

SAMA INSIDER

JULY 2015

**Free State crisis:
SAMA doctors
speak**

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PUBLISHED AS A SERVICE TO ALL MEMBERS OF
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CONTENTS

JULY 2015



- 3 **EDITOR'S NOTE**
Unfortunately, they have a point
Conrad Strydom
- 5 **FROM THE PRESIDENT'S DESK**
Towards sustainable relevance
Prof. Lizo Mazwai
- 6 **FEATURES**
SAMA news in brief
SAMA Communications Department
- 7 **Free State healthcare in crisis**
Conrad Strydom
- 11 **Member profile**
Conrad Strydom
- 12 **SAMATU news**
SAMA Trade Union
- 13 **National TB and HIV hotline for health workers**
SAMA Communications Department
- 14 **MEDICINE AND THE LAW**
The right to fair labour practices – the Constitutional and Labour Act context
Mpotlana Daniel Madiba
- 15 **Fatal condition**
Medical Protection Society
- 16 **GENERAL NEWS**

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Conrad Strydom
Editor: *SAMA INSIDER*

Unfortunately, they have a point

Day is around the corner for the South African private health system, if the Department of Health's (DoH) submission to the Competition Commission is anything to go by. The submission, which is available on the commission's website, makes it clear that the DoH believes what private health providers have been denying for years: that their costs are exorbitant and that patients are being milked for every possible cent.

The minister, in case none of you noticed, has made reforming private healthcare something of a pet project, an adjunct to his overriding aim of ushering in universal health coverage via the National Health Insurance (NHI) programme. Right now NHI, without so much as a White Paper visible, is the driving force behind healthcare in this country, causing pre-emptive manoeuvring in both private and public sectors. The problem for private practitioners is that the minister is not simply pushing a pet programme; he has a point, multiple ones. Hospital and specialist markets are indeed subject to concentration – graphs prepared by UCT's Health Economics Unit prove as much. The current healthcare structure places no emphasis on preventative medicine because there is no profit incentive to do so – who can argue with that? A lack of regulations regarding service definitions and coding have given rise to an environment where medical aids can improvise costs at their discretion – this is also unfortunately true.

The private sector may yet escape censure on these issues thanks to any number of legal acrobatics, but, much as one does hate to side with government, ethics is on the side of the minister in this case, and the public has taken notice. Private professionals would do well to adapt now, being in the privileged position of having the shape of future changes to their work environments in clear sight long before they arrive.

Our lead article this month is an in-depth look at the state of the public health system in the Free State, taken from interviews with members of SAMA's provincial branch structure. While the situation is indeed dire, many of these courageous doctors remain hopeful of change in the future. You can read the article on pages 7 to 9.

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MEMBER BENEFITS

Towards sustainable relevance



Prof. Lizo Mazwai, *President: SAMA*

In my previous articles for this publication I have addressed matters of reform and transformation in medical education and training, including the mode and site of education delivery. These proposed reforms were intended to impact positively on the profession in terms of improved quality of healthcare service delivery, and were tailored to fit the particular healthcare system we favour in our South African context. However, many other factors besides our educational structure have also been identified as impacting on our profession and practice, and need to be addressed with all urgency. These factors are by and large external or parallel developments to the profession and are often not issues that are of the profession's making. The question we must ask ourselves is

how the profession has responded collectively to the changes that these developments have brought about.

One of the major stakeholders – and perhaps *the* major stakeholder – that healthcare service providers in this country must take note of has been and remains the South African Medical Association. I have had occasion to address other forums on issues affecting South African healthcare and one of the most disturbing questions that kept being posed to myself and others was how relevant the profession is in addressing and responding to the changes that we face, and whether we are capable of responding to them as a collective. The need for this collective response indicates why SAMA is of the utmost importance and why we have the utmost relevance in the South African context.

Key issues

The key issues at these discussions revolved around leadership, governance, membership and organisational relevance in a changing environment or world order. An evaluation of these issues has to occur in the face of a challenge to maintain a balance between existing, time-honoured and tested social and professional values against a rapidly changing world order dominated by materialism, consumerism and a post-modern philosophical approach towards ethical values. Many of these issues are relevant to us, and should be explored thoroughly, not so much in hope of answers but to stimulate debate regarding them.

Organisations can by nature easily become bureaucratic institutions that adopt conservative

values in order to maintain stability. This has the danger of being inflexible and causes the organisation to run the risk of being irrelevant. Organisations should also be dynamic and flexible enough to adapt appropriately to a changing environment and emerging challenges.

The need for collective response indicates why SAMA is of the utmost importance and why we have the utmost relevance in the South African context

Adaptability

Herein lies the crux of relevance – the extent to which an organisation, its leadership and membership are capable of accommodating and adapting to change in an imaginative, innovative and visionary way while maintaining the organisation's integrity, values and stability. This includes the ability to identify factors that impede or retard progress and abandoning them, and the ability to retain factors that promote and facilitate progress. The key to this process is to maintain a legacy that can bridge inter-generational gaps in order to sustain relevance in the future.

Transformation in health education

Recently released material suggests that progress has been made in transforming the demographic make-up of South African medical students, although faculty members are still overwhelmingly white. The following information was collected in a survey of four South African universities by the *Mail and Guardian*.

UCT: In 2015, UCT's first years were 33.9% black, 27.7% white, 22% coloured and 11.8% Indian with 4.4% belonging to other demographics. The number of black students is down from 49% in 2010. The medical faculty is currently 64% white, 10% black, 8% Indian and 15% coloured.

Wits: 47.2% of first-year medical students are black, followed by 19.6% Indians, white students at 17.9% and coloured students at 3.7%. Although impressive, the ratio of black students is significantly less than the 63.3% who enrolled in 2010. Wits' medical faculty is mostly white, these comprising 62% of faculty numbers, followed by black lecturers at 20%, Indians at 12% and coloured 6%.

