

SAMA INSIDER

JULY 2014

**National
Council 2014**

**Foreign
qualified doctors**

**Is the
Certificate
of Need
constitutional?**



**SOUTH AFRICAN
MEDICAL ASSOCIATION**

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EDITOR'S NOTE JULY 2014



Conrad Strydom
Editor: SAMA INSIDER

Your red tape will arrive shortly, sir

Which industry is more closely regulated – healthcare or nuclear power? Most doctors already know the answer to that. As soon as they leave medical school practitioners learn to deal with the vast array of regulatory bodies, laws and stipulations that govern everything from patient-doctor interaction to the seemingly infinite number of codes that determine how much doctors may charge their patients. Things are not yet as bizarre in South Africa as they are in Britain, where a top neurosurgeon recently quit after being told not to wear a wristwatch, but the recent implementation of sections 36 to 40 of the National Health Act implies that the state is eager to catch up.

Doctors are now required to apply for a Certificate of Need from the Department of Health (DoH) if they wish to keep practising. The DoH have been known to take actions which few in the healthcare industry support – sometimes this is courageous, but in this case it smacks of an overzealous need to regulate. What's more, the whole thing might be unconstitutional. On pages 13 and 16 we feature the first of a series of articles, authored by Advocate Willem Smit, which examine the constitutional validity of the Certificate of Need – required reading for those who don't fancy more paperwork.

SAMA's recent National Council was a vote of confidence in the present leadership. Dr Mzukisi Grootboom and Dr Mark Sonderup were re-elected to three-year terms as board chairman and vice-chairman respectively. There were minor changes to the makeup of the various board committees, with a greater number of representatives from the SAMA Trade Union being elected. We feature picture-filled coverage of this event on pages 6 to 8. Finally, turn to page 17 for an article about the ever-divisive issue of foreign qualified doctors, courtesy of SAMA's senior legal advisor, Julian Botha.

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Medical ethics, medical professionalism and dual loyalty conflicts



Prof. Ames Dhai, President, SAMA

Recent communication on military medical ethics caught my attention so I felt the need to discuss the meaning of ethics in the healthcare context and look at how this differed from the law. The World Medical Association's (WMA) *Ethics Manual* defines ethics as "a study of morality which involves careful and systematic reflection on and analysis of action and behaviour". Ethics concerns itself with the moral choices made by people and includes the study of right and wrong actions. Morality can be considered as the value dimension of human decision-making and behaviour and includes nouns like 'virtues', 'rights' and 'responsibilities' and adjectives like 'good', 'bad', 'right', 'wrong', 'just' and 'unjust'.

Despite ethics being closely related to the law, ethics and the law are not identical. However, in several countries, including South Africa, ethics is incorporated into some aspects of the law. Ethics, especially in the healthcare context is found in the Bill of Rights of the Constitution, certain Acts of Parliament (e.g. the National Health Act), and regulatory and policy documents which make provision for healthcare practitioners to be punished should their conduct be deemed to be unethical.

Ethical codes in healthcare prescribe the norms to regulate practitioners thereby providing the framework and guidelines for morality in healthcare and practice. The Hippocratic Oath, while more than 2 500 years old, is considered even today as the most fundamental underpinning of the moral values shared by healthcare practitioners.

This is echoed in the WMA's Declaration of Geneva (a modern day version of the Hippocratic Oath) and several other codes and declarations emanating from the WMA.

While to benefit and not to harm is widely accepted as the most enduring legacy of the Hippocratic Oath, the Nuremberg Trials following World War II exposed the atrocities committed by medical practitioners and clearly demonstrated the fact that all practitioners do not abide by the Hippocratic commitment. Hence, professional conscience and responsibility had to be revisited. The body set up to do this was the WMA, a body that the SAMA is affiliated with. The WMA has been especially active in developing ethical norms in the arena of military ethics where practitioners invariably find themselves in dual loyalty conflicts. Dual loyalty conflicts occur when health practitioners have simultaneous obligations to patients and third parties (the state, in the case of the military) and conflicts of obligations arise with the best interests of the patient coming under threat. While health practitioners under such situations may not have a choice in determining their loyalties, medical ethics always puts the interests of the patient over and above any other interests. Hence, when the practitioner elevates the interests of the third party above that of the patient, dual loyalty becomes a problem.

Four WMA policy statements deserve mention:

- Declaration of Geneva: "I will not use my medical knowledge to violate human rights and civil liberties, even under threat."
- International Code of Medical Ethics: "A physician shall be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity".
- Declaration of Tokyo: "The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife."
- Regulations in times of armed conflict: "Medical ethics in times of armed conflict is identical to medical ethics in times

of peace, as stated in the International Code of Medical Ethics of the WMA. If, in performing their professional duty, physicians have conflicting loyalties, their primary obligation is to their patients; in all their professional activities, physicians should adhere to international norms and conventions on human rights, international humanitarian law and WMA declarations on medical ethics."

The WMA defines the profession of medicine as an occupation characterised by dedication to the well-being of others, high moral standards, a body of knowledge and skills and a high level of professional autonomy. The latter would apply especially when facing situations of dual loyalty conflicts. The WMA further states that medical professionalism extends beyond the relationship between a physician and a patient to involve a relationship with society. This is characterised as a social contract.

Medical ethics always puts the interests of the patient over and above any other interests

Within the South African context the HPCSA, whose vision and motto is to guide the professions and protect the public, is the statutory body responsible for setting standards for the ethical and professional conduct of practitioners registered with it. However, practitioners look not only to the HPCSA for ethical guidance but also the SAMA whose standards are benchmarked by the international guidance documents of the WMA. Ethical guidelines are not usually legal documents and while their implementation depends much on the moral orientation and motivation of individual healthcare practitioners, it would be prudent for practitioners to remember their quasi legal standing in terms of their principles being incorporated into country level legal structures.

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- South African Medical Association Continued Professional Development Accreditation
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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's 2014 National Council meeting

Advocate Yolande Lemmer, Company Secretary, SAMA Legal and Governance Department

Following the adoption of its Memorandum of Incorporation and Company Rules on 12 April 2014, SAMA held a successful National Council meeting on 23 – 24 May 2014. The SAMA National Councillors attending the meeting, held at the Southern Sun International Hotel at the OR Tambo Airport, elected the SAMA leadership who will be responsible to carry the Association forward for the next three years. Dr MJ (Mzukisi) Grootboom (KwaZulu-Natal) was re-elected as chairperson and Dr MW (Mark) Sonderup (Western Cape) as vice-chairperson. The term of office of the current president of the Association, Prof A (Ames) Dhai (Gauteng) continues until October 2014, whereafter the presidency will be taken over by Prof EL (Lizo) Mazwai (Eastern Cape), who was elected as president-elect at the meeting.



