

# SAMA INSIDER

MARCH 2016

**Medical malpractice  
costs: Towards a  
solution**

**Moot Hospital  
healthpost sets the  
pace in NHI**



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

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**Diane de Kock**  
Editor: *SAMA INSIDER*

## Achieving the best possible outcome

**T**he overriding theme of this issue of *SAMA Insider* is the challenge of working within the constraints of the system to achieve the best possible outcome for all.

This is highlighted in Prof. White's President's Message on page 4 where she urges the profession to ensure that our citizens are afforded the "wealth of good health". On page 5, Julian Botha advises against an adversarial or confrontational approach to the crisis of medical malpractice costs. Dr Mabasa, on page 8, writes in his personal capacity on the commission of inquiry into the HPCSA, and on page 10 the GPPPC look at seven priority areas that will require focus in 2016 as they strive to meet member expectations. Bernard Mutsago's article entitled "NHI will work best when there is harmony" on page 13 again emphasises that change is needed in healthcare delivery in South Africa and quotes Dr Nicholas Crisp's comment: "It's time for everyone to be a South African first and then whatever else they want to label themselves only secondarily; what is the alternative?"

Dr Angelique Coetzee, from our Gauteng North branch, is extremely positive about NHI, a system she feels is a major step in delivering healthcare to all South Africans. "We must stop criticising the system, we need to give it a try" – perhaps an apt and relevant comment on the content of this issue?

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## “Health is real wealth and not pieces of gold and silver”

Mahatma Gandhi



Prof. Denise White, SAMA President

In January the *Mail and Guardian* convened a “Thought leader dialogue on healthcare” symposium at which I was privileged to be the chairperson.

Delegates had the opportunity to engage with leading opinion and policymakers in the field, including SAMA. They were updated on our public and private healthcare systems, as well as the state of the nation’s health. The hope was that this forum would produce innovative ideas on healthcare reform. From a personal perspective it was apparent that the “elephant in the room” was the proposed National Health Insurance (NHI) policy.

**There is no doubt that the status quo is untenable. We are on a path to nowhere with health unless reform commences with urgency.**

It is known that government’s National Development Plan has mandated a reorganisation of the entire health system, public and private, within a 14-year time frame. “Ribbon-cutting” on a restructured universal healthcare system is scheduled for 2030.

In his keynote address, Dr Yogan Pillay, the deputy director general of the National Department of Health (DoH), informed us that universal health coverage and NHI are just a part of the discussions on health reform. He presented data showing that South Africa (SA) has made headway in improving health and life expectancy of South Africans by stabilising the prevalence of HIV/AIDS and TB, and by reducing maternal, child and infant mortality. However, the country still falls far short of meeting the millennium development goals for health. The DoH has set itself the ambitious targets of drastically reducing HIV prevalence (to less than 0.1%) by curtailing child, infant and maternal mortality, and increasing the overall life expectancy of South Africans (estimated in 2010 at 53 years for males, 55 years for females) to 70 years by 2030.

While certain speakers were upbeat about achieving a single health system within the time frame, others were more circumspect and tentative in their prognosis. Suggested solutions touched on the principles of Private Public Partnerships, funding models, task shifting, and the innovative uses of technology and digital devices – such as cell phone apps for monitoring and accessing healthcare.

Problems that were highlighted in the private sector included increasing costs, planning in silos, the hospi-centric focus of healthcare and an over-supply of hospital beds.

From the information presented, it is evident that constituents of the public health sector are in a dismal and deteriorating state and yet are expected to deliver healthcare with insufficient resources and unmanageable budget constraints.

As healthcare providers we are all aware that our health system is a complex and inequitable one with an ever-widening gap between the private and public sectors. There is no doubt that the status quo is untenable. We are on a path to nowhere with health unless reform commences with urgency. And in moving forwards, much “gold and silver” will be required to bring about meaningful change. But money is a rapidly depreciating resource in our already cash-strapped economy. It has been mooted that more will simply have to be done with less! How feasible is such a proposal moving forward?

The World Health Organization (WHO) has laid out the building blocks required for health systems. It is a useful checklist to appraise where

we currently are and the long haul required to build a universal, equitable and accessible healthcare system for all South Africans.