UFS: Long-running efforts at transforming the university's health sciences seem to be paying off, with 46% white students (down from 73% in 2010), 33% black, 11% coloured and 10% Indian as of 2015. The university faculty is another matter, with 84% white lecturers, 9% black, 6% coloured and 1% Indian.

Stellenbosch: SU's first-year students are 38.7% white, 27.7% coloured, 22.1% black and 11.5% Indian. The proportion of white students is down from 47% in 2010, and the number of black students is up from 12.5% in 2010. The university's faculty is 74% white, 13% coloured, 7% black and 6% Indian.

The fact that many qualifying black candidates are from disadvantaged backgrounds and can't afford to study medicine is being cited as the main reason for the low intake of black students at most universities, while UFS chancellor Prof. Jonathan Jansen attributed the high proportion of white medical academics to a scarcity of black doctors willing to teach in a higher education context.

SAMA news in brief

Drug stocks depleting

Drug stock-outs are becoming more and more prevalent throughout the country, posing a severe threat to patients with chronic conditions such as HIV/AIDS and TB. Health department officials have variously denied the shortages or blamed them on "circumstances beyond our control." Of particular concern are the national shortage of ARVs and injectable penicillin, although SAMA vice-chairperson Dr Mark Sonderup has noted that these are just the tip of the iceberg and that drug shortages have reached crisis proportions. SAMA chairperson Dr Mzukisi Grootboom, meanwhile, condemned the shortages but noted that stock-outs have been a constant feature in provinces such as KwaZulu-Natal for the last 10 years at least. "This is nothing new. The state is simply refusing to govern and use the mandate given to it by taxpayers," Dr Grootboom was quoted as saying.

Dr Ramathuba appointed Limpopo Health MEC

Dr Phophi Ramathuba, the long-serving president of the SAMA Trade Union and active member of the National Council and Board of SAMA, has been appointed MEC for Health in Limpopo on the recommendation of provincial premier Stan Mathabatha. Her appointment was part of a shake-up of the Limpopo cabinet that saw several MECs released from service or redeployed to other portfolios.

In a statement released shortly after her appointment was announced, SAMA acknowledged Dr Ramathuba's enormous contribution to the public health sector and the struggle for improved labour rights for South African doctors. "On behalf of the

association, we thank her for what she has contributed and wish her all the best in her new endeavour. We know she understands the challenges of healthcare in the public sector better than most and believe that she is well poised to tackle these challenges in her province in order to improve the services and lives of our people," said SAMA chairman Dr Mzukisi Grootboom. Dr Ramathuba has resigned as SAMATU president and as chief executive officer of Voortrekker Hospital in Mokopane.

Sparks fly at SA AIDS Conference

The seventh annual SA AIDS Conference, organised by SAMA subsidiary the Foundation for Professional Development (FPD), did not pass by uneventfully this year, with a number of shake-ups occurring at the well-publicised event. The Treatment Action Campaign (TAC) caused quite a stir by renewing its call for the resignation of Free State Health MEC Benny Malakoane while Malakoane was seated in the audience, citing corruption and mismanagement. This echoes reports from SAMA's Free State branch that indicate the province is suffering a crisis comparable to the situation in the Eastern Cape. On the final day of the conference, health minister Dr Aaron Motsoaledi acknowledged that the country's drug supply is dwindling and disclosed the fact that South Africa has no available BCG stocks to protect infants from contracting TB.

Tim Noakes hearing postponed

The HPCSA hearing of SAMA member and Banting diet guru Prof. Tim Noakes has been postponed until November 23 of this year. Noakes, whose revival of the Banting diet

has caused a sensation locally, is charged with unprofessional conduct after advising a mother to place her infant on a low-carb, high-fat diet via his Twitter feed. The unprofessional conduct charge, brought by Association of Dietetics of South Africa (ADSA) chairperson Claire Strydom in February, has been criticised as excessive, since it places Noakes in the same category as serious offenders like Dr Wouter Basson, and could result in him being struck from the doctors' roll. However, the situation has been welcomed by Noakes himself, since he believes it will force the HPCSA to investigate the nutritional value of his diet as opposed to infant diets recommended by organisations such as ADSA which typically include large servings of cereal, a Banting no-no.

Health numbers

- **40 billion:** The projected annual rand cost of South Africa's HIV programme by 2033, more than double the R21 billion currently spent on it.
- **3.1 million:** The number of South Africans currently receiving ARV treatment.
- **1.2 million:** The number of pregnancies that occur annually in South Africa.
- **670 000:** The number of new patients that need to be placed on ARVs every year if the National Development Plan 2030's HIV/AIDS-related goals are to be met.
- **383 354:** The number of pregnant women who have signed up for the Department of Health's MomConnect programme, nearly four times more than in any comparable programme globally.



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Free State healthcare in crisis

Conrad Strydom

At the recent seventh annual SA AIDS Conference in Durban – an event organised by SAMA subsidiary the Foundation for Professional Development (FPD) – activists from the Treatment Action Campaign dramatically refocused attention on the woes of the Free State health department when they called for the resignation of Health MEC Benny Malakoane. Malakoane, who was present at the conference, was not acknowledged by Deputy President Cyril Ramaphosa when he welcomed dignitaries to the event, raising hopes that cabinet is finally taking the state of the province's healthcare system seriously.

The provincial health department has been under administration since last year, burdened with a crippling R700 million debt and allegations of systemic mismanagement and corruption. Non-payment of salaries, among a host of other difficulties, has resulted in an exodus of senior medical officers from the province's public health system and morale is generally low. Comparisons have been drawn to the collapse of public healthcare in the Eastern Cape, although there is a belief that the Free State's problems have not been as widely publicised.

Despite setbacks, doctors in the province have adopted a "grin and bear it" approach while struggling to make the best of a difficult situation. *SAMA Insider* spoke to some representatives from the Free State's SAMA branch structure to determine what the situation on the ground is like and what the future holds for the province's beleaguered healthcare system.

