

SAMA INSIDER

AUGUST 2014

**SAMATU calls
for action**

Medical brain drain



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EDITOR'S NOTE AUGUST 2014



Conrad Strydom
Editor: SAMA INSIDER

Lofty ideals or the almighty buck?

At a recent event in Sandton, Dr Joy Lawn of the London School of Health and Tropical Medicine ventured that every year 5.5 million babies die globally due to a lack of investment in maternal and newborn care. A figure that high serves to highlight why the Millennium Development Goals were implemented in the first place. It is simply unconscionable that such a large number of children have to die in an age when technological advances are pushing the limits of the possible into science-fiction territory.

Perhaps, however, the failure of well-intentioned, idealistic projects such as the Millennium Development Goals is that they assume an absolute amount of goodwill and pure intent will be present among those who have to execute these plans. In reality, the banal economics of today's marketplace often overwhelm the best intentions. It is a plain fact that far more attention will be given to providing state of the art care to the children of rich parents than the children of the working poor. Doctors who allow such a state of affairs to continue are, unfortunately, enabling an environment in which the ideals of the Hippocratic Oath are overshadowed by the superficialities of the market.

The SAMA Trade Union has been highly active lately. On page 7 we cover the national executive council meeting that was recently held at the SAMA head office in Pretoria. A number of important resolutions were taken at the meeting that are sure to affect public sector doctors very directly. We also examine the current state of the 'brain drain' in South African medicine on page 10. Finally, the Certificate of Need (CoN) continues to be a bone of contention. We feature part 2 of an ongoing series of articles about the constitutionality of the CoN on pages 12 to 18.

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To feed or not to feed



Prof. Ames Dhai, President, SAMA

At the end of June, I received a request for information on the forced feeding of prisoners from Dr Leonid Eidelman, president of the Israeli Medical Association. The Israeli Medical Association was preparing an urgent petition to the Israeli High Court of Justice in objection to a proposed bill, which was currently being fast-tracked into legislation. The new legislation would enable prison authorities to force-feed prisoners, whose lives are danger, following a decision by the district court. Dr Eidelman had written to all National Medical Associations (NMA) requesting information regarding any sort of legislation, ruling or ethical rules in World Medical Association (WMA) member countries that permitted the use of force-feeding in the case of imminent life-threatening conditions.

In particular, if such a law existed in the country or if the NMA raised the issue in an ethical code, he requested information on the following:

- Whether these instruments specifically referred to prisoners on hunger strike
- Whether doctors were obliged to perform force-feeding in any specific case
- What the ethical stand of the Association was on the matter.

SAMA does not have a formal policy on the issue and in responding to Dr Eidelman, I looked at the HPCSA Ethical Guidelines, WMA documents, (in particular, the Declarations of Malta and Tokyo) and South African law (the Constitution, the National Health Act and common law precedents). I was fortunate to have the assistance of Mr Julian Botha, our senior legal advisor, who very ably and promptly prepared a comprehensive opinion for me to use. Pertinent aspects of the opinion follow below:

S6 of the WMA's Declaration of Tokyo (1975) states that:

"Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner."

This prohibition is reinforced by WMA's Declaration of Malta on hunger strikers. Principle 2 states:

"Respect for autonomy. Physicians should respect individuals' autonomy. This can involve difficult assessments as hunger strikers' true wishes may not be as clear as they appear. Any decisions lack moral force if made involuntarily by use of threats, peer pressure or coercion. Hunger strikers should not be forcibly given treatment they refuse. Forced feeding contrary to an informed and voluntary refusal is unjustifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable."

The Declaration of Malta also provides 'Guidelines for the Management of Hunger Strikers'. Guideline 13 states:

"Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting."

In terms of the Bill of Rights the Constitution section 10 affirms that:

"Everyone has inherent dignity and the right to have their dignity respected and protected."

Section 12 states that:

"12. (1) Everyone has the right to freedom and security of the person, which includes the right:

- (a) not to be deprived of freedom arbitrarily or without just cause;*
- (b) not to be detained without trial;*
- (c) to be free from all forms of violence from either public or private sources;*
- (d) not to be tortured in any way; and*
- (e) not to be treated or punished in a cruel, inhuman or degrading way.*

(2) Everyone has the right to bodily and psychological integrity, which includes the right:

- (a) to make decisions concerning reproduction;*
- (b) to security in and control over their body;*
- (c) not to be subjected to medical or scientific experiments without their informed consent."*

The National Health Act in section 6 provides as follows:

"6. User to have full knowledge

(1) Every healthcare provider must inform a user of:

- (a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;*
 - (b) the range of diagnostic procedures and treatment options generally available to the user;*
 - (c) the benefits, risks, costs and consequences generally associated with each option; and*
 - (d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal.*
- (2) The healthcare provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which takes into account the user's level of literacy."*

Similar stipulations are provided by the HPCSA guidelines on Informed Consent. In the South African context, the principle of patient autonomy is sacrosanct. It is protected in our health legislation and regulatory guidelines to the extent that a recipient of health services has the right to refuse health services. Treatment of patients can only be provided where informed consent is obtained. Our legislation and guidelines even go as far as to respect the wishes of an individual who is not able to give or refuse consent at the time when the healthcare is required (due to, for example, unconsciousness) but had, on a previous occasion indicated that they refuse consent.

By its very nature, the administration of force-feeding is cruel, inhuman, and degrading. It infringes upon the human dignity of the person who is subjected to it. It is therefore clearly in conflict with the provisions of sections 10 and 12 of the South African Constitution. In addition it also infringes upon the principle of patient autonomy.

For four decades, the international medical community, at least that community represented at the WMA, have unequivocally stated that the force-feeding of prisoners is unethical and cannot be supported (as per the WMA Declarations of Tokyo and Malta).

The proposed legislation in Israel that will legally permit the force-feeding of prisoners flouts internationally accepted ethical principles and cannot be justified. It will place Israeli doctors, who wish to practise their profession in an ethical manner, in an impossible situation as they would have to act unethically in order to obey this legislation.

Based on this exercise and the opinion, SAMA will now be compiling a policy on the issues of hunger strikes and force-feeding.

SAMA Trade Union calls for mending of public health sector

Conrad Strydom

At the SAMA Trade Union's (SAMATU) national executive council meeting on 11 July, the union's leadership made a firm stand against the continued exploitation of South Africa's public sector doctors. During the course of the meeting, numerous issues affecting doctors were raised and a number of resolutions made concerning how best to deal with them. SAMATU president Dr Phophi Ramathuba and others were quick to point out that members should be ready to move beyond dialogue when engaging with corrupt or dysfunctional hospital administrations.

