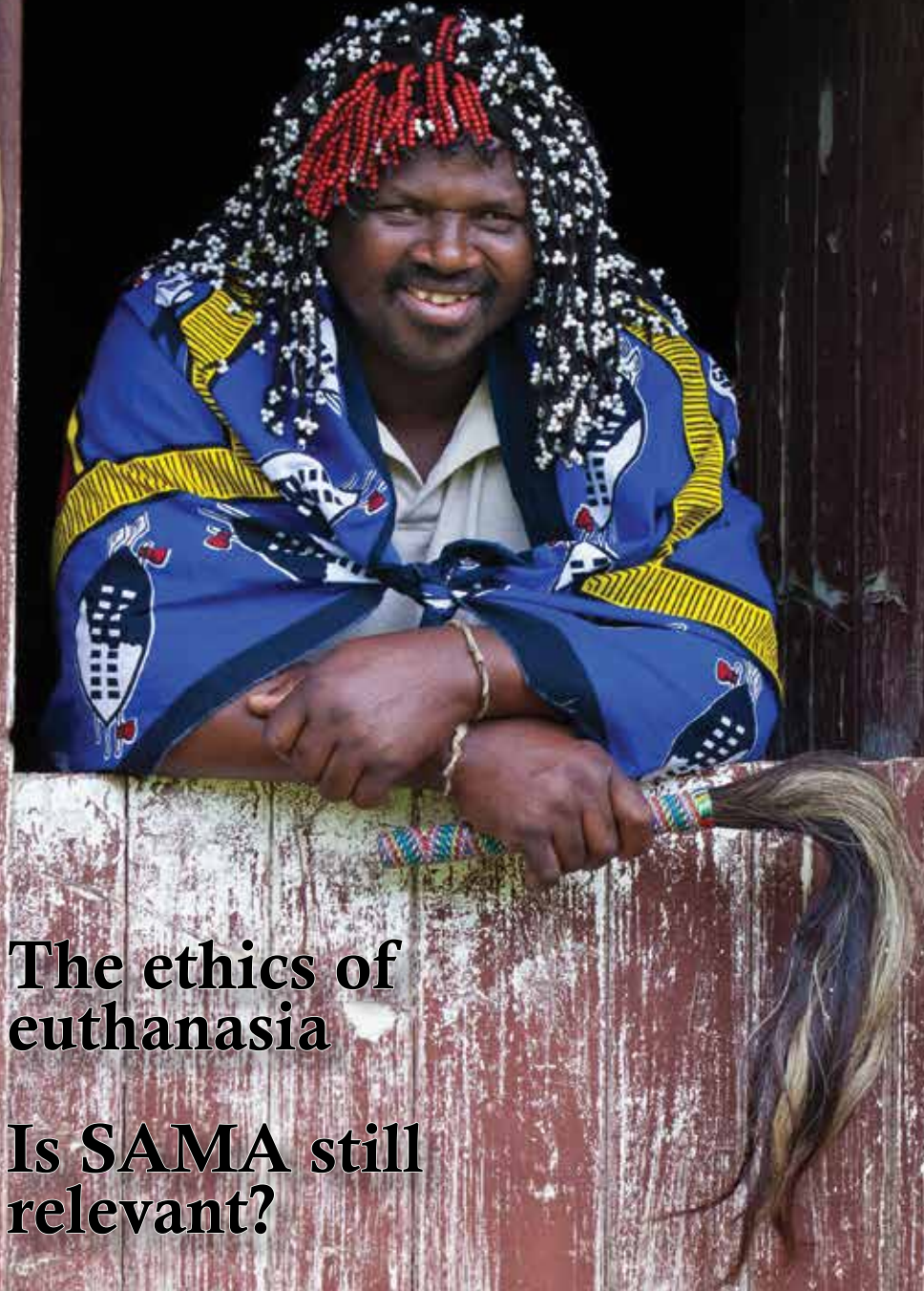


SAMA INSIDER

JUNE 2015



**The ethics of
euthanasia**

**Is SAMA still
relevant?**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

**SOUTH AFRICAN
MEDICAL ASSOCIATION**

Research in Action Conference

14, 15, 16
July
2015

July

2015

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19	20	21	22	23	24	25
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The Cancer Association of South Africa (CANSA) and the Stellenbosch University (incorporating the African Cancer Institute) announce that the next CANSA Research in Action Conference is to be held at the modern STIAS Wallenberg Research and Conference Centre in Stellenbosch from 14 - 16 July 2015. Register via email to avictor@cansa.org.za

CANSA aims to bring together the South African cancer research community spanning the research spectrum from epidemiology, early diagnosis of cancer, reducing cancer risk, services for cancer patients and survivors as well as research relating to cancer biology/biochemistry/molecular biology to policy research. It also provides a venue for networking and cross-fertilisation between research disciplines.

All CANSA's type A research grantees have been invited to present their research in seven sessions arranged in series providing a comprehensive view of CANSA sponsored research at universities. There will also be a panel discussion on the Future of Cancer Research in South Africa on the Thursday afternoon as the final session.

Further details available on <http://www.cansa.org.za/cancer-research/>
For any queries, contact Alice Victor via e-mail at: avictor@cansa.org.za

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MEMBER BENEFITS



Conrad Strydom
Editor: *SAMA INSIDER*

Bob's your uncle

Former *SAMJ* editor Prof. Dan Ncayiyana made an interesting point at the Steve Biko Centre for Bioethics' recent seminar on whether assisted suicide should be legalised. He pointed out that assisted suicide was consistent with medical ethics and that there were compelling arguments in favour of it. However, it would never work in practice in a South African context, since we had neither the administrative capacity nor the "respect for life" required to run such a sensitive programme.

If your health sector is in such a mess that the state can't even trust doctors to kill people properly, you know that we are closer to the precipice than lemmings in suicide season. In all honesty, the current euthanasia debate has not been much of a PR victory for doctors, a group almost as desperately in need of a public makeover as Robert Mugabe. The medical community has come across as extremely paternalistic and narrow-minded in this debate, and the populace has noticed. Remember, the only tangible effect Robert Mugabe has had on the average South African is to ensure that your Joburg cab driver is probably a Shona speaker. The tangible effects doctors are having on South Africans every day include presiding over one of the most dysfunctional public and most expensive private healthcare systems in the entire world, according to data obtained by UCT's Health Economics Unit.

We focus on the euthanasia debate that took place at Wits on pages 6 and 7. We also print a polemical article by Dr Wim Beukes, current president of SAMA's Tygerberg Boland branch, on pages 9 and 10. On page 16 we discuss the recent JUDASA AGM and interview that association's fiery new chairperson, Dr Tshilidzi Sadiki. If you have any comments or queries, do not hesitate to contact me via email at csstrydom.mail@gmail.com.

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MEMBER BENEFITS

SAMA news in brief

Euthanasia

On 30 April, Cape Town lawyer Robert Stransham-Ford passed away hours before a Pretoria High Court verdict found in favour of his contention that he had a constitutional right to be euthanised. Although the Stransham-Ford verdict has not legalised euthanasia, it does open the door for similar cases to be heard in courts throughout the country and has elicited furious debate among medical practitioners and the general public. SAMA released a position statement shortly after the verdict was announced indicating its strong opposition to assisted suicide. According to SAMA chairperson Dr Mzukisi Grootboom, the termination of life is not a proper concern of doctors. "Ethics takes precedent over the laws of a country," he was quoted as saying.

In the wake of the Stransham-Ford verdict, the Steve Biko Centre for Bioethics, run by SAMA's immediate past-president Prof. Ames Dhali, convened a seminar on euthanasia at Wits' health sciences faculty on 14 May. The seminar included Prof. Dan Ncayiyana, Prof. Willem Landman of Dignity South Africa, Dr Liz Gwyther of the Hospice Palliative Care Association of South Africa and Prof. David McQuoid-Mason of UKZN's legal faculty. For a full report, see overleaf.