The keystones include:

- Leadership and governance
- Adequate healthcare funding
- A suitably skilled healthcare workforce
- Appropriate medical products and technologies
- Appropriate information and research
- Improved service delivery.

**In the face of these enormous challenges, as a profession our commitment and goal must be to ensure that all our citizens are afforded the “wealth of good health”**

Inefficiency in any one of these building blocks impairs a healthcare system and adversely impacts on its overall performance.

In their paper *Health and Health care in South Africa – 20 years after Mandela*, Mayosi and Benatar give a sobering account of the many challenges facing us, as well as the socio-political and economic factors that are likely to delay and impede effective delivery of accessible and equitable healthcare to our most needy and deprived citizens.

They suggest that “appropriate responses to SA healthcare challenges would be to address the social determinants of health (which lie outside the health system) as a national priority, strengthen the healthcare system, and facilitate universal coverage for healthcare”.

In the face of these enormous challenges, as a profession our commitment and goal must be to ensure that all our citizens are afforded the “wealth of good health” as Ghandhi so poignantly expressed.

Mayosi BM, Benatar SR. Health and health care in South Africa – 20 years after Mandela *N Engl J Med* 2014; 371(14):1344-1353 [http://dx.doi.org/10.1056/NEJMs1405012]

# Medical malpractice costs: Towards a solution

Julian Botha, *Strategic Accounts Manager: SAMA Private Practice Department*

The steeply rising costs of medical malpractice or indemnity cover presents a massive challenge to medical practitioners in private practice. The sharp increase in the cost of this cover is attributable to the commensurate increase in litigious claims against medical practitioners. These claims occur not only in the private healthcare sector but increasingly in the public health sector. So much so that a number of provincial departments of health have massive accumulated debts in malpractice claims.

**The situation is dire and poses a significant threat not only to the medical profession, but to the public as well**

In March 2015, the Minister of Health convened a Medico-Legal Summit. In his address to the delegates, the Minister was vociferous in laying the blame almost squarely at the feet of the legal profession. Essentially, the rationale is that amendments to the Road Accident Fund Act, limiting claims for general damages, and the Contingency Fee Act encourage legal practitioners to pursue medical malpractice claims as a replacement source of income. In addition the fact that attorneys, in terms of the Contingency Fee Act, are entitled to agree with clients to receive a percentage of the final settlement paid in lieu of their normal fees allegedly encourages legal practitioners to inflate their claims in order to ensure a higher fee pay-out at the end.

The beliefs that the root causes of the sharp rise in claims are attributable to these two factors are shared by many, but respectfully, this is an over-simplified analysis of the situation. While these two factors may be contributory causes, there are a number of other factors which have also given rise to the spectre of litigation against medical practitioners. These include, but are not limited to an increased awareness of patients' rights, the difficult economic climate in South Africa (SA), which

may tempt patients and their families to secure a "quick pay-out" from ostensibly affluent medical practitioners and/or their insurance carriers, the dire state of our under-resourced and undermanned public health service where patient care is unintentionally compromised. The list goes on and on.

Although there may be a debate on the causes of this increase, it would be dangerous and fall into the trap of playing the blame game – where each interested party persists in accusing others of causing the situation while accepting no accountability themselves.

The fact of the matter remains that the situation exists, medical malpractice claims are sharply increasing, the quantum of the damages sought are spiralling and, as a consequence, the costs of insuring against these claims is also increasing. The situation is dire and poses a significant threat not only to the medical profession, but to the public as well. Should current trends continue, it will become increasingly unaffordable for certain specialists to continue to practise. This, in turn, will impact the public as the availability and access to specialist care will become a rare commodity.

The focus must now be not on the apportionment of blame and dwelling on the diagnosis of the problem, but on finding workable, sustainable and affordable solutions to the problem.

As part of the Minister of Health's Medico-Legal Summit in March 2015, stakeholders participated in workshops to deal with various aspects of this issue. One of the proposals, originally mooted by SAMA, was the establishment of an alternative forum for the adjudication of medical malpractice claims, modelled along similar lines to the CCMA. The benefits of such a forum would include having a simpler, cheaper and more accessible process which would be less formalistic and litigious but rather seek to obtain fair and rational outcomes without the lengthy and strictly formal nature of normal court proceedings. It would also lift some of the burden on the courts which are overburdened.