More than politics

"The major problem with the Free State health crisis is that the media has portrayed it as a political issue," one SAMA doctor said, on condition of anonymity. "For health workers, it is an emotional and ethical issue. I don't care about internal issues at the health department; my problem is seeing patients with meningitis sleeping on the floor or on makeshift bunks, without medication to alleviate their pain."

The sentiment is echoed by other Free State doctors, who generally express distaste at the way problems within the provincial health department have overshadowed service delivery issues on the ground. Malakoane's continued tenure as Health MEC also raised very few eyebrows among the doctors surveyed. When political machinery did intrude in the workplace, it was often in the form of intimidation against whistle-blowers or workers



Pelonomi Regional Hospital has suffered severe equipment and drug shortages during the past decade

critical of department policy, particularly after a damning report written by anonymous doctors that appeared on activist website *groundup.co.za* earlier this year necessitating an official response from the provincial health department.

"When Netcare tried to fix our broken toilets, they were thrown out and told not to interfere in health department matters"

"A culture of intimidation extends throughout the entire system," the anonymous source said, "People that are vocal about the situation are targeted personally and victimised. You may for instance find yourself subject to disciplinary hearings for the slightest infraction if you speak up, while colleagues who keep their mouths shut are left alone." The source detailed how both SAMA Trade Union and Democratic Nursing Organisation of South Africa (DENOSA) were being targeted for raising labour issues with hospital managers. "Even people who work at the department's own complaints hotline are discouraged from reporting these complaints to their superiors. It's ridiculous."

Both hospital managers and the upper echelons of the Free State health department

displayed no interest in applying workplace legislation such as the Labour Relations Act in health facilities, multiple sources noted, with some typifying the situation as "lawless". Political appointments and cronyism have also contributed to the alarming exodus of medical officers from the province, particularly at the Universitas complex, as detailed in the *Groundup* report. "As many as nine HODs have left Universitas this year alone," said Welkom-based Dr Mathabo Hlahane, general secretary of SAMATU's Free State provincial executive committee (PEC). "Patients are being turned away in droves because of a lack of personnel, but HR managers are doing nothing to replace the doctors that have left."

Stock-outs

Central to the worsening crisis is the lack of basic medical supplies, a countrywide problem that is particularly keenly felt in the Free State. According to Dr Deon Menge, immediate past president of SAMA's Free State branch, even the most basic wound dressings are seldom available and patients are forced to default on their medications. "Some of the shortages are bizarre, such as the fact that there is not a single gastroscope in the entire province," he said. "But what is most concerning is the lack of mesh for operations, causing some procedures to be delayed for up to six months."

At Pelonomi Hospital in Bloemfontein, hospital management has not ordered new surgical gloves in well over a year and Dr Menge relates having to order bulk packs of Evergreen plastic gloves from a local store as a substitute. "These gloves are of terrible quality



Despite budget shortfalls, hospitals in the Free State have been receiving Panorex dental x-ray machines whether they have dental facilities or not

and we often have to change them up to eight times during an operation,"he said,"and when you try to use the cautery, the current shocks you right through the glove." However, he noted that these shortages were not universal throughout the province. "I know for a fact that doctors at Universitas have excellent gloves."

"If the department could just ensure there are enough consumables, half of the issues in the province would be solved"

Dr Hlahane can't remember the last time she saw essentials such as pethedrine or high blood pressure medication in stock at Bongani Hospital. "If only we had access to wound dressings, at least we could attempt certain operations, but we often don't have even that." Even commonly available items such as laundry detergent and printer ink are in short supply. According to an anonymous source, doctors often joke

about using the "pharmacist's catch of the day" when in need of antibiotics, using whatever antibiotic medication is on hand – obviously a suboptimal state of affairs. "The ARV stock-outs are most keenly felt, especially since the national Department of Health is always citing ARV rollout as one of its success stories." Intravenous nutrients, ECG paper, cardiotocography paper, tuberculin and numerous other essentials are in very short supply with no indication of when – or if – new stock will be arriving.

There are also concerns that some of the supplies that do get restocked are being acquired via middle men that charge exorbitant fees for their services. "Look at the example of Draw-Tex, a wound dressing which is produced right here in Bloemfontein for R200 a packet," Dr Menge said. "For some reason, the department awarded a tender for Draw-Tex to an international firm that charges R600 a packet. We have reason to believe that there are middlemen in the supply chain who are pocketing excessive profits from transactions like these.

"If the department could just ensure that there are enough consumables to go around, half of the issues in the province would be solved," Dr Hlahane noted. Even food is in scarce supply at hospitals, however. At hospitals such as Pelonomi, the health department is trying to save money by taking away staff meals for doctors who work shifts of up to 30 hours. "It used to be that you would at least get a meal to see you through the long hours, but now even that has been taken away, in direct contravention of labour legislation," Dr Menge said.

The area around Pelonomi is dangerous, particularly at night, yet doctors at the hospital are forced to venture into the surrounding neighbourhood in search of food at "ungodly hours of the night.

"This is especially dangerous for the female doctors," Dr Menge said. "A few years ago a female paediatrician was raped here at Pelonomi and that memory is still very fresh in all our minds."

It is not only drug supplies that are in short supply, however. Gaining access to basic equipment appears to be a constant struggle and existing equipment is not replaced when it breaks down. Doctors complain about struggling to adjust old, heavy theatre beds, with a number developing back problems as a result. If patients require a CT scan, they could find themselves referred to hospitals that they have no means to travel to, due to a bizarre confluence of events that has seen hospitals with CT scanners without trained radiologists to man them while hospitals with radiologists on the payroll lack CT scanners. When equipment does arrive, it is often not quite what health workers had expected. As

noted in the Groundup expose, Panorex dental X-ray machines, which cost up to R250 000 each, were delivered to every hospital in the province in the last few years, whether they offer dental services or not.