"We must show the authorities that we are serious in enforcing our rights as doctors," Dr Ramathuba said. Though the means by which collective action would be taken was not specified, the SAMATU leadership remained adamant that the union should be seen as a structure that can threaten non-functional hospital administrations if the need arises. "We must ensure that they take us seriously," Dr Ramathuba said.

of the various trade union structures that are available to them and to help build the type of union they would like to be part of.

Another burning issue was the need for an increased advocacy role for the SAMATU. While the union has secured several noteworthy successes over the years, it was of the utmost importance to continue pushing the Department of Health (DoH) to apply the changes SAMATU has asked for. "It is especially important that the DoH gives us clarity on the RWOPS situation," Dr Ramathuba said, referring to draft RWOPS policy supplied by SAMA that the DoH had provisionally accepted last year. "We want to know from the minister when he plans on implementing the policy we discussed."

The issue of commuted overtime again reared its ugly head. The SAMATU National Executive Committee (NEC) called on the DoH to cease making adverse changes to the commuted overtime policy without consulting doctors in the process. "Doctors are being forced to accept whichever version of commuted overtime seems best at the moment from the DoH's perspective," Dr Ramathuba lamented. "They need to consult with us before making such drastic changes, or else they will lose whatever credibility they still have among the doctors."

Doctors, in turn, also need to be more aware of the DoH's internal programmes, such the Performance Management and Development System (PMDS). "Many doctors are not progressing on their OSD notches and grades because they do not complete their PMDS records on time or are not aware that they must do so," Dr Phalane said.

The training of registrars and interns was a definite sore point with the NEC members. Hospital interns are currently suffering due to a lack of adequate training conditions and supervision at many hospitals throughout the country. This is having a serious effect on the quality of the doctors that are being produced. The high failure rate among registrars was also highlighted. It was suggested that the Colleges of Medicine of South Africa (CoMoSA) might have a hand in this since its policies have not incorporated labour-related issues such as maternity leave for registrars. "It is very irresponsible of CoMoSA to fail a female registrar because she got pregnant,"

South African Registrars Association (SARA) chairperson Dr Masinga said. "Registrars are not only students, they are also employees who should have access to the protection afforded them by the law."

“SAMATU has been speaking out about the leadership void [at provincial health departments] for a long time now, but no action has been taken by those in power”

The SAMATU NEC called attention to the deteriorating state of the country's public health system and noted that there were a growing number of calls for provincial health departments to be placed under administration. "The DoH has allowed certain provinces to become jokes," Dr Ramathuba said. The NEC demanded that the DoH provide strategic leadership as outlined in the 10-point plan approved by minister, citing the escalating crises in the Free State, Limpopo and the Eastern Cape as particularly noteworthy examples of a dysfunctional health system. "Without adequate leadership these vital public institutions simply cannot function," Dr Ramathuba noted. "SAMATU has been speaking out about this leadership void for a long time now, but no action has been taken by those in power."

On a positive note, the SAMATU NEC noted the good work that was being done by doctors throughout the country who were volunteering their services at traditional circumcision ceremonies. While it was unfortunate that 26 deaths had been reported at non-medical initiation schools, the growing participation of the country's doctors was to be commended.

“Doctors are being forced to accept whichever version of commuted overtime seems best at the moment from the DoH’s perspective”

SAMATU's service to its members was highlighted as the union's most salient feature. To ensure that members receive the best service possible, the need to improve the internal systems at SAMA was raised. "We must ensure that we build proper national and provincial trade union structures to ensure that members are adequately represented," said SAMATU general secretary Dr Mahlane Phalane. "These structures should be fully functional and able to quickly deal with input from shop stewards on the ground at various health facilities around the country." The leadership also called upon members to avail themselves

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Post-antibiotic era conundrum: is over-prescription the culprit?

Bernard Mutsago, SAMA Health Policy Researcher



the antibiotic revolution, today the world stands in frustration, troubled by a new epidemic: antimicrobial resistance, a monster that threatens to reverse all the previous gains. A solution is urgently needed as the germs are developing resistance even to the most potent of antibiotics. The World Health Organisation (WHO) and the Centers for Disease Control (CDC) have recently warned of a post-antibiotic era if something is not done to rectify the situation.

Is over-prescription of antibiotics behind the rising resistance? While over-prescription is not the sole driver of resistance, it is a major part of the problem. Statistics show that health workers contribute to irrational use of antibiotics through over-prescribing. In trying to pinpoint the cause of this problem in South Africa, Marc Mendelson (*SAMJ* 2012, vol 102: 7), with specific reference to multi-drug resistant Gram-negative bacteria such as carbapenem-resistant enterobacteriaceae (CRE), noted that "this is a home-grown problem, generated and perpetuated by doctors, nurses and allied healthcare workers in South Africa".

Over-prescribing is the secondary epidemic. It can be due to economic incentives (e.g.

profits from both prescribing and dispensing) insufficient training of prescribers, and patient expectations, among other reasons. As observed in China, hospitals that rely on pharmaceutical sales for income have an incentive to overprescribe.

The CDC in America recommends that hospitals implement 'antibiotic stewardship' programmes. Antibiotic stewardship refers to "a multifaceted approach that healthcare organisations undertake to optimise prescribing, including policies, guidelines, surveillance, education and audit". Fortunately in South Africa some hospitals have introduced antibiotic stewardship programmes. For example, Groote Schuur Hospital recently introduced an antimicrobial resistance team to control unnecessary prescription of antibiotics.

The global village is faced with a situation that calls for urgent action. As investment into new drugs for infectious diseases is costly, and drug research effort is diverted to more profitable drug research, it is high time health professionals, including doctors, reflected on their prescribing habits and their practice ethos and shy away from self-interest in the course of making prescription decisions.

For mankind, the gains of the 'antibiotic revolution' have been immeasurable. Today, unlike decades ago, babies escape the sword of severe killer diseases, organs can be transplanted easily, life expectancies have spiked, and the complexion of medicine has totally changed.

While mankind for many years celebrated the annihilation of several epidemics through

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A guide for public service employees assuming temporary positions of authority

Wandile Mphahlele, Industrial Relations Advisor: SAMA Trade Union



knowing whether the appointing authority has necessary delegation, whether the post is funded and without an appointment letter.

In a case of filling a position that already exists, i.e. someone has resigned or left for any other reasons, there will be little contest as to whether the post is funded as it already exists.

Employees must be slow to accept acting positions in newly created posts without first satisfying themselves that all the requirements set out by the collective agreement have been met.

The most common problem that arises is when the appointment is not made in writing and whether the appointing authority has the necessary delegation to appoint. Employees must insist on having their appointments made in writing and that the appointing authority has the necessary delegation powers. These are noted excuses that the employer makes for not paying the acting allowance.

