

SAMA INSIDER

AUGUST 2015

**SAMA calls for
judicial review
of Compensation
Fund**

**Free resources for
SA doctors**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
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COMMON CLINICAL PROBLEMS AND THEIR SOLUTIONS

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Conrad Strydom
Editor: *SAMA INSIDER*

We need more shrinks

A recent article in the *Sunday Times* asked readers to take a test to see whether they had succumbed to "South Africanosis" and were "as crazy as their country". As facetious as the article was, it did contain a kernel of truth, as anyone who recently watched parliamentarians making donkey noises could attest; we are a bit nutty. More's the pity, then, that a 2012 study revealed there are only 320 practising psychiatrists in the entire country, representing a ratio of one for every 150 000 citizens. This is despite the fact that nearly one in three South Africans will suffer from a mental disorder in their lifetime.

As early as 2000, data already indicated that neuropsychiatric disorders ranked third in their contribution to South Africa's national burden of diseases. Psychiatrists are particularly concerned about the prevalence of depression and related disorders among HIV patients, a silent epidemic that is seldom considered. This indifference to mental health issues is also apparent in the low priority given to psychiatric medications on the Essential Drug List. As a result, psychiatrists in the public sector (only 120 at last count) are among those most affected by drug stock-outs. Their patients often suffer severe withdrawal symptoms when they cannot take their medication and some are even at risk of suicide or self-harm in such cases.

Perhaps more can be done to entice undergrad medical students into the field? Either way, South Africa's growing mental health burden will have to be addressed sooner rather than later. In this issue of the *SAMA Insider*, we take a look at SAMA's recommendation to its members not to treat COVID patients unless their injuries are life-threatening. We inform members about a few of the multitude of free resources that are available to them on page 9. You can also learn more about the annual SAMA photography competition on page 13.

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SAMA news in brief

COID system denounced

SAMA has taken the unprecedented step of asking its members to treat Compensation for Occupational Injuries and Diseases (COID) patients only if their conditions are life-threatening. The association has also requested its members to refer all other COID cases to public facilities, and issued a call to President Zuma and Labour Minister Mildred Oliphant to institute a judicial enquiry into the non-payment of Compensation Fund claims. SAMA, in its capacity as the country's largest representative body for medical doctors, issued a statement on Wednesday 15 July denouncing the Department of Labour's (DoL)'s dysfunctional system, under which doctors who treat patients that are injured on duty have to be remunerated from the Compensation Fund, a trust set up under the 1993 COID Act. However, nearly all COID claims are going unpaid in recent years, despite ongoing efforts by SAMA and other organisations. "The DoL has been unwilling or unable to fix COID," SAMA chairperson Dr Mzukisi Grootboom was quoted as saying. According to Dr Grootboom, the situation is not only having an extremely negative impact on private doctors, some of whom rely on COID pay-outs, but also on patients, who will now be forced to seek medical assistance from the country's poorly equipped public facilities. "These are drastic measures, but experience has shown us that those at the top have no interest in fixing the COID system," Dr Grootboom said. "This has to change, for the good of both patients and doctors."

NHLS letter

SAMA, along with the Rural Doctors Association of South Africa and the Treatment Action Campaign, has sent a strongly-worded letter to the Department of Health (DoH) regarding the state of the National Health Laboratory Service (NHLS). The NHLS, which performs all the samples testing for public health facilities, has experienced continued financial instability for a number of years. This is largely due to provincial health departments not paying their bills and ignoring requests to do so. The KwaZulu-Natal health department alone is rumoured to owe over R3 billion in outstanding payments. The NHLS, in turn, is alleged to owe R300 million to its suppliers. The SAMA Trade Union has been an active presence at the NHLS, advocating

for fair treatment for the physicians employed there. NHLS employees are subject to the same ill treatment prevalent in other public health institutions, turning to organisations such as SAMA for labour arbitration in the case of unpaid overtime and non-payment of salaries. It is hoped that the DoH will pressure provincial departments into paying their NHLS accounts.

New billing codes proposed

In the ongoing fallout of the Competition Commission's enquiry into the private healthcare industry, SAMA and the South African Private Practitioners Forum (SAPPF) have been cited by the Board of Healthcare Funders (BHF) for their alleged role in implementing "unjustifiable tariffs" through their coding practices. SAMA and the SAPPF, who collaborate in drawing up codes for use by private practitioners and service providers, have been criticised for the revised codes that were released earlier this year via the Medical Doctors Coding Manual (MDCM), which have in some cases introduced multiple codes for procedures which used to have very few codes. SAMA's codes are based on a coding system called current procedural terminology (CPT), which some healthcare funders do not subscribe to. SAMA and the

SAPPF have, however, invited the BHF and other healthcare stakeholders, including the DoH, to a meeting later this year to present proposed changes to billing codes. An attempt by the DoH to institute guideline tariffs for the healthcare industry was rejected by the Constitutional Court in 2010, although there are rumours that the establishment of an independent body to review codes might be on the cards.

SA doctors held in China

SAMA was quick to respond to the detention of 10 South African citizens, including medical doctors Dr Feroz Suliman, a general surgeon at Waterfall Hospital, and his wife, Dr Shehnaaz Mohamed, by Chinese authorities who believed they were affiliated with a terrorist organisation. SAMA vice-chairperson Dr Mark Sonderup described the detention as an outrage. "You cannot simply detain people carrying the passports of another country without having clear reasons as to why you are doing so," he was quoted as saying. "The South African government must step up to the plate and help its citizens." The detention was first reported by Gift of the Givers, whose head, Dr Imtiaz Sooliman, has previously been honoured by SAMA for his organisation's charity and disaster relief initiatives.

Health numbers

- **R5 billion:** The total amount of money provincial health departments are alleged to owe the National Health Laboratory Service.
- **R18 000:** The extra amount of money an average family of four has to spend to shop for healthier groceries every year.
- **34:** The number of the world's 196 countries that have some form of action plan to deal with the threat of antibiotic-resistant superbugs, according to a WHO report.
- **18:** The average number of days South African depression sufferers are absent from work due to their condition, according to a study by health research firm Hexor.

About SAMA

The South African Medical Association (SAMA) is a non-statutory professional association for public and private sector doctors. It is the largest such body in South Africa, with over 17 000 registered members, including some of the most well-known names in local medicine, and is the national representative at the prestigious World Medical Association. A registered non-profit, SAMA is dedicated to furthering the interests of its members in a healthcare environment that often places practitioners last. SAMA has proven itself to be the national leader in healthcare activism on numerous occasions, fighting against the exploitation of doctors in the private sector and, via its trade union arm, the terrible conditions prevalent in public health facilities. SAMA seeks to empower doctors by promoting the integrity and image of the health profession, developing skills in the health sector and lobbying for improvements in health policy.



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 - Hair rejuvenation procedures.
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ACCREDITATION

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COURSE FEE

R 51 984 (inclusive of all vat and taxes where applicable)
Course intake will start 1 May and close on 31 July 2015
R 2 300 registration fee (non – refundable)
R 12 996 per module (inclusive of the registration fee)

REGISTRATION

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SHORT COURSE

CLINICAL MANAGEMENT OF MULTIDRUG-RESISTANT TUBERCULOSIS

Ranking 7th in reported TB cases, South Africa is among the 22 high-burden countries targeted as part of the World Health Organisation's Stop TB Initiative. In 2002, 224 420 TB cases were reported. Of these, 182 583 were pulmonary TB cases, of which 98 800 cases were new infectious cases. The incidence rate in 2002 was 494 per 100 000 population. The increase in TB is closely related to the HIV epidemic; a recent study revealed that 58% of TB patients were co-infected with HIV.