The HPCSA has also widely condemned the verdict. HPCSA president Prof. Sam Mokgongwe has made it clear that the council's ethics committee is opposed to any form of assisted dying and has warned medical practitioners that the HPCSA will strip practitioners who participate in euthanasia of their right to practise medicine. The HPCSA will do so even if a court has separately determined that a doctor may euthanise a patient.

Dr Wouter Basson

Dr Wouter Basson has taken a few members of the HPCSA's Professional Conduct Committee to court – because of their membership of SAMA! Dr Basson objected to the fact that both professors Jannie Hugo and Eddie Mhlanga are SAMA members, given SAMA's vocal support for removing him from the doctors' roll. Dr Basson also objected to the fact that SAMA members had been engaged as consultants by the HPCSA during the course of his hearing.

Compensation Fund

Months after announcing its Umehluko system to handle the electronic submission of injury-on-duty claims, the Department of Labour's Compensation Fund infrastructure came to a screeching halt due to the fund's inability to process payouts. The new system's failure prompted CompSol, which handles 40 - 60% of claims against the fund on behalf of medical service providers, to withdraw its prefunding service for "at least" six to eight weeks. The move has potentially disastrous consequences for the country's private healthcare sector, which includes a fair number of medical practices built around processing COID claims. SAMA has lodged a complaint regarding the matter with Public Protector Thuli Madonsela. For more on this issue, see page 12.

JUDASA

The Junior Doctors Association of South Africa (JUDASA), a subsidiary structure of the SAMA Trade Union, elected new leaders at its annual general meeting in Pretoria. JUDASA's former vice-chairperson Dr Sadiki was appointed chairperson for 2015/16. See page 16 for a full report.

inPractice Africa

SAMA subsidiary the Foundation for Professional Development (FPD) is collaborating with the US Agency for International Development (USAID) and Wits University to develop an initiative called inPractice Africa, an online learning resource for South African clinicians, particularly those who deal with HIV and HIV/tuberculosis-coinfected patients. inPractice Africa users will be able to participate in CPD certificate programmes and have instant access to practice guidelines and drug reference information. For more information, visit www.inpracticeafrica.com.

Health numbers

- **R23 billion:** The combined value of the more than 231 000 outstanding Compensation Fund claims.
- **11 million:** The number of South Africans estimated to suffer from hypertension.
- **153 000:** The estimated size of South Africa's population of sex workers, 25% of whom can be found in Gauteng.
- **130:** The number of heart attacks estimated to occur daily in South Africa. There are 240 strokes.
- **80%:** The amount of current cardiovascular diseases that could be prevented by reducing salt intake.
- **66%:** The reduction in the number of South African children under the age of two admitted to hospital with rotavirus-caused diarrhoea since the introduction of a new vaccine in 2009.



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Euthanasia controversy debated at bioethics seminar



Conrad Strydom

After Cape Town attorney Robin Stransham-Ford's application to terminate his own life was granted by a High Court judge, many healthcare stakeholders, including SAMA, the HPCSA, the Hospice Palliative Care Association of South Africa (HPCASA) and the Department of Health, reaffirmed their opposition to physician-assisted suicide. According to SAMA chairperson Dr Mzukisi Grootboom, pain is not a persuasive reason to end a patient's life, especially given the efficacy of modern palliative care treatments. "We should rather advocate for terminally ill patients to have access to better palliative care resources," he was quoted as saying.

It was to gain some clarity on this matter that Wits University's Steve Biko Centre for Bioethics, run by former SAMA president Prof. Ames Dhai, convened a special seminar (complete with 4 HPCSA-accredited ethics points) called "Reflections on End-of-Life Decisions" at the Wits Faculty of Health Sciences Building on 14 May. Speaking to a capacity crowd, opening speaker Prof. Willem Landman of Dignity SA and the Ethics Institute of South Africa, noted that the public debate regarding euthanasia was irrelevant since it failed to recognise the authority that the court had exercised in this matter.

"The South African Law Commission issued a report during late president Mandela's time in office which outlined a compelling constitutional basis for euthanasia," Prof. Landman said, "However, this report has remained buried for the last 17 years." Referring to the South African constitution as an ultimately ethical document, Prof. Landman emphasised that the euthanasia debate should properly take place in a legal framework, guided by the ethical structure of the constitution.

"Life can become so lacking in dignity that we should be able to waive our right to it"

"We are here to make a decision about the ethics of this matter," Prof. Landman said, "but before we can do that we must ask ourselves what we base our ethical values on." He noted that the Minister of Health, Dr Aaron Motsoaledi, had warned that doctors should not be seen as "people who kill." But doctors are killing patients every day," he said, "either by withholding treatment or terminating treatment due to resource unavailability and sundry other reasons."

Prof. Landman was dismissive of the call for increased palliative care, stating that palliative care treatments were not optimal and also had no bearing on the legal nature of the argument. He also dismissed Dr Motsoaledi's assertion that legalised euthanasia would lead to abuses, saying that there was a lack of real-world evidence for this based on the history of euthanasia in regions where it was legal, such as Oregon and the Netherlands. He also took issue with the idea that physicians were "taking the will of God into their own hands," pointing out that this depended on which interpretation of God's will one followed.

"It is a legal truism that the right to life as guaranteed in our constitution is ultimately a right not to be killed," Prof. Landman said. "However, life can become so lacking in dignity that we should be able to waive our right to it." He ended his argument by pointing out that it was both ironic and shameful that president Mandela, who had appointed the SA Law Commission to investigate euthanasia 17 years ago, was kept alive artificially for as long as he had been. "I hardly think the late president

appreciated this assault on his dignity," Prof. Landman said.

The next speaker was the chief nursing officer at the Department of Health, Dr Jabu Makhanya, who described the euthanasia issue as "sensitive but significant." She offered that nurses often have a more practical view on health issues, and from a nursing perspective the euthanasia issue was one on which the HPCSA would have to decide. She noted that government policies for terminally ill patients that were suffering a severe amount of pain were clear and did not currently make provision for euthanasia. "However," Dr Makhanya said, "It is not uncommon for nurses to allow terminally ill patients to go home to their families, since they know these patients will die soon. In these circumstances, patients have a right to choose where they would like to die."

The next speaker was former *SA Medical Journal* editor Prof. Dan Ncayiyana, who opened his argument by stating that end-of-life decisions are very complex and depend on the particulars of each case. He referred to three separate cases in his own experience, including the death of his own wife, who passed away before she could reach a decision about ending her own life. "As you can see, each case is unique and there is no such thing as a one-size-fits all approach to this matter," he said. For a minority of people, hospice care was simply not effective enough to counter their pain levels. In addition, studies had shown that pain was often not the main reason for requesting a termination of life.

"The most painful aspect of being terminally ill is that one often can't take of oneself and consequently one becomes a burden to others," Prof. Ncayiyana said. He also questioned the uproar that the High Court decision had caused, "since many more deaths are caused by poor doctor decisions than there ever will be by euthanasia." Ultimately, the case for euthanasia was

"The case for euthanasia is compelling, but it has to take place in a safe and secure environment. South Africa is neither safe nor secure."



Prof. Willem Landman

compelling and consistent with the ethical principles of beneficence and autonomy. "But euthanasia has to occur in a safe and secure environment," Prof. Ncayiyana said, "and I think we all know South Africa is neither safe nor secure. It is first of all a highly unequal country. Secondly, our culture lacks an ethos of respect for life, especially in our public hospitals, where patients are regularly scolded and insulted. This is not an environment where one can make proper decisions about life and death. Lastly, we simply don't have the capacity to supervise a euthanasia programme at the moment."