Dr MJ Grootboom
SAMA Chairperson



Dr MW Sonderup
SAMA Vice-Chairperson



Prof. A Dhai
President



Prof. EL Mazwai
President-Elect

Besides the chairperson and vice-chairperson, the following Professional Affairs Standing Committee chairpersons and Trade Union office-bearers will constitute the SAMA Board of Directors (in alphabetical order):

Dr MR Abbas	Chair: Finance Committee	Dr S Maweya	Chair: Health Policy Committee
Dr Y Baldeo	Chair: Social and Ethics Committee	Dr PC Ramathuba	Trade Union President
Dr ZO Brey	Chair: Audit and Risk Committee	Dr G Reubenson	Chair: Education Science and Technology Committee
Prof. A Dhai	Chair: Human Rights Law and Ethics Committee	Dr S Sham	Trade Union Vice-President (Public Sector) (ex officio)
Dr TE Maleka	Trade Union Vice-President (EDOPS) (ex officio)	Dr MM Stoltz	Chair: Constitutional Matters Committee

The chairpersons of the Specialists Private Practice Committee (SPPC) and General Practitioners Private Practice Committee (GPPPC) are still to be elected and their names will be available shortly.



Dr PC Ramathuba



Dr G Reubenson



Dr S Sham



Dr MM Stoltz



Dr MR Abbas



Dr Y Baldeo



Dr ZO Brey



Dr TE Maleka



Dr S Maweya

SAMA Professional Affairs Standing Committees 2014 – 2017

The following additional members were elected to the various SAMA Professional Affairs Standing Committees, to be chaired by the committee chairs listed below.

Audit and Risk Committee	Constitutional Matters Committee
Chairperson: Dr ZO Brey	Chairperson: Dr MM Stoltz
Members	Members
Dr LJ Mphatswe	Dr BWN Mabaso
Dr WN Goosen	Dr M Van der Schyff
Dr SNE Mazaza	Dr C Mojapelo
Prof. ATO Abdool-Carrim	Dr GJJ Smit
Dr RR Green-Thompson	Dr RJ Tuft
Education Science and Technology Committee	Finance Committee
Chairperson: Dr G Reubenson	Chairperson: Dr MR Abbas
Members	Members
Dr K Spencer	Dr L Mbodi
Prof. DW Steyn	Dr PZM Mbeje
Dr M Naidoo	Dr M Thandrayen
Dr LMB Majake	Dr S Chetty
Dr S Shinta	Dr M Du Plessis
Health Policy Committee	Human Rights Law and Ethics Committee
Chairperson: Dr S Maweya	Chairperson: Prof. A Dhai
Members	Members
Dr KP Tabata	Dr MCE Ati
Dr LM Shange	Dr NJ Masinga
Dr S Sham	Dr A Coetzee
Dr S Toni	Dr J Van Niekerk
Dr DP Menge	Prof. C Grobler

In terms of the Companies Act and by reason of its Public Interest Score, SAMA must have a Social and Ethics Committee. This committee is a new addition to the existing SAMA committee structures.

Social and Ethics Committee

Chairperson: Dr Y Baldeo

Members

Dr I Ntatamala
Dr A Hussain
Dr ZM Bikitsha
Dr A Marais
Dr CM Khoza

National Council Resolution: Certificate of Need:

“That the relevant committees engage with the Department of Health to get clarification on behalf of the profession and that SAMA takes the lead, working with other affected parties in the industry, to find solutions and, if necessary, take action in ensuring that the rights of our members are protected ...”

At the cocktail function Professors DJM Ncayiyana and JP Van Niekerk were honoured for their exceptional contributions to the *South African Medical Journal* and all the other journals published by the Health and Medical Publishing Group (Pty) Ltd (HMPG), a full subsidiary of SAMA, marked by decades of outstanding professional commitment.

The National Council noted a number of reports by outgoing committee chairs. The SAMA Trade Union was congratulated on their excellent progress since the finalisation of

their Trade Union Constitution and leadership in 2013 and the notable difference their activities made in addressing the difficulties of doctors in the public sector.

The SAMA subsidiaries – the Foundation for Professional Development (FPD) and HMPG – performed exceptionally well since the previous National Council meeting in September 2012. To support the execution of its mission and vision (to build a better society through education and development, by catalysing social change through developing

people, strengthening systems and providing innovative solutions) FPD has already secured just over R1 billion in forward funding up to 2018. These funds are being utilised to train students (FPD is an accredited Private Higher Education Institution and 251 290 students have already been trained in FPD courses from 1998 until the end of 2013), and to provide a variety of ancillary educational, research and capacity development benefits in conjunction with its various business partners, sponsors, donors and offices throughout the country.

To name but a few of FPD's commendable achievements since it was founded in 1998 – the value of scholarships provided amounts to over R330 million up to the end of 2013, successful apprenticeship programmes recently launched assist to transition students from academia to the workplace, international and national conferences (for example ICASA and the SA Aids Conference) are successfully organised and supported, research projects to strengthen the academic and research health sector deliver a valuable contribution within the South African health context and capacity development in especially the public sector is enhanced via projects such as the district HSS project, and a PEPFAR USAID programme that supports health system strengthening in nine districts in the country. In partnership with the government, 390 000 patients are being assisted with ART, and 1 743 301 clients received HCT. FPD's national TB/HIV hotline has already received 5 850 calls since its inception. FPD also assisted in placing 2 900 foreign qualified healthcare professionals in South Africa, in partnership with AHP. Other projects FPD is involved in include funding research on reasons for the poor conviction rate in respect of sexual assault, and support to the 'First things first' campaign that provides 100 000 HIV tests at academic campuses. FPD provides scholarships on clinical courses to SAMA members, including free online courses and subsidised workshop courses. They also provide a free fully downloadable app on TB/HIV medicine.

FPD actively supported the turnaround strategy implemented at HMPG by, among others, sponsoring the *AFJPE (African Journal of Health Professions Education)* and sponsoring the new international *Journal on Strengthening Health Services*. HMPG also achieved the nearly impossible – since starting to implement their financial turnaround strategy with the appointment of a CEO to implement such strategy in September 2013, a negative financial result stretching over the previous seven years was turned into a net profit of approximately R1.5 million at the date of the National Council meeting. Although the strategy implemented included drastic cuts in expenses, strategic imperatives implemented created innovative future solutions and a strengthened working relationship between the SAMA subsidiaries, to the benefit of all SAMA members.

The various challenges facing all doctors in the country were also noted with concern and specific issues discussed to establish a way

forward included, among others, the roll-out of NHI and its consequences, and the signing into law of Sections 36 to 40 of the National Health Act, resulting in the 'Certificate of Need' requirements suddenly facing all health

professionals. The SAMA chairperson reiterated SAMA's commitment to visibly and effectively represent its members' interests in all these 'bread and butter issues' that have, or stand to have, a severe impact on their daily lives.



Guests at the National Council cocktail function held on 23 May



Prof. Ames Dhai presented Prof. DJM (Dan) Ncayiyana (top) and Prof. JP Van Niekerk (above) with a token of appreciation for their dedicated services on behalf of HMPG and SAMA.

Superbugs: Are the bugs winning the war?

Sarah van Staden



Professor Guy Richards

People the world over are admitted to hospital for a particular problem and acquire secondary infections there, which can be fatal. In Africa, outbreaks of deadly viruses, such as Ebola and Marburg, are on the increase, causing a rising number of fatalities over the past ten years.

What is happening to our world? Are we in the grips of a global 21st century superbug plague?

These are the questions that Professor Guy Richards and Professor Adriano G Duse have been grappling with for some time.