COURSE CONTENT

- » MDR-TB Strategies;
- » Epidemiology of MDR-TB;
- » Case Finding Strategies and Case Definitions;
- » Diagnosis of MDR-TB;
- » Treatment Strategies for MDR-TB;
- » Designing MDR-TB Treatment Regimens;
- » Ancillary Medication and Adjuvant Therapies;
- » Drug Adverse Effects;
- » Special Situations;
- » MDR-TB and HIV;
- » Monitoring and outcome evaluation of MDR-TB patients;
- » Recording and Reporting;
- » Managing MDR/XDR-TB Contacts;
- » Infection Prevention and Control;
- » Treatment delivery strategies and community based support and
- » MDR-TB in Prisons.

ACCREDITATION

Accredited, according to the HPCSA CPD Guidelines for Health Professionals - November 2006, for 30 CEU's on level 3.

COURSE FEES

R 3 940 (inclusive of all vat and taxes where applicable)

COURSE FEES

17 – 19 July 2015	Durban
07 – 09 August 2015	Pretoria
04 – 06 September 2015	Cape Town
13 – 15 November 2015	Polokwane

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Why the Compensation Fund is failing private doctors

Conrad Strydom

The Compensation Fund's medical aid division, established to remunerate South African doctors who treat workers injured while on duty, is "dysfunctional", according to recent press statements by the South African Medical Association (SAMA). At a press conference held at SAMA's head office in Pretoria on Wednesday 15 July, SAMA chairperson Dr Mzukisi Grootboom called for an end to maladministration and inefficiency at the fund, which has been plagued by issues including late payments and the non-payment of claims. Furthermore, Dr Grootboom took the unprecedented step of asking SAMA members not to treat patients that were injured on duty unless their injuries were of a "life-threatening nature."

"The Compensation Fund has been given more than enough chances to prove its willingness to reform, to no avail"

"We are dismayed that the fund cannot meet its lawful obligations," Dr Grootboom said. "Not only is it failing South African doctors, it is also failing the workers it claims to support." The R52 billion Compensation Fund, which is part of the Department of Labour's Compensation for Occupational Injuries and Diseases (COID) system, has suffered from severe delivery issues over the last few years, resulting in multiple changes of administration at the fund and a number of investigations into its workings by organisations such as SAMA and the Democratic Alliance.

"The problem is that we cannot stand aside and wait for things to change by themselves anymore," Dr Grootboom said. "The Compensation Fund has been given more than enough chances to prove its willingness to reform, to no avail. As we speak, there are ten-year old claims that have still not been paid out. That is why SAMA is taking this unprecedented step, to draw attention to this crisis."

SAMA has approached the fund's administrators multiple times over the last decade,

but despite having received repeated assurances, no reforms were instituted. The association was invited to attend a recent meeting between the Compensation Fund and healthcare stakeholders by the fund's acting commissioner, Vuyo Mafata, but opted not to, resulting in a public tongue-lashing from the commissioner.

According to Mafata, Parliament's Standing Committee on Public Accounts has been looking into the state of the fund and has made recommendations that could see the first signs of change begin to appear. However, the DA believes the only way to salvage the fund is to privatise it, citing the lack of IT and human resources capacity in the public sector as the major barrier to efficient service delivery. Compensation Fund payments have previously been outsourced to private sector firm Compsol, but the current crisis was largely precipitated by Compsol's announcement that they would not pay doctors in advance for claims, since the DoL had been unable to pay the R556 million it owed them.

"This fund receives hundreds of millions of rands every year," Dr Grootboom said, "and this creates a valid expectation among workers that they will be taken care of in their time of need. It is time that the state takes its legal obligations seriously and delivers the service it has promised." By referring COID patients to state healthcare facilities, SAMA hopes it can save a number of private practices and community health centres that are dependent on Compensation Fund payouts from going under. Said Dr Grootboom: "Some of these practices have no option but to close down, and this is especially tragic in the case of institutions like the Workers' Accident Rehabilitation Centre in Durban, which was a pillar of the community." In many cases, doctors who treat COID patients are forced to cover the costs of treatment from their own pockets,

hoping that the fund will recompense them further down the line.

A SAMA survey of private practitioners in Gauteng indicated that 65% of those surveyed had problems sourcing payments from the Compensation Fund. More staggering still was the amount of money owed to these doctors – an average of R895 000 per practitioner. This situation has caused many doctors to refuse to see COID patients, even before SAMA issued its statement, with an average of 65% of doctors in one survey stating that they would not treat workers that were injured on duty. Also of concern are reports that state facilities are also turning injured workers away.

"In many cases, doctors who treat COID patients are forced to cover the costs of treatment themselves"

SAMA has issued a call for President Zuma and Labour Minister Mildred Oliphant to institute a judicial enquiry into the state of the Compensation Fund. The association is confident that such an enquiry will find evidence of widespread maladministration and incompetence at the fund, and that it will also bring to light the unwillingness to implement change on the part of administrators that has prevented the fund from executing its duties. Whether any such enquiry will take place remains to be seen, although SAMA remains hopeful that serious interventions might yet save the fund from total collapse.

SAMA's case against the Compensation Fund

- The fund fails to process and pay legitimate claims
- It is unable to fulfil its obligations as outlined by legislation
- Continued non-payment is having an adverse effect on doctors and patients
- The fund has a decades-long backlog of payments not yet processed
- Many years of negotiations with the fund have led to nothing
- There are indications of severe maladministration at the fund
- Problems at the fund have already resulted in numerous practices closing their doors
- A judicial enquiry into the fund is necessary to determine the extent of its problems

Member profile: Dr Hilda du Plessis

Conrad Strydom

Not everyone who studies medicine does so directly after high school. Some walk a more windy road into the profession, as Dr Hilda du Plessis can attest. Dr du Plessis, a general practitioner from Wonderboom, Pretoria, studied drama and enjoyed a brief acting career before becoming a doctor, partly because an aptitude test said she shouldn't. When she is not running her practice, Dr du Plessis serves as a board member of SAMA's Gauteng North branch and as a member of SAMA's national Finance Committee.

What made you decide to forsake drama for a medical career?

After school, I enrolled at the University of Pretoria, but I wasn't sure what I wanted to study, so I went for an aptitude test. The test results indicated that I should study anything other than drama, due to my extremely shy nature. Needless to say, I soon enrolled for a drama degree, since I reasoned that the only way to get rid of my shyness was to perform in front of people. I also wanted to study medicine, but felt that I needed to plunge into drama first. It was a very interesting experience! However, in the back of my mind I knew I didn't want to be an actress for the rest of my life. I performed in a number of plays and met all the famous local film and theatre people of the day. I shared a flat with Amanda Strydom and went to class with Karel Trichardt, but because of my growing need to be a doctor I left that life behind and went to work as a volunteer at Livingstone Hospital in Port Elizabeth and KwaZakhele Hospital in the Eastern Cape. It was 1981 and there was a state of emergency in the country. In remote areas like KwaZakhele, necklacing and other violent acts took place regularly, and I saw some shocking things. However, my resolve was strengthened and I started studying medicine soon after.