"Judge Fabricius' decision has no bearing on other courts – it is merely a guideline for future cases of this nature"

The next speaker was HPCASA CEO Dr Liz Gwyther. True to her profession as a palliative care physician, Dr Gwyther asked for greater emphasis to be placed on implementing palliative care programmes in South Africa. "There are many different forms of pain, and we need a holistic approach to deal with each of them," she said. "If we could only treat this

problem holistically, there would be no cause for a euthanasia debate since no one would feel the need for it." Dr Gwyther pointed out that suffering is a highly personal concept and not easy to pin down. In response to Prof. Landman's polemic regarding president Mandela, Dr Gwyther noted that, although the president had undoubtedly been kept alive too long, "all that was really needed in his case was an agreement between doctor and patient to allow natural causes to result in death. This is, however, not the same as actively requesting a doctor to end one's life."

She noted that, while terminally ill patients often suffer from extreme mood swings and emotional outbreaks, "our goal as palliative physicians is to swing with them, not to hold them down in one place." She typified euthanasia as a psychological response to the lack of control terminally ill patients experience. "We all go through life believing that we are in charge of ourselves, but when we learn that this is not true, we seek to reassert our control."

According to the next speaker, UKZN law professor David McQuoid-Mason, the legal issue was both more and less complicated than people thought. "The National Health Act clearly states that you have the right to refuse treatment, so even if euthanasia becomes legal – which it hasn't – you can still refuse to perform it if your conscience dictates you shouldn't." He also pointed out that there was a distinction between active and passive euthanasia. "Active euthanasia is when you hasten, rather than prolong death. Passive euthanasia is when you allow a disease to kill a patient. Only the first one is illegal."

Prof McQuoid-Mason cautioned doctors that in cases of euthanasia, there can be many causes of death, but that the event which finally hastens the death of the patient is seen as the legal cause. "So don't go thinking that the argument 'the cancer would have killed him anyway' holds water in court," he said. He did point out, however, that every case of euthanasia that has been tried under South African law has resulted in extreme leniency from the courts. "One doctor even had his sentence suspended until such time as the judge left the courtroom." He counselled doctors to secure a court order before they attempt to euthanise a patient and to keep in mind that the High Court decision had not legalised euthanasia.

"Judge Fabricius' decision has no bearing on other courts. It merely serves

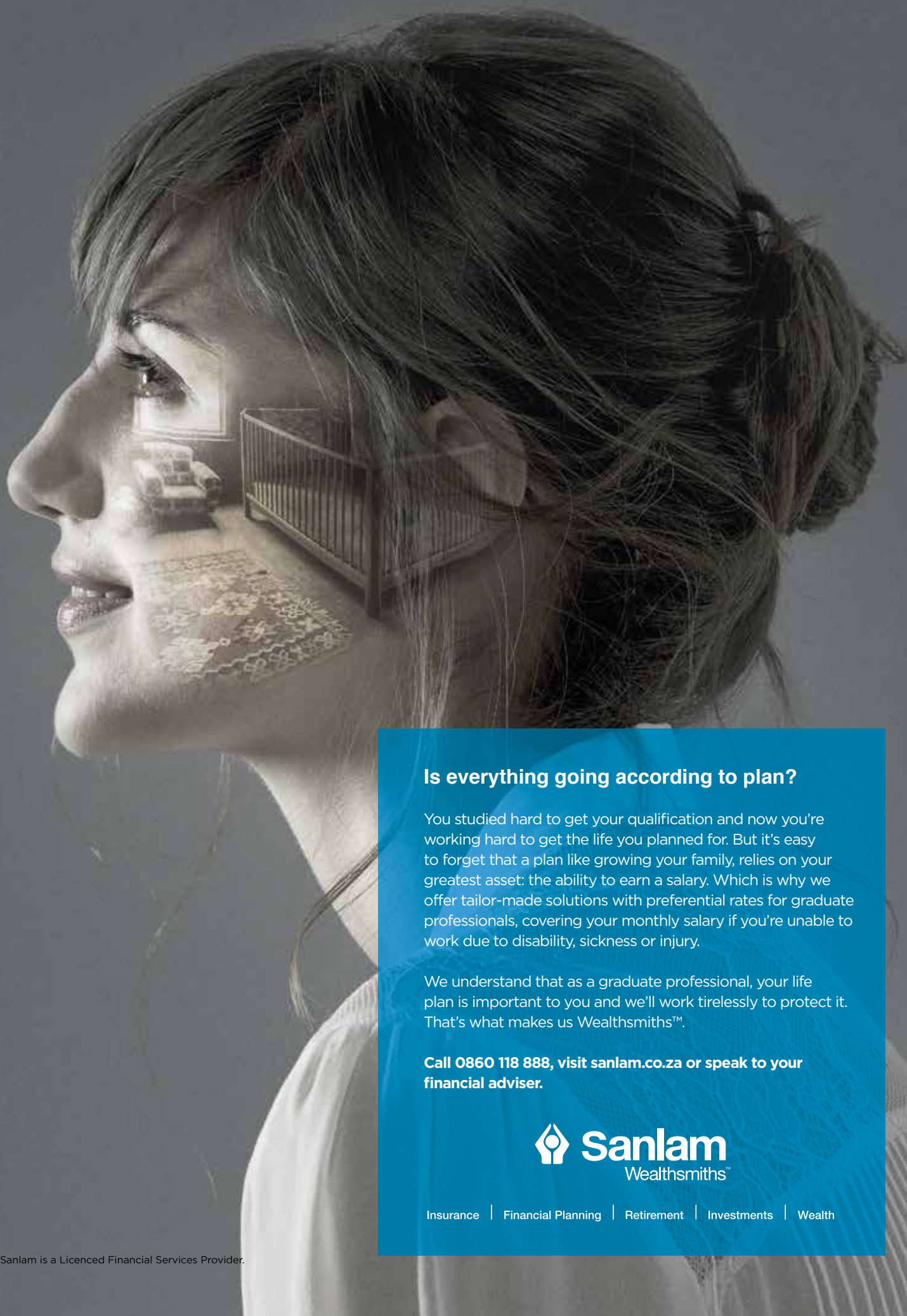
as a guideline for future cases of this nature and judges can even choose to ignore it they wish." After the speakers had finished, SAMA's Dr Grootboom and the HPCSA's Prof. Sam Mokgokong joined the speakers for a brief panel discussion. Prof. Mokgokong stated the HPCSA's position very clearly, indicating that anyone found guilty of euthanasia would be barred from the profession.

According to Prof. Mokgokong, the HPCSA's ethical rules were very clear on this issue. Even in the event that euthanasia should become legal, the HPCSA would only accept euthanasia as valid if the patient was "competent" while making the decision.

"We all go through life believing that we are in charge of ourselves, but when we learn that this is not true, we seek to reassert our control"

Dr Grootboom reiterated SAMA's official view on the matter, referring to euthanasia as "not a doctor's duty" and "bad for our reputation as doctors." He noted that the World Medical Association, to which SAMA belongs, had resolved against euthanasia at its council meeting earlier in the year. "Euthanasia is not simply unethical, it is also unlawful," he said. He emphasised that SAMA supported the HPCSA's view that palliative care was the correct response to excessive pain. "Palliative care has improved to the extent that we don't need to consider euthanasia," he said. In response, Prof. Willem Landman indicated that this view does not take the severe side-effects of many palliative treatments into account. "Besides, very few patients have access to palliative care," he said. "What happens to those who can't afford hospice treatments?"

After a summation by Prof. Laetitia Rispel, head of Wits' School of Public Health, the attendees left with a vivid impression of the complexity of the euthanasia issue and the diversity of viewpoints it engendered.



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Is SAMA still relevant?