Employees must insist on having their appointments made in writing and that the appointing authority has the necessary delegation powers

The agreement

Clause 3.1 of Resolution 1 of 2002 reads as follows:

"3.1 An employee appointed in writing to act in a post of a higher grade than the grade of the employee by the Head of Department or his/her delegate at provincial or national level (hereafter the appointing authority) shall be paid an acting allowance to act in vacant post provided that:

- 3.1.1 The post is a vacant and funded post
- 3.2.2 The acting period is longer than six weeks
- 3.3.3 The appointing authority is a level higher than the acting appointee
- 3.1.4 The employee must accept the acting appointment"

It is trite that any appointment beyond qualifications mentioned above will be *ultra vires*, thus rendering the appointment unlawful. In most cases, acting appointments are made and accepted without an employee

The SAMA's Trade Union structure includes a dedicated corps of industrial relations and legal advisors who are tasked with protecting public sector doctors against exploitation. The public health sector is often a very frustrating environment for employees. Issues such as the following are a constant headache for public sector doctors:

- Excessive overtime demands from hospital management
- The non-payment of commuted overtime
- Staff shortages
- Lack of career advancement opportunities
- Unsafe working conditions
- The dysfunctional OSD system

Despite these developments in case law, employees are advised to ensure that actual authority exists, i.e. the appointment is in writing and make sure that the appointing authority has the necessary power to do so, at least by insisting on a written confirmation of authority.

We further advise that such appointments must be made by the chief executive officer of the institution and/or the head of human resources department. These are institutional accounting officers. Employees should be slow to accept appointment from any other source.

It is advisable to contact SAMA for advice if the acting period exceeds the six weeks prescribed period and the appointment does not comply with other requirements as set out above relating to the PSCBC Resolution of 2002.

The SAMA Industrial Relations advisors can be reached on the following numbers: 012-481 2028/2032/2096 or at labour@samedical.org.

If at any time you experience a work-related issue, the SAMA Trade Union's Industrial Relations advisors will be there to listen to your complaint and act on your behalf. Between September 2012 and September 2013, the SAMA Trade Union secured R4.6 million in outstanding payments and legal settlement costs for its members.

Brain drain leaves health system in need

Dr Deepa Shastry

Brain drain, also known as human capital flight, is defined as the mass emigration of technically skilled people from one country to another in search of a better standard of living, quality of life, higher salaries and access to advanced technologies. The phenomenon of 'brain drain' is not unique to South Africa alone. Nearly all the developing countries of the world suffer some amount of loss of specialist workers.

This is of growing concern worldwide due to the impact it has on healthcare systems, especially in developing countries. For healthcare workers, popular destinations include the USA, UK, Canada and Australia. While the global economic recession of 2008 has seen the return of approximately 350 000 skilled workers across different sectors back to South Africa, this has done little to alleviate the crisis facing South Africa's public healthcare.

Inappropriate and inconsiderate commuted overtime hours foster a poor balance between work and social life

South Africa currently has a doctor-patient ratio of eight doctors per 10 000 patients. Cuba, in contrast, has 67.2 doctors per 10 000 patients. Our eight medical schools produce a pithy 1 200 medical graduates a year, despite population growth and the soaring numbers of patients with HIV and tuberculosis. Not all 1 200 of these graduates are being absorbed into the public healthcare system. Partly due to budget constraints and a fixed lecturer to student ratio, the eight medical schools are unable to produce more doctors.

The Cuban programme was established in order to cover South Africa's graduate shortfall. Currently, it accounts for 8% of the annual 1 200 graduates and has proven to be highly controversial. The South African public

overwhelmingly relies on public healthcare services – up to 85% of the population. However, less than 40% of doctors currently serve in a public capacity. For the public health system to function adequately, it requires an estimated 3 500 new doctors. About half of these are needed in Limpopo province, where the public health system is barely functional.

South Africa urgently requires more public sector healthcare workers if it is going to be able to improve healthcare outcomes and access. Although the Cuban training programme has produced as many as 400 doctors over the past four years, the process takes longer and the burden of disease differs with greater focus on preventative measures as well as primary healthcare. These differences require adjustments for these students upon return to South Africa and this has led to discussion over whether the cost of such a programme would best be spent building more medical schools and hospitals in South Africa.

Within the healthcare sector there are many contributors to brain drain. These include a shortage of staff and overburdened state facilities with poor resources as well as a lack of job opportunities both in terms of specialisation and for those with non-clinical interests in medicine. Also, many government facilities do not respond to resumes and there is little information available about job opportunities. The public sector is also unable to retain talented individuals with an interest in teaching, since there is a lack of facilities for advanced research or research funding. Inappropriate and inconsiderate commuted overtime hours foster a poor balance between work and social life.

The greatest impact of brain drain is the direct loss to the underdeveloped and low-income countries who train these experts at a great cost while the receiving country stands to gain from this. This greatly slows down progress as there are not enough experts within the field or many experts are concentrated within the urbanised areas.

There is no single way to counter the brain drain and turn it into a brain gain. Some of the measures that have been suggested include that the private health and corporate sectors provide a source of the core ideas on staff training and

recruitment processes that government facilities can implement in order to improve working environments for employees. Constant training should be offered to staff members, funded by the employer in the form of leadership programmes, customer relations and core related training with promotional incentives to keep staff motivated. Flexible working hours must also be implemented somehow.

For the public health system to function adequately, it requires an estimated 3 500 new doctors

Ultimately, governments must accept and understand that health professional mobility is part of the 21st century and therefore countries are competing with the best institutions in the world for quality manpower. Therefore, developing countries need to look at ways in which health professionals in the developed world may also have work portfolios in the developing world. There must be a greater collaboration between developed and developing countries to create ways in which professionals can contribute their knowledge, clinical and research skills to their country of origin.

The value and effectiveness of individuals depends on their connection to the people, institutions and organisations that enable knowledge creation and together constitute a propitious environment.

Health services in the developing world must be supported to maintain their skilled personnel. Only when health staff, whatever their cadre, have the tools they require to do their job, training opportunities, a network of supportive colleagues and recognition for the difficult job they do, are they likely to stay when opportunity beckons from elsewhere.

PPU to host 2014 MDCM training workshops

SAMA Private Practice Department

The South African Medical Association (SAMA) has identified the need for procedural training in the private sector and medical scheme industry. To this end, Medical Doctors Coding Manual (MDCM) training workshops will be held at SAMA Head Office in Pretoria.

It is vital to understand coding when rendering accounts to third party payers as well as during the assessment of claims, as incorrect coding has great financial implications for doctors in the private sector. If a practice's coding is in order, the doctor concerned can attend to their patients knowing that matters of payment will be dealt with accurately and with a minimal amount of confusion. In contrast, a medical practice which does not attend to coding matters is destined to be an unhappy one.

The workshops will start off with 'Coding 101' which provides basic training in the use and interpretations of the Rules and Modifiers applicable to the coding structure. Time will also be allocated to informal discussions of general problems experienced by coders.