"Superbugs are micro-organisms, such as viruses and bacteria, which modern medicine is struggling to combat because they are becoming increasingly virulent and resistant to antibiotics or vaccines. At the same time, very few new drugs or vaccines are coming out of the pharmaceutical pipeline," explains Professor Duse, the Head of Clinical Microbiology and Infectious Diseases, School of Pathology in the Faculty of Health Sciences, Wits University.

"We are talking about a crisis where people in ever-greater numbers are no longer responding to the available treatments and the problem is growing, with disastrous consequences. This is largely as a result of the abuse of antibiotics – both their incorrect prescription and over prescription," adds Professor Guy Richards, the Academic Head of the Division of Critical Care in the Faculty of Health Sciences, Wits University, and the Director of the Department of Critical Care at the Charlotte Maxeke Johannesburg Academic Hospital.

In short, antibiotic abuse destroys people's infection-fighting, good bacteria and replaces them with hostile, antibiotic resistant bacteria or superbugs. Which is why, when you accompany Professor Richards on his ward rounds, you immediately notice how strict he is about the administering of antibiotics.

"All doctors, veterinarians and hospitals have to become extremely circumspect about when and for what they prescribe an antibiotic and which antibiotic they prescribe, because we are at the end of the antibiotic era. Pharmaceutical companies are not producing new generations of antibiotics because it is not profitable for them, and we therefore have to make sure that we extend the lifespan of existing antibiotics," he explains.

Professor Richards says that doctors and hospitals that do not pay immediate attention to this are exacerbating the infection crisis in communities and hospitals worldwide. Vets, too, have to play their role, as he explains:

"Antibiotics are used in certain livestock situations as growth stimulants and the overuse of them leads to the growth of resistant superbugs, which are easily passed from animal to person and from person to person, or they make their way into the sewer systems and multiply.

"We are at the end of the antibiotic era"

"The health of humans is inextricably linked to the health of animals and the environment. Addressing the connections between health and the environment requires an urgent expansion of interdisciplinary collaborations and strong political and global will," adds Professor Duse who will be focusing on the challenges posed by agents that cause viral haemorrhagic fevers such as the Ebola and Marburg viruses.

Duse has firsthand experience of people infected by these killer viruses. In December 2012 he was appointed World Health Organization Expert Consultant for the Infection Control Group for the Ebola haemorrhagic fever outbreak response team in Uganda. In April 2014 he was deployed to Liberia to assist with the containment of the Ebola virus outbreak.

"We are seeing an increase in both fatal infections and in infections that used to be



Professor Adrian Duse

curable but are no longer, as well as an increase in hospital-acquired infections or what we call nosocomial infections," continues Professor Richards, who cites the following studies:

The European Prevalence of Infection (EPIC) study demonstrated 21% of patients in ICUs had nosocomial sepsis, the European Study of GN Infection (ESGNI)-007 found an overall infection rate of 9.9% and the ESGNI-008 study found an overall infection rate of 26.8% post-major heart surgery.

"There are more than two million nosocomial infections per year in the United States, with 90 000 deaths and annual hospital costs of US\$ 5.7 billion," says Professor Richards who believes that certain hospital groups and medical aids in South Africa have data on nosocomial infection rates in South Africa which have not been shared with the public.

"Our levels of resistance and infection are possibly higher than the United Kingdom or United States because our infection control practices are not always as specific as they should be," he suggests.

"Every hospital and every ward has a different microbe profile and it is critical to know what bacteria or viruses patients are likely to encounter in each unit, in order to be precise about the type of antibiotics prescribed. This is especially critical in ICU where patients are seriously ill or at risk and their immune systems are often already compromised.

"In addition, hospital staff need to take extreme care to follow anti-infection protocol because infections are all too easily contracted, either intravenously or via other procedures."

New contact details for dispensing queries

SAMA Private Practice Department

Debbie Enslin from the National Convention on Dispensing reports that she has recently been advised that the Licensing Unit at the National Department of Health has set up a new email address to be used for all queries concerning dispensing licences. The email address is dispensepps@health.gov.za.

It is important, for follow up purposes, to maintain a paper trail of all queries submitted until the query has been satisfactorily resolved.

The following salient points must be noted regarding dispensing licenses:

- In terms of an amendment to the existing dispensing license regulations, all dispensing licences issued in terms of regulation 18 remain valid until suspended or revoked by the Director General in terms of Section 22E of the National Health Act.
- However, an annual fee of R200 must be paid. Please note that up until July 2009 the annual fee was R600 per annum. Many

doctors are in arrears with the payment of annual fees as, in the past, an annual invoice or notification of fees due was not sent to dispensing doctors by the National Department of Health. From 2015, annual fees will be payable on or before 28 February, and authorised prescribers will be reminded to pay their annual fees 90 days prior to due date. If a doctor paid a renewal fee of R500 just prior to this amendment and did not have the licence renewed that amount will be credited to his/her account and off-set against future annual fees.

- Dispensing licences which were issued before 1st December 2013 were endorsed with an expiry date. Therefore, the Licensing Unit of the National Department of Health has embarked on a process of contacting authorised prescribers in order to do the following:
 - Verify and update contact details and practice information;

- Advise doctors of the status of their accounts and request payment of any outstanding annual dispensing licence fees; and
- Issue an amended dispensing licence (i.e. one which is not endorsed with an expiry date).
- This process will be done in chronological order, according to the expiry dates of these licences.
- If an authorised provider is not contacted 60 days prior to the expiry of his/her dispensing licence it would be advisable to contact the National Department of Health, preferably by email, in order to ensure that the department has correct contact details.

If no response is received within 10 working days, correspondence may be referred, for follow up, to the National Convention on Dispensing at the following email address: dispensing@mweb.co.za.

HPCSA guilty verdicts

SAMA Private Practice Department

SAMA is publishing this information to make our doctors aware of the Health Professions Council of South Africa (HPCSA) investigations which are based on complaints received from patients. It is a list of claims that have resulted in guilty verdicts at the HPCSA from January to March 2014. This information is a clear indication of matters that often lead to claims at the regulatory body.

1. Claiming for services not rendered/inaccurate accounts

- Claiming for procedures and/or medicine from patients/medical schemes that were not performed/dispensed
- Irregular claims and incorrect tariff codes

2. Failure to provide adequate care

- Failure to recognise and act on complications subsequent to an operation
- Failure to provide adequate post-operative care
- Failure to care for critically ill patients, follow up on test results and attend to ICU patients
- Failure to assess and/or examine patient adequately

- Failure to consider differential diagnosis in pre-operative assessment
- Abandoned patient in care of other attendants
- Did not allow patient to be transported by ambulance
- Did not follow-up patient in another hospital

3. Failure to obtain informed consent

- Failure to obtain:
 - Financial consent for procedures to be performed
 - Disclosure of information regarding the cost/fees to the patient
- Treatment of minor children without consent of parents
- Quotation to patient was for routine surgery and did not indicate that additional charges could apply to unscheduled/emergency procedures

4. Dispensing of inappropriate medication

- Dispensing of inappropriate medication for children under the age of 12 years
- Dispensing expired medicine

5. Breaching patient confidentiality

- Divulging of confidential patient information without the written consent of the patient
- Breached patient confidentiality by faxing test results to the patient's workplace

6. Over-servicing

7. Split-billing

8. Charging of an administration fee

9. Upfront payment before services are rendered

10. Unregistered practitioners as locums

11. Unlicensed research conducted without consent of hospital manager

12. Patient communication

- Failure to communicate with patient in a polite and professional manner
- Communicated with patient in a rude/disrespectful manner which amounted to verbal abuse

13. Sexual harassment

14. Misrepresentation of scope of practice

15. Post-mortem

- Performed inadequate/incomplete post-mortem resulting in incorrect cause of death

16. Correspondence from HPCSA

- Non-response to HPCSA correspondence

Don't stop the ritual, stop the deaths

Dr Mahlane Phalane, General Secretary: SAMA Trade Union

The circumcision ritual is an integral part of many cultures and religions and is a global practice. This ritual is common practice not only among disadvantaged cultures, but also in educated, rich societies. Nelson Mandela, an educated and civilised man by anyone's standards, underwent the traditional Xhosa initiation and circumcision ritual in 1934, when he was 16 years old.