SAMA Tygerberg Boland branch

If SAMA wants to be representative and expand its membership, the organisation should help to restore trust and confidence in the medical profession, according to Tygerberg Boland branch president Dr Wim Beukes



Dr Wim Beukes

Is SAMA still relevant in this day and age? This was the question Dr Wim Beukes posed in his presidential address at the annual function of the Tygerberg Boland branch of the South African Medical Association in March, as he focused the spotlight on the role of the Association and its members in the changing context of South African society and the world.

"How does a representative medical association carry the torch of the medical profession in society within an ever-changing world? It is an environment where there is a growing critical attitude towards doctors and the medical profession, the stuff that binds us together," he said.

He pointed out that the cracks were all too visible with sensational media reports highlighting the profession and what it stands for, for all the wrong reasons. While the private sector is blamed for the unsustainable high cost of healthcare for a small percentage of the population, the public sector is censured for failing at the basics of healthcare provision for the rest of the country, despite

spending almost eight per cent of its GDP on healthcare. "If we look deeper we see that it is our medical professionalism that is at stake," Dr Beukes said, pointing to a 2007 white paper by the WMA that describes the skills, attitudes, values and behaviours of those practising medicine. It includes concepts such as the maintenance of competence regarding knowledge and skills sets, personal integrity, altruism, adherence to ethical codes of conduct, accountability, dedication to self-regulation and the exercise of discretionary judgement.

"It is also the moral understanding among medical practitioners that gives reality to what is commonly referred to as the social contract between medicine and society", Dr Beukes said. "This contract in turn grants the medical profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. It is a mouthful to digest and I do believe this definition is not entirely true.

"My opinion of medical professionalism is that our value as individuals and as a profession comes down to trust. It begins and ends there. However, there are factors from the outside and from within which have eroded this sacrosanct value, which means the profession has lost influence on medical matters. We are becoming irrelevant."

According to Dr Beukes this irrelevance is painfully clear when:

- Doctors are not the first person people seek out when they need medical advice
- Patients question and challenge our decisions
- We are definitely not leading the charge in any national issues related to health care
- SAMA is not mentioned once in the 2014 Health System Trust report on the engagement of private doctors in the new NHI
- Contractual agreements with third parties have been taken over by IPAs and managed care administration entities
- We've lost our right to self-regulation to a Health Professions Council which has become an advocate for our patients, but funded by us

- We've lost our collective strength when it comes to negotiations, where we have to piggy-back on bigger unions because there are too few doctors.

"The song, 'I've lost that loving feeling ...' comes to mind, a song ironically sung by the Righteous Brothers."

It is therefore no wonder that the profession suffers from a collective malaise. "We are impatient, off-hand, paternalistic and in many ways, without us even realising it, we have become the doctors that we never wanted to be. As part of the health industry, we became anxious and uncertain about the future because we have no influence on the future. While we strive towards noble ideals, aware of personal and financial sacrifices already made, we as professionals are asking ourselves: 'What for?' This attitude is not only bad for the profession but also for our patients."

He listed some of the external challenges that gave rise to this situation, including:

The exponential growth of technology

"Medical information that once was the exclusive domain of the medical profession is now available at the push of a button. Patients challenge our clinical expertise and question our treatment modalities."

Consumer attitudes and expectations

"The growing intensity of consumer-oriented attitudes has increased consumer expectations. Please note that I refer to the consumer because there has been a clear shift in emphasis. Whereas the consultation process and the doctor-patient relationship previously comprised voluntary participation, good communication, empathy and continuity of care without any conflict of interest, it has now been replaced by the consumer's expectation of a technically confirmed diagnosis (that costs money), at a convenient time and as quickly as possible. In the South African context, with our cultural diversity and differences, the explanation of sickness and the treatment thereof must be comprehensive and comprehensible within the limited time available to us."

Self-diagnosis and self-medication

"This consumer attitude has shifted societal attitudes and led to patients self-diagnosing and self-medicating before they see us. Private enterprise has seen this gap and is advertising unregulated or untested health products on billboards, the *Sunday Times*, *Die Son* and the World Wide Web. It is ironic that most of these products have comfortably passed any accountability for adverse outcomes by stating that 'if you are not sure, please consult your doctor'. This has forced me to include a question on OTC drugs as part of my history-taking. Patients very often justify this by saying, 'I'll rather use natural products' (even if these products are twice the price). They pay out of pocket with no questions asked, but I bear the brunt of an angry patient if he/she has to make a R10 co-payment on a proven, evidence-based drug. Adding to this, the poor doctor needs to be knowledgeable about everything from Brindle berries to Oriental Water Plantain!"

"We've lost our right to self-regulation to an HPCSA which advocates for our patients while being funded by us"

Worrying uncertainties

A final external factor, according to Dr Beukes, is the unfair influence and limitation placed on the individual doctor in the public and private sectors. "Although we have seen praiseworthy changes in healthcare legislation and practice, it is unfortunate that the continuation of unsustainable free-market policies, inadequate economic growth, rapid urbanisation, migration, corruption and poor management of public services have increased health disparities. Whilst the proposal for a national health insurance (NHI) is part of a welcome resurgence in the public discourse about poverty, health and access to health facilities, the White Paper on the NHI is still pending. The NHI pilot districts have failed to engage and to get medical practitioners to contribute with only 175 doctors contracting for the 900

posts for which money has been set aside. Earlier this year, there were palpitations and shortness of breath regarding the Certificate of Need being signed into proclamation by President Zuma and thus, effectively, becoming part of the National Health Act – just to say a week later, 'Don't worry now because there are no regulations in place'. It is this uncertainty that has many doctors worried."

The medical industry and managed care added tremendous additional frustration, forcing doctors to comply with many pre-authorisation procedures, prescribe from multiple complex formulas and collect revenue from a variety of diverse income streams. All of these had an impact on the time doctors spent with their patients, leading to patient discontent. And to add insult to injury, law firms are announcing in prime time adverts that they are ready to give the dying doctor the death blow. Agreeing with this sentiment, the Medical Protection Society used ethics-laden sessions to tell us that most doctors are sued, not for negligence, but because they maligned the profession's core values – respect, trust, empathy, integrity, fairness, accountability, leadership and collegiality.

"The challenges that doctors experience from within their own ranks include the risk of business interests interfering with the interests of patients. Anything affecting a doctor's insights and decision-making to the detriment of a patient should be reconsidered. Whenever our thinking is centred on 'What's in it for me', our consumer interests have vetoed the interests of our patients.

"Our silence about the unprofessional behaviour of a colleague causes suspicion when the public starts wondering whether we are not perhaps ready to protect our profession at all costs."

According to Dr Beukes, the medical profession has not kept pace with the changing expectations of communities. "If we want to restore the doctor-patient relationship, we must restore trust and confidence. Our behaviours created the distrust. If SAMA wants to be representative and expand its membership, the organisation should focus on this problem and re-affirm the definition of medical professionalism and the importance of the doctor-patient relationship.

"That means members should be publicly praised and supported. There should also be an understanding of the things that 'make doctors tick'; that the 'burn-out' currently threatening

the profession, is due to external pressures that cause frustration and uncertainty. We are so angry at each other because of this distrust, we cannot internalise each other's points of view. Government blames money-hungry private medicine and the private sector screams about corruption and ineffective management of public services. The angrier we are, the less we are able to hear what the other party has to say, and how much worse that which they feel, will get.

"Our silence about the unprofessional behaviour of a colleague makes it seem like we are willing to protect our profession at all costs"

"We need to communicate openly and constructively about this loss of trust," Dr Beukes says. "It may involve talking about obstacles, the need for collective help from fellow doctors and awareness of what brought us here in the first place.

"The focus on poorly functioning doctors had distracted from the fact that medicine and the professionalism of doctors have been vital and creative forces for individual and societal well-being."

