopefully legitimise the practice of RWOPS while eliminating the potential for wrongdoing by unscrupulous practitioners. According to Dr Phalane, the new policy is a step in the right direction and will help to heal the image of healthcare workers that had been damaged by the recent RWOPS controversies.



Members of the Gauteng Provincial Executive Council at the first meeting in Pretoria

Member profile: Dr Lehlohonolo Makhakhe

Dr Lehlohonolo Makhakhe is a member of the Senior Employed Doctors Association of South Africa (SEDASA). He lives in Welkom. In his spare time, Dr Makhakhe is a keen writer and has just released his first collection of short stories entitled *Choices*.

You recently published a collection of short stories called *Choices*. What is the book about and why did you write it?

Firstly, *Choices* was conceived as a collection of African tales. I wanted to create a selection of proudly South African stories which reflected strong moral values. The stories in *Choices* cover a wide range of issues and deal with them using humour, compassion and sadness – the full gambit of human emotions. Above all else, it is a book that celebrates the art and marvel of writing.

Does writing help you cope with life as a doctor?

Yes, it does. I have been a doctor for nearly seven years and it has been one of the most fulfilling adventures I have ever had. I always

dreamed of becoming a medical doctor, but it certainly can take its toll on you. Writing is a very special form of art that complements my life and relaxes me enormously, so I suppose it does offer some form of escape. Writing is a passion of mine; there is nothing quite the same as using one's imagination to bring about a story that is meaningful, inspiring, yet still enjoyable for the reader.

Is there something you believe SAMA could be doing more effectively?

SAMA is already doing a grand job. No other association in South Africa endeavours to cater for medical professionals as well as SAMA does. I have had the pleasure of attending the 2014 SEDASA AGM, and witnessed a group of passionate doctors who have committed their lives to bringing about a great level of care. The reason I stick with SAMA is because it is such a rich source of professional, highly dedicated people. They should keep up the good work and continue to grow.

Where can people buy your book?

They can pick it up at all good bookshops countrywide. It is also available via Amazon



Choices is a new collection of short stories by SEDASA's Dr Lehlohonolo Makhakhe

and Exclusive Books as an ebook. Alternatively, a signed copy of the book can be obtained via the website www.choicesthebook.co.za.

SAMA raises concerns about new sections in the National Health Act

Dr Mzukisi Grootboom, *Chairperson, SAMA*

Sections 36 - 40 of the National Health Act 2003 came into effect on 1 April 2014 when the President passed a proclamation. These sections relate to the requirement that will now be imposed on all 'health establishments' (which, by definition, include private medical practices) and 'health agencies', to be in possession of a Certificate of Need in order to operate.

Section 36 prescribes the process and requirements for an application to the Director General of Health to obtain a Certificate of Need, as well as the requirements to renew the licence.

Section 36(1)(d) provides a 'grace period' of two years (from 1 April 2014) to obtain the Certificate of Need in order to continue with the operation of a health establishment. In the absence of any regulations published in terms of section 39, and given the public participation requirement in issuing new

regulations, it is submitted that this two-year period is not feasible.

Section 37 provides that a Certificate of Need issued in terms of section 36 may be valid for a period not exceeding 20 years. Section 38 provides for an appeal mechanism that is available for a person aggrieved by a decision taken by the Director General. Such an appeal must be directed to the Minister of Health.

At this stage, no such regulations or draft regulations have been published. Section 39(1)(b) does leave a 'door open' to allow for a 'grandfather clause' which may exempt existing health establishments. However, there is no guarantee that this will occur. The Minister of Health is not obliged to make any regulations. In terms of section 40, it is a criminal offence to operate a health establishment without a Certificate of Need. The offence is punishable by a fine and/or up to five years imprisonment.

SAMA has a number of serious concerns regarding the implications of this legislation. It can be questioned whether the unfettered control afforded to the Director General of Health over the health industry in respect of this 'licensing requirement' for health establishments is a justifiable limitation on the economic and professional rights of medical professionals.

It can also be argued that the imposition of such an administrative burden, together with the anticipated bureaucratic challenges that may ensue in the processing of applications and issuing of Certificates of Need may ultimately serve to create yet another barrier to the access to healthcare by the South African public.

SAMA is considering options to address these concerns. We are open to partnering with other affected parties in the industry to find solutions and, if necessary, to take action in ensuring that the rendering of healthcare to all South Africans is not impeded.