Traditional circumcision needs to be respected and accepted as a sacred cultural ritual. What needs to be condemned is any attempt to reduce this African ritual to a get-rich-quick-scheme at the expense of the health and lives of African children. No young man should lose his life, or any of his organs, because of a custom.

Culture is a complex phenomenon. Cultural anthropologist Edward Tylor defined it as "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by a member of society". This is an evolutionist anthropo-

logical view, which seeks to define culture as something that a human being acquires, not something they are born with. This view makes a strong case for the necessity of cultures to evolve and adapt to changing material conditions. The African traditional circumcision ritual is one of these aspects of culture that must evolve to meet present conditions.

Circumcision may be a mystery to many people, but denouncing it as barbaric or backward is pointless. Franz Fanon argued that "The claim to a national culture in the past [rehabilitates] a nation and serves as a justification for the hope of a future national culture." It is therefore important that traditions be maintained.

However, there can be no excuse for the recent spate of circumcision-related deaths. Complications can and do occur anywhere, but avoidable or preventable complications should never be allowed to happen. Reports have shown that about 30 000 kids undergo the ritual annually, with an average of 31 deaths

per year from 1995 to 2005. In 2013, 50 initiates died in Mpumalanga while 30 deaths were reported in the Eastern Cape. This is a societal challenge that requires us to work together to find sustainable solutions.

We all have a responsibility to ensure that this sacred African ritual is respected and conducted in a safe manner. Fanon said that "the unpreparedness of the educated classes, the lack of practical links between them and the people, their laziness, and ... their cowardice at [decisive moments] of the struggle will give rise to tragic mishaps." As a medical profession, we want to respond to this quote by joining traditional leaders at their traditional circumcision schools to prevent tragic mishaps.

We call on traditional leaders to lead with vision, traditional circumcision school principals to conduct themselves with honour and parents to be responsible and active participants in the entire ritual. The state, meanwhile, must regulate and support the custom and not seek to remove it.

Industry-wide short term insurance increases

The Professional Provident Society (PPS)

In 2013, South Africa experienced the worst hail damage in 40 years, totalling 60% of the approximately R2.5 billion insured damage last year according to the KPMG Short Term Insurance Industry update. The increase in natural disasters, coupled with the weakening rand and a rise in motor accidents, has dealt heavy blows to the insurance industry over the past 12 months – all contributing to above-average premium increases across the short-term insurance industry in 2014.

This is according to Nazeer Hoosen, executive director: PPS Short-Term Insurance, who says that the catastrophic events that hit South Africa over the past few years, starting with the fires in St Francis Bay and Hermanus in 2012 and the extreme weather that hit the country late in 2013, have added to the industry wide premium increases this year.

"The reality is that this hasn't only affected PPS, the entire short-term market has undergone a number of premium increases – with many increasing the premiums around the 15% mark," he says.

He adds that not even actuarial analysis was able to predict another natural catastrophic event in 2013 after what happened in 2012. "The chances of something happening were really minimal and this left local insurers exposed. With the market being under-priced in order to remain competitive any major disaster would have had a direct impact on the industry, which is exactly what happened." Coupled with the depreciation of the rand, this meant that import prices went up on top of this, resulting in the increased cost to repair and replace imported goods.

"Unfortunately, the challenge that we are facing is that the loss ratio on the book of business is at a level that is not sustainable and any other underwriter would not be prepared to take on the risk at the previous premium levels," he adds.

In the case of the premium increases that PPS has had to introduce in 2014, member's individual loss ratios were taken into consideration when these were implemented. "At the time that this took place, all members were informed about the increase

and, where necessary, PPS even facilitated alternative options for members through another underwriter," points out Hoosen.

Hoosen reaffirms that PPS, as a mutual company, does not have profit as a motive but rather to ensure that members enjoy a sustainable premium. "This would need to be a premium that would be able to withstand the loss ratios and we have worked closely with the underwriter to minimise any ambitious profit expectations that they might have had."

"While the insurance market continues to try its best to ensure its members do not receive a hefty increase year-on-year, it is important to understand that there are very valid reasons behind the hardening of the market and the resulting premium increases," he says.

"Consumers should start incorporating possible premium increases into their budget plans to ensure they can afford to protect their possessions against theft, loss or damage. Failure to have adequate insurance cover can result in hefty financial repercussions in the long term," concludes Hoosen.

An update on ICD-10 coding

SAMA Private Practice Department

In order to ensure consistent ICD-10 coding throughout South Africa, the Department of Health (DoH) publishes the ICD-10 Master Industry Table for South Africa (MIT) from time to time.

The MIT is specifically created to ensure that:

- All health industry role players have easy access to a locally applicable set of codes;
- The integrity of the ICD-10 coding system can be maintained at a central point; and
- The list can simply and easily be incorporated into any software or paper-based system for coding of claims for submission, as well as for adjudication of those claims from a medical schemes perspective.

The 2014 ICD-10 MIT implementation date was 1 January 2014.

A list of added and deleted codes have been compiled and published on the DoH website (www.doh.gov.za) to help healthcare stakeholders update older versions of ICD-10 Coding manuals, in-house browsers and ICD-10 search engines.

The list could also be used as an additional reference to existing ICD-10 manuals to ensure that the codes used comply with the industry standards when submitted on claims.

Healthcare funders have been asked to send warning messages to providers of healthcare from 1 June 2013 informing them that ICD-10 phases 3 and 4.1 will be implemented on 1 July 2014.

The implementation of phase 3 and phase 4.1

Phase 3 implementation commenced on 1 January 2006. During phase 3 implementation, all healthcare providers are required to submit claims and assign codes to health records with complete codes (third, fourth or fifth character codes, as appropriate). The validation of all primary and secondary codes as well as the validation of combination coding rules is required during this phase. All injury and poisoning codes must be accompanied by external cause codes.

All outstanding phase 3 validations will commence on 1 July 2014.