He emphasised that transparency was especially important in this process. "Let's honestly examine the cost of healthcare, make comparisons and find the middle ground regarding what we are worth in monetary terms. I get the idea that we are so scared to tell our colleagues what we earn because we are worried we're actually doing better than we thought. We cannot claim health as a certainty because we know that our judgement has failed us many times in our careers – not because we made the wrong decisions but because we cannot guarantee life. You all know about cases where, medically speaking, patients had hopeless prognoses but still survived, or cases where patients were doing well and died. We are but instruments in God's hands."



Fully sponsored **ONLINE** Financial Management Course for SAMA Specialists and Registrars

3 CEU's

SHORT COURSE

SHORT COURSE IN FINANCIAL MANAGEMENT

It is imperative that private specialist practices are managed as a well functioning business. Private practices require financial thinking and smart decision making by these specialists. Specialists training unfortunately does not prepare the specialist for managing a practice and more specifically, dealing with money matters.

The FPD launched the short course in financial management to assist specialists who are SAMA members with developing a strong foundation in the basics of accounting and financial literacy. We would like to avoid decisions being made without analyzing the risk and reward or the profit and cash flow of the particular practice. This course will impart the knowledge necessary for private practitioners to understand and manage the financial aspects of their practice.

WHO SHOULD ENROLL

Specialists and Registrars.

COURSE DESIGN

This is an online course. Participants have 3 months to complete the assessment process from date of registration.

COURSE CONTENT

Upon successful completion of this training participants will be able to:

- » Apply personal finance and planning;
- » Demonstrate an understanding of business processes and finances;
- » Explain financial terms and definitions;
- » Interpret financial statements;
- » Identify and demonstrate an understanding of sources and applications of capital in a business;

- » Describe the effect of working capital management;
- » Identify the Golden rules for investments through ratio analysis;
- » Explain the importance of cash flow and demonstrate the ability to effectively manage it;
- » Demonstrate an understanding of budgeting principles and processes; and
- » Describe practical tips to protect practice finance.

ACCREDITATION

Accredited according to the HPCSA CPD Guidelines of November 2006 for 3 CEU points on level 2.

ASSESSMENT

Participants will be assessed by means of a multiple choice questionnaire.

CERTIFICATION

To qualify for the certificate of completion for this short course, participants should successfully complete the assessment process.

COURSE FEE

This course is fully sponsored by Investec for all Specialists and Registrars who are SAMA members.

REGISTRATION

www.mpconsulting.co.za and register your profile. Thereafter you may login and navigate to FPD Business School and access the online events.

FOR MORE INFORMATION

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Member profile: Dr Felicia Tshite-Molamu



Most doctors don't give a second thought to scrubs, the sterile clothing hospital-based doctors have to wear while on duty. Dr Felicia Tshite-Molamu, an ENT surgeon, has given the matter quite some thought, establishing a clothing line composed solely of comfortable, stylish scrub wear that discerning physicians won't mind wearing. You can view her clothing range by visiting www.dreamdoctorcollection.com.

What prompted you to design your own scrubs?

During my first few months as a practising doctor, I realised that the standard-issue scrubs don't distinguish between doctors, nurses and

hospital support staff such as the operating theatre cleaners. This often has quite an effect on some patients and might even damage their confidence in you. That is why I decided to establish the Dream Doctor range. It is a way for doctors to distinguish themselves from other hospital staff and inspire confidence in our patients and in ourselves, because when we look good we feel good. We design scrubs for use while completing your ward rounds and performing general duties, but we also have a range of sterile scrubs for use in theatre. The vast majority of our scrubs are for ladies, since that is where most of the demand has come from, and feature very feminine cuts that accentuate one's figure. Just because you have become a doctor doesn't mean you have to give up on style!

Clothing you wear in theatre must be clean. But when you are finished with a medical procedure, it is nice to do your ward rounds or admin actually feeling like you are dressed in a way that matches your position of authority.

How have colleagues responded to your scrubs design?

Initially there was quite a bit of shock at the idea, but it picked up steam very quickly. I think many doctors are realising that there is a trend in this

direction and have come out in support of me. After all, my clothing fulfils all the functions of regular scrubs, but with none of the drawbacks. There is a great amount of interest in this among the student interns, and they will take the trend forward even if no one picks up on it right now.

Is gender equality alive and well in the medical workplace?

It has definitely improved. There is a good balance between male and female in most of the specialist fields, although there are some exceptions. The undergrads at my alma mater are equally split along gender line, and I find that quite encouraging. The real issue in terms of transformation is the ongoing dominance of white practitioners in some specialist fields, but that will change eventually.

If you could be health minister for a day, what would you do?

I would make sure that all hospital workers wear my scrubs. But honestly, someone needs to invest money in making doctors feel good about themselves. We have a very demanding job and are often neglected. We need someone to appreciate us occasionally and make us feel good about ourselves and our profession. Hopefully, the Dream Doctor collection will contribute to that.

A GP's right to practise balanced billing

Dr Jacob Mphatswe, *Chair: GPPPC*

This method of billing is legal. Balanced-billing is when the service provider sends identical accounts to both the patient and the scheme indicating the full amount for the service delivered, but specifying the portion owed by the patient and the portion of benefits the medical scheme is prepared to pay for the service rendered.

It is permissible to make use of columns on the account to indicate which portion of the total amount constitutes the medical scheme's benefit portion (first column) and the balance portion payable by the patient (second column).

The final column should reflect the total charge for a particular service.

The future of GP private practice

The year 2015 has turned out to be a very challenging and difficult year for GPs in private practice. At the beginning of the year the SAMA General Practitioner Private Practice Committee experienced a huge number of complaints from GPs nationally. The GPs complained that

their private practices were deprived of a well-deserved cash flow. This situation was due to the medical schemes' poor performance on the requirement of the Medical Scheme Act to settle the practice payment within 30 days.

Secondly, there seems to have been a large shift by medical scheme members from higher and better scheme options to the lower schemes. A significant portion of medical schemes members have also downgraded to managed care options. Rather unfortunately managed care options do not offer sustainable professional fees and as a result have become detrimental to the sound financial management of medical practices in general.

Thirdly, the GPs have allowed third parties to determine unsustainable professional fees by accepting the dictatorial approach by funders without the consultation of the profession. Lastly, the current model of financing and managing medical practices has become outdated and out of line with present economic conditions.

Resolution

In the light of the current economic circumstances and demand for improved ethical practice of medicine and provision of quality healthcare, the SAMA General Practitioner Private Practitioners Committee (GPPPC) has resolved unanimously to consult the SAMA GP membership to get their input on the issues surrounding medical scheme contracting and the GP's right to balance bill. The GPPPC is of the view that members should engage in robust and transparent debates to investigate their entitlement to practise balance billing to save the GP profession from unintended consequences of having been denied access to this right. Unfortunately the status quo has occurred partly due to the GPs accepting contracting methods that disallowed them from exercising this right. Ironically, medical aids allow specialists and pharmacies to charge co-payments. Subsequent to the ensuing discussions the GPPPC shall implement the mandate received from the SAMA GPs. Please send your response to the GPPPC via jackieb@samedical.org.



SAMAREC/CPD SERVICES AVAILABLE:

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



WHAT WE ARE ABOUT

SAMAREC:

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

CPD:

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

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

Public service wage agreements for 2015 reached

SAMA Trade Union

Following a lengthy eight-month process of negotiations for revised wages and other terms and conditions of employment for public service employees, the parties in the Public Service Co-ordinating Bargaining Council (PSCBC) reached an agreement on wages and other terms of employment on the evening of 19 May 2015. The agreement reached is a multi term one that will be in effect from 1 April 2015 to 31 March 2018 based, among others, on the following terms:

Salary adjustments

For 2015/16 Financial Year: Seven (7%) per cent across the board [CPI plus 2.2%], implementable from 1 April 2015. The employees will receive a payback in this case as April has passed already.