Training will take place over two days at the SAMA Head Office in Pretoria. Requests for training in other centres will be considered. Included in the registration fee of R2 000 per person (including VAT) is an electronic version of the MDCM, training manuals, attendance certificate and a light lunch (please indicate dietary requirements).

The following dates are available for people who wish to attend:

- 13 – 14 August 2014
- 20 – 21 August 2014
- 27 – 28 August 2014
- 03 – 04 September 2014

The target audience for these workshops are:

- Doctors' staff
- Practice managers
- Bureaus
- Medical schemes

Please note that these workshops are not intended for doctors but for administrative and support personnel who assist doctors in matters related to coding.

'Coding 101' is aimed at people who have to compile accounts for the first time as well as established coders who would like to refresh their knowledge on coding.

A medical practice which does not attend to coding matters is destined to be an unhappy one

Payments must be confirmed a week prior to the workshop date in order to secure your booking. For an invoice, please email us your full company details, including the VAT Number.

Should you have any queries please contact the SAMA Coding Unit at coding@samedical.org or 012 481 2073.

More needs to be done to safeguard public doctors

SAMA Trade Union

It was with great sadness that the South African Medical Association (SAMA) noted the murder of Dr Michael Aluko in Khayelitsha on Thursday. Dr Aluko, a Nigerian national, drove to a cafe near Khayelitsha Hospital, where he was on duty, to get some food. Unfortunately, he was hijacked and killed along the way.

Nightshift doctors in dangerous areas are forced to take an unnecessary risk if they have to venture outside their facility for basic necessities

SAMA extends its condolences to Dr Aluko's family, friends and colleagues and laments the loss of yet another of our medical professionals, more so given the preventable nature of this tragedy. In recent years, the Positive Practice Environment Campaign, which is endorsed by SAMA, has been drawing attention to the poor safety conditions at public health facilities. Doctors have been killed, assaulted and raped while on duty.

A doctor should not be forced to leave a public medical facility at night to buy food at a convenience store. It would be a simple matter for the Department of Health or hospital administrators to dedicate a space for a canteen in their facilities. Nightshift doctors in dangerous areas are forced to take an unnecessary risk if they have to venture outside their facility for basic necessities.

Dr Aluko was practising in South Africa because we do not produce enough medical practitioners of our own. Doctors

like him are national assets – let us ensure that the administrators of public facilities take simple, common-sense measures to protect them.

Tragedies such as the death of Dr Aluko are the reason why SAMA and the Democratic Nursing Organisation of South Africa (DENOSA) originally joined forces to endorse the Positive Practice Environment (PPE) campaign. This campaign aims to establish the eight pillars of a safe working environment in South Africa's hospitals. These eight pillars are:

- Workplace security
- Timely remuneration
- Proper equipment
- Adequate medical supplies
- Proper use of resources
- Continuing education of health workers
- Support for professional development
- Respect for healthcare professionals

The Certificate of Need – is it constitutional? (Part 2)

Advocate Willem Smit

This is part two 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' (CoN) from the Department of Health. Health practitioners and establishments who do not have a Certificate of Need will not be allowed to practise medicine. In these articles, Advocate Smit will examine whether the Certificate of Need infringes the constitutional rights of healthcare practitioners and patients.

Prescribed health services delivered to patients (customers) by healthcare providers and health establishments are also regulated by the Consumer Protection Act. If a patient's records are therefore moved to a new location without his permission, such a patient can claim that he received unsolicited services in terms of section 21 of the Consumer Protection Act. There will be no obligation on such a patient (consumer) to pay for these unsolicited goods or services.

In a scenario in which a certain health establishment and/or healthcare provider has been denied a 'Certificate of Need' to continue to provide any further prescribed health services (they have, in other words, been forced by the Department of Health to immediately close its doors) the implications for existing patients (consumers) who attended and made use of that specific health establishment's prescribed health services in the past up to the date of the denial of the 'Certificate of Need' are going to find themselves in a very difficult situation.

They are going to be in a position where they can't get hold of any of the medical records kept by their health establishment and/or healthcare provider or any further advice or information for whatsoever reason or purpose.

Section 36 of the National Health Act is very strict in its stipulations that no prescribed health services are allowed and a health establishment is not allowed to continue to operate without being in possession of a 'Certificate of Need'.

The handing over and the supplying of existing patients (consumers) with their records, the giving of access to medical records falls under the definition of 'health services'. The Health Professional Council of South Africa (HPCSA) also promulgated strict ethical rules concerning the provision of access to medical records. Without being in possession of a 'Certificate of Need', a health establishment and/or healthcare provider cannot continue to provide this 'health service'. He/she cannot give any further future advice or information for whatsoever request or purpose to a patient (consumer).

If they do continue with this part of 'health services' they are running the risk of being prosecuted for contravening the stipulations of Section 40 of the National Health Act and a registered healthcare provider, under the Health Professions Act 56 of 1974, can also be prosecuted by the HPCSA for "unprofessional conduct".

Without being in possession of a 'Certificate of Need', a health establishment and/or healthcare provider cannot continue to provide this 'health service'

Access to medical records

Healthcare providers and health establishments are going to find themselves in a very awkward situation if the government fully implements the stipulations of these newly active sections of the National Health Act. Section 36 of the National Health Act forbids practitioners to practise any further medical services, which includes the forwarding to or the supplying of existing patients (consumers) with their records without a valid 'Certificate of Need'. If they did not adhere to the stipulations of Section 36 they are running the risk of being prosecuted for contravening the stipulations of Section 40 of the National Health Act.

On the other hand, if they do deny existing patients (consumers) access to their medical records and decline to forward information

to them on request, because of not being in possession of a 'Certificate of Need', they are running the risk of being prosecuted for contravening the stipulations of Section 90 of the Promotion of Access to Information Act 2 of 2000.

This whole scenario is contrary to the Hippocratic Oath of healthcare providers and their professional ethical standards as prescribed and required by the HPCSA.

Infringement of the constitutional rights of patients

Against the background of the above facts and arguments it is clear and a fact that the rights of existing patients/consumers concerning their human dignity and bodily integrity, equality (which includes the full and equal enjoyment of all rights and freedoms), freedom and security of the person, privacy and access to information as enshrined under sections 9, 10, 12, 14 and 32 of the Constitution of an existing specific healthcare provider are going to be infringed if and when the Department of Health denies the issuing of a 'Certificate of Need' as defined in the National Health Act, to their existing specific healthcare provider to continue to provide prescribed health services or to continue to operate a health establishment at their current location (his or her residential practice address) where he or she supplied medical services in the past until the date of the denial of the 'Certificate of Need'.