I work five days a week and do after-hours work, but the enormous expense of running a practice means I barely break even

Did drama teach you anything that you can apply to your medical practice?

Drama taught me to be very observant, and that is something medicine also emphasises. A medical career is also quite dramatic – you deal with life and death issues, after all. I try to incorporate some drama into my dealings with patients every now and then. Children, especially, are more responsive to this kind of approach. I still love the theatre, but medicine will always be my true calling.

What challenges do you face in your daily practice?

There is never enough time! In order to make enough money you have to see a great many patients, but you can't rush from one patient to the other – you have to give enough time to each one. It is quite a struggle and it is sometimes hard to keep afloat, quite frankly. I work five days a week and do after-hours work, but the enormous expense of running a practice means I barely break even. Like most GPs, I have to make at least R1 000 an hour to stay viable. However, I am usually lucky to make half that. Another problem is how one often feels like nothing more than a bridge between patients and their medical aids. Patients expect the most out of their medical aids, and when they don't get it, they blame us. Medical aids are also blatantly using GPs to do their paperwork for them. All of this proves how undervalued we GPs are, when we could be coordinators of patient care. This would avoid duplication of care, as multiple specialists prescribe medicines to patients that end up clashing and causing unforeseen

side effects. Nevertheless, being a GP is an awesome experience. We get to treat every kind of patient, from newborns to the very old – my oldest patient is 104!

How do you feel about the NHI programme?

In principle, it is perfect. Healthcare should be free for all, but it won't work in South Africa because such a small proportion of the population is working and earns a decent wage. Telling people that can afford medical aid that they must sit in long queues at NHI clinics is a disaster waiting to happen. As long as people can afford medical aid cover, doctors will opt not to work for the state. Public healthcare has become far too cumbersome and bureaucratic to support a programme like NHI – and this problem didn't start with the ANC, by the way. I worked in public hospitals back in the day and it was no picnic back then, either. If NHI is to work, we need to implement something like the Canadian model, featuring lots of small, efficient, outsourced clinics. Dr Motsoaledi is to be commended for his passion, but the system he proposes is bad for GPs. If we have to spend much of our time in clinics making R300 to R400 an hour, we might as well close our practices now.

Is there anything you want SAMA to do differently?

It would be nice to see more engagement between members and SAMA. Right now it feels like every doctor is in their own camp. It is definitely SAMA's responsibility to reach out to its members more, in ways that they will appreciate, rather than paternalistically prescribing things to them. It would be a great idea to create an online forum on the SAMA website where members can log their comments and complaints. Before we at SAMA can unite the profession, we must first get everyone talking to each other.

Before we at SAMA can unite the profession, we must first get everyone talking to each other

Free resources available for SA doctors

Conrad Strydom

The information age has flooded our lives with digital aids of every description. The right app, database or program at the right time can greatly enhance the lives of medical practitioners – and a lot of it can be had for free. There are also a multitude of free services available for doctors in the know, from toll-free hotlines to free online courses complete with CPD accreditation. *SAMA Insider* has drawn up a list of some of these free resources in the hope that they may be of use to SAMA members.

HIV Clinical Guidelines app

Developed by local open-source healthcare pioneers The Open Medicine Project South Africa (TOMPSA), this app was created for the Department of Health and is a comprehensive database of South African HIV/AIDS treatment guidelines. Should the DoH decide to alter these guidelines, the app will immediately update to reflect these changes. Health workers can use the app to report problems at healthcare facilities such as a lack of training or drug stock-outs. Health workers can consult the app to see whether their patients are eligible for antiretroviral (ARV) treatments, consult a dosage calculator to determine the correct amount of ARV treatment that should be administered in paediatric cases, or read the latest information regarding drug interactions and side effects. The app also includes information that can guide clinicians through the process of managing difficult HIV cases, such as patients with renal failure, and detailed drug information that can be used during treatment literacy sessions. A similar app devoted to tuberculosis treatment is reputedly on the way. To download this excellent resource, search for “HIV Clinical Guidelines” in Google Play or the App Store.

EM Guidance app

In a similar vein to the HIV Clinical Guidelines app – and also developed by TOMPSA – is the EM Guidance app, created to provide doctors with on-the-spot emergency medicine information. Developed in conjunction with emergency medicine specialists from the universities of Cape Town and Stellenbosch, this very handy app provides in-depth

instructions for resuscitation, general emergency conditions and local EM policies. It can be downloaded from iTunes, the App Store or Google Play.

Medicine Price Registry

Although originally designed for use by patients, this online application is also useful for doctors. Type the name of any medication into this registry and you will be provided with the single exit price of that medication and a list of all the generics available for it. This makes it arguably the fastest way to find a complete list of alternatives for expensive medication and can also allow doctors to craft prescriptions that suit the budgets of their patients. The registry is updated regularly and can be accessed at www.health-e.org.za/medicine-price-registry.

MPS online resources

The Medical Protection Society is an old hand at providing doctors with essential information. They have a page on their website entirely dedicated to online resources for practitioners, all available free of charge. The page provides access to the latest editions of all of MPS’s prestigious publications, including the Casebook. You can also download an app on this page that will allow you to read MPS publication on your iPhone or Android tablet. It includes a number of factsheets on issues like patient confidentiality and writing witness statements or reports. It also links to a little-known but highly useful series of MPS advice booklets on everything from common problems in general and hospital practice, ethics, the intricacies of patient consent in South Africa and even guidelines on how to handle the media. The page can be found at www.medicalprotection.org/southafrica/casebook-and-resources.

Free online CME courses

Medical Practice Consulting (MPC), a company that works very closely with SAMA, has a list of online CME courses on its website, many of which are sponsored or free for SAMA members. Most of the courses have been accredited with CEU points. Some of the courses that are available include the FPD’s Short Course in Financial Management,

which is sponsored for medical specialists and registrars, a Short Course in Death Certification that is free to all practitioners, and a course entitled Aspects of Female Medical Doctors, presented by the newly-formed Medical Women Association of South Africa (MWASA), which is also free. The full list of online courses can be found at www.mpconsulting.co.za/online-cme.

Toll-free national HIV hotline for health workers

This service, featured in the *SAMA Insider* before, answers queries related to patient treatment. The hotline’s staff are trained to provide accurate information on all aspects of HIV/AIDS care, including testing, post-exposure prophylaxis, preventing mother-to-child transmission, ARVs, drug interactions, the treatment of opportunistic infections, drug availability and adherence support. The hotline operates from Monday to Friday, from 08:30 to 16:30. You can call the hotline on 0800 212 506.

Public health vacancies posted by African Health Placements

Feel like a change of scenery? African Health Placements (AHP) maintains a list of vacancies in the South African public health sector on its website. Vacancies for medical officers, specialists, clinical managers, heads of department and even pharmacists are listed. AHP specialises in sourcing and placing doctors in often remote, under-served areas, hence most of the vacancies listed are for rural parts of Limpopo, KwaZulu-Natal and the Eastern Cape. To view the website, visit www.ahp.org.za/vacancies.