For 2016/17 Financial Year: A salary adjustment shall be based on the average projected CPI plus 1%. This adjustment will be implemented effective from 1 April 2016.

For 2017/18 Financial Year: A salary adjustment shall be based on the average projected CPI plus 1%, implementable from 1 April 2017.

The other collective agreements that were also signed, in addition to the wage agreement, are as follows:

- Government Employees Housing Scheme (GEHS)
 - This allowance has increased from R900 to R1 200. An important point to remember is that employees who are on cost to company are not eligible to receive or benefit from the housing allowance adjustment (R1 200). However, as per the draft agreement, they will be allowed to participate in the scheme insofar as advisory services are concerned.
- Review of Government Employees Medical Scheme (GEMS)
- Post retirement benefits
- Review of the categories contained in the Danger Allowance agreement
- New danger dispensation for the public service.

For any further information and clarity on the wage agreement, please email the SAMA Trade Union's representatives Adv. Daniel Madiba at danielm@samedical.org and Polelo Ndala at polelon@samedical.org or phone 012 481 2090.

About the Public Service Co-ordinating Bargaining Council (PSCBC)

The PSCBC is an independent organisation that acts as a forum for the settling of labour disputes in the public sector. It was established in terms of Section 35, 36 and 37 of the Labour Relations Act. Since its establishment, the PSCBC has served been central to dispute resolution in the public sector, where large-scale collective bargaining agreements are reached between employees and the state employer on a regular basis. It is a self-funded independent entity, not a government structure.

The SAMA Trade Union is a party to the PSCBC's Public Health and Social Development Sector Bargaining Council (PHSDSBC), along with the Democratic Nursing Organisation of South Africa (DENOSA). Over the years the SAMA Trade Union has used its seat at the bargaining council to advocate for members with regards to (among others):

- Commuted overtime
- Unfair wage increases
- The RWOPS issue
- Unsafe working conditions
- Lack of basic equipment in health facilities.

The SAMA Trade Union's participation at the PSCBC is driven by the ethos of collective bargaining, in terms of which grievances against the employer are best resolved when employees are represented en masse. The latest wage increases, which are higher than those offered by the employer, indicate the efficacy of participation in the council.

Purchase the all new 2015 SAMA eMDCM online

The 2015 SAMA electronic Medical Doctors' Coding Manual (eMDCM) is now available! - previously known as the eDBM -

The 2015 updated program includes:

- All the 2015 Procedural Billing Codes
- New easy to use search functionality
- Own fee can be used to automatically calculate procedural tariffs
- Interpretations and ICD-10 codes included
- For now only available for Windows

SAMA has been the custodian of doctors' procedural codes since 1944. SAMA will continue to produce and protect these codes for future generation of doctors, because they represent the scope of practice of the medical profession.



SAMA eDBM™

Normal Price: R 719

SAMA members' first copy: R 238

To purchase the new 2015 eMDCM visit SAMA's website at www.samedical.org

Register a profile on the website to qualify for the discount

Healthcare needs caring people, not just a budget

Dr Mahlane Phalane, General Secretary: SAMA Trade Union

There is a simple requirement for a healthcare system that wishes to become effective, efficient and responsive: caring, competent and compassionate stakeholders. It is often said that "people do not care how much you know, but how much you care". The biggest problem in our challenged healthcare system is a lack of caring and compassionate stakeholders, coupled with a serious level of incompetence and laziness.

All stakeholders, especially health professionals and communities, must work together to reclaim our healthcare system. We must swiftly displace tendercare and bring back healthcare. We should push aside those who put profit above the lives and health of the people. We should incapacitate or remove those who are unwilling or incapable of driving our ideals of quality and accessible healthcare for all. We ignore the challenges in our healthcare system at our own peril; the lessons of a weak healthcare system in West Africa, as exposed by the Ebola

Without caring, competent and compassionate stakeholders, the health budget brings no hope to the sick and the poor

epidemic should be a wakeup call for us. Medical experts worldwide are in agreement that it is not a question of if but when the next epidemic is going to strike. Is South Africa going to be ready?

The key therefore is not just how much budget is allocated to health, but how that money is going to be used. Are projects and tenders going to be allocated based on genuine needs within the healthcare system or selfishly, in a myopic way, to make a living while killing hundreds of people due to a lack of resources? Unless or until we realise and accept that our actions and omissions can and sometimes actually do result in diseases, disabilities or even deaths, we will never fix the problems in our healthcare system. A cleaner should know that if a hospital is not spotlessly

clean it becomes a breeding ground for deadly bacteria. Security personnel should appreciate that if a hospital is not safe the lives of the patients, their visiting relatives and the staff will be put in danger. Politicians, managers, health professionals and businesses operating in healthcare must know that there is no wealth without health. The most pertinent question to us is no longer how much money has been budgeted for health, but how much of it is really going to be used for much needed, life-saving programmes and projects. Without caring, competent and compassionate stakeholders, the health budget brings no hope to the sick and the poor, instead representing a selfish opportunity to get rich while punishing the less fortunate.

Doctors salute nurses on International Nurses Day

SAMA Trade Union

The South African Medical Association Trade Union (SAMATU) would like to salute the nurses in South Africa and around the globe for being the backbone of the healthcare system. Today marks International Nurses Day under the relevant theme of "A Force for Change; Care Effective and Cost Effective". We would like to thank our nurses for taking care of the sick, for being

advocates for patients, and for supporting doctors in treating patients.

SAMATU would like to call upon nurses in line with today's theme to become a force for change and join us in changing our healthcare system for the better. Let us together strive for the realisation of our Positive Practice Environment campaign. Let us together reclaim those hospitals and clinics where the nursing matron and the medical superintendent are

running real and caring healthcare, not our current dispensation of selfish tendercare with no regard to the plight of the sick and the poor. We wish our nurses strength, wisdom, dedication, a limitlessly caring attitude and professionalism in discharging their noble responsibility of nursing the wounds and illness of our people. As doctors, we too deserve a national and international day of reflection and celebration of our noble profession.

SAMA saddened by death of Dr Ramathuba's father

SAMA Communications Department

It is with deep sadness that the South African Medical Association has learned of the passing of Mr Tshavhumbwa Reuben Ramathuba of the village of Mashamba in Venda, Limpopo. Mr Ramathuba was

the father of Dr Phophi Ramathuba, the President of the SAMA Trade Union and a member of the SAMA Board of Directors, on which she serves as an Executive Committee member.

SAMA wishes to take this opportunity to express its deepest condolences to Dr Phophi Ramathuba, her family, friends and colleagues during this time of mourning. May the soul of Mr Ramathuba rest in peace.

Young doctors impress at JUDASA AGM

Conrad Strydom



The newly-elected JUDASA national executive committee has undertaken to tackle issues facing junior doctors in South Africa

Issues affecting the country's junior doctor corps were addressed at the Junior Doctors Association of South Africa's (JUDASA) recently-held elective annual general meeting. Taking place over the weekend of 18 and 19 April at the stately Kievits Kroon Hotel on the outskirts of Montana, Pretoria, the JUDASA AGM saw young doctors from all over the country gather to discuss issues of relevance to their practice environments and to agree on resolutions that will guide the association in the year ahead. The attendees included one JUDASA member from the Free State who had recently become the country's youngest hospital CEO.

The meeting saw a host of speakers tackle difficult issues including the poor working environment and lack of resources in public health facilities, the poor supervision of interns during their training, poor remuneration for junior doctors and misguided government policies regarding continuing professional development programmes.