The Minister of Justice also advised that there is an intention to establish an office of the "Medical Ombudsman". This must be seen as a positive step taken by the Minister and will, no doubt, assist in alleviating the litigious burden faced by our courts by resolving issues and complaints, where possible, before formal litigation is embarked upon.

Arising from the conference was the proposal and subsequent gradual introduction of a mediation process, led by a retired judge of the High Court that seeks to resolve malpractice complaints by means of a mediation process. While this project remains in its infancy, it will undoubtedly continue to assist in resolving complaints before costly litigious claims are lodged.

In November 2015, the Medical Protection Society (MPS) convened a conference in which a paper: "Challenging the Cost of Clinical Negligence" was presented and discussions were held with various interested parties. It is not possible to deal with the paper in depth here, instead we will focus on the proposal made which may be of assistance in containing the medical malpractice/negligence crisis, and, in time turn the tide.

**Each of the role-players in the industry must take responsibility to contribute towards these solutions. An adversarial or confrontational approach to this crisis will lead to catastrophe.**

In summary the MPS made six main recommendations:

- The development of a complaints process which is consistent, efficient and allows for local resolution. Of importance here is the acknowledgement that in the absence of a place where aggrieved patients can lodge their complaint and have it properly dealt with, their first option is to consult an attorney, who in turn will embark on litigation.
- The introduction of a "Certificate of Merit". This proposal, modelled after the Australian system, compels the plaintiff attorney to certify that the case has merit. If it transpires that the case has no merit and is frivolous, that attorney can be made to pay the legal

costs of the defending party. This would clearly discourage the institution of claims without merit by unscrupulous attorneys.

- An Alternate Dispute Resolution mechanism should be established.
- The introduction of a "pre-litigation resolution framework" which will allow opposing parties easier access to the information held by the other, thereby facilitating a more rapid process and encouragement to settle matters.
- Procedural changes to the litigation process are required to prevent the time consuming

exchange of documents and information which is prevalent in the current litigation procedures and that cause matters to drag on for years. This process must be shortened and even provide for early exchange of expert's evidence/reports and mandatory meetings between opposing experts to narrow down the issues.

- The limitation of damages (both special and general) must be considered. While the complexities of damages, especially future damages, are immense, it remains important, and increasingly necessary to

investigate a reasonable capping of the damages that can be awarded.

It is clear from the proposals arising from the Minister of Health's Medico-Legal summit and from the proposals made by the MPS that the solutions which are under consideration will take time to implement; some will require legislative amendment. It is a journey that must be undertaken. Each of the roleplayers in the industry must take responsibility to contribute towards these solutions. An adversarial or confrontational approach to this crisis will lead to catastrophe.

## Prof. Du Toit-Prinsloo realises a lifelong dream

*SAMA Communications Department*

American television series have popularised the work of forensic pathologists. In these shows, characters portray highly skilled, highly intelligent forensic detectives, people such as Dr Temperance "Bones" Brennan (Bones), Dr Gil Grissom and Catherine Willows (CSI), and Dr Maura Isles (Rizzoli and Isles).

But these characters are fictional. Few people know that behind the scenes, many of these characters are based on real-life forensic experts, medical specialists with the same qualities we see in our TV heroes.

One such real-life specialist is Prof. Lorraine Du Toit-Prinsloo, recently promoted to adjunct professor in the Department of Forensic Medicine in the Faculty of Health Sciences at the University of Pretoria.

Prof. Du Toit-Prinsloo was appointed to this post earlier this year. It's a position she says she is honoured to occupy.

"It's something you really have to work hard to get and I am extremely happy to be here. I knew from my third year in medicine that forensic medicine was something I wanted to do, so to be teaching this now is really satisfying," says Prof. Du Toit-Prinsloo.