All providers must apply the following by 1 July 2014 in order to comply with the

phase 3 requirements. The phase 3 validation requires a scheme/administrator to apply the following validation on ICD-10 codes received on claims:

- All ICD-10 codes must be valid as per the MIT
- The primary ICD-10 code must be valid for use in the primary position as indicated on the MIT (clinical validation will be part of phase 4)
- The secondary ICD-10 code(s) must be a valid secondary ICD-10 code(s) as per the MIT
- The correct / maximum level of specificity for every primary and secondary code(s), i.e. the code must be valid at a 3, 4 or 5 character level as per the MIT

At the ICD-10 task team meetings held on the 3 April 2014, a concern was noted relating to the impact that the ICD-10 age and gender edits will have on paediatrician claims

- Chapter XIX (S & T codes) codes must have external cause codes as secondary codes up to the full level of specificity
- Rejections can be expected if external cause, asterisks, sequelae and non-clinically valid codes are reported in the primary position

Implementation of ICD-10 phase 4.1 will commence on 1 July 2014

- Implementation of gender edits as per volume two of the WHO manual.

- Implementation of age edits where it is included in the ICD-10 code or information in volume one (tabular listing) of the WHO manual.

At the ICD-10 task team meetings held on the 3 April 2014, a concern was noted relating to the impact that the ICD-10 age and gender edits will have on paediatrician claims (practice types 32 and 33) on 1 July 2014's go-live of phase 4.1 for ICD-10 clinical validation. Warning message statistics from schemes indicate that this provider group will experience a high rate of claim rejections, based not on clinical inaccuracies, but on the administrative process of billing paediatric services on the maternal account, until such time that newborns are registered and can be identified and billed for as separate entities.

Based on this motivation, the task team has agreed to defer the validation and rejection of paediatrician claims (practice types 32 and 33) for the ICD-10 age and gender edits from 1 July 2014.

A process will be established to engage with this provider group to better understand their claims administration processes in order to resolve this issue towards compliance with the required Phase 4.1 clinical validations.

For more information, read the 'Notification on implementation of ICD-10 phase 3 and phase 4.1' as published on the National Department of Health website at <http://www.health.gov.za/icddoc.php>

Implementation of ICD-O (morphology codes)

The implementation of ICD-O (morphology codes) will not be implemented on 1 July 2014. The implementation date has been postponed and the new implementation date will be communicated.

The morphology code records the kind of tumour that has developed and how it behaves. This means that morphology codes will need to be supplied with all chapter two (neoplasm) codes of the tabular listing in volume one of WHO ICD-10 books, where surgery has been performed or where pathology/laboratory investigations have been done to confirm the underlying cell type of the neoplasm.

The Certificate of Need – is it constitutional?

Advocate Willem Smit

This is part one of a series of articles dealing with newly operational sections of the National Health Act that require health practitioners and establishments to apply for a 'Certificate of Need' from the Department of Health. Health practitioners and establishments who do not have a Certificate of Need will not be allowed to practice medicine. In these articles, Advocate Smit will examine whether the Certificate of Need infringes the constitutional rights of healthcare practitioners and patients.

On 21 March 2014, in terms of section 94 of the National Health Act, the President determined 1 April 2014 as the date on which Sections 36, 37, 38, 39 and 40 of the National Health Act will come into operation.

Section 36 stipulates the following:

"A person may not–

- establish, construct, modify or acquire a health establishment or health agency;
- increase the number of beds in, or acquire prescribed health technology at, a health establishment or health agency;
- provide prescribed health services; or
- continue to operate a health establishment or health agency after the expiration of 24 months from the date this Act took effect, without being in possession of a Certificate of Need."

Every 'health agency', 'healthcare provider' and 'health establishment', as defined under the National Health Act, is obliged to apply for a 'Certificate of Need' from the Director General and must pay an application fee for permission to continue with the delivery of 'health services' before 1 April 2016.

The National Health Act 61 of 2003 was passed by Parliament to implement the right of everyone to have access to healthcare services. This right is guaranteed by section 27 of the South African Constitution, which places express obligations on the state to progressively realise socio-economic rights, including access to healthcare, by making use of reasonable legislative and other measures to achieve the progressive realisation of the rights enshrined under Section 27 of the Constitution.

Persons (healthcare providers) registered in terms of the Health Professions Act have exercised their freedom of choice concerning their "Freedom of trade, occupation and profession" as enshrined under section 22 of the Constitution, which stipulates that every citizen has the right to choose their

trade, occupation or profession freely. It also stipulates that the practice of a trade, occupation or profession may be regulated by law.

The potentially wide scope of section 26(1) under South Africa's previous Constitution of 1993, which was subjected to a complex internal limiter contained in s 26 (2)11, has been replaced by a narrower formulation of section 22 in South Africa's latest Constitution which is based more closely on comparative precedent.

As in South Africa, the German Basic Law provides that all Germans have the right to freely choose their trade or profession, although the practice thereof may be regulated by law. Past litigation based upon these sections of German law may afford some guidance to the scope of section 22 of the Constitution. In the German Pharmacy Case 7BVerfGE 377 (1958) the facts were as follows:

"Bavaria restricted the number of pharmacies licensed in any given community. The state's Apothecary Act provided for the issue of additional licences only if the new pharmacies would be commercially viable and cause no economic harm to nearby competitors. In 1955 Bavaria invoked this statute to deny a licence to a person who had recently migrated from East Germany where he had been a licensed pharmacist. The aggrieved applicant filed a constitutional complaint against the decision of the Bavarian government and the statutory provision under which the action was taken.

"The court found against the applicant but in so doing set out the following principles: For it is clear from the text of article 12(1) that occupational choice is to remain 'free' while the practice of an occupation may be regulated. This language does not permit an interpretation that assumes an equal degree of legislative control over each of these aspects'.

"The more legislation affects the choice of a profession, the more limited is the

regulatory power. This interpretation accords with the basic concepts of the Constitution and the image of man founded on those concepts. The choice of an occupation is an act of self-determination, of the free will of the individual; it must be protected as much as possible from state encroachment. In practising an occupation, however, the individual immediately affects the life of society; this aspect of [vocational activity] is subject to regulation in the interest of others and of society.

"The legislature is thus empowered to make regulations affecting either the choice or the practice of a profession. The more a regulatory power is directed to the choice of a profession, the narrower are its limits; the more it is directed to the practice of a profession, the broader are its limits.

"(c) . . . The general principles governing the regulation of vocational activity may be summarised as follows:

"The practice of an occupation may be restricted by reasonable regulations, predicated on considerations of the common good.

"The freedom to choose an occupation, however, may be restricted only for the sake of a compelling public interest; that is, if after careful deliberation the legislature determines that a common interest must be protected, then it may impose restrictions in order to protect that interest – but only to the extent that the protection cannot be accomplished by a lesser restriction on freedom of choice.

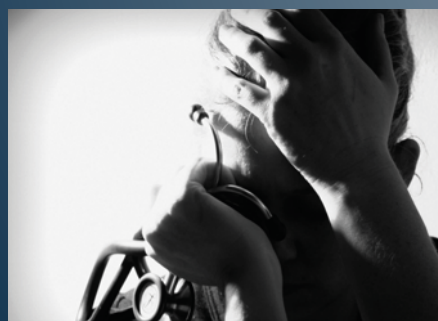
"In the event that an encroachment of freedom of occupational choice is unavoidable, lawmakers must always employ the regulative means least restrictive to the basic right."