Rounds List app

A cutting-edge piece of software, Rounds List enables doctors and other health workers to upload patient information to a cloud-based rounds list, eliminating the need for a paper list. Team members with access to the rounds list can upload vital patient information. All data uploaded to the app is encrypted, so you don’t have to worry about violating patient confidentiality by exposure to third parties. This is a universal iOS app that works on the iPhone, iPad and iPod Touch. Look for it on iTunes.

Another milestone for SAMA PPD

SAMA Private Practice Department

In our quest to position the SAMA Coding Unit at the forefront of medical coding in this country, we have added another first to our array of achievements.

Ms Zandile Dube, a Coding Consultant at SAMA, has recently qualified as a Certified Professional Coder (CPC), becoming the third SAMA employee to hold such a qualification. This is a major achievement, given the dearth of professional coders in South Africa. Zandile joins an elite group of clinical coders active in the Southern Hemisphere.

According to the American Academy of Professional Coders (AAPC) website, "AAPC's Certified Professional Coder (CPC®) credential is the gold standard for medical coding in physician office settings and held by nearly 102 000 coding professionals. A Certified Professional Coder has proven by rigorous examination and experience that they know how to read a medical chart and assign the correct diagnosis (ICD-9), procedure (CPT®), and supply (HCPCS Level II) code for a wide variety of clinical cases and services."

This is one of the PPD team's proudest moments so far.

Here is what Zandile had to say about her achievement:

"I was introduced into the medical coding industry in September 2004 when I was doing a Health Benefits Administration Learnership with the Discovery Health Institute. We were taught about the whole medical scheme industry, including managed care, ICD 10 codes, NHRPL, processing of claims, fraud, and so forth. In 2005 I started working for Discovery Health as a Claims Assessor, where I picked up lots of experience in the areas of claims assessment, claims auditing and medical coding. I started working for SAMA on a part-time basis in 2009, and was appointed as a permanent staff member in February 2010.

"Working for SAMA was a huge challenge at first. Coding was especially difficult because I had to learn a lot about anatomy, physiology and medical terminology, but because I am a hard worker and my colleagues are always there to assist and advise, I have managed to complete a Certificate in Medical Terminology and Anatomy through The Foundation for Professional Development (FPD) and CPC



Physician-Based Medical Coding through AAPC.

"Through hard work and determination, I am proud to be a Certified Professional Coder (CPC) today."

We at SAMA's Private Practice Department are looking forward to tapping into Zandile's newly acquired skills, knowledge and expertise, for the betterment of service delivery to the SAMA membership.

Doctors' coding manual workshops announced

SAMA Private Practice Department

The South African Medical Association (SAMA) has identified the need for procedural training in the private sector and medical scheme industry. For this reason, and as part of efforts by the SAMA Private Practice Department to enhance the skill sets of private sector doctors and their staff, Medical Doctors' Coding Manual (MDCM) Training Workshops will be held at the SAMA Head Office in Pretoria in the coming months.

It is vital to understand coding when rendering accounts to third party payers as well as during the assessment of claims, as incorrect coding can have great financial impact on doctors in the private sector. SAMA's Coding Unit has long been a leader in the field of coding in South Africa and has developed the MDCM to be the premier manual for those involved with coding on a regular basis.

The workshops will start off with 'Coding 101' which provides basic training in the use and interpretations of the Rules and Modifiers applicable to the coding structure. Time will also be allocated to informal discussions of general problems experienced by coders. Training will be provided by SAMA's experienced coding staff, recognised throughout the industry as experts in their field, and will include everything of relevance to a foundational and advanced understanding of coding in South Africa.

Training will take place over the course of two days at the SAMA Head Office in Pretoria. Requests for training in other centres will be considered. Included in the registration fee of R2 800 per person (including VAT) is the 2015 MDCM Book, a training manual, an attendance certificate and a light lunch (please indicate any

special dietary requirements you may have, such as vegetarian or halaal).

The target audience for these workshops includes:

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

People who wish to attend the workshop are welcome to apply for the sessions that will be held on 26 and 27 August (subject to change).

Payment has to be confirmed a week prior to the workshop to secure your booking.

For an invoice, please email us your company details, including the VAT Number.

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

Snap to it! 2015 SAMA/MPS competition entries now open

SAMA Communications Department

SAMA's 2014 photography competition was an overwhelming success. We were inundated with well-captured pictures that spoke to the following themes: work environment, emotions and community health. We hope that this year will be no different.

We asked members to take pictures that provide a window into the time they spend saving lives in hospitals or in private practice, especially exceptional moments and experiences they share with their patients, fellow doctors and nurses. This year, we would like to continue with the same themes while adding a category on community health programmes to highlight activities that our members are involved in, but which are seldom recognised or captured.

The South African Medical Association (SAMA) is pleased to announce that entries for the association's annual photography competition are now open to all SAMA members.

This is a long-standing initiative of SAMA's which has been warmly received by its members.

We anticipate drawing an even bigger number of entries this year than in years past. We are also happy to announce that some of the entries we receive will be auctioned, with the returns going to two charity organisations.

The competition's themes are:

- Work environment
- Emotions
- Community health.

All entries will be displayed at the 2015 SAMA Conference, while the winning entries will be published in the *SAMA Insider* following the conference. A panel of experienced judges have been selected to judge the entries. As only digital prints are submitted, access to the original file may be required for winning entries. SAMA reserves the right to print, publish and exhibit any work submitted free of charge, but picture copyright will otherwise remain with the photographer.

The competition is open to all SAMA members in good standing and the deadline for all entries is 31 August 2015. Entry fees



are R90 per entry per category (students and interns are only charged R40). Entries must be submitted via the SAMA photography competition website (www.samedical.co.za/photography). The entrant must be the sole author and owner of the copyright of all entries. All entries should be converted to an sRGB colour profile and resized so that the horizontal and vertical axes do not exceed 900 pixels. Files

should not be larger than 10MB or smaller than 2MB. Please supply information regarding the type of camera used, the exposure of the image (aperture, shutter speed, ISO), its focal length and a short description of the image.

Competition winners will be announced in September. For more information, contact Precious Qwabe on (012) 481 2164 or email preciousq@samedical.org.



Additional Member Benefits



Alexander Forbes

Herman Steyn

012 452 7121 / 083 389 6935 | steynher@aforbes.co.za

Offers SAMA members a 20% discount on motor and household insurance premiums.



Automobile Association of South Africa (AA)

AA Customer Care Centre

0861 000 234 | kdeyzel@aasa.co.za

The AA offers a 12.5% discount to SAMA members across its range of AA Membership packages.



Barloworld

Lebo Matlala (External Accounts Manager: EVC)

011 052 0167

LeboM@bwmr.co.za

Barloworld Retail Digital Channels offers competitive pricing on New vehicles; negotiated pricing on demo and pre-owned vehicles; Trade in's; Test Drives and Vehicle Finance.



Legacy Lifestyle

Patrick Klostermann

0861 925 538 / 011 806 6800 | info@legacylifestyle.co.za

SAMA members qualify for complimentary GOLD Legacy Lifestyle membership. Gold membership entitles you to earn rewards at over 250 retail stores as well as preferred rates and privileges at all Legacy Lifestyle partnered hotels and further rewards back on accommodation and extras. Claim your membership at www.legacylifestyle.co.za/SAMA, all you need is your mobile number to earn or redeem rewards. Travelling SAMA members can book their travel online or speak with our concierge service at Travel By Lifestyle (www.travelbylifestyle.co.za) Legacy Lifestyle, the rewards you've earned will pay for the Lifestyle you deserve.