Section 3 (o) of the Health Professions Act and Section 22 of the Constitution

In any discussion of section 3(o) of the Health Professions Act and section 22 of the Constitution, the right of patients to access information held by a healthcare provider is of the utmost importance. As discussed earlier, patients (consumers) do have the 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 respectively.

Healthcare providers' obligations

Persons (in this case 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 in the Constitution under section 22, 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 regulation of the medical profession is done through the Health Professions Act under the direct supervision of the HPCSA. It is a prerequisite that every person (healthcare provider) who does want to practise the practices listed under section 17 of the Health Professions Act must first register under the Health Professions Act.

After registering, a person has an obligation to behave towards users of their health services in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality as stipulated under Section 3 (o) of the Health Professions Act.

It is the very essence of this obligation of persons (healthcare providers), as registered in terms of the Health Professions Act, towards their existing patients (consumers) as discussed above that is now going to be unconstitutionally infringed, limited and overrun by the stipulations of sections 36 to 40 of the National Health Act if and when the Department of Health is going to deny the issuing of a 'Certificate of Need' as defined in the National Health Act, to an existing healthcare provider to continue to provide prescribed health services or to continue to operate a health establishment at a certain location.

This situation, which is going to be caused by the stipulations of section 36 to 40 of the National Health Act in the overregulation of persons (healthcare providers), as registered in terms of the Health Professions Act, gives rise to yet another reason why it can be argued that Sections 36 to 40 of the National

Health Act are not going to stand the test of constitutionality under the Constitution of the Republic of South Africa.

Sections 36 to 40 of the National Health Act are not going to stand the test of constitutionality under the Constitution of the Republic of South Africa

The HPCSA's obligations under the Health Professions Act

When reading the stipulations of section 3 (o) of the Health Professions Act and section 22 of the Constitution, concerning the stipulations of sections 36 to 40 of the National Health Act, it is clear that the obligation of the HPCSA under the Health Professions Act is to ensure that persons, registered in terms of this Act (healthcare providers), behave towards users of health services in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality, and that disciplinary action is to be taken against persons who fail to act accordingly.

But what is the HPCSA going to do if a person, as registered in terms of this Act, can't continue to behave towards his or her existing patients (customers) in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality as discussed above, because the Department of Health has forced him or her to close his or her practice by denying such person a 'Certificate of Need' to continue to provide health services to his or her patients (customers) as required by Section 3 (o) of the Health Professions Act?

Discrimination by healthcare providers against other providers

Is the implementation of sections 36 to 40 of the National Health Act going to result in future in a scenario wherein a supplier ('health

establishment' or 'healthcare provider') who does want to sell his 'health establishment' or medical practice to a fellow 'health establishment' or 'healthcare provider' going to be forced to discriminate against certain potential buyers, because they are not in possession of a 'Certificate of Need' from the Department of Health to run that 'health establishment' or medical practice at that existing business address of such a 'health establishment' or medical practice?

Section 8 of the Consumer Protection Act as read with section 9 of the Constitution of the Republic South Africa and Chapter 2 of the Promotion of Equality and Prevention of Unfair Discrimination Act prohibit unfair discrimination by a supplier ('health establishment' or 'healthcare provider') who does want to sell his 'health establishment' or medical practice to a fellow 'health establishment' or 'healthcare provider'.

There is still at this stage a free flow of business surrounding the sale of 'health establishments' or medical practices to fellow 'health establishments' or 'healthcare providers'.

Sale of health establishments after 1 April 2016

Now that sections 36 to 40 of The National Health Act have come into operation, it is going to result in a situation where a supplier ('health establishment' or 'healthcare provider'), who does want to sell his 'health establishment' or medical practice to a fellow 'health establishment' or 'healthcare provider' after 1 April 2016, is going to be forced to discriminate against certain potential buyers who are not in possession of a 'Certificate of Need' from the Department of Health.

When a supplier ('health establishment' or 'healthcare provider') does want to hire the services of a locum (healthcare provider), after 1 April 2016, they are going to find themselves in the same situation. The locum must be in possession of a 'Certificate of Need' which allows him or her to work at the location specified.

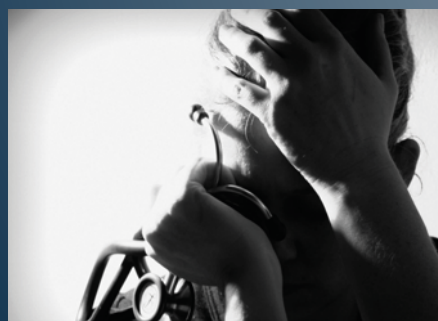
This new state of affairs is totally contrary to the requirements and provisions of section 8 of the Consumer Protection Act as read with section 9 of the Constitution and Chapter 2 of the Promotion of Equality and Prevention of Unfair Discrimination Act which prohibit unfair discrimination during the above described transactions.

Further, sections 770, 871 and 9 of the Constitution protect the law under section 8

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

of the Consumer Protection Act as read with Chapter 2 of the Promotion of Equality and Prevention of Unfair Discrimination Act by prohibiting the legislature, the executive, the judiciary and all organs of state to promulgate law which infringes citizens of South Africa's Constitutional rights as enshrined under the Constitution of the Republic of South Africa.

It is clear that the legislature has now promulgated law in the form of sections 36 to 40 of the National Health Act which infringes certain citizens of South Africa's constitutional rights as enshrined under the Constitution of the Republic of South Africa.

Regulations required

There is no obligation under section 39 or section 90 of the National Health Act on the Minister to make regulations under this sections of the Act, because of the word "...may..." which appears in Section 39 and Section 90 of the National Health Act.

A person who wishes to obtain or renew a 'Certificate of Need' must apply to the Director-General in the prescribed manner and must pay the prescribed application fee. The word 'prescribed' is defined in the act in the following way: "prescribed' means prescribed by regulations made under section 90".

Applicants who want to obtain a 'Certificate of Need' from the Director-General must first wait for the Minister's regulation in which he has dealt with "the prescribed manner" in which applications must be forwarded to the Director-General and "the prescribed application fee" to be paid with an application.

The Minister must publish all regulations proposed to be made under this Act in the *Government Gazette* for comment at least three months before the date contemplated for their commencement.