Dear CPD client,

We wish to take this opportunity to thank you for your continued support through the completion of our online CPD questionnaires as well as to share some exciting news with you. HMPG's journal CPD questionnaires will be moving to the Medical Practice Consulting (MPC) CPD platform (www.mpconsulting.co.za) as part of a strategy to consolidate all South African Medical Association (SAMA) members' CPD certificates and history.

All SAMA CPD certificates (whether for annual conferences, branch meetings or workshops) are already available online on the MPC CPD platform and moving all active HMPG online CPD questionnaires to the same platform will mean that all SAMA member CPD certificates will be issued in one central, convenient location – resulting in less admin for our CPD clients.

An additional benefit is that the MPC CPD manager can complete your IAR form on your behalf (no more countless hours of reconciling CPD records before a compliance audit) and submit your CPD history to the HPCSA once you have approved it and are happy with the results. All that is required of you, when you are ready, is to click a single button to submit your CPD Activity Record to the HPCSA. Nothing will, of course, ever be submitted without your prior approval and consent.

The MPC system also adds additional functionality to the CPD questionnaires and the system has been set up to make the process as easy to follow as possible.

The South African Medical Association (SAMA) board has concluded that the CPD services associated with the *South African Medical Journal* (incorporating Continuing Medical Education) and the *South African Journal of Bioethics and Law* will only be offered to registered and fully paid-up SAMA members, as per the SAMA member benefit schedule; therefore, you will be required to register a profile on the MPC CPD system (if you do not already have one – if you already have one, login as usual) and to supply your SAMA membership number. You will be required to do this only once. Your membership will be validated in real-time and you will be able to access the journal CPD questionnaires. This once-off registration should not take more than 2 minutes and you will be on your way to completing the CPD questionnaires.

Below are some questions and answers that will assist you in getting started.

When will the CPD questionnaires move to MPC?

All HMPG-issued journal CPD questionnaires will move to the MPC CPD platform from February 2014 onwards. This will include all prior CPD questionnaires that are still active.

What website do I access to complete the HMPG questionnaires?

www.mpconsulting.co.za

Who is MPC?

Medical Practice Consulting (MPC) is a group company of SAMA. MPC has historically hosted CPD at SAMA's annual conferences, issued all SAMA member CPD certificates and has hosted SAMA's online branch elections. By moving active HMPG journal CPD questionnaires to the MPC system, SAMA members will have all their CPD certificates in one central, convenient location. MPC has also been supplying the Foundation for Professional Development distance learning courses online for the last 2 years and has hosted some of the largest online training initiatives in the South African healthcare industry.

What do I need to register a profile on the MPC CPD system?

MPC does not retain any confidential information on their database, so you will not be requested to share your telephone number, practice or home address. All that is required for registration is your name, surname, specialty, SAMA membership number and HPCSA number (which is included on your CPD certificate to comply with HPCSA CPD requirements).

How long will registration take?

Completing registration should take no longer than 2 minutes – please remember to have your HPCSA (MP Number) and SAMA membership number at hand.

What about my historic CPD certificates on the www.cpdjournals.co.za website?

If you register on the MPC CPD platform with the same email address as you were using on the www.cpdjournals.co.za website, MPC will import all your CPD certificates for the last 36 months into your MPC CPD manager for you. Alternatively you can still login to www.cpdjournals.co.za and save any CPD certificates that are still valid (remember that CEUs have a 24-month shelf life and expire after 24 months).

What happens if I run into technical difficulties?

Simply complete an online contact form and MPC will assist you with your technical problem. If your SAMA number for some reason does not match that in the SAMA membership database, MPC will assist with rectifying the problem. MPC's contact details are available online: www.mpconsulting.co.za/contact-us

Sincerely,
Gert Steyn
CEO, Health and Medical Publishing Group (HMPG)

Risk Management in medical practice and hospitals

This article on non-clinical attributes is the fifth part of the article first published in the February edition of *SAMA Insider*.

Non-clinical attributes

While a combination of safety-aware systems and good clinical skills will go a long way towards creating a safe service for your patients, there is a third crucial component that glues it all together. This sphere of practice is commonly referred to as non-technical skills and is defined as: "The cognitive, social and personal resource skills that complement technical skills and contribute to safe and efficient task performance". While much of the research carried out to date on non-technical skills for clinicians has focused on high-risk specialties, generic attributes such as good communication skills and the ability to reflect and learn are applicable in any healthcare setting.