Her name will, however, not be unfamiliar to some people. She is a seasoned forensic pathologist who has testified in several court cases. A notable line from a newspaper article from one such case sums up the role she played when it noted "(Judge Nico) Coetzee accepted the evidence of forensic pathologist Dr Lorraine Du Toit-Prinsloo that ..."

Born in Bloemfontein, Prof. Du Toit-Prinsloo obtained her MB ChB at the University of Pretoria in 1999. Six years later she completed a diploma in forensic pathology, DipForMed

(SA) Path at the College of Medicine South Africa (CMSA). The same year she obtained a Certificate in Medicine and Law (CML) from Unisa.

In 2008, Prof. Du Toit-Prinsloo completed FCForPath (SA) at the CMSA and the MMed-(Path)(Forens) at the University of Pretoria. She started her career in Mpumalanga and the Northern Cape and worked as the resident medical officer at the Winterbourne Hospital in the UK for a year before returning to SA in late 2002.

On her return, she began working for the Gauteng Department of Health where, in 2004, she was the senior medical officer in the Department of Forensic Medicine. Here she performed medico-legal postmortem examinations and scene visits.

From January 2005, Prof. Du Toit-Prinsloo was the registrar in the Department of Forensic Medicine conducting postmortem examinations, scene visits, and providing testimony in court cases. She was also involved in providing practical teaching to medical students, a function that has steadily increased over the years.

In addition to teaching students, she also provided training to the SA Police Services on medico-legal investigations of death and forensic pathology. She has also presented several CPD courses in forensic pathology.

"It's really important to train new forensic pathologists. We have one of the highest crime rates in the world but, unfortunately, we don't always have the resources to ensure the in-depth scrutiny of all forensic investigations (such as molecular/genetic testing in sudden unexpected death cases). That is one of the reasons I am honoured



*Prof. Du Toit-Prinsloo*

to be given this opportunity because it will make a difference down the line," Prof. Du Toit-Prinsloo says.

Apart from working, and teaching, Prof. Du Toit-Prinsloo has supervised and/or co-supervised 15 postgraduate students in various disciplines aligned to forensic pathology, authored and/or co-authored more than 20 articles in peer-reviewed or refereed publications, and made several presentations at conferences and workshops locally and internationally.

In 2012 she was the chairperson of the Faculty of Health Sciences Education Innovation Committee. In 2015 she attended the Academic Advisory Committee that saw to the removal of the prerequisite examinations from the MMed(Path)(Forens) degree to be aligned with the expectations of the CMSA for the FCForPath(SA) degree, and the introduction of a PhD in the field of medical criminalistics.

As if all of this wasn't enough, Prof. Du Toit-Prinsloo is actively involved in four new research proposals, is a wife, and mother to two children.

# Professional autonomy and self-regulation: Guidance from SAMA

Dr Mzukisi Grootboom, SAMA Chairman

Recent media statements attributed to the MEC for Health in the Free State calling doctors “child murderers”, the recent spate of suspensions of medical professionals in our public hospitals and the public pronouncements made by the National Minister of Health, have highlighted the threat that our profession faces in terms of its clinical independence and self-regulation.

These utterances raise concerns and ethical challenges as to how we as professionals should deal with such issues, both in the public sector as well as every sphere where we as a profession serve our patients.

- The doctor has an obligation to provide his or her patients with competent medical care and to report to the appropriate authorities those doctors who practise unethically and incompetently, or who engage in fraud or deception.
- The doctor should be free to make clinical and ethical judgments without inappropriate outside interference.
- Ethics committees, **statutory bodies** and other forms of peer review have long been established, recognised and accepted by

organised medicine to scrutinise doctors’ professional conduct and, where applicable, impose reasonable restrictions on the absolute professional freedom of doctors.

SAMA reaffirms that:

- Professional autonomy and the duty to engage in vigilant self-regulation are essential requirements for high-quality care and therefore are patient benefits that must be preserved.
- As a corollary, the medical profession has a continuing responsibility to support, participate in and accept appropriate peer review activity that is conducted in good faith. We cannot allow any of our colleagues to be subjected to kangaroo courts or the court of public opinion without due process.

SAMA’s position is that:

- A doctor’s professional service should be considered distinct from commercial goods and services, not least because a doctor is bound by specific ethical duties which include the dedication to provide competent medical care.