"The building blocks for a great public health system are here, but we need to persevere"

Sometimes health officials will heed a call to expand hospital facilities, but neglect to fill newly-built expansions with the equipment necessary to run them. Consistently, requests to purchase equipment for empty wards get lost in the health department bureaucracy. At Pelonomi, work on a state-of-the-art ICU ward was begun seven years ago, but was never completed due to reasons that have never been explained. "It should have taken six months to build that ICU, but seven years later we still don't know what the status of that project is," Dr Menge said. This is situation is similar to that of the medical facility constructed at Trompsburg in the southern Free State, which was completed last year but has remained unopened due to a dispute between the provincial departments of health and public works.

Broken elevators have in the past required hospital workers to carry patients up and down stairs. Even dead patients have to be removed from wards by carrying them down staircases, often within sight of terrified patients who are awaiting treatment. To add to staff discomfort, the toilets at Pelonomi have been non-operational for close to ten years. Staff have shown the broken toilet facilities to MEC Malakoane but the department has yet to send a team to the facility to address the issue. "When Netcare, who shares some facilities with us, decided to intervene and send a team to fix the toilets, they were thrown out and told not to interfere in health department matters," Dr Menge said.

Staff exodus

The exodus of staff from formerly prestigious facilities such as Universitas has been the most devastating blow to the provincial health system. The problem not only extends to doctors, with support staff and nurses also abandoning state facilities in droves. There is particular unhappiness among junior staff

“I don’t care about [politics], my problem is seeing meningitis patients sleeping on the floor without medication”

members about the treatment of the 117 healthcare workers who were suspended earlier this year because they protested the situation in the province.

“It’s crazy having to work like this,” Dr Hlahane noted. “One of the issues that worries us most during the working day is how few specialists we have left. There are no obstetricians and gynaecologists at Bongani Hospital here in Welkom, nor any stenographers. Often there is simply nothing we can do for patients.”

Human resources and labour issues lie at the heart of staff dissatisfaction. Recently, many medical officers and sessional doctors in the Free State resigned because they hadn’t been paid for three months. “That is an example of how one problem is creating another,” said SAMATU industrial relations advisor Simon Buthelezi. “Since these sessional doctors are mostly employed due to staff shortages. However, since there is no money to pay them, they quit and staff shortages are compounded even more.”

Bonuses are never paid to doctors, possibly due to the size of these bonuses compared to those of junior staff. “I can’t remember the last time a bonus was paid to any doctor in the Free State,” Dr Menge said. “It doesn’t even matter to the employer that they are legally obliged to do so.” Staff shortages have also meant that the doctors who stay behind often have to work shifts of 30 or more hours. They are seldom remunerated for these long hours under the department’s commuted overtime policy.

“The political infighting also means that the presence of staff at management level is not stable,” Dr Hlahane said. “We do not have a CEO or clinical manager here at Bongani because they were suspended for reasons that are still unclear to us. This kind of thing also results in registrars leaving the province because there is often no one to train them.”

Even the province’s steady stream of interns is under threat, since the poor conditions at provincial hospitals have resulted in multiple ultimatums from the Health Professions Council of South Africa (HPCSA). If hospitals are judged unfit for patients, the HPCSA can revoke their training licenses and reassign their interns, decreasing staff numbers even further. The province’s huge backlog of patients bears witness

to the devastation wrought by these shortages. “Six months is the current waiting period for surgeries,” Dr Menge said. “Obviously, many of these patients die before they get to theatre.”

SAMA intervention

According to Dr Hlahane, the SAMATU PEC has made repeated attempts to sit down with the MEC of Health and premier Ace Magashule, to no avail. “We are being ignored more often than not,” she said. “The government is completely unwilling to reach a consensus with outside parties. It is only when someone threatens to go to the media that they jump.”

Although the provincial department is difficult to deal with, many local SAMA branch members believe that some progress has been made over the last five years. “There have been many small victories in this battle so far,” Dr Menge noted. “We used to have huge problems keeping equipment sterile – that’s been sorted out. SAMA has taken matters into its own hands at times, and we have fixed roads around hospitals, installed fences and security cameras and ensured that doctors who have not been paid in months get their money. The province is certainly going through a rough patch, but very active work is being done behind the scenes by organisations like SAMA, DENOSA and the TAC to fix the situation, and we are winning, slowly but surely.”

Despite difficulties in their training environment, Free State registrars still maintain a 100% pass rate, and the province’s medical trainees often finish in the top 10% countrywide. The province’s woes have also seen a surge of activism among local health professionals that was not present a decade ago. “If you look at where we are now, compared to where we were ten years ago, you have to admit that we have come a long way.”

The Free State’s SAMA membership has risen steadily over the last few years as doctors begin to see how essential labour issues are to contemporary medical practice. “People are noticing that SAMA gets things done when other organisations can’t,” Dr Hlahane said. “When salaries don’t get paid or doctors get intimidated, we are the only ones with the clout to fix these issues.”

There is consensus among Free State branch members that the entire Free State health department needs to be dismantled and



A patient, after an operation, lies on the floor in a Free State health facility

reassembled from the ground up. “Everything from the university to the peripheral clinics need urgent attention,” Dr Menge said, “but we are confident that this can happen.” It remains to be seen what – if anything – will happen to improve service delivery at the provincial health department. Both Premier Magashule and MEC Malakoane have so far appeared untouchable, although the deputy president’s recent refusal to acknowledge the MEC could indicate that a change is on the way.

“I know how tough it is,” Dr Menge said, “but now is not the time to abandon ship. We are on the verge of turning things around in the Free State, but we need health workers to stay and help. If there is no one around to attend to patients, why would the department even bother implementing the changes we have been asking for? There are many positives. Even here in Pelonomi, which is one of the worst hospitals in the country right now, we have one of the world’s best-equipped laparoscopic simulation units. The building blocks for a great public health system are here, but we need health workers to persevere.”