Medical Practice Consulting

Werner Swanepoel

0861 111 335 | werner@mpconsulting.co.za

20% discount on assessment of Practice Management Applications (PMA) and Electronic Data Interchange (EDI) systems.

SAMA and Merck Serono are offering SAMA members a first-of-a-kind and FREE FPD online CPD courses on Fertility and Hyperthyroidism on www.mpconsulting.co.za. Each course is worth 3 CPD points. The benefit is a saving of R465.00 per member per course.



Medport

Shelly van Dyk

087 550 1715 | support@sosit.co.za

A personalised portal website; an optional public webpage to make their services known (Private Practice); access to a HPCSA accepted CPD Manager; a consolidated e-mail account; online data storage space; unique applications to manage their medical career; additional applications to download onto your portal page; easier and user friendly access to the internet; listing of your Private Practice on the SAMA Geomap Directory.

MEMBER BENEFITS



Additional Member Benefits



Mercedes-Benz

Mercedes-Benz South Africa (MBSA)

Lebo Selumane

012 677-1855/082 412 7229

Lebogang.matlhare@daimler.com

Mercedes-Benz offers SAMA members a special benefit through their participating dealer network in South Africa. The offer includes a minimum recommended discount of 3%. In addition SAMA members qualify for preferential service bookings and other after market benefits.

MTN Service Provider

Oswin Lottering

083 222 1954

Lotter_o@mtn.co.za

Melissa Adriaanse

083 212 3905

Adriaa_m@mtn.co.za



We are pleased to offer SAMA members 18% discount. The discount however only applies to new additional contracts and also when the user is due for upgrade. Discount will not apply to International Roaming and Dialling, SMS' and Data packages. Please note that this is extended out to the family and the discount is on VOICE packages only as well.
Monthly Service Charge: less 18% (eighteen percent) discount.
Usage Charge: less 18% (eighteen percent) discount (excluding international calls, international roaming, SMS, MMS and data Usage Charges).

SAMA eMDCM

Zandile Dube

012 481 2057 | coding@samedical.org



67% discount on the first copy of the electronic Medical Doctors Coding Manual (previously known as the electronic Doctor's Billing Manual).

SAMA CCSA

Leonie Maritz

012 481 2073 | leoniem@samedical.org



CCSA: 50% discount of the first copy of the Complete CPT® for South Africa book.

SOSit

Shelly van Dyk

087 550 1715 | support@sosit.co.za



20% discount on Information Technology support and a 24/7 callout service.

Tempest Car Hire

Corinne Grobler

083 463 0882 | cgrobler@tempestcarhire.co.za



SAMA members can enjoy discounted car hire rates with Tempest Car Hire.

V Professional Services

Gert Viljoen

083 2764 317 | gert@vprof.co.za

10% discount on medical practice bureau service through V Professional Services.



Vox Telecom

DJ Viergever

Sales - 087 805 0003 / Technical - 087 805 0530 | sales@voxtelcom.co.za/ help@voxtelcom.co.za



Provide email and internet services to members. Through this agreement, SAMA members may enjoy use of the samedical.co.za email domain, which is reserved exclusively for doctors.

MEMBER BENEFITS

SEDASA presents HIV/AIDS prevention talk at seventh SA AIDS conference

Comrade Ayodele Aina, national chairperson: SEDASA

The Senior Employed Doctors of South Africa (SEDASA) a subcommittee of the South African Medical Association Trade Union (SAMA TU) has, in line with its 2015 AGM theme and resolutions, namely 'Moving towards action', presented a talk on proper condom use and the management of the human immunodeficiency virus. The talk entitled 'The Role of Labour Unions in the Prevention and Management of HIV/AIDS in Health Sectors' was delivered at the seventh SA AIDS Conference in Durban. SEDASA has long been concerned about the lack of knowledge regarding the prevention and management of HIV/AIDS that is so prevalent in our healthcare sector and even among doctors.

The duties of trade unions extend beyond the wearing of red caps, shirts, underpants and tracksuits!

Right is one of the highlights of SEDASA's presentation, indicating proper condom use. The use of condoms remains one of the best prevention methods to combat HIV/AIDS infection, but is still not understood by large sections of the healthcare and general population. As South Africa moves towards achieving the healthcare goals outlined in the National Development Plan 2030 and the 90/90/90 principle that seeks the achievement of zero stigma, zero discrimination, zero new infections and zero deaths. We at SEDASA call on 99% of the population to be tested, for 99% of those who have tested positive to be placed on ARVs and for that 99% of the population on ARVs to have viral suppression.

PROPER USE OF CONDOM



**SOUTH AFRICAN MEDICAL ASSOCIATION
Trade Union (SAMA TU)**

SEDASA



Male Condom











Remember:

- Do not use grease, oil, lotion, or petroleum jelly (vaseline) to make the condom slippery. These substances can make the condom break. Use only jelly or cream that does not have oil in it.
- Use a new condom each time you have sex.
- Only use a condom once.
- Store condoms in a cool, dry place.
- Do not use a condom that may be old or damaged.

Female Condom








The female condom is used during intercourse to prevent pregnancy and help reduce to risk of sexually transmitted diseases. The female condom can be found at most drug stores and some supermarkets and isn't hard to use once you give it a chance. If used correctly, the female condom will give any woman a 5 out of 100 chance of getting pregnant within a year.



Oral Dem

DO YOU USE THEM?

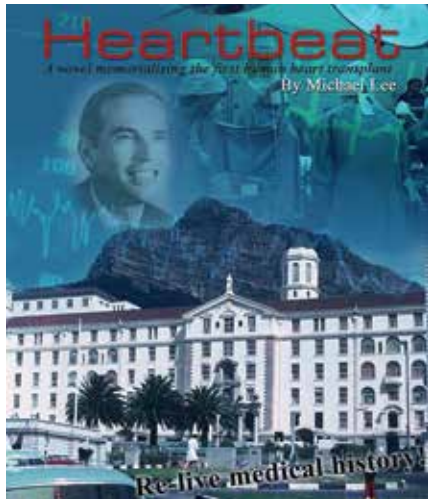
According to our records, no trade union has ever made such a presentation to a national conference before, and we hope that we have set a precedent that others will follow. It is evident that the duties of trade unions extend beyond the wearing of red caps, red

shirts, red underpants, red tracksuits, carrying placards and striking! If given the appropriate platforms, trade unions can also educate and uplift the sectors they serve.

Amandla! Towards quality healthcare for all!

Novelised account of first heart transplant published

SAMA Communications Department



One of South Africa's greatest scientific achievements, the first successful human heart transplant, has been turned into a gripping novel by Cape Town writer Michael Lee. The novel, entitled *Heartbeat*, opens on the afternoon of 2 December 1967 with Professor Chris Barnard trying to relax at his home in Zeekoevlei as he anxiously waits for news from Groote Schuur of a suitable heart donor for his dying patient Louis Washkansky. He thinks back over his life and how he has risen from obscurity

to become a pioneering heart surgeon on the brink of a breakthrough that would make medical history. At the same time, he's afraid of the crippling effects of arthritis which was diagnosed just over a decade ago in 1956.