It is submitted that these principles should be used, albeit cautiously, in the interpretation of the scope of section 22. In short, an unreasonable legal restriction on the rights enshrined in section 22 should be subject to some measure of scrutiny, if only to test that the practice is regulated rather than the

continued on page 16



SAMA/MPS PHOTOGRAPHY COMPETITION 2014



MPS



LOOKING FOR
**YOUR
BEST
SHOT**
20 MAY - 30 JULY

work environment • emotions • community health



SAMA/MPS PHOTOGRAPHY COMPETITION 2014



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 their members.

Our 2013 photography competition was a success with well captured pictures that spoke to the competition's theme - "A Day in a life of a Doctor" - and we hope that this year's entries will maintain these standards. We asked members to take pictures and share part of their time spent in hospitals or in their private practices - 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 with an added a new category on Community Health programmes or activities that our members are often involved in and are never recognised or captured.

Themes are as follows:

- * **Work Environment**
- * **Emotions**
- * **Community Health**

This is a long standing initiative for both SAMA and MPS which has been greatly received by its members. We anticipate drawing an even bigger number of entries this year and are also happy to announce that some of the entries received will be auctioned and the returns will be awarded to two charity organisations, respectively.

All entries will be displayed at the 2014 SAMA Conference and winning entries will be published in the SAMA and MPS magazines. A panel of experienced judges have been selected to judge the entries.

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 at the SAMA Conference in Durban.

COMPETITION DETAILS

- Entry categories: Work Environment, Emotions and Community Health.
- Prizes will be awarded for category winners and additionally, Judges favourite picture.
- Entrant must have taken the picture and hold the copyright.
- As only digital prints are submitted, access to the original file may be required for winning entries.
- SAMA/MPS reserves the right to print, publish and exhibit any work submitted free of charge, but picture copyright will otherwise remain with the photographer.
- Photography credits will be acknowledged.

COMPETITION CLOSING DATE

30 July 2014, midnight

ENTRY FEES

- R80.00 per entry per category.
- R30.00 per entry per category for students and interns.
- Enter as many pictures as you want per category, but remember that fees are per picture.

PRIZES

Winners will be selected as per category:

- Emotions - R2,000
- Work Environment - R2,000
- Community Health - R2,000
- This year, we have added a judge's pick/favourite which will be awarded with R1,500

Should you have any queries or require assistance please don't hesitate to contact us.

Zukiswa Nomnganga
(012) 481 2052
zukiswan@samedical.org
www.samedical.org/sama-photography-competition-2014.html

right curtailed or negated. The measure of scrutiny is built *inter alia* into the following stipulations of the Constitution of the Republic of South Africa:

Section 27 (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

Section 36 (1) The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including:

- the nature of the right;
- the importance of the purpose of the limitation;
- the nature and extent of the limitation;
- the relation between the limitation and its purpose; and
- less restrictive means to achieve the purpose.

(2) Except as provided in subsection (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.

Sections 36 to 40 of the National Health Act have to do with the following words as stated above:

"The practice of an occupation may be restricted by reasonable regulations predicated on considerations of the common good." It is this article's contention that these sections do not amount to reasonable regulations of the type specified.

Judicial review

On page 116 of The New South African Legal Order by David van Wyk and John Dugard, the authors write about the process approaches to judicial review. South African courts can follow when reviewing unreasonable legislative measures by the state by discussing the way in which the Federal Constitutional Court of Germany dealt with similar issues:

"The FCC distinguishes between three levels of review mere control of manifest (evident) infringements; control of the justifiability (*vertretbarkeit*) of state action; and intensive control of the content of the regulation. The FCC determined that the intensity of judicial scrutiny depends on the nature of the material regulated by the legislation, the intensity of the legislative invasion, the importance of the legal goods in question, and the possibility (or impossibility)

of making clear and straightforward decisions. The principle of proportionality has therefore not been the only yardstick to determine the constitutionality of Grundrecht limitations."

Human dignity, equality and privacy, for example, are denied to those who have no or limited access to health, food and shelter

The National Health Act and the Constitution

Section 27 of the Constitution obviously refers to health. But all the rights in our Constitution are indivisible, interrelated and mutually supporting. This means that it is important to achieve the realisation of some rights in order to enjoy other rights.

Human dignity, equality and privacy, for example, are denied to those who have no or limited access to health, food and shelter. In terms of section 9, everyone has the right to equality, including access to healthcare services. It follows that individuals should not be unfairly excluded in the provision of healthcare.

The imperatives of section 27 should therefore not be seen in isolation but as a necessary part of the achievement of all the rights contained in the Bill of Rights.

Constitutional rights of patients/consumers

Are patients/consumers' constitutional rights to human dignity and bodily integrity, equality, freedom and security of the person, privacy and access to information as enshrined under sections 9, 10, 12, 14 and 32 of the Constitution going to be infringed if the Department of Health decides to refuse the issuing of a Certificate of Need?

Patients have a right to access information that is held by another person if it is required for the exercise or protection of a right – this may arise in relation to accessing one's own

medical records from a health facility for the purposes of lodging a complaint or for giving consent for medical treatment.

This right also enables people to exercise their autonomy in decisions related to their own health, an important part of the right to human dignity and bodily integrity in terms of sections 9, 10 and 12. The ethical rules of the HPCSA are very strict on the maintenance of medical records and they have strict reasons why these records should be retained.

It is also clear when reading the purpose and policy of the Consumer Protection Act as well as those of the Promotion of Access to Information Act, the Protection of Personal Information Act and the Promotion of Equality and Prevention of Unfair Discrimination Act, that the purpose and policy of all these Acts are to express and adhere to the rights and freedoms of patients (consumers) and healthcare providers as enshrined under sections 9, 10, 12, 36, 37, 14, 32 and 38 of the to information 39 of the Constitution.

When reading the stipulations of Section 36 of the National Health Act it is clear that the Department of Health's goal in the issuing or denying of a Certificate of Need is to allow certain health establishments or healthcare providers to continue to provide prescribed health services or to close down others.

It is also obvious that the forced closure of certain health establishments and healthcare providers will take place without consideration for those existing patients (consumers) who made use of the healthcare services that are being closed down.

This violates the patient's constitutional rights as enshrined under sections 9, 10, 12, 14 and 32 of the Constitution and the stipulations of sections 13, 19, 21 and 68 of the Consumer Protection Act.

Section 6844 of the Consumer Protection Act stipulates that if a consumer (patient) exercised, asserted or sought to uphold any right set out in the Consumer Protection Act or in an agreement or transaction with a supplier, the supplier must not in response discriminate directly or indirectly against that consumer, compared to the supplier's treatment of any other consumer who has not exercised, asserted or sought to uphold such a right, or penalise the consumer or alter, or propose to alter the terms or conditions of a transaction or agreement with the consumer to the detriment of the consumer or take any action to accelerate, enforce, suspend or terminate an agreement with the consumer.

Foreign qualified doctors working in South Africa

Julian Botha, Senior Legal Advisor: SAMA



There are many doctors from various parts of the world who have elected to come to South Africa and contribute their skills and training to the provision of healthcare in this country.

The purpose of this article is to deal with a number of issues that affect these doctors, to assist in clarifying the various requirements that must be met in order to be properly registered in South Africa and to highlight certain challenges met by these doctors.

Registration of foreign qualified doctors

In order to practise medicine in South Africa, a practitioner must be registered with the Health Professions Council of South Africa. It is a criminal offence to practise if not in possession of this registration.