The Free State health crisis in a nutshell

- The provincial health department is R700 million in the red.
- There are widespread stock-outs of essential consumables like ARVs, painkillers and wound dressings.
- Labour laws are consistently flouted and doctors often go unpaid for months at a time.
- Allegations of corruption and mismanagement have followed the provincial health department, which has been under administration since last year.
- The lack of medical supplies and poor working conditions have resulted in an exodus of health workers to provinces such as the Western Cape.



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

Member profile: Dr Munyadziwa Kwindiwa



Although SAMA and the Health Professions Council of South Africa (HPCSA) are at odds on many issues, a fair number of SAMA members work for the HPCSA. The two organisations are also frequently mentioned together in the media, as happened during Dr Wouter Basson's recent encounters with the council. Apart from being an active member of SAMA, Dr Munyadziwa Kwindiwa is also a senior official at the HPCSA, serving as the council's ombudsman. A family physician, Dr Kwindiwa has a BSc degree from the University of Venda, an MB ChB from the University of KwaZulu-Natal, and an MMed from Medunsa. He is currently completing an MSc (Med) in Bioethics and Law at Wits. In his spare time Dr Kwindiwa serves as the pastor of Christ Worshippers Church on the corner of Thabo Sehume and Bloed streets in the Pretoria CBD, a stone's throw from the Department of Health.

How does the future look for South African healthcare?

I must disagree with the prophets of doom and say that our future is looking very bright. For the very first time, those in charge of healthcare policy in our country are taking an active approach towards reforming the entire system. This is very apparent when one looks at the outline of National Health Insurance (NHI). It is a policy that is very clearly aimed at sweeping reforms that will simultaneously bring the greatest benefit to health workers and to our patients. When one also looks at what the Department of Health is trying to do at the Competition Commission, one can only describe it as courageous. They are trying

to do what no one has had the courage to do so far, which is enforce pricing regulations in private healthcare. The fact that we have a health department that is independent enough to take such actions gives me plentiful hope for the future.

What challenges do you face at the HPCSA?

The most obvious issue is that we need to ensure that doctors are given more guidance on complying with health legislation and the council's rules. Based on the kinds of complaints we deal with, it is becoming obvious that there is a lack of clarity concerning one's obligations as a doctor. We as the HPCSA need to improve the guidance we extend to practitioners, especially regarding fees. Most practitioners think that it is sufficient to tell their patients that they charge 'medical aid rates' or a 'standard fee'. Doctors who do this are not being specific enough. Many of them know exactly how much the procedure will cost but don't inform their patients because they don't want to scare them away. In my view, this is a very serious offence that amounts to fraud, but the HPCSA has been handing out slaps on the wrist for it. If this is how we deal with fraud, how can people take us seriously? Both the HPCSA and SAMA must make it clear to practitioners that patients must always be informed of the exact rand value of a procedure in terms of section 53 of the Health Professions Act, section 6 of the National Health Act and section 7 of the HPCSA's Ethical Rules. Patients have a right to make an informed decision about their treatment options and practitioners must inform patients about the cost of services. The HPCSA is drawing up rules for informed consent that will further address some of these issues.

What are the most common avoidable mistakes doctors make?

There are quite a few! Firstly, it is very surprising how few doctors take medical reports seriously. It must become an essential part of your daily routine. These reports may not be important to you, but they are very important to your patients. There have been instances where patients have lost their jobs because doctors haven't filled in temporary incapacity forms on their behalf. Reports must be issued promptly; it is just one of those things that practitioners

must attend to. What's more, the significance of every question in these forms must be understood. Communication between doctors and patients is also poor across the board. Doctors need to learn what it is they have to communicate with patients and how to communicate it. Above all, doctors must never, ever use their receptionists to communicate clinical information. This is surprisingly common, and it will reflect very badly on you should a matter so communicated end up in court or at the council. Another issue of concern is the rise in defensive medicine. Doctors are even cutting patients loose if they don't take their medication. SAMA needs to address these issues too, by organising CPD courses to educate doctors.

For the very first time, those in charge of healthcare policy in our country are taking an active approach towards reforming the entire system

What is SAMA's role in the current medical climate?

SAMA has a very important role since it is the only organisation that can unite doctors in both private and public practice and that can ensure that the conditions of service are good enough to practise in. SAMA can highlight the issues that need intervention and engage the Department of Health like no other organisation can. SAMA can also do much to rectify policies such as RWOPS, which the evidence suggests is being roundly abused. We have even found that many RWOPS doctors who are employed by the state full time are instead running private practices full time. Conversely, private doctors who are contracted to do session work in public hospitals are instead subcontracting other doctors to do the work and keeping a 'finder's fee' to themselves.

SAMATU



RWOPS update – June 2015

The South African Medical Association Trade Union (SAMATU) has been dealing with the issue of Renumeration for Work Outside the Public Service system (RWOPS) for many years, advocating for a solution that will benefit all parties concerned. Unfortunately, we have had very little success in this regard. We treat this matter with all the urgency and

seriousness it deserves. We have previously consolidated all the inputs made by you, our members, and submitted them to the national Department of Health. The department's draft paper on RWOPS has been sent to us for final inputs and we will not rest until this issue is resolved and our members are able to practise in peace.

We have further engaged with the Government Employees Medical Scheme (GEMS) and made it perfectly clear to them that RWOPS is a matter between the state employer and its employees. GEMS has no business interfering in labour relations issues such as RWOPS. We thank you all for your inputs and will keep you updated on developments in this critical matter.

Limpopo desperately needs a medical school

The people of Limpopo desperately need a medical school to help meet their ever-increasing health needs. It has been over twenty years since plans were first made to start a medical school in Limpopo. The people of Limpopo have suffered enough: the dire shortage of specialists, the lack of hospital beds despite increasing demand, and the lack of a state-of-the-art tertiary hospital in the province deny the millions of people in Limpopo access to high-quality specialised healthcare services.