Then a car accident happens in Main Road, Salt River, fatally injuring 25-year-old Denise Darvall and killing her mother. An ambulance takes the accident victims to Groote Schuur Hospital where a neurosurgeon declares Denise brain-dead after sustaining multiple skull fractures. Her father, Edward, is deeply distressed. The registrar at the cardiac unit, Dr Bossie Bosman, identifies Denise as a possible heart donor. When he is informed that Saturday evening, Barnard rushes to the hospital and calls in his heart team from all over the Cape Peninsula, including his brother Marius, who is celebrating his 16th wedding anniversary and is well wine and dined.

The novel takes the reader on a thrilling ride through the ensuing operation, focusing on inner and outer conflicts as Dr Barnard wrestles with his own characteristic doubts, seeking inspiration to fulfil his unlikely dream of making medical history ahead of American surgeons ready to carry out the same kind of operation. When the operation proves to be a success, a media storm erupts, creating an international media storm. Behind the

scenes, though, Barnard's team struggle to fight the twin threats of rejection – when the body rejects the transplanted heart as foreign – and infection. During these 18 days of survival, there are highs and lows, times of hope and times of despair, shared by the staff and the family and friends of Washkansky alike. It's a medical battle for life under extraordinary conditions, many of which are unknown due to the unprecedented nature of the first transplant in the world.

Eventually, after a valiant fight from the heart team, the nursing staff and Washkansky himself, the patient succumbs to pneumonia, the transplanted heart still in perfect working order. *Heartbeat* takes the reader inside A Theatre and B Theatre to share the intimate experience of the actual operation which made medical history, as well as into the hearts and minds of Washkansky and the team at Groote Schuur who tried everything to save him.

According to the author, "the book is a factual account of one of the greatest breakthroughs in medical history, made more potent by the fact that it is all based on first hand accounts by participants, including the memoirs of both Barnard brothers. Additionally, every fact presented in the book was checked by the Heart of Cape Town museum in Groote Schuur."

UNESCO and Wits announce course for ethics teachers

UNESCO Bioethics Section

The United Nations Educational, Scientific and Cultural Organisation (UNESCO) is pleased to announce an Ethics Teacher Training Course (ETTC) scheduled to take place at the University of the Witwatersrand (Wits), in Johannesburg, from 31 August to 4 September 2015. The ETTC is a collaborative effort involving UNESCO and the Steve Biko Centre for Bioethics at Wits.

The course offers a unique opportunity for participants from South Africa and other countries in the region to enhance their teaching and professional capacities in bioethics and ethics. The ETTC is designed to advance pedagogical capacity for ethics teaching and improve the quality of ethics education around the world and is based

on a five-day training module developed by UNESCO in collaboration with global experts in ethics education. The course is conducted by a team of international and local experts with extensive experience in ethics education.

The module contains the following key components:

- Global Perspective on Ethics Teaching: Trends, Challenges and Opportunities
- The UNESCO Core Curriculum as a Tool for Promoting Quality Ethics Education
- Ethics Teaching in Action: What and How to Teach (A Model Lesson)
- Workshop: Sharing Experiences in Ethics Teaching from the Local Perspective
- Classroom Communication: Pedagogy and Psychology of Ethics Teaching

- Simulated Teaching Presentations by Participants.

All successful candidates for the course must have a degree in areas such as law, medicine, health sciences, philosophy, ethics, or social sciences; experience in, or future plans of teaching ethics; and a good command of the English language. The course is open to other ethics professionals and practitioners. Applicants who wish to register for the course should submit a registration form to the Secretariat of the Bioethics Section of UNESCO at ettc.wits@unesco.org. For more information, please contact Mr Abdul Rahman Lamin at UNESCO Regional Office for Eastern Africa in Nairobi, Kenya at ar.lamin@unesco.org; or visit www.unesco.org/bioethics.



How PAIA affects doctors

Medical Protection Society

The following article was prepared by the Medical Protection Society to inform their members about their rights and duties with regard to the Promotion of Access to Information Act.

The Promotion of Access to Information Act 2000 (PAIA) gives everyone the right of access to records held by either public or private bodies for legitimate purposes. In the latter case, people should be allowed access to “any information that is held by another person and that is required for the exercise or protection of any rights”. This includes access to health records.

Either the patient him- or herself, or someone authorised to act on the patient’s behalf, can request access; ordinarily the request itself is made in writing and should be responded to within 30 calendar days.

The only ground for refusing access is if disclosure “to the relevant person” (i.e. the patient or the person requesting access on the patient’s behalf) “might cause serious harm to his or her physical or mental health, or well-being”.

The Act sets out detailed conditions in this section. Essentially, it states that if the person tasked with deciding whether to grant access or not (the “information officer”) thinks that disclosure might result in serious harm to the relevant person, he or she must consult with a healthcare practitioner nominated by the relevant person. If the relevant person is under the age of 16, the nomination must be made by a person with parental responsibility. If the patient lacks capacity, the nomination must be made by a person appointed by the court to manage the patient’s affairs.

If the nominated healthcare practitioner, after viewing the records, agrees that disclosure would be likely to cause serious harm to the relevant person as outlined above, the information officer may still allow access to the records if he/she is satisfied that adequate counselling arrangements have been made “to limit, alleviate or avoid” such harm. The appointed counsellor must be given access to the record before access is allowed to the requester.

Relatives

Relatives have no automatic right of access to an adult patient’s records. If the patient lacks the mental capacity to consent to disclosure, a relative may apply for access to the medical

records under the Promotion of Access to Information Act.

Parents and guardians

The parents of a child under the age of 12 should be given access to the child’s medical records if they request it, but bear in mind that if the child has had a termination of pregnancy, this information should remain confidential unless the child consents to its disclosure.

If a child is aged 12 or more, and has the maturity to understand the implications, you will need to secure the child’s consent before disclosing his or her medical record.

Deceased patients

The principle of confidentiality extends beyond a patient’s death. Generally speaking, information should only be disclosed to third parties with the consent of the deceased’s next of kin or executors, but there are exceptions to this rule – information can be disclosed if it is required by an inquest magistrate, for example.

In addition to obtaining the authority of the deceased’s next of kin or executor, the HPCSA’s advice is to consider the circumstances when deciding whether to accede to a request for information and to consider the effect that disclosure is likely to have on the deceased patient’s partner or family.

Court orders

You should comply with a court order to disclose health records. Even if you have concerns about disclosing the records, you should still comply with the order and attach a covering letter to the judge or the registrar of the court describing your concerns. Generally, compliance with a court order should be considered mandatory, but in exceptional circumstances, if you have concerns, it may be appropriate to seek advice from MPS. The mere threat of a court order is not sufficient authority to disclose.

The police

In general, the police have no more right of access to confidential information than

anybody else, except in the following circumstances:

- The patient has given consent to the release of information.
- The information is needed in compliance with a court order.
- A written directive has been issued by a judge or a magistrate in terms of section 205(1) of the Criminal Procedure Act 51 of 1977 to disclose information.
- The public interest in disclosing information outweighs the public interest in preserving patient confidentiality. This is not a decision to be taken lightly, so it is best to consult with an MPS medicolegal adviser or a colleague when weighing these competing interests.