After a welcoming address by outgoing JUDASA chairperson Dr Courage Khoza, SAMA Trade Union president Dr Phophi Ramathuba took to the podium and expounded on the current state of public healthcare. According to Dr Ramathuba, the public health system has deteriorated to the point where doctors can never feel comfortable at their workplaces. "The employer is using a divide and rule strategy in the workplace," she said. "And we are letting them get away with it. Instead, we should join hands with the nurses and other health workers to make sure the employer knows his place." She referred to employers who actively incite some parts of their workforce against other parts. "They are making the rounds at

hospitals and telling the nurses 'Those doctors think you're stupid', while telling the doctors 'Those nurses are incompetent'. Their real objective is to prevent us from uniting."

The outbreak of xenophobic attacks in Johannesburg and Durban was constantly on the agenda, with both JUDASA and SAMA Trade Union representatives expressing their solidarity with foreigners working in South Africa. This was despite the enormous burden that illegal foreign residents have on the public health sector. "Some hospitals have too many illegals," Dr Ramathuba said. "Since they are not counted as citizens, hospitals can't get resources allocated to service them."

It was agreed that the best way to increase the association's membership was to provide services to non-members as a way of demonstrating the association reach. As many speakers pointed out, the strength of JUDASA and the SAMA Trade Union lay in their direct access to some of the country's top health decision makers and growing reputation as agents of change in public healthcare.

An interview with the new JUDASA chair

SAMA Insider asked newly-elected JUDASA chairperson Dr Tshilidzi Sadiki to share his vision for the association and the future of healthcare in this country. Dr Sadiki served as vice-chairperson during the 2014/15 period.

What do you see as the purpose of JUDASA?

JUDASA is there to look after the interests of all junior doctors, such as interns and community service doctors, and also to introduce junior members to the ethos and causes we hold dear at the SAMA Trade Union. We take up issues such as the poor quality training many junior doctors receive and fight against things that hamper their career development. An example is the fact that many junior doctors who have their training sponsored by either their provinces or the national Department of Health have to work in public service for a certain number of years as a provision of these sponsorships. However, their internships and community service years are not counted when determining how many years they have to work off. We see this as a patently unfair labour practice.

Do you have any special projects lined up for this year?

We have a number of special projects. One is our annual medical circumcision programme, which we run during the winter school holidays. We are also very keen on travelling to schools and getting the students to choose a career path in medicine. We recently visited a secondary school in Bogom, Polokwane to do just that. We have received great feedback regarding these programmes, from the public and our fellow doctors alike.

What is the most pressing issue facing junior doctors?

The most pressing issue is the issue of proper supervision. Doctors in training are often deployed to the rural areas where there is a distinct lack of specialised doctors who are capable of supervising them. As a result, junior doctors are not learning evidence-based medicine anymore, and this is a disaster for our country's healthcare sector. Due to a lack of equipment and drugs available to them during training, many junior doctors who were deployed to remote areas struggle to compete with their more learned counterparts.

We also strongly object to the Department of Health's continuous abuse of junior doctors by seeing us as part of a workforce, not as trainees. We are deployed on internship and community service in order to learn, not to plug gaps in the department's service delivery.

What will it take to change the healthcare sector in South Africa?

First, we must start running programmes encouraging high school learners to enroll in medicine. Second, we need to encourage the funding of underprivileged learners who wish to become doctors. Third, we must provide mentorship programmes to these learners once they become medical students. These mentors must be junior doctors who know the struggles medical students have to go through. Fourth, we need to make sure that this support is continuous and lasts until the junior doctor can stand on his or her own two feet. Many people complain about the lack of health professionals in our country, but what they don't see is how many prospective doctors don't finish (or don't even start) their studies due to financial difficulties.

Head of MPS's Africa desk fields queries

Conrad Strydom



Dr Graham Howarth is MPS' go-to guy for their African market. As head of medical services for Africa, Dr Howarth supervises MPS' activities on South African soil, where close to 10% of the society's members reside. He is a Stellenbosch medical graduate and former UP lecturer with a clinical background in obstetrics and gynaecology.

Despite many official denials to the contrary, rumours that MPS plan on leaving the South African market persist among local practitioners, owing largely to the society's withdrawal of its medico-legal consulting service in 2012. At the time, MPS explained away the resulting confusion by stating that the move was part of a process whereby telephonic consultations were being centralised in their UK office. The worsening medical litigation climate in South Africa has, however, prompted new rumours

of a pull-out. *SAMA Insider* managed to ask Dr Howarth about this and other matters.

The big question most South African practitioners want answered is whether MPS still retains confidence in the South African private healthcare sector given the litigation crisis we are experiencing?

I can confirm that MPS does indeed retain confidence in the South African private healthcare sector. We will operate in South Africa for as long as South African practitioners want us to stay.

Would MPS consider withdrawing from the South African market if the situation here becomes untenable?

MPS has been in South Africa since 1957 and certainly has no intention of leaving. MPS operates in many challenging environments throughout the world and we remain 100% committed to operating in them.

South African health minister Dr Aaron Motsoaledi has mentioned the UK and New Zealand as countries which have succeeded in managing their own healthcare litigation crisis. Can South Africa learn anything from the way things are done in the UK?

There can be no doubt that South Africa can

learn from other systems. We understand that there is currently a ministerial task team investigating health systems in other countries and we welcome any such effort. MPS is also considering this issue in some depth, and hopes to publish policy recommendations based on our findings later in the year.

Given doctors' notoriously high levels of job stress and the gravity of their responsibilities, do you believe doctors are often treated too harshly when they make mistakes?

There can be little doubt that doctors in South Africa work under difficult conditions, but I have no reason to believe that they are treated harsher than doctors that we assist in other jurisdictions. Medicine is not a stress-free profession and the nature of the job demands a lot from you.

Is MPS at all concerned about section 56 of the Health Professions Act, which, if implemented, could broaden the scope of unnatural death under South African law and potentially lead to even more litigation cases?

With respect to any broadening of the definition or understanding of an unnatural death, I think it is unlikely to lead to an increase in litigation, although I appreciate that it may give rise to an increase in medicolegal matters.

SAMA responds to euthanasia ruling

SAMA Human Rights, Law and Ethics Committee

On the 30th of April last week, a judge in the Pretoria High Court granted an application by Advocate Robin Stransham-Ford to be assisted by a willing and qualified medical practitioner to end his life either by the administration of a lethal agent or by providing him with the necessary agent to administer himself. In other words, the applicant was granted the legal right to die and the doctor who assisted in his demise would not be prosecuted. The High Court emphasised that the order should not be read as endorsing the proposals of the End of Life Decisions Bill in the Law Commission report of November 1998. It also highlighted that the Order applied only to

this index case and that anyone who required the assistance of a medical practitioner to commit suicide would need to approach the Court and that each application would be considered on its own merits. Fortunately, the patient had died that morning prior to the Court Order being issued.

Notwithstanding the Court decision that the medical practitioner who assisted the patient would not be held accountable criminally or civilly, the South African Medical Association (SAMA) cautions its practitioners that the Health Professions Council of South Africa's (HPCSA) Policies nevertheless remain in force and such activities by practitioners could result in disciplinary sanctions by the HPCSA.

SAMA also highlights the value of palliative care for the relief of pain and suffering for patients who are terminally ill and stresses that pain cannot be viewed as a persuasive enough reason to resort to the extreme measure to end one's life. Healthcare practitioners have obligations to patients in the palliative care setting and these duties extend to that of advocating for access to quality palliative care for patients who are terminally ill. SAMA does not support the right to die in law and opposes euthanasia and doctor-assisted suicide in line with the HPCSA's policies and the World Medical Association's Guidelines and Codes on the subject.