How the DG will consider applications

The stipulations of the Promotion of Administrative Justice Act play a role if and when the Director-General of the Department of Health is going to consider an application for a 'Certificate of Need'. If and when the Director-General of the Department of Health is going to consider an application for a 'Certificate of Need' (execute an "administrative action" as "an organ of state" as defined in the Promotion of Administrative Justice Act), he must comply with the strict stipulations of the Promotion of Administrative Justice Act 3 of 2000 by considering and taking into account all the stipulations as prescribed by section 3 of this

Act and the stipulations as prescribed under section 36 (3) of the National Health Act which consists of the following requirements:

- the need to ensure consistency of health services development in terms of national, provincial and municipal planning;
- the need to promote an equitable distribution and rationalisation of health services and healthcare resources, and the need to correct inequities based on racial, gender, economic and geographical factors;
- the need to promote an appropriate mix of public and private health services;
- the demographics and epidemiological characteristics of the population to be served;
- the potential advantages and disadvantages for existing public and private health services and for any affected communities;
- the need to protect or advance persons or categories of persons designated in terms of the Employment Equity Act, 1998 (Act 55 of 1998), within the emerging small, medium and micro-enterprise sector;
- the potential benefits of research and development with respect to the improvement of health service delivery;
- the need to ensure that ownership of facilities does not create perverse incentives for health service providers and health workers;
- if applicable, the quality of health services rendered by the applicant in the past;
- the probability of the financial sustainability of the health establishment or health agency;
- the need to ensure the availability and appropriate utilisation of human resources and health technology;
- whether the private health establishment is for profit or not; and
- if applicable, compliance with the requirements of a certificate of non-compliance.

Existing health establishments are consistent with municipal planning guidelines

Most, if not all health establishments or rooms of healthcare providers, up to now, have been erected or established according to consistent municipal planning under supervision of the Municipalities Urban and Regional Planners, specifically because of various factors surrounding the running of health establishments or rooms of healthcare providers.

Special attention is given during the consideration of an application to the municipality, when an application has been forwarded to a municipality for the erection of a building in which a health establishment or room for a healthcare provider is going to be erected or established because of the fact that health establishments or the rooms of healthcare providers generate medical waste which can be a health risk for the surrounding population of health establishments or rooms of healthcare providers.

"Medical care is vital for our life, health and well being, but the waste generated from medical activities can be hazardous, toxic and even lethal because of their high potential for disease transmission. The hazardous and toxic parts of waste from healthcare establishments comprising infectious, medical and radioactive material as well as sharps constitute a grave risk to mankind and the environment, if these are not properly treated/disposed of or are allowed to be mixed with other municipal waste." (quoted from <http://waset.org/publications/9996582/poor-medical-waste-management-mwm-practices-and-its-risks-to-human-health-and-the-environment-a-literature-review>)

“Medical care is vital for our life, health and well being, but the waste generated from medical activities can be hazardous, toxic and even lethal because of their high potential for disease transmission”

Director-General can be forced to give reasons for denying a CoN

Is the Director-General of the Department of Health, when considering an application for a 'Certificate of Need' for an existing health establishment or healthcare provider going to infringe or overrun the past consistent health services development in terms of national,

provincial and municipal planning which has been followed up to now surrounding all the factors as discussed above?

It seems as if the Director-General of the Department of Health can be forced, when denying in future a 'Certificate of Need' for an existing health establishment or healthcare provider, to give reasons why he is infringing and overrunning the past consistent health services development in terms of the municipal planning under which the health establishment or healthcare provider was operating in the past.

Section 3 (5) of the Promotion of Administrative Justice Act stipulates that where an Administrator (in this case the Director-General of the Department of Health) is empowered by any empowering provision to follow a procedure which is fair but different from the provisions of section 3 (2) of the Promotion of Administrative Justice Act, the administrator may act in accordance with that different procedure.

Sections 36 to 40 of the National Health Act prescribe no procedure which empowers the Director-General of the Department of Health to follow, in giving existing patients/consumers (a certain part of the public), whose rights are going to be affected by his administrative action a chance to be heard.

Section 36 (3) (e) of the National Health Act stipulates that the Director-General must consider "...the potential advantages and disadvantages for existing public and private health services and for any affected communities".

This stipulation does make it very clear that existing patients of an existing health establishment or a healthcare provider must be heard when their existing health establishment or healthcare provider's application for a 'Certificate of Need' is considered by the Director-General.

Therefore he must, in connection with this aspect of his administrative action, adhere to the applicable stipulations under the Promotion of Administrative Justice Act to give effect to the right to procedurally fair administrative action.

Section 4 of the Promotion of Administrative Justice Act

If and when the Director-General of the Department of Health is going to consider an application for a 'Certificate of Need' (execute an "administrative action" as "an organ of state") he or she must comply with the strict stipulations of the Promotion of

Administrative Justice Act, Act 3 of 2000 by considering and taking into account the stipulations of section 4 of this Act, because of the facts as discussed previously.

Patients, health establishments and healthcare providers can approach any division of the High Courts of South Africa with an application ... wherein the Court can be asked to declare the stipulations of Sections 36 to 40 of the National Health Act unconstitutional ...

It is clear and a fact that the rights of existing patients/consumers (a group or class of the public) concerning their human dignity and bodily integrity, equality (which includes the full and equal enjoyment of all rights and freedoms), freedom and security of the person, privacy and access to information as enshrined under sections 9, 10, 12, 14 and 32 of the Constitution of an existing health establishment or a specific healthcare provider are going to be infringed if and when the Department of Health denies the issuing of a 'Certificate of Need' as defined under the National Health Act, to their existing specific healthcare provider to continue to provide prescribed health services or to continue to operate a health establishment at the location (his or her resident practice address) where he or she supplied medical services in the past up to the date of the denial of the 'Certificate of Need'.

In terms of section 4 (1) of the Promotion of Administrative Justice Act, Act 3 of 2000, the Director-General of the Department of Health

must, before he considers an application for a 'Certificate of Need' of an existing health establishment or a specific healthcare provider or any new application decide whether:

- to hold a public inquiry in terms of subsection (2);
- to follow a notice and comment procedure in terms of subsection (3);
- to follow the procedures in both subsections (2) and (3);
- where the administrator is empowered by any empowering provision to follow a procedure which is fair but different, to follow that procedure; or
- to follow another appropriate procedure which gives effect to section 3, concerning the rights and interests of existing patients/consumers (a certain part of the public) who were going to be affected by his administrative action/decision.

Remedies available to healthcare providers and patients

There are certain remedies available to patients, health establishments and healthcare providers on how to approach the unreasonable and unconstitutional infringing effect of Sections 36 to 40 of the National Health Act and the role that section 94 of the Consumer Protection Act can play in the solving of this problem.

Patients, health establishments and healthcare providers can approach any division of the High Courts of South Africa with an application, based on the facts and authority as discussed above, wherein the Court can be asked to declare the stipulations of Sections 36 to 40 of the National Health Act unconstitutional when read with the applicable stipulations, as discussed above, surrounding the Constitution of the Republic of South Africa.

The stipulations of Section 27 of the Constitution of South Africa are clear. The state is only allowed to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of the rights as stipulated under section 27 of the Constitution of South Africa. There is an obligation that they must do it, they must only make use of reasonable legislative measures.