Solicitors

Solicitors may request a copy of a patient’s medical records in relation to a claim. If the solicitor is acting for the patient, you should not release the records without the patient’s (or a legally recognised proxy’s) consent. If the solicitor is acting for a third party, you should not release the records unless the request is made in terms of the Promotion of Access to Information Act and the information requested is:

- About an individual who has given written consent to the requester or you for the disclosure to be made;
- Already publically available;
- Information which belongs to a class of information that would or might be made available to the public in any event;
- About an individual’s physical or mental health, or wellbeing who is under the care of the requester and who is under the age of 18 or is incapable of understanding the nature of the request and giving access would be in the individual’s best interests;
- About an individual who is deceased and the requester is the next of kin or the solicitor is making the request with the consent of the deceased’s next of kin.

(See Chapter 4 section 63(1) and (2) to the Promotion of Access to Information Act 2 of 2000.)

ICD-10 Coding

Previously the HPCSA "strongly recommends" getting a patient's written consent before disclosing information to a medical scheme. Such written consent can be a "once-off" applying to patient contact concerning the same or a similar clinical condition, but subject to verbal reminders and confirmation (which should be documented in the patient's records). When the patient presents with a new condition, it will be necessary to obtain new written consent. The 2008 booklet makes no such recommendation.

The patient's consent must be fully informed, based on a full and frank discussion about who will be accessing the information and for what purpose, and the implications of disclosure versus non-disclosure. The patient should be informed that the medical scheme has the discretion to reject claims with a U 98.0 code (Patient refused to disclose clinical information).

Doctors who provide services that do not involve direct contact with the patient (pathologists, for example) should confirm with the commissioning doctor that the patient has consented to his/her medical information being accessed and to clinical information being disclosed to his/her medical scheme.

SAMA members must submit PAIA manuals by 31 December

The Promotion of Access to Information Act (PAIA) was promulgated in 2000 and had since been enforced by the Department of Justice. In terms of the Act, all information held on a person is confidential and may not be disclosed to any third party without the written consent of the person about whom the information is held. At the time of promulgation, the Act provided that all entities must declare the information which is available in their businesses in the form of a manual which had to be submitted to the SA Human Rights Commission. In the case of doctors, all those in private practice had to adhere to the requirements of PAIA.

Correspondence together with a pro forma PAIA manual was circulated to SAMA members during the course of 2003. Subsequently, the submission date for manuals to be submitted was extended numerous times and now finally to 31 December 2015 (provided that the practice did not have more than 50 employees or a turnover equal or higher than R5 million per annum: the submission date for those private businesses has lapsed).

The SAHRC has sent a reminder to all SAMA members who have not complied with the Act to compile an information manual and submit it to the SA Human Rights Commission on or before 31 December 2015.

Please e-mail a signed copy to lidlamini@sahrc.org.za and post a hard copy to the following address belonging to the Commission:

Private Bag X2700
Houghton
2041

For more information relating to compliance with section 51 of the Promotion of Access to Information Act, contact Lindiwe Dlamini on 011 877 3803, via fax on 011 403 0625 or via email at lidlamini@sahrc.org.za.

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

Capulotomy or arthrotomy or biopsy or drainage of joint; Large joint (including three weeks after-care)

1	1
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3.2.1	3.2.1
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The right to refuse treatment

Julian Botha, Strategic Accounts Manager: SAMA Private Practice Department



The current debate regarding the recent decision by Judge Fabricius in the matter of Robert Stransham-Ford has sparked intense debate regarding the issues, considerations and beliefs relating to the question of “active euthanasia” and assisted suicide.

It is not the purpose of this article to jump into the fray and participate in that debate, but rather to draw attention to a related issue in respect of patients who, for a variety of reasons, decline to undergo medical treatment. This issue is, in fact wider than the “end of life” decision, but can occur even when the patient is not terminally ill. It also involves the patient’s fundamental right to make choices regarding their healthcare. South African legislation respects and promotes the principle of patient autonomy, and nowhere is this more evident than in the National Health Act (NHA). Section 6 of the NHA provides as follows:

“6. User to have full knowledge

(1) Every health care provider must inform a user of-

(a) the user’s health status except in circumstances where there is substantial evidence that the disclosure of the user’s health status would be contrary to the best interests of the user;

(b) the range of diagnostic procedures and treatment options generally available to the user; (c) the benefits, risks, costs and consequences generally associated with each option; and (d) the user’s right to refuse health services and explain the implications, risks, obligations of such refusal.”

Of particular importance here is subsection (d) which places a direct and unequivocal obligation on the healthcare provider to inform the patient (‘user’) of their right to refuse health services. Not only is a healthcare provider duty bound to inform their patients of this right, they are compelled to respect that choice.

This places practitioners in an invidious ethical position. Medical practitioners may be faced with patients who, in spite of being given all relevant information in respect of their condition and the optimal treatment thereof, nevertheless refuse to provide consent for that treatment. The patient, therefore, knowingly embarks on a course of action which will adversely affect their health. The practitioner is obliged to adhere to the ethical principles of non-maleficence (healthcare practitioners should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest) and beneficence (healthcare practitioners should act in the best interests of patients even when the interests of the latter conflict with their own personal self-interest).

It would appear to fly in the face of these ethical principles for a medical practitioner to allow a patient to choose not to receive treatment and potentially harm themselves by that choice. The underlying and guiding principle of ‘first, do no harm’ would seem to be incongruous with allowing a patient to continue this course of action (or inaction). There would not appear to be an easy ethical answer to this question, but the fact of the matter remains that compliance with the prevailing legislation must take precedence.

The Ethical Rules also make reference to the practitioner’s obligation to respect the patient’s choice, at Rule 27A:

“27A. Main responsibilities of health practitioners

A practitioner shall at all times -

(b) respect patient confidentiality, privacy, choices and dignity;

(d) provide adequate information about the patient’s diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to his or her health and that of others.”

The Ethical Rules, published as Regulations to the Health Professions Act (and are thus legislation) echo the contents of section 6 of the NHA and reinforce the principle of patient autonomy, and particularly the patient’s ‘right to choose’.

It must, however, be borne in mind that the patient concerned must have decisional capacity, the absence of which, in any event, would result in the patient being unable to provide informed consent at all.

It is therefore clear that South African law requires a practitioner to respect the choice of the patient, even where that choice may adversely affect the patient’s health, or where it may result in hastening the death of the patient. This right stems from the fundamental right to self-determination and is perhaps best summed up by Judge Ackerman in the seminal case of *Castell v. De Greef* (1994):

“It is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment.”

The patient’s right to self-determination is therefore the paramount principle that must be adhered to and it is the duty of the medical practitioner to ensure that the patient has all the relevant information required to exercise this right, and thereafter to respect and act in accordance with whatever choice that patient makes.

MMPA 18th Annual Congress



Tsogo sun – riverside sun hotel 4-5 September 2015



2 day Medical Congress: Informative presentations. MMPA sponsors your spouse for the Gala dinner and accommodation.

Enjoy a family week-end away. Kids under 18, sharing with parents - stay free including B&B

This CPD Accredited Congress will be of interest and great benefit to all practicing health care professionals.