Communicating with patients

The patient's agenda

- Ideas, concerns, expectations (ICE)
- Feelings, thoughts, effects
- Understanding of his/her feelings

The doctor's agenda

- Signs and symptoms
- Investigations
- Differential diagnosis

As the above illustrates, patients and doctors tend to approach the consultation with markedly different agendas – a situation that can easily lead to misunderstandings, frustration and disappointment unless the needs of each party are met.

Most experts in the art of communication with patients agree that it is important to find out what the patient's ideas, concerns and expectations are (ICE). Patients hold all sorts of beliefs – about the nature of illness, about their bodies and about treatments – about which their doctors are often blithely unaware. These hidden attitudes and beliefs may determine the degree to which they comply with treatment. In the UK, for example, it has been estimated that between 30% and 50% of patients do not take their prescribed medicine as recommended and, very often, the prescribing doctor is completely unaware of the fact. Patients may also have unrealistic expectations about the outcome of treatment.

If there is little chance of returning a patient to full health without any residual problems, you should discuss these limitations openly so that the patient is spared the experience of disappointed hopes (or at least experiences them early enough to come to terms with the news while treatment is still ongoing). Quite apart from your professional obligation to obtain informed consent to treatment, preparing patients for less than optimal outcomes is not only humane but also an effective risk management measure. Angry, disappointed patients are far more likely to sue when the outcome of clinical care fails to meet their expectations.

Patients and doctors tend to approach the consultation with markedly different agendas – a situation that can easily lead to misunderstandings, frustration and disappointment unless the needs of each party are met

Taking time to listen

An often-quoted study from the 1980s, in which researchers observed GP consultations, found that doctors were interrupting patients an average of 18 seconds into a consultation. A second, and larger, study carried out 12 years later by Marvel *et al.* found that the mean time before the patient was 'redirected' by the doctor was 23.1 seconds. Most of the redirections occurred after the patient had expressed their first concern, and this then became the focus of the ensuing consultation regardless of whether the patient considered it the most important of the concerns he/she wished to raise. Once the discussion became

focused on a specific concern, the likelihood of returning to complete the agenda was very low (8%). Apart from the obvious risk of missing important and relevant information, when consultations are conducted along these lines they often take longer than they need to. Assume that each patient attends the consultation armed with at least three concerns that they want to address (research indicates that this is about right). Most people will rehearse in their heads what they want to tell you, and the order in which they want to tell it – i.e. they have an agenda. If you interrupt that agenda, or divert them from it, the likelihood is that they will, in attempting to deliver the rehearsed story, start repeating themselves, forcing you back over ground already covered.

It is also likely that the first concern mentioned is inconsequential compared to the others, and if you seize on it as the reason for the consultation, you will be using up valuable time that could be better used exploring the real problem. It may seem risky just to let the patient talk until he/she runs out of steam, but in fact Marvel *et al.* found that when patients with one or more concerns were given the opportunity to give a full account at the outset of the consultation, the time taken averaged only 32 seconds.

Marvel *et al.* concluded that: "Given the relatively small proportion of the interview needed to clarify the patient's concerns, the related decreased likelihood of late-arising concerns and the difficulty of exploring new concerns late in the visit, the data supports complete agenda setting as an efficient manner to open the medical encounter.

"Despite concern that a patient-centered approach will take more time, our study further reinforces that soliciting all of the patient's concerns does not decrease efficiency. Using a simple opening solicitation, such as 'what concerns do you have?', then asking 'anything else?' repeatedly until a complete agenda has been identified appears to take six seconds longer than interviews in which the patient's agenda is interrupted.

"One style that seemed useful was to follow each open-ended solicitation with a focused open-ended question (e.g. 'tell me more about the leg pain'), then revert back to another open-ended solicitation (e.g. 'anything else?') before moving into closed-ended questioning and the examination."

Active listening skills

- Open-ended questions – questions that cannot be answered in one word and require the patient to expand.
- Open-to-closed cones – move towards closed questions at the end of a section of the consultation.
- Checking – repeat back to the patient to ensure that you have understood.
- Facilitation – encourage the patient both verbally ("go on") and non-verbally (nodding).
- Legitimising patient's feelings: "This is clearly worrying you a great deal, " followed by, "You have an awful lot to cope with," or, "I think most people would feel the same way."
- Surveying the field – repeated signals that further details are wanted: "Is there anything else?"
- Empathic comments – "This is clearly worrying you a great deal."
- Offering support – "I am worried about you, and I want to know how I can help you best with this problem."
- Negotiating priorities – if there are several problems, draw up a list and negotiate which to deal with first.
- Summarising – check what was reported and use as a link to the next part of the interview. This helps to develop a shared understanding of the problems and to control the flow of the interview if there is too much information.