7th SA AIDS CONFERENCE

9-12 June 2015

ICC Durban

Reflection, Refocus and Renewal

Abstracts are invited for the following Conference track themes:

- Track 1: **Basic and Clinical Sciences**
- Track 2: **Epidemiology, Prevention and Public Health**
- Track 3: **Social, Economic Sciences and Human Rights**
- Track 4: **Best Practices, Programmes and Ethics**
- Track 5: **Community Exchange Encounters**

Abstracts can be submitted online at www.saaids.com



Important Dates

1 December 2014

Closing date for early registration

20 January 2015

Closing date for abstract submissions

16 February 2015

Closing date for scholarship applications

22 May 2015

Closing date for pre-conference registration

9 June 2015

Onsite registrations

www.saaids.com

Stroke after carotid surgery

The Medical Protection Society shares a case report from their archives

Miss C, a 30-year-old accountant, developed an asymptomatic left-sided neck lump. A CT scan revealed a 23 x 17 x 27 mm mass at the carotid bifurcation consistent with a carotid body tumour. Miss C saw a vascular surgeon, Professor A, who noted there was no significant medical or family history and confirmed that she was normotensive with no neurological signs.

He explained that this was a rare tumour with the potential for malignancy and recommended surgical excision, which he undertook the following day. Miss C signed a consent form completed by Professor A for "radical excision of left carotid body tumour".

During surgery, the carotid bifurcation was damaged, resulting in rapid blood loss of approximately 1 100 mls. Professor A recorded that the bleeding was controlled by clamping the common carotid artery three times for a total of 16 minutes. The injury was repaired "with difficulty" using a 5/0 prolene suture and at the end of the procedure there was good flow in the internal carotid artery.

Postoperatively, Miss C was transferred to the ICU where she was extubated and initially appeared drowsy, but had no obvious neurological deficit. She remained stable overnight but the following morning appeared drowsier and was noted by the nursing staff to have profound right-sided weakness.

Dr B, ICU anaesthetist, reviewed Miss C and attributed her drowsiness to opiate toxicity and prescribed naloxone. Miss C's condition did not improve and when Professor A saw her, he arranged an urgent MRI scan. This demonstrated a large left middle cerebral artery territory infarction with complete occlusion of the entire extra-cranial left common carotid, internal carotid, external carotid arteries. Despite further intervention by the ICU team and neurosurgeons, Miss C suffered permanent brain damage with severe hemiplegia and cognitive impairment requiring continuous nursing care.

The family of Miss C initiated proceedings against Professor A and Dr B, as they were critical of numerous aspects of their care.

Expert opinion

Expert opinion agreed that arterial bleeding from excision of a carotid body tumour is a



well-recognised and inherent potential risk of such surgery and Professor A handled this complication in an appropriate and timely manner. Although questioning the need for three periods of carotid clamping, it was felt that the total time of potential cerebral ischaemia was relatively short and the alternative approach of arterial shunting carried its own additional risks.

Postoperatively, Miss C initially appeared neurologically intact and experts therefore felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also agreed that while anti-coagulation may have prevented thrombus formation, such a strategy would have carried a high risk of major haemorrhage and was contraindicated.

The experts raised concerns regarding the failure of the nursing staff to inform the medical team immediately when Miss C demonstrated neurological deterioration. Dr B was also criticised for not performing a full neurological evaluation and wrongly attributing the decreased conscious level simply to opiate toxicity. It was speculated that the resulting delay in the diagnosis and treatment of Miss C's stroke may have led to a worse neurological outcome.

However, the main focus of criticism centred on the consent process. Experts questioned why Professor A carried out surgery the day after the initial consultation, given the slow growing nature of carotid body tumours. Miss C's family felt the process had been rushed

and that she had not fully understood the magnitude of the risks of surgery.

Indeed, there was no documented evidence that any of the major complications had ever been discussed and Professor A accepted that the process of informed consent had been inadequate.

The case was settled for a high sum, reflecting the severe neurological outcome and the need for continuous care.

Learning points

- Communicating within the team is important – the nursing staff did not inform the medical team of the patient's deterioration – consider a team approach for raising concerns.
- Good communication and documentation are essential in the process of consent. Patients must be made aware of the risks of surgery and their implications. This should include common complications as well as any serious adverse outcomes, including rare complications, which may result in permanent disability or death. Patients need to be able to weigh up the benefits and risks of medical intervention so that they can make an informed decision as to whether they want to proceed.
- Complications can and do occur and are not necessarily a sign of negligence.
- Litigation can be prevented or successfully defended if patients are warned about the risks in advance and this discussion is recorded.

SAMA mourns passing of Dr Pol Doussy

SAMA Gauteng North Branch

It is with great sadness that SAMA's Gauteng North branch has learnt of the passing of one of its most long-standing members, Dr Pol Doussy. Dr Doussy, a familiar face to colleagues and branch members alike, passed away on 14 April at the age of 91. Born in the Netherlands on 23 February 1924 to Belgian parents, Dr Doussy

moved to Pretoria in 1950 after receiving a postgraduate study grant from the Belgian government. From 1954 to 2014, Dr Doussy operated in private practice in Pretoria. He spent many years involved in the South African Medical Association (then MASA) as treasurer and later president of the Gauteng Branch. He was also a past member of MASA's

Federal Council, General Practitioners' Group and Finance Committee. In addition to his medical degree from the University of Ghent and MB ChB from Tuks, Dr Doussy also held a BA in Archaeology and the History of Art from the former institution. He will be sorely missed by his colleagues, patients and surviving family members.

Physician leaders urge governments to protect healthcare

World Medical Association

The World Medical Association (WMA) is urging governments around the world to ensure that several major trade agreements they are negotiating will protect, promote and prioritise public health and the provision of health care. The WMA has also expressed grave reservations about the level of secrecy surrounding discussions on the agreements, which it described as anti-democratic.

At its recent Council meeting in Oslo, WMA leaders approved an emergency resolution which welcomed the aim of trade agreements to produce economic benefits, but demanded firm assurances over four new agreements - the Trans Pacific Partnership, the Trans Atlantic Trade and Investment Partnership, the Trade in Services Agreement and the Comprehensive Economic and Trade Agreement.

The resolution added that a proposed mechanism for investors to bring claims against governments could be used to challenge evidence-based public health laws including tobacco plain packaging and could threaten tobacco control, alcohol control, regulation of foods and beverages, access to medicines, healthcare services and environmental protection and climate change improvements. Such challenges may undermine efforts to improve health, tackle the social determinants of health and ultimately harm patients.

WMA President Dr Xavier Deau said: 'We are asking our national medical association members to urge their governments to ensure that these trade agreements do not interfere with governments' ability to regulate health and healthcare, or to guarantee a right to



health for all. We want governments to oppose any provisions and mechanisms which would compromise access to healthcare services or medicines.

'The negotiation of these agreements has been one of the best kept secrets of our time. Negotiating documents are withheld from the public and parliaments. While this secrecy continues, the medical profession has every right to be cautious and suspicious. These agreements must not interfere with governments' ability to regulate health or healthcare or to guarantee a right to health for all.'



Mr A Lamera is the current recipient of the Tygerberg Boland branch's student bursary



The Tygerberg Boland branch recently granted lifetime membership to doctors who have been part of the association for 40 years or more, including Dr F van der Riet (right), pictured here with branch chairperson Dr Wynand Goosen



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KEYNOTE SPEAKERS

ASSA Prof Walter Biffi (USA)	SASES Prof Didier Mutter (France)
SAGES Dr Nageshwar Reddy (India) Dr Ailsa Hart (UK) Prof Chris Mulder (Netherlands)	VASSA Prof Iris Baumgartner (Switzerland) Dr Nils Kucher (Switzerland)
TSSA Prof Herman du Plessis (SA)	



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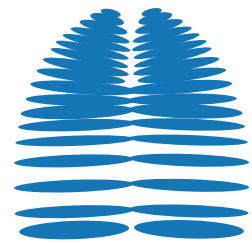
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