Doctors who hold foreign qualifications may apply for registration with the HPCSA. The qualifications are considered by the Medical and Dental Board (MDB) of the HPCSA against minimum requirements which they set.

The registration, if granted, is in the category 'Public Service' which means that doctors so registered may not work in the private sector (until their registration status is changed).

Applicants must submit all the required documentation and take (and pass) the Board examination for foreign qualified doctors. The MDB may, in special circumstances, and at their sole discretion, exempt an applicant from having to undergo the Board examination.

It is important to note that the MDB evaluates the qualifications obtained and

applies a 'grading system' to international universities. Qualifications obtained from universities that do not have a high enough 'grading' will not be automatically recognised and accepted by the MDB.

In addition to the above requirements, applicants who are South African citizens are also required to first obtain a letter of endorsement from the National Department of Health in Pretoria prior to submitting their application.

Private practice

In order to work in the private sector, a doctor who holds a foreign qualification must obtain registration in 'independent practice'. For ease of reference, we reproduce the relevant extracts from the HPCSA's *Guidelines for Registration of Foreign Qualified Medical and Dental Practitioners*:

Registration in the category independent practice (general practitioner)

- Only applicants who hold registration in the category Public Service (General Practitioner) and have served a probation period of one year by submitting two six monthly reports signed by the Supervisor will be considered for registration in the category Independent Practice (General Practitioner). Such applicants are required to apply to the Board for approval to sit the examination for independent practice. Upon successful completion of the university examination, an applicant will have to submit an application to register in the category independent practice. Such application should further be supported by the Foreign Workforce Management Programme of the National Department of Health confirming that the applicant had met the requirements pertaining to permanent resident status in South Africa and that there would not be any objection to his or her registration in independent practice or to submit a certified copy of the South African Identity document.
- Examinations at the EXIT level of the final South African University examination in medicine/dentistry and a medico-legal and ethical assessment will take place in October/November annually as determined by the University in South Africa.

- The applicant should apply to the University of his/her choice. Applicants have to apply on their own behalf by –
 - submitting the letter of approval issued by the Board; and
 - paying the examination fee as determined by the University.
- The number of applicants to be accommodated for an examination will be decided upon by each Faculty and applicants must meet the requirements set by the Faculty.
- Applicants are required to pass examinations in all relevant subjects. The results of the examination in all subjects will thereafter be submitted to the Examinations Committee of the Board for a final ruling on the registration of each applicant.
- Should the applicant PASS the examination, a Certificate of Competence will be issued to him/her and he/she may proceed to apply for registration as a medical practitioner or dentist in Independent Practice;
- Should an applicant fail the examination, he or she may –
 - be afforded an opportunity to have his competency re-assessed in a future examination;
 - be afforded an opportunity to be re-assessed only once.
- If an applicant fails the examination twice, the Examinations Committee of the Board may in its discretion and in cases of special merit only decide to advise the applicant to contact a University of choice to be accommodated for the required additional education and training.

Registration as a medical practitioner/dentist in the category independent practice (specialist)

- Registration in the category Independent Practice (Specialist) is possible only for persons who hold foreign specialist education, training and qualifications subject thereto that the applicant complies with the requirements for registration in the category Independent Practice (General Practitioner) (regulation 2(5) of the Regulations published as Government Notice No. R. 1203 of 28 November 2000). The application should further be supported by the Foreign Workforce Management Programme of the National Department of Health.

- An applicant may apply to the Board for registration by submitting –
 - proof of holding a specialist qualification in a speciality recognised by the Board in terms of Act No. 56 of 1974 (attach a copy of degree certificate certified by a Notary Public and a sworn translation thereof in English);
 - a certificate issued by the foreign university or other educational institution to confirm that –
 - the qualification was accredited or recognised in the country of origin;
 - the standard of the qualification was acceptable to the Registration or other relevant Authority in the country of origin;
 - the applicant's education and training time complied with the minimum requirements in the country of origin.
- information on the nature and duration of such specialist education and training;
- proof of having held registration as a medical practitioner/dentist/specialist in the country of origin;
- proof of compliance with the requirements for registration in the Category Independent Practice in South Africa;
- an application for registration as a medical practitioner/dentist in the Category Independent Practice (Specialist) (Form 21), duly completed;
- the prescribed registration fee –
 - for registration as a specialist;
 - for registration of the relevant foreign qualification as an additional qualification.

In order to practise medicine in South Africa, a practitioner must be registered with the Health Professions Council of South Africa

- Upon submission of the required information, the application will be submitted to the relevant Subcommittee of the Board. In the discretion of the Committee an applicant may be required to –
 - submit proof of having obtained a South African specialist qualification

- in a recognised speciality (usually a Fellowship in the relevant speciality awarded by the Colleges of Medicine of South Africa); OR
- submit proof of having completed a period of specialist education and training required by the Subcommittee as holder of an approved Registrar post and having held registration as a Registrar for such period.
- The scope of practice of such practitioner will be confined to the registered speciality ONLY. The locality of practice shall be unrestricted, while the continuation of registration shall be subject to CPD requirements and the requirements of professional conduct.

Problems encountered by foreign qualified doctors

Over the past few years, the SAMA Head Office has attempted to assist a large number of doctors who hold qualifications obtained in other countries to obtain registration in both public and private sectors, but who have encountered seemingly insurmountable obstacles.

Administration

The vast majority of these obstacles relate to administrative inefficiency on the part of the HPCSA officials.

Examples of such obstacles include the 'loss' or 'misplacement' of submitted application forms and supporting documentation which was duly submitted – or even allegations that this documentation was never submitted in the first place (despite proof to the contrary).

A further challenge faced by applicants, relating to the first example is that the committee convened to review applications meets infrequently – therefore any documents that 'go missing' result in a delay of several months in processing the application. When this occurs, prospective applicants may forfeit positions in the public service which they have obtained and are thus unable to practise for several months.

Foreign qualified doctors have further complained to us that their communication with the HPCSA is not responded to in a timely fashion, or at all, and this creates a significant impediment in resolving outstanding issues.

Non-adherence to procedures

However, not all problems faced by foreign qualified doctors in obtaining registration can be blamed upon administrative

inefficiencies. It does occur that the doctor concerned fails to follow the procedure for application precisely. The MDB cannot process or condone a deficient application – it is bound by the procedure as laid out in the guidelines.

We would call upon the HPCSA to improve their administrative efficiency and encourage all foreign qualified doctors wishing to register in South Africa to adhere strictly to the procedures

Misperceptions

We have, on a number of occasions dealt with matters relating to doctors who feel aggrieved when their applications are rejected, or where they are required to sit for the Board examinations when their colleagues who come from the same country are successful in their application or are exempted from the requirement to pass the Board examination.

One of two things has occurred here. Firstly the MDB may have exercised their sole discretion to exempt an applicant from writing the examination. Secondly the accepted applicant may have studied at a different university whose qualifications are recognised by the MDB.

In conclusion, we would call upon the HPCSA to improve their administrative efficiency and encourage all foreign qualified doctors wishing to register in South Africa to adhere strictly to the procedures laid out in the guidelines.