The stipulations of sections 36 to 40 of the National Health Act are not reasonable, but extreme measures by the Department of Health in their effort to make medical services more available to all of South Africa's citizens over a broader spectrum at places where

medical services are not readily available by forcing existing specific healthcare providers and health establishments at certain places to close down and/or to move to other places where medical services are not readily available without keeping in mind that existing patients (consumers) of the health services providers and health establishments' rights concerning their human dignity and bodily integrity, equality (which includes the full and equal enjoyment of all rights and freedoms), freedom and security of the person, privacy and access to information as enshrined under sections 9, 10, 12, 14 and 32 of the Constitution are going to be infringed.

Also, their constitutional right under section 27 (1), that everyone has the right to access to healthcare services is going to be infringed and curtailed, because they now have to find other places where medical services are readily available. Whereas, in the past, this service was readily available to existing patients of an existing specific healthcare provider and/or health establishment at a specific certain place.

In truth, the Department of Health is going to shoot themselves in the foot with their extreme measures under sections 36 to 40 of the National Health Act, because on the one hand they are going to try to make medical services more available to a certain part of South Africa's citizens, but with the other hand they are going to take away the medical services of certain other South African citizens as discussed above.

It is also true that patients usually make use of healthcare services in areas where they work. The Department of Health must keep in mind that many South African citizens who live in places where medical services are not readily available do work in places where medical services are readily available.

Infringement of the Bill of Rights

The stipulations of section 36 and specifically section 36 (2) of the Constitution are clear. No law may limit any right entrenched in the Bill of Rights, except as provided in Section 36 (1) or in any other provision of the Constitution. The rights in the Bill of Rights of existing patients (consumers) of healthcare providers and health establishments concerning their human dignity and bodily integrity, equality (which includes the full and equal enjoyment of all rights and freedoms), freedom and security of the person, privacy and access to information as enshrined under sections 9, 10, 12, 14, and 32 of the Constitution and also their constitutional right under Section 27 (1) which stipulates that "Everyone has the right to have access to

(a) healthcare services, 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."

Sections 36 to 40 of the National Health Act have existed for 10 years, but were not signed into law until 21 March 2014. Why was this section not signed into law ten years ago?

The stipulations of sections 36 to 40 of the National Health Act, as discussed above, are not reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, but are extreme measures by the Department of Health in their effort to make medical services more available to all of South Africa's citizens over a broader spectrum at places where medical services are not readily available by forcing existing specific healthcare providers and health establishments at certain places to close down and/or to move to other places where medical services are not readily available.

There are less restrictive means available which the Department can use and should have used in the past ten years to achieve the purpose of making medical services more available to all of South Africa's citizens over a broader spectrum at places where medical services are not readily available. Sections 36

to 40 of the National Health Act have existed for 10 years, but were not signed into law until 21 March 2014. Why was this section not signed into law ten years ago?

Neglect by the Department of Health

If the Department of Health had started to manage the establishment of new health establishments ten years ago then this extreme measure would not be necessary now in their effort to make medical services more available to all.

Another question must be asked. Can the Director-General expect and require health establishments, who already existed and who were already busy with the delivery of healthcare services, before the new National Health Act 61 of 2003 came into operation under the old Health Act 63 of 1977, to apply afresh for a 'Certificate of Need'?

Under the new National Health Act a stipulation appears under section 93 (2)91 which reads as follows:

"Anything done before the commencement of this Act under a provision of a law repealed by subsection (1) and which could have been done under a provision of this Act must be regarded as having been done under the corresponding provision of this Act."

Under the old Health Act regulations were made and enforced in respect of private hospitals, nursing homes, maternity homes or other similar institutions where nursing is carried on for the benefit of patients accommodated therein and where fees are charged by the owner or lessee of any such hospital, home or institution in respect of nursing services rendered to such patients or where contributions are made by such patients towards the cost of such services *inter alia* relating to the registration and inspection of such hospitals, homes or institutions; and in respect of any place, excluding a hospital, or a private hospital, nursing home, maternity home or other institution referred to in paragraph (a), where surgical or other medical activities are performed in respect of which special equipment or facilities are necessary *inter alia* providing for the registration of such places and the inspection of such places, equipment and facilities.

Because of this, the Director-General can't expect health establishments and healthcare providers, who already existed and who were already busy with the delivery of healthcare services before the new National Health Act came into operation to apply afresh for a 'Certificate of Need'.

Headaches and hypertension

The Medical Protection Society shares a case report from their files

Mr J was 43 and unemployed. He developed headaches and complained that sunshine hurt his eyes and he was bothered by noise. He made an appointment with his GP, Dr A, explaining that he had tried over-the-counter painkillers but that they did not help when he had one of his pounding headaches. Dr A documented Mr J had presented with headaches with some features of migraine and prescribed some tramadol.

Five years later, Mr J was struggling with headaches. He wondered if he needed new glasses so he visited his optician. His optical prescription had changed and he was given some new glasses, but when his headaches persisted he decided to see his GP again.

Dr A documented that he was suffering with headaches that were present in the morning and in the evening. He checked his blood pressure, which was 110/80. Mr J was also complaining of toothache and Dr A suggested that he saw a dentist, in case the headaches were related. Dr A considered other causes of his headache and noted that Mr J had also complained of neck pain. He suggested some exercises for cervicalgia.

Mr J visited his dentist who referred him to a consultant oral maxillofacial surgeon. He thought his headaches were coming from temporo-mandibular joint dysfunction, possibly secondary to a tender wisdom tooth. He had his wisdom tooth extracted under sedation. His blood pressure was not taken at this time. At his review, it was noted that his headaches had improved and could be managed with paracetamol alone. Mr J felt better and had been able to find a job in a supermarket.

The same year Mr J became concerned because he saw blood in his urine. He made an urgent appointment with his GP. Dr A documented that he had no dysuria or suprapubic pain. He noted that Mr J was very anxious about it and referred him to urology to investigate his painless haematuria. There was no mention of headaches at this consultation and his blood pressure was not taken.

A month later, Mr J fell whilst stacking shelves at work. He couldn't get up and noticed that his right side felt weak and his voice was slurred. An ambulance was called and took him to the Emergency Department, where a CT scan showed a large

intraparenchymal bleed with extension into the left ventricle and midline shift.

He became agitated, irritable and started vomiting. His GCS dropped to seven and he was admitted to ITU where he was intubated and ventilated. His blood pressure was found to be 260/140. His left pupil was found to be larger than the right and was unreactive.

Mr J had a left frontal craniotomy, releasing 230ml of haematoma blood. He remained ventilated for over a week because of issues with high blood pressure. Mr J was found to have left ventricular hypertrophy on ECG and impaired renal function. His hypertension persisted after he was extubated and he was found to have grade 2 hypertensive retinopathy.

A month later, Mr J was discharged home but had developed epilepsy and significant cognitive impairment. He needed neurorehabilitation, was unable to work, and required care.