The South African Medical Association Trade Union (SAMATU) calls for the immediate implementation of plans to establish a medical school in Limpopo. This will eradicate the province's ineffective and inefficient patient referral system. The training would be decentralised

to help improve the accessibility and quality of specialist care in peripheral hospitals within the province. This would further help with the recruitment and retention of scarce health professionals. We demand a world-class medical school that will be a centre of excellence. It must be internationally competitive, a research and development institution and a centre for a caring approach to medicine. SAMATU will work tirelessly until this desperate need is met in preparation for the implementation of National Health Insurance (NHI). To this end a provincial meeting of doctors, nurses and other stakeholders will be held in Polokwane at Bolivia Lodge on 30 May 2015. The meeting will be addressed by the national Minister of Health, Dr Aaron Motsoaledi.

Doctors must adapt or die professionally and financially

SAMA Trade Union

The medical profession must make a decision to adapt or die both professionally and financially. The Department of Health's current review of policies such as commuted overtime and session contracts, their banning of RWOPS, their failure to implement occupational specific dispensation (OSD) and the performance management development system (PMDS), and the increasingly challenging working conditions in public healthcare will only get worse unless we stand up as individuals and as a profession to

face them head on. Leadership is as strong or as weak as the membership it serves.

Mahatma Gandhi told us long ago to "be the change we want to see". We must add to this by paraphrasing Steve Biko to tell you that "doctor, you are on your own". In trying to address the above challenges, and any other challenges you may be facing, we recommend that you attend the following doctors' congress:

Date: 30 May 2015

Time: 09h00-16h30

Theme: Reclaiming our profession

Guest Speaker: Honourable Minister of Health, Dr Aaron Motsoaledi

Venue: Bolivia Lodge, Polokwane

It is your choice whether you continue to be a highly qualified and hard-working professional but a poorly treated doctor, or stand up and make a difference. If you don't stand up for yourself and your profession, no one will.

RSVP now, since space is limited, by contacting Vuyisani at samalpb@samedical.org or 015 295 7899.

National HIV and TB hotline for health workers

SAMA Communications Department

The HIV/AIDS epidemic is a phenomenon every practising South African healthcare worker will have to deal with during the course of their career.

The Medicines Information Centre (MIC) situated within the Division of Clinical Pharmacology, Department of Medicine at the University of Cape Town is the largest and only clinically-based medicine information centre in South Africa. It is dedicated to providing unbiased, up-to-date and well-researched drug information, in consultation with a multidisciplinary healthcare team. In collaboration with the Foundation for Professional Development, USAID and PEPFAR, the MIC provides a toll-free national HIV and TB hotline to all healthcare workers in South Africa for patient treatment-related enquiries.

Call them – they will gladly assist you! Alternatively send an SMS or 'Please Call Me' to 071 840 1572. This service is free and is brought to you as a result of the generous support of the American people through USAID and PEPFAR.

What questions can you ask?

The toll-free national HIV and TB healthcare worker hotline provides information on queries relating to:

- HIV testing

- Post exposure prophylaxis: healthcare workers and sexual assault victims
- Management of HIV in pregnancy, and prevention of mother-to-child transmission
- Antiretroviral therapy
- When to initiate
- Treatment selection
- Recommendations for laboratory and clinical monitoring
- How to interpret and respond to laboratory results
- Management of adverse events
- Drug interactions
- Treatment and prophylaxis of opportunistic infections
- Drug availability

- Adherence support
- Management of tuberculosis.

When is this free service available?

The hotline operates from Mondays to Fridays 8.30am – 4.30pm.

Who answers the questions?

The centre is staffed by specially-trained drug information pharmacists who share 50 years of drug information experience between them. They have direct access to the latest information databases and reference sources and the clinical expertise of consultants at the University of Cape Town's Faculty of Health Sciences, Groote Schuur Hospital.



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Code

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Enter one or more keywords or select item codes to search.

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3.2.2	3.2.2
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3.2.3	0583

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

The right to fair labour practices – the Constitutional and Labour Act context

Advocate Mpotlana Daniel Madiba

The Labour Relations Act (LRA) 66 of 1995, provides in terms of Section 185(1)(b) for the right not to be subjected to unfair labour practices, and defines an unfair labour practice in section 186(2) as follows: 'Unfair labour practice' means any unfair act or omission that arises between an employer and employee involving:

- Unfair conduct by the employer relating to the promotion, demotion, probation (excluding disputes about dismissals for a reason relating to probation) or training of an employee or relating to the provision of benefits to an employee.
- The unfair suspension of an employee or any other unfair disciplinary action short of dismissal in respect of an employee.
- A failure or refusal by an employer to reinstate or re-employ a former employee in terms of any agreement.
- An occupational detriment, other than dismissal, in contravention of the Protected Disclosures Act, 2000 (Act No. 26 of 2000), on account of the employee having made a protected disclosure defined in that Act.

The courts have held that this list of unfair labour practices is exhaustive (*Nawa v. Department of Trade and Industry* [1998] 7 BLLR 701 (LC) at 703) which means that an act or omission by the employer that does not fall within the scope of one of the above would not amount to an unfair labour practice as envisaged in the LRA. The Public Service Coordinated Bargaining Council (PSCBC), Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) and the Commission for Conciliation, Mediation and Arbitration (CCMA) have jurisdiction to adjudicate unfair labour practice disputes as defined by the LRA.

We have now seen that the definition is much narrower and that it brings about certain limitations in the pursuit of unfair labour practice disputes at the workplace. Employees might view certain acts or omissions by the employer as unfair but these may not be recognised as such in

It is clear that if s186(2) of the LRA does not cover the conduct on the part of the employer, which is perceived to be unfair, the employee is not left without recourse

terms of the narrow definition of contained in the LRA.

So what if an act or omission does not constitute an unfair labour practice as per the LRA? Does it mean that employees do not have any recourse? Employees may seek recourse under the Constitution in certain circumstances, if the above situation applies.