(Gask and Usherwood, *ABC of psychological medicine: the consultation*, *BMJ* 324 (2002) 1567-8).

General advice about communicating with patients

When you are discharging patients from your care, tell them about arrangements you have made for follow-up care and give them appropriate advice about what to do if symptoms recur.

- Patients who are kept informed about their condition and involved in deciding on the appropriate treatment are more likely to comply with the treatment you suggest, and less likely to complain if things go wrong.
- It is particularly important that you tell patients about the possible side-effects of the drugs or treatment you are ordering, and that they know what complications to look out for and what to do if they develop.
- Warn patients about the risks before carrying out any procedures or prescribing medication.

- When you are discharging patients from your care, tell them about arrangements you have made for follow-up care and give them appropriate advice about what to do if symptoms recur or complications develop. If they are receiving long-term therapy, tell them when to return for review and what symptoms or signs of adverse effects or changes in their condition to report. If possible, give them an indication of when they might expect to see an improvement in their condition, and when to seek medical advice if no progress is made within a certain timescale.
- Document any advice you have given the patient. It is useful to document in the record any supporting literature or written information given to the patient.

Even though we all know that to err is human, few of us can easily accept our own mistakes

If things go wrong

Even though we all know that to err is human, few of us can easily accept our own mistakes. This is probably more the case in healthcare than in most other occupations, because errors can have such serious consequences. In a survey of Medical Protection Society (MPS) members who had experienced untoward incidents in their practice, almost all of them found that it shook their confidence and eroded their job satisfaction. Complaints from patients tended to be taken as personal attacks, with the doctor feeling angry, hurt and betrayed. Some of these effects lasted for years. The intensity and duration of the emotional aftermath does not seem to relate closely to the seriousness of the error or the nature of the complaint; the crucial factor is the ability of the individual doctor to put the experience into perspective and seek out practical and emotional support.

Lessons to be drawn from this

- Assess the circumstances realistically. Do not blow an error or a complaint out of all

proportion; remind yourself of all the things you do get right and all the patients who are satisfied with your care.

- Talk the matter through with trusted colleagues and friends who can both empathise with you and give you a realistic assessment of the situation.
- Contact the MPS for practical assistance in dealing with a complaint or claim and for advice about handling the emotional repercussions.
- Learn from the situation. If you did make a mistake, acknowledge it. Report it as an adverse incident and engage with your colleagues in developing strategies to prevent similar errors occurring in the future.
- If you have been unjustly accused of substandard care, think what may have brought the accusation about – was it a communication problem, for example? How might you have handled it differently?
- If a patient has complained about you, try not to react defensively by avoiding the issue or making counter-threats. The hospital will handle the complaint, but you should be prepared, if it turns out that you have made a mistake, to give the patient their due – a full face-to-face explanation, a sincere apology and an assurance that you will take steps to avoid a repetition of the problem.
- If, after the complaint has been investigated, it is evident that the complaint has no foundation, you might still consider seeing the patient to explain the outcome of the investigation, give a full account of events and try to ascertain whether the complaint has been caused by a misunderstanding that you can put straight.

Patients expect a great deal from their doctors, not least of which are superhuman abilities. This means that you are almost certain to disappoint some of your patients some of the time. All you can hope to do in the circumstances is to try to turn negative experiences into positive learning opportunities, thus refining your skills and building, rather than eroding, your confidence.

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

The Road Accident Fund and the medical profession

Dr M J Oosthuizen

Let's be honest. The Road Accident Fund (RAF) does not necessarily have the best reputation among the medical fraternity. Whether you work in the private or public sector, the general sentiment is that the RAF is an organisation that is best avoided if possible. If you have to work with them, you had better prepare yourself for an arduous journey, because following the treatment of a victim of a motor vehicle accident (MVA) or a pedestrian vehicle accident (PVA), the road to reimbursement is usually paved with mounds of required paperwork, patient information and delays in payment from the RAF.

But perhaps this view is about to change. After all the RAF was originally established by the Department of Health (DoH) not only to assist victims of MVAs and PVAs, but to ensure fair remuneration for the medical professionals who provide care to these victims.

Since January 2014, the RAF has embarked on a project to try to improve its relationship with the medical fraternity as represented by SAMA. Through a series of interviews and site visits, a systematic analysis has been done to identify the major problems that hamper collaboration between the medical profession and the RAF. The general consensus reached was that before the RAF could embark on a public relations campaign to court the profession, it needs to first address the concerns of the profession around the centralised claim processing system. Ideally this will lead to better relations between the two parties to the benefit of the victims of MVAs and PVAs.