At his nephrology follow-up, his blood pressure was 150/100 despite four antihypertensive drugs, but there was no evidence of LVH on echocardiogram.

Mr J made a claim against his GP. He felt that the diagnosis of hypertension had been missed and the delay in treatment had caused his brain haemorrhage. It was alleged that Dr A had failed to take his blood pressure despite persistent headaches and haematuria. He believed that Dr A had diagnosed somatisation headache without examining him.

Expert GP opinion had only one criticism of Dr A, in that he failed to examine the optic fundi when he presented with headaches in the morning. The opinion of a professor of cardiovascular medicine was also gained. He concluded that the intracerebral bleed was likely to be due to a small vascular abnormality rather than due to malignant or accelerated hypertension.

He thought that he probably had only mild to moderate hypertension before his bleed because he had been found to have only grade 2 hypertensive retinopathy. There was no papilloedema, haemorrhages or exudates which accompany accelerated or malignant hypertension.

Expert opinion also felt that the very high blood pressure readings at the time of the stroke represented the usual physiological reaction to a cerebral bleed and did



not represent the true ongoing level of hypertension. He discounted the relevance of headaches as a sign of hypertension in this case. He explained that hypertension usually only causes headache if it is malignant or accelerated, which he believed was not the case.

The case was successfully defended pre-trial and all costs were recovered.

Learning points:

- Tragic events don't always equate to negligence.
- MPS successfully defended the claim by gaining expert opinion from three doctors.
- It is useful to remind ourselves of the stages of hypertensive retinopathy and remember to examine the fundi in patients with hypertension.¹

References

1. www.gpnotebook.co.uk/simplepage.cfm?ID=-46858224&linkID=18777&cook=yes

The original case report can be found in MPS's edition of Casebook Vol. 22 no. 2 – May 2014 at <http://www.medicalprotection.org/southafrica/case-reports-may-2014>

SAMA attends consultative meeting on Certificate of Need

Julian Botha, Senior Legal Advisor, SAMA

On 18 June, SAMA was invited to a consultative meeting at the Department of Health (DoH) offices in Pretoria by the Director General (DG) of Health. The meeting focused on the proclamation of sections 36-40 of the National Health Act.

The DG indicated that this was the first of a series of meetings being convened with various sectors of the healthcare industry. She indicated that the purpose of these consultative meetings was to find ways to address concerns and to assist in drafting regulations which will give effect to sections 36-40.

The DoH emphasised that an important aspect of addressing the quadruple burden of disease problems faced by South Africa was the equitable distribution of health resources. Significantly, the Certificate of Need applies to both the Public and Private Sector.

The interpretation of the wording of section 36(1) was debated extensively. Consensus was achieved on the application of this section to individual practices as they fall under the definition of 'health establishment'. The attendees, however, were not in agreement as to whether the Certificate of Need is attached to a person

or to a place. No resolution of this particular issue was arrived at.

Other issues raised in respect of this section included the current absence of 'norms and standards' as referred to in section 36(5). The concerns raised by the attendees can be grouped into three categories:

Legal concerns

The legal concerns are referred to above and relate primarily to the question of who precisely must hold a Certificate of Need. In addition the 'clock is ticking' and the consultative and regulatory process is unlikely to be concluded prior to 1 April 2016.

The issue of potential contravention of competition law was also raised. The DoH expressed the belief that the National Health Act prevailed over the Competition Act in any potential conflict of laws situation. The DG further undertook to engage with the panel of the Competition Commission Market Inquiry to discuss the Certificate of Need issue.

It was emphasised to the DoH that the regulations to be drafted cannot be in conflict with the provisions of the Act and therefore cannot override or alter the empowering provisions.

Perceptual concerns

The DoH was informed that constituent members of the various attending groups were very concerned about the Certificate of Need as they did not wish to be 'forced' to practise their profession in a place of the department's choosing. The practitioners were further concerned that no meaningful consideration would be given to the financial viability of their practices – and feared specifically that they would be allocated to areas where it would be impossible to earn a sustainable living.

It was suggested to the DG that it would be preferable to incentivise practitioners as opposed to placing them under the threat of criminal sanction for non-adherence. The DoH was in agreement with this approach.

Logistical concerns

It was made clear that the amount of time left before the deadline of 1 April 2016 was wholly inadequate to consult, draft and enact regulations and then begin accepting and processing applications for Certificates of Need. The period in which to do this must be extended. The DG undertook to investigate with her legal advisors on how this postponement could be achieved.

the training of interns and registrars and conditions of service.

The following people were elected to the provincial executive committee:

- Chairperson: Dr MC Diba
- Vice-chairperson: Dr N Mofolo
- Secretary: Dr MM Hlahane
- Treasurer: Dr D Menge
- Organiser: Dr A Letsele

Free State elects local SAMATU PEC

The SAMA Trade Union (SAMATU) has established a new provincial executive committee (PEC) in the Free State province as part of its ongoing drive to create functional trade union structures throughout the country. The PEC will guide the activities of the SAMATU in the Free State, which is currently a hotspot of mismanagement and corruption in the public health sector.

At a 19 July meeting at the University of the Free State, members of SAMA's Free State branch who are working in the public sector, met to elect their chosen representatives. Doctors were concerned about changes to the commuted overtime system, issues with performance management and development systems (PMDS), occupational specific dispensation (OSD) translation,

Prof. Boet Dommisse was a leading light in OB/GYN



The South African Medical Association (SAMA) notes with sadness the passing of Emeritus Professor Boet Dommisse. Prof. Dommisse was a distinguished head of the Obstetrics and Gynaecology Department at the University of Cape Town's Faculty of Health Sciences, which he shepherded and safeguarded through the national transition period post-1994, as well as a former president of the South African Society of Obstetricians and Gynaecologists (SASOG).

Prof. Dommisse is fondly remembered by his former colleagues at UCT's Maternity Centre for his practical and conscientious approach to his patients. He was also known as a professional and highly effective teacher who taught many of today's obstetricians and gynaecologists the finer points of their craft.

SAMA extends its condolences to his wife Anne, his children Janette, Susan and Jannie and their respective families.



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- STI's
- Mental Health

FPD also offer short courses that focusses on **chronic illnesses** such as cardiovascular disease, allergies, asthma, diabetes mellitus, epilepsy, the rational Use of Antibiotics and rheumatology.

The **FPD School of Health Sciences and Medical Practice Consulting** have joined forces to offer healthcare professionals (HCP's), **online CPD courses** that are actual and relevant to delivering healthcare services in South Africa. The portfolio of Health Science courses are specifically designed to enhance the **clinical skills** of HCP's and are taught through a combination of assessed self-study (with detailed study material and online training) led by leading national experts.

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- Mental Health
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