Suspected epilepsy: when to warn

The Medical Protection Society shares a case report from its archives

A girl of eight, L, was brought by ambulance to the Emergency Department (ED) with a history of a fit during a lesson in school. There was no reliable history: according to friends who had been playing with L, she had touched an electrical socket, fallen, and then had a fit lasting about five minutes, from which she spontaneously recovered.

Shortly after L's parents had arrived in the ED, she was seen by the on-call paediatric team. By this stage she had fully recovered. Her parents were keen to take her home. The on-call paediatrician noted that there were no signs of any acute infectious aetiology for the fit, and no evidence of any burn injury associated with an electrical discharge.

It was unclear whether a head injury had been sustained either before or during the incident. Because of uncertainty around the aetiology, a CT brain scan was performed. This was reported as normal. L's parents were advised that further investigations would be organised as an outpatient, and to bring L back if any further episodes occurred. However: there was nothing in the notes to suggest the hospital intended to rule out anything serious, like epilepsy.

An electroencephalogram (EEG) was arranged for two weeks and a follow-up appointment was made for the paediatric outpatient clinic in six weeks in order to discuss the results of the EEG. Unfortunately, L did not attend for her EEG. The hospital did not have a 'Did not attend' policy in place, and no further action was taken by medical staff as a result of this.

Four weeks later, L was again brought into the ED by a teacher from her school. On this occasion the history was a little vague; it seemed that L had fallen to the ground, possibly as a result of a faint. It was unclear whether she had hit her head on a desk or on the floor. When on the floor, she had been noted to have some persistent blinking and unusual side-to-side movements of the head and one hand.

When examined in the ED about one hour after the episode, L was alert and co-operative. Neurological examination was unremarkable. A further CT brain scan was performed, and again reported as normal. On this occasion L's parents were advised that further investigations including an echocardiogram

and an EEG were necessary, that these would be arranged as an outpatient and that she would be seen in the paediatric department with the results of these.

She was discharged home with the planned EEG and follow-up appointment booked for two weeks and four weeks respectively. Ten days later, L was found drowned in the bath at home. L's parents made a claim against the hospital treating L.

Expert evidence on behalf of the parents advised that had the parents been made aware of the possibility of epilepsy as a diagnosis, and been given appropriate advice, that they would have prioritised the EEG appointment; and they would have followed standard advice given to parents of children with a diagnosis of epilepsy, ie, to ensure that she was supervised during baths, or to take only showers. The claim was settled for a moderate sum.

Learning points

- Doctors may be faced with a dilemma when counselling parents about conditions in their child that are unconfirmed and still under investigation. There is a delicate balance to be found between causing undue anxiety if the condition is subsequently not diagnosed, and failing to provide parents with sufficient information for them to take appropriate precautions. In the case of a child who has had two episodes that are suggestive of a fit over a short period of time and in which investigations for epilepsy are underway, it would be prudent both to offer some precautionary advice to parents and to document the advice given.
- In the UK, NICE's clinical guideline 137 *The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care*, issued in January 2012, states that:
 - All children, young people and adults with a recent onset suspected seizure should be seen urgently (ie, within two weeks) by a specialist (ie, a paediatrician with training and expertise in epilepsy). This is to ensure precise and early diagnosis and initiation of therapy as appropriate to their needs.
 - Following a first seizure, essential information on how to recognise a



seizure, first aid, and the importance of reporting further attacks should be provided to a child, young person or adult who has experienced a possible first seizure, and their family/carer/parent as appropriate. This information should be provided while the child, young person or adult is awaiting a diagnosis and should also be provided to their family and/or carers.

- Children, young people and adults with epilepsy and their families and/or carers should be given information to include (where appropriate):
 - epilepsy in general
 - risk management
 - first aid, safety and injury prevention at home and at school or work.
- The time at which this information should be given will depend on the certainty of the diagnosis, and the need for confirmatory investigations.
- In this instance, the parents' failure to bring the child for the initial investigation may have been a contributory factor. Had a 'Did not attend' policy been in place, there would have been an opportunity to review the records and to establish whether further efforts should have been made to ensure that the child was brought for medical assessment or treatment.

Gauteng holds AGM at Wits Medical School

The SAMA Gauteng branch held its annual general meeting on 7 May. The event, held at the Department of Surgery in the Wits Medical School, was well attended by branch members, and was a great opportunity to reflect on the happenings of the year that had been.

Of note were: the branch's very active role in addressing the commuted overtime crisis at Charlotte Maxeke Hospital; a successful awards dinner held at Houghton Country club; a productive Private Practice Indaba and most recently Prof. Ames Dhali's courageous involvement in the SAMA EGM.

Prof. Martin Veller, branch president for 2013, welcomed Prof. Johnny Mahlangu to the council as the branch president for 2014. The event was also an opportunity to honour the branch's life members. These are members who have belonged to the branch for 40 years or more.

The evening concluded with an enlightening address by the guest speaker, Discovery Health's Dr Ayanda Ntsaluba, in which he reflected on the Department of Health's plan for universal health access and the National Health Insurance.



Prof. Martin Veller welcomes incoming branch president Prof. Johnny Mahlangu

Free State seeks investigation of provincial Department of Health

Dr N Mofolo, SAMA branch chairperson: Free State

We are deeply concerned about the current state of the Free State Health department's finances and the impact this is having on service delivery and training. It is unethical for health departments to be placed under administration due to poor financial planning and maladministration by previous executives in the provincial health departments.

We call upon hospital managers to take proactive steps to actively engage clinicians in rationalising services and to inform members of the public about the current situation. We also call upon clinicians not to expose patients and themselves to unacceptably high levels of risk, and to report every incident or adverse event in writing to hospital management and SAMA. Academic training at training hospitals

has also been seriously and negatively affected by the state of the provincial department's finances – an absolutely untenable situation.

We call upon the national Minister of Health and the Treasury to urgently intervene in addressing the ongoing and worsening crisis in the Free State health department, where patients' lives and employees' jobs are at risk.

New Dean for the Wits Faculty of Health Sciences



Professor Martin Veller

Professor Martin Veller, MBBCh, FCS(SA), MMed(Surg), has been appointed as the new Dean of the Faculty of Health Sciences at Wits University. Veller, a vascular surgeon, was Head of the Department of Surgery in the School of Clinical Medicine at Wits from November 2001 to February 2013. He will assume the deanship on 1 July 2014.

Veller received his pre- and postgraduate training at Wits where he qualified in general surgery in 1987. He subsequently undertook a one year research fellowship at St Mary's Hospital, Imperial College, London.

Veller was appointed *ad hominem* Professor in the Faculty of Health Sciences at Wits in April 2002. He is currently the President of the College of Surgeons of the Colleges of Medicine of South Africa as well as the President of the World Federation of Vascular Societies.

"It is a privilege to be given the opportunity to lead a very large and productive Faculty of Health Sciences into an era when this country faces extensive healthcare reforms," says Veller.

"Our society has experienced many challenges in the provision of high quality healthcare. Amongst the most important is the dire shortage of healthcare professionals who are responsive to the needs of the society in which this Faculty exists. This is one of the most significant contributors to the social and economic disparities in our society.

"Wherever we, as the Faculty, focus our efforts into the future, we must always be cognisant of our primary aim. This is that we want to help improve the healthcare provision for every individual, based on the fact that a country whose citizens are healthy will flourish."



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