SAMA has been engaging with the RAF to help identify the major problem areas. These include the following key areas identified for improvement. At the RAF level it was noted that the most important issues that need to be addressed are the following:

- **Improve turnaround time of processing claims:** Ensure that all claims are paid within 90 days of submission.
- **Review the base tariff system:** Amend the current base tariff system so that it is competitive with tariffs charged by private medical aids.
- **Allow the electronic tracking of claims:** Enable the electronic tracking of claims from submission to payment, by making use of a specific incident number that identifies a specific case/claim – allowing medical practices to track the processing of RAF claims.

- **Improve on the clarity of the undertaking certificate (slip):** This will entail the RAF improving their undertaking certificate that they issue to authorise treatment for accident victims. The certificate specifies which conditions are being covered and linked to ICD10 codes.

As with all negotiations, there is a required *quid pro quo* from the profession. SAMA and FPD have agreed to work with the medical practitioner community to address service provider issues identified by the RAF that delay payment of RAF claims. These include:

- Incorrect completion of the RAF2 form and non-submission of basic supporting documents such as clinical notes, invoices, etc.
- Lack of understanding of the base tariff system used by the RAF to pay supplier claims.
- Removing the obligation on medical practitioners to submit the Officers Accident Report (OAR) as a supporting document. Currently, in order to submit an OAR, the supplier needs to source it from the police station where the accident was reported.
- Unwillingness by government hospitals to submit claims for services provided at public sector facilities given that such claims are paid over to the Treasury rather than the facility.

To address these supply-side problems, the following solutions are proposed, to which SAMA, FPD and the RAF seem amenable:

- **The implementation of an Incident Number System:** This would involve the creation by the RAF of a generic code or incident number that can be used on all documents relating to a specific case. It has been suggested that we use the SAMA membership portal as the access portal to RAF data such as the incident number and claim-related information, using the specific incident number. Doctors will, however, have to get consent from their patients to access this information.
- **Remove the onus from suppliers to provide OARs:** The RAF will pursue a change of policy that will require the SAPS to submit OARs using the Incident Number System, rather than the medical practitioner.
- **Provide state hospitals with a yearly finalised claims report:** The report will enable hospital administrators to see the total finalised supplier claims paid out, and

allow them to reconcile the payments with their records. The individual hospitals can then claim this money from the provincial DoH account. Hopefully this will provide incentive for government hospitals to submit better quality supplier claims.

- In order to improve the medical profession's knowledge of the RAF and its procedures, educational material will be provided in the form of journal articles, mini-workshops and online CPD courses by FPD and SAMA. These will address the following points:
 - Electronic submission and tracking of a claim.
 - How to complete the RAF2 form.
 - The reviewed RAF base tariff system and the process involved in apportioning funds to a claim.
 - The new format of the undertaking certificate.
 - The function of the undertaking certificates and pre-authorisations.
 - The incident number system.

Although we are in the early stage of addressing these problems indications are positive that the RAF is serious about resolving the problems identified by SAMA.

Definitions

Supplier claims: The claims submitted by a supplier of services to the RAF for remuneration in the form of the RAF2 form and accompanying documents. Please note this does not include undertakings.

Undertakings: The RAF identifies patients who need further care after initial treatment. The RAF undertakes to provide remuneration for the cost of care. An undertaking functions in one of two ways: 1) undertaking certificate or 2) pre-authorisation service.

Undertaking certificate: A document issued by the RAF to a victim who requires further care for injuries sustained during an MVA. The undertaking certificate is provided to the supplier of services as surety that the RAF will cover expenses for the treatment of a specific injury.

Pre-authorisation: Similar function to a medical aid pre-authorisation service.

OARs: Officer's Accident Report

RAF2 Form: A form completed by a supplier when lodging a claim for services rendered by the RAF.

Common can be complicated

The Medical Protection Society shares a case report from their files

Miss G, 11 years old, was taken by her mother to see General Practitioner Dr A with coryzal symptoms and a discharging right ear. She appeared quite well during the consultation, so Dr A advised symptom control measures for otitis media and advised she return for review in a week.

A week later, the patient was feeling worse, complaining of earache and neck stiffness and a poor appetite. Dr A reviewed her as planned and documented a negative Kernig's sign, with no evidence of photophobia or rash. He prescribed antibiotics and reassured her that she should recover soon – but that she should return again if she became any worse.