Constitutional recourse

Section 23(1) of the Constitution affords everyone the right to fair labour practices. This provision and its meaning in relation to the LRA were dealt with in the case of *Mathews v. Glaxosmithkline SA (Pty) Ltd* [2006] 27 ILJ 1976 (LC). In this case the employee was retrenched and offered a different severance package than what other employees had been given in the past. The employer was of the view that they did not have an obligation to pay the same severance benefits to different employees. The employer's conduct did not fall within the definition of an unfair labour practice as set out in s186(2) of the LRA and the employee pursued the matter on the basis that his constitutional right to fair labour practices as per s23(1) of the Constitution had been breached. The employer argued that the employee was not entitled to any course of action as his claim fell outside the scope of unfair labour practices as defined by the LRA and that if the Labour Court found that the conduct did in fact constitute an unfair labour practice as per the LRA definition, the matter should have been referred to as a relevant dispute resolution forum and the court would therefore not have jurisdiction.

The court was of the view that if there was no reasonable explanation for treating

these employees differently, the employee would have a claim under s185 of the LRA for unfair dismissal (which would equip a suitable dispute resolution forum with jurisdiction). If it was a matter of unfair discrimination, the employee might then have had the right to pursue the issue in terms of s6 of the Employment Equity Act. There was, however, evidence of reasonable grounds for differentiating between employees and the court therefore had jurisdiction as there had been no unjustified differentiation or unfair discrimination.

The Labour Court held that any party who alleged that a practice was not regulated by the LRA could approach a court as a result of the provisions of s23 of the Constitution. It should, however, be noted that there would only be a course of action under the constitution, if the LRA did not regulate a specific matter which amounted to a breach of a person's constitutional right to fair labour practices (the so-called 'constitutional avoidance' principle). In this case the court was satisfied that the employer's conduct was challenged on reasonable grounds.

It is clear that if s186(2) of the LRA does not cover the conduct on the part of the employer, which is perceived to be unfair, the employee is not left without recourse. Matters of unfair discrimination would be pursued through a suitable forum, based on the provisions of section 6 of the Employment Equity Act and unfair conduct not falling within the ambit of the LRA or the Employment Equity Act could be challenged in the Labour Court. Although taking an issue to Labour Court may be a costly affair, it might provide the protection and justice which one is unable to obtain through the LRA's narrow definition of an unfair labour practice.

Fatal condition

The Medical Protection Society shares a case report from its archives

Mrs J, a 62-year-old housewife, did not visit her GP often. However, she consulted Dr D with a two-week history of coryzal symptoms. Apart from hypothyroidism, she was otherwise fit and well, but for the previous fortnight she reported lethargy, body aches and a cough productive of green sputum. Dr D recorded a temperature of 40°C with a pulse of 102, respiratory rate of 24 and oxygen saturation levels of 95%. Despite a lack of chest signs on auscultation, he commenced treatment for a lower respiratory tract infection, prescribing co-amoxiclav and clarithromycin, which the patient had taken in the past without problems.

The following day Mrs J felt worse rather than better and her husband requested a visit at home. This time she was seen by Dr A, who found that her fever continued and she now had a sore throat and a rash. Her husband mentioned that she had been confused through the night and had been hallucinating. Dr A measured her temperature at 40.5°C and found her throat to

be red and swollen with bilateral exudates. He documented a blanching rash on her chest and back, which appeared to be erythema multiforme. He also noted bilateral conjunctivitis, for which he started chloramphenicol.

Since she also complained of thrush, Dr A added Canesten to his script and advised Mrs J to give the antibiotics longer to work, and to take paracetamol, ibuprofen and fluids to control her fever.

Mrs J continued to deteriorate and the following morning she called the surgery again. She spoke to Dr C, explaining that she was unable to swallow any medication due to her sore throat. The rash and fever were ongoing. Dr C converted the paracetamol and antibiotics to a dispersible form and advised she crush the clarithromycin. She advised the patient to seek medical attention if the fever persisted once she managed to swallow her medications.

Later that day, Mrs J deteriorated further and her husband called the surgery, this time speaking to Dr B. She was now unable to swallow fluids at all. Dr B advised she would need IV treatment and told them to go urgently to the Emergency Department (ED). The ambulance transferred them to hospital within 30 minutes.

On arrival in the ED a temperature of 39 was recorded. Mrs J was noted to have macules and papules with urticarial plaques and bullous erythema multiforme over her face, scalp and neck as well as her trunk (30% of her body). Oral ulceration and conjunctivitis was present.

A diagnosis of Stevens-Johnson syndrome was made, presumed secondary to penicillin or to mycoplasma pneumonia, and she was transferred to the ICU where she remained for over a month. CXR showed a left lower zone consolidation and skin swabs detected herpes simplex virus, which was treated with acyclovir. By the time Mrs J was discharged from ICU her skin had greatly improved, but she had become colonised with *Pseudomonas* and suffered with recurrent chest infections. She had significant muscle loss, which required intensive physiotherapy.

Another month after being discharged to the ward, Mrs J's breathing began to deteriorate and she was transferred back to ICU with severe type 2 respiratory failure attributed to toxic epidermal necrosis (TEN), and associated bronchiolitis obliterans. She was intubated, ventilated and treated with methylprednisolone, cyclophosphamide and IV immunoglobulin. Despite this, Mrs J continued to deteriorate and died.

Expert opinion

Experts reviewing the case were critical of Dr A and considered she had breached her duty of care in this case. When she visited Mrs J, there was a clear deterioration in her condition. She was febrile, hallucinating and had a widespread rash. Dr A maintained that she had been concerned about the patient but felt that hospital admission would not have changed the patient's treatment at this point.

It was unclear whether the Stevens-Johnson syndrome was drug-induced and expert opinion agreed that it was reasonable for Dr D to have commenced antibiotics in a patient with no history of drug allergy, who had been given both of the medications in the past without problems. It proved difficult to speculate on whether or not earlier withdrawal of these medications would have affected Mrs J's outcome.

MPS served a detailed letter of response, defending the claim on a causation basis. As a result, the case was discontinued.