For more details, please contact candiceu@mpas.org.za/ 011 498 7269

The swollen knee

The Medical Protection Society shares a case report from their archives

Forty-four-year-old Ms M presented to her GP with pain and swelling of her right knee. She had experienced similar symptoms three years earlier while pregnant but had not undergone any investigations at the time. The GP made a provisional clinical diagnosis of recurrent meniscal injury and referred Ms M for an MRI scan.

The radiologist, Dr A, reported the scan as normal. Plain films taken at the same time showed evidence of mild degenerative change and several small loose bodies above and below the joint, which were not considered significant. Ms M underwent a course of physiotherapy.

Fourteen months later she re-presented with acute locking of the knee after an aerobics class. She was experiencing difficulty sleeping and reduced movement in the knee joint and was referred to Dr B, who noted tenderness over the medial side of the joint and a 15 degree fixed flexion deformity. He advised an arthroscopy for further evaluation. This confirmed the presence of multiple loose bodies and attached soft tissue structures. Dr B made a provisional diagnosis of a foreign body reaction and took biopsies for histology.

Interpretation of the histology proved extremely challenging and the specimens were sent to a number of eminent pathologists for review. The consensus was that this was a high-grade, undifferentiated soft tissue sarcoma, although malignant pigmented villonodular synovitis (PVNS) could not be entirely excluded.

A further MRI scan was carried out, which identified a residual soft tissue mass that was also biopsied and confirmed to be consistent with the initial histology. Ms M underwent an above knee amputation followed by chemotherapy.

She subsequently made a claim against Dr A for alleged failure to properly interpret and report on the original MRI scan, thus leading to a delay in diagnosis of synovial sarcoma, which necessitated an above knee amputation.

Expert opinion

In the opinion of the MPS radiology expert, Dr J, Dr A had under-reported the MRI scans

in that he had failed to mention the presence of a joint effusion with non-specific tissue in the supra-patellar pouch. In his opinion, however, it would have been inappropriate on this evidence to consider a sarcoma in the differential diagnosis. In the context of a recurrent acute episode these findings were likely to represent breakdown products of blood.

Further investigation would have been dictated by the subsequent clinical course of events, albeit that this may have been influenced by the MRI findings. Dr K, the orthopaedic expert, agreed with Dr J that the MRI findings were non-specific and not indicative of malignancy. Had the MRI been reported in the terms suggested by Dr J, Dr K considered it likely that the GP would have reassured Ms M and treated her conservatively with physiotherapy, which was, in fact, what happened.

Had Ms M's symptoms not settled down following the first MRI scan it is likely the GP would have referred Ms B to an orthopaedic surgeon who would probably have arranged an arthroscopy, and biopsied the lesion. This would have resulted in the same course of action and outcome as that which subsequently transpired. The treatment options that would have been offered would have been above knee amputation or tumour resection followed by radiotherapy. The prospects of success for the latter option would have been low, with a high risk of recurrence.

In Dr K's opinion, the only safe option was above knee amputation. He disagreed with the claimant's expert, Dr C, that amputation would have been avoided had the diagnosis been made 14 months earlier.

MPS argued that although there was a breach of duty by Dr A in failing to report



the presence of an effusion and soft tissue within the knee joint, this would not have altered the outcome. Had Dr A reported the MRI scan correctly, management would have been dictated by the subsequent clinical course and would most likely have been conservative in the first instance. From the outset, above knee amputation would have remained the only curative treatment option, and hence the amputation could not be attributed to any failure on Dr A's part to report the abnormalities on the original MRI scan and so causation could not be established.

Although the claimant could not be persuaded to discontinue on the causation defence alone, it enabled MPS to settle the case for a reduced amount, based on the patient's additional pain and suffering.

Learning points

- A poor outcome does not necessarily mean negligence.
- In radiology, errors of perception or interpretation that lead to a failure to recommend further investigation may constitute a breach of duty, even if the diagnosis cannot be made from the presenting features. The same principle also applies to failure to elicit or correctly interpret clinical signs and symptoms.
- Breach of duty alone is insufficient to establish negligence. The claimant must prove a causal link between the breach and the subsequent injury or harm suffered.

WMA urges Australian government not to silence physicians

World Medical Association (WMA)

The WMA has called on the Australian government to allow doctors to speak out about the health of asylum seekers held in Australian detention centres.

In a letter to Australia's Prime Minister Tony Abbott, the WMA's president Dr Xavier Deau and chair Dr Ardis Hoven say that the recent Australian Border Force Act effectively silences physicians who address the health conditions of asylum seekers. The legislation imposes a penalty of two years' imprisonment on any person, doctor or otherwise, who discloses information obtained by that person while working as an employee of a service provider to the relevant government department, namely Immigration and Border Protection.

In their letter, the WMA leaders say: 'This we must assume extends to doctors working

in refugee centres who report on their observations arising from their work.

"This is in striking conflict with basic principles of medical ethics. Physicians have to raise their voice, if necessary publicly, when health conditions of their patients, be those free or in detention, are unacceptable. From the incoming reports we must assume that this is the case in the detention centres under responsibility of the Australian Government. We applaud and support those colleagues who advocate for their patients and speak out.

"We do support the motion by Australian Medical Association National Conference calling on the Australian government to amend the legislation to provide an exemption for public interest disclosure. Nothing less would be appropriate for a democratic state."

Commenting on the letter, Dr Deau said: "This is effectively an attempt by the Australian government to gag physicians by making their advocacy for the healthcare of asylum seekers in Australian detention camps a criminal offence. Such a procedure is not acceptable."



Gauteng North awards lifetime membership

SAMA's Gauteng North branch has awarded lifetime membership to a number of its branch members in recognition of their long and valued service to the association. SAMA often awards lifetime membership to doctors who have demonstrated faithful and unwavering

support over a long period of time. The following members were awarded lifetime membership:

- Dr A Joosub
- Dr TM Kluyts
- Dr IJ Kriel
- Dr LB Lemmer

- Dr CN Nauhaus
- Dr PR Makhambeni
- Dr JP Pretorius
- Dr TG Rosch
- Dr CJB Smit
- Dr DL Smit
- Dr W Theron.

UCT Bioethics Centre to host euthanasia symposium

The University of Cape Town's prestigious Bioethics Centre will host an assisted suicide and euthanasia symposium on 18 August at the New Groote Schuur Hospital's Lecture Theatre One. Medical practitioners and other interested parties are free to attend.

The symposium will address the debate surrounding euthanasia that was recently

reopened when the Pretoria High Court ruled that the doctor treating Cape Town lawyer Robin Stransham-Ford would not be prosecuted if he assisted Mr Ford in terminating his life. The symposium will cover topics related to the legal aspects of euthanasia, presented by UCT's Prof. David Benatar, Dr Tom Angier and Andrew Fisher; the view of the palliative care community, as

represented by Dr Liz Gwyther, and a neuro-scientific rationale for assisted dying presented by Prof. Sean Davison. The symposium will begin at 13:30 and end by 17:30.

When: 18 August 2015

Where: New Groote Schuur Lecture Theatre One

Attendance: Open to all interested parties

CONGRESS ANNOUNCEMENT

19TH Annual Controversies and Problems in Surgery

Theme: Serious complications after common procedures and their management

Saturday 3rd and Sunday 4th
October 2015

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