Miss G continued to deteriorate over the next few days, prompting her mother to call the clinic. She spoke to a locum, explaining that her daughter had no energy and had developed problems with her vision. The locum told her not to worry and reassured her that these symptoms were consistent with glandular fever, and to come for a review if symptoms persisted after a week.

Four days later, the patient's mother called the surgery to request an emergency appointment and again spoke to the locum. She was informed that there were no appointments available until the following afternoon. Neither of these telephone consultations were documented in the case notes.

The following day, Miss G attended her emergency appointment with Dr A. Her mother explained that she had been getting worse all week and at one point experienced temporary loss of vision. Dr A noted she had an unsteady gait when she entered the clinic, and on examination had fixed pupils with marked papilloedema. He arranged immediate admission to hospital.

The paediatric team documented palsy of cranial nerves three, four, six and seven with gross papilloedema, and arranged urgent imaging. This confirmed a cerebral sinus venous thrombosis and a middle ear infection with a right mastoiditis. She was transferred to the neurosurgical unit for thrombolysis, CSF drainage and acetazolamide, and discharged a month later.

The family lodged a negligence claim against Dr A, stating that he failed to refer for urgent investigation following their second consultation. They asserted that had Miss G



received earlier treatment, she would not have suffered from reduced visual acuity or frequent headaches.

Expert opinion agreed that, based on Dr A's account of events and the subsequent notes made by the hospital regarding the onset of visual symptoms, he performed an appropriate examination and provided a reasonable standard of care during his second consultation.

However, it was evident from the course of events that Miss G did deteriorate and the emerging visual symptoms allegedly reported to the locum did demand an urgent assessment. Failure to arrange immediate review fell below a reasonable standard of care and Dr A and his practice carried vicarious liability for this error.

Miss G's family alleged she was unable to use public transport unaccompanied due to her persistent symptoms, which would hinder future employment prospects. The Medical Protection Society's legal team made use of video surveillance in this case, which provided evidence that Miss G appeared very comfortable using public transport independently. This reduced the final settlement offer significantly, although the case was still settled for a substantial amount.

Learning points

- The importance of documenting every consultation, including telephone consultations, is highlighted once again with this case. Disciplined documentation of every clinical encounter means that when a claim or complaint arises, you can feel more

confident defending your position.

- A reminder regarding telephone consultations is that arrangements should be made for face-to-face review if any concerns are raised regarding a patient's clinical condition.

- A patient who develops new symptoms should be reassessed and the diagnosis reviewed. In this case the nurse should not have made a new diagnosis of glandular fever over the telephone without arranging for the patient to be seen.

- This case is a reminder that common ailments can develop rare complications. The majority of cases of otitis media seen in general practice will resolve without complications; however, health professionals should remain vigilant to the possibility of disease progression. Safety netting measures protect you and your patient.

- Asking the patient to attend for a review is an important safety net to put in place, but it is important to be able to follow this up. Lack of available GP appointments means that clinical staff are often in the position of triaging patients without seeing them in person, which can lead to a deteriorating patient being overlooked. Clinical staff should be trained to spot red flags and be aware of developing symptoms that require immediate review.

- Mastoiditis is now relatively rare. The incidence of the condition following acute otitis media reduced from 50% to 0.4% following the introduction of antibiotics. Prior to this, mortality rates were 2 per 100 000 compared to <0.01 per 100 000.

2014 photography competition – entries now open

Zukiswa Nomnganga

The South African Medical Association (SAMA) and Medical Protection Society (MPS) are pleased to announce that the entries for the 2014 photography competition are now open to all members of both organisations, irrespective of speciality in the medical fraternity.

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

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

This year, we would like to continue with the same theme, adding a category on the

community health programmes or activities that our members are often involved in but which are rarely recognised or captured. The themes are as follows:

- Work environment
- Emotions
- Community health

Capture every moment

This is a long-standing initiative for both SAMA and MPS, and has been well received by its members. We anticipate drawing an even bigger number of entries this year and are happy to announce that some of the entries

received will be auctioned, with the returns awarded to two charity organisations.

All entries will be displayed at the 2014 SAMA Conference and winning entries will be published in the SAMA and MPS magazines.

The competition is open to all SAMA and MPS members in good standing.

The deadline for all entries is 30 July 2014. Winners will be announced in August.

SAMA/MPS photography competition entries are featured on the cover of *SAMA Insider*.

To enter the competition and for more information, please go to the SAMA website or directly to the competition link: <https://www.samedical.org/sama-photography-competition-2014.html>



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