Learning points

- Take care to revisit the earlier diagnosis of another doctor, especially if the condition has changed. Treatment does take time to work, but in this case, a more careful assessment was needed in light of the changes in the patient's condition. Expert opinion agreed hospital admission should have been initiated earlier for Mrs J, but was unlikely to have made a difference to the overall outcome.
- The decision as to whether to admit patients to hospital is often very difficult – documentation of observations is important so that if there is any uncertainty later regarding a hospital admission, someone reading your notes can be clear how the patient was at the time, and why you agreed on the course of action.



Health must be given higher priority in climate summit

World Medical Association



Physician leaders are pressing for health issues to be given a greater priority. Prompted by the recent preparatory discussions in Bonn for the climate change summit to be held in Paris in December, the World Medical Association (WMA) has urged its 111 national medical associations to make their voices heard.

The WMA, representing 10 million physicians worldwide, has written to its members urging them to write to their national negotiating representatives to emphasise that climate change is the greatest global health challenge of the 21st century.

Physician leaders have serious concerns about the adverse effects of climate change on health, such as disease and injury, increased malnutrition, and premature deaths, particularly among the most vulnerable populations.

In its letter, the WMA says: "The coming 21st Conference of the United Nations Framework Convention on Climate Change next December constitutes a decisive opportunity to address these challenges through an effective universal agreement

"Adverse effects of climate change on health [include] disease and injury, increased malnutrition, and premature death, particularly among the most vulnerable"

bringing health to the forefront of the global warming debate and mitigating the severe health risks facing the world."

WMA President Dr Xavier Deau said he was very concerned that crucial health issues were being ignored in the build up to the summit and time was running out for the voice of the health community to be heard.

He said the negotiations needed to transform energy systems from fossil fuels to renewables. "Reducing fossil fuel consumption improves air quality and public health, as well as mitigating climate change. Last week's resolution by the World Health Assembly on air pollution is a clear and positive step towards the improvement of the lives and health of millions of people who suffer from poor air quality. However, we believe that much more needs to be done globally and domestically to take fully into account the health

impact of climate change and to engage the health sector in the process.

"Improving insulation in homes and buildings can protect people from extreme temperatures and reduce energy consumption. We need to get people to adopt a more active lifestyle. So we need to see an expansion of public transport systems to improve health through increased physical activity and reduced air pollution.

"All these changes would provide significant economic savings. Climate action that recognises these benefits can improve health, support sustainable development, and advance global equity.

"National medical associations have a vital part to play in persuading the world that the impact of climate change on health is one of the most significant measures of harm associated with our warming planet."

Gauteng North looking for 'feel-good' stories

SAMA Gauteng North

The SAMA Gauteng North branch wants to hear from any of its members who helped the injured during the recent xenophobic attacks in the province, or who have done – or know someone who has done – work that uplifts patients and their communities or alleviates suffering. Many Gauteng North branch members have been known to go above and beyond the call of duty before and the branch

council believes it is high time that their stories are made known. Too much negative information has been presented about doctors in the past. To counter this media trend, the sterling work of our doctors needs to be made known to the public and their peers via publications like *SAMA Insider*. Send your feel-good stories or information about our unsung heroes to samagnb@samedical.org or call (012) 481 2102.

Cape Western branch seeking donations for Mandela Day

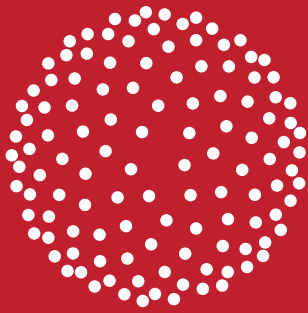
Dr S M Lison, Chairperson: SAMA Cape Western Branch

During the Cape Western branch's last branch council meeting the branch resolved to participate in the Groote Schuur Hospital Tin Drive. This initiative aims to donate tins of food to benefit the aged and has been highly successful in the past. The branch is eager to make a difference in the lives of the elderly and would appreciate all the assistance it can get in this matter.

The Cape Western branch would like to appeal to all its members to assist by donating tinned food parcels as part of the branch's activities for Mandela Day 2015. In 2014, the branch managed to donate R6 700 to the Baphumelele Orphanage in Khayelitsha. The Baphumelele Orphanage has been open since 1989. Run by community leader Rosalia Mashale, Baphumelele operates a number of community outreach projects and has even set

up a preschool for underprivileged kids in the Khayelitsha area. Tins can be dropped off at the office of the Cape Western Branch at Suites 9 and 10 of the Lonsdale Building, cnr Lonsdale and Gardner Way, Pinelands before Friday 17 July 2015.

For enquiries please contact Emily at emily@samacwb.co.za or Chenienne at chenienne@samacwb.co.za or on 021 532 3910 during office hours (08h30 – 16h00).



ASSHH

Association for the Social Sciences
and Humanities in HIV

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IMPORTANT DATES

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for abstract
submissions

27 March 2015

Closing Date for
early registration

19 June 2015

Closing date for
pre-conference
registration

6 July 2015

Onsite registration

The 3rd International ASSHH Conference **RHETORIC AND REALITY** **6 - 9 July 2015**

Building on the success of the first two ASSHH (Association for the Social Sciences and Humanities in HIV) conferences in Durban (2011) and Paris (2013), the 2015 conference will critically examine the growing gap between rhetoric and reality in the national and international HIV response.

Of strong interest to researchers, policy makers, programme managers, community workers and practitioners, this 3rd conference will provide opportunities for wide-ranging discussion and debate on the following themes:

- (Re)-writing the history of AIDS: whose facts, whose visions, whose stories?
- An 'epidemic of signification' – cultural and media representations 30 years on, in the era of PrEP and 'universal' access.
- Sexual orientation and gender identity – a new or enduring battleground?
- The politics of 'practice': research and practitioner perspectives on programme development.
- Power, politics and resistance: the demise of agency in the face of constraint?
- Positive nostalgia(s) and the international HIV response.
- Renewing social sciences and humanities research in the response.

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