- Any judgement of a doctor’s professional conduct or performance must incorporate evaluation by the doctor’s own professional peers, who, by their training and experience, understand the complexity of the medical issues involved.
- Any procedure for considering complaints from patients or the Department of Health which fails to be based on good faith evaluation of the doctor’s actions or omissions by that doctor’s peers is unacceptable. Such procedure or even utterance would undermine the overall quality of medical care provided to all patients. It will also have a huge impact on how the public and our patients view the doctors in the country.
- SAMA would like to appeal to all the politicians and officials, as custodians of our public health facilities, to make use of the existing clinical governance structures that exist in their hospitals as well as the statutory bodies who are tasked to deal with such issues instead of dealing with perceived problems in the media.

## Health effects of second-hand smoke

World Medical Association

A new online course for physicians to help them assess the health effects of second-hand tobacco smoke on children’s health has been made available by the World Medical Association (WMA).

The course helps physicians understand the robustness of the existing evidence. It also assists them in exploring intervention methods and legislation to minimise the exposure to tobacco smoke for infants and children. It has been developed by the School of Policy, Government and International Affairs at George Mason University in Arlington, Virginia, USA in collaboration with the WMA.

WMA president Sir Michael Marmot said: “Infants and children are the most vulnerable

in the population when it comes to exposure to tobacco smoke. Whether it is in cars or the home, secondhand tobacco smoke is causing immense damage to the health of children.

“Physicians have to do more to press for smoking bans and tobacco free environments. Millions of children are breathing air polluted by tobacco smoke. We can intervene on behalf of infants and children and we must.”

### Tuberculosis and multidrug-resistant TB

This course, which is free of charge, allows physicians to register for continuing medical education credits. The course is available alongside the recently updated WMA

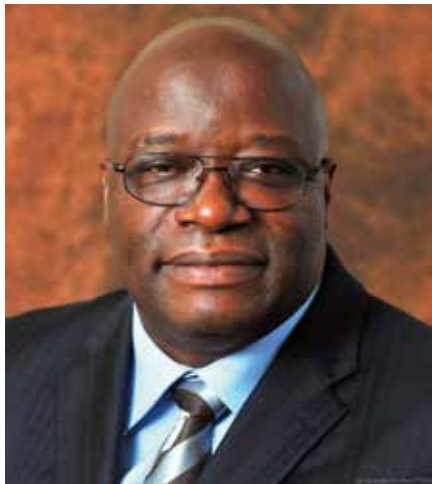


learning programme for multidrug-resistant TB guidelines. This course is also a free self-learning online tool and is available in English and Mandarin Chinese on the WMA website. It allows physicians around the world to learn and test their knowledge about multidrug-resistant TB which is spreading around the world and is difficult to treat.

The course was developed with the WMA by the New Jersey Medical School Global TB Institute.

# Delayed and non-implementation of the commission of inquiry into the HPCSA: Mutilation of victory

Dr Norman Mabasa



I write as an ordinary member of SAMA and as such my views are mine and they do not reflect the views of the SAMA Board and/or its leadership.

I was greatly elated to read SAMA's recent press release which lamented the slow progress in implementing the recommendations in the HPCSA report released more than three months ago by the Minister of Health. The statement by SAMA should be commended and supported as well as any interactions that may arise therefrom.

The reponse to the media release happened to come from the HPCSA and I must say what is contained in that response takes us no further than we were before they responded. The less said about their response the better, lest our attention be defocussed from the real issues.

**The HPCSA and all other stakeholders, especially medical practitioners should be consulted throughout the process**

What I know from the report, as read by the Minister, I shall dissect into two major sections in order to simplify the way the

report should have been handled and still should be, even now.

The issues raised in the report should be subdivided into statutory and operational issues. The statutory issues fall within the competence of the Minister and no other person. The operational issues fall within the HPCSA after being duly empowered by the Minister to act as such.

The Minister announced the following:

- That the CEO/Registrar, the COO and the legal services or unit manager should be subjected to disciplinary inquiry
- That the HPCSA as it is now should be "unbundled".

The rest of the oratory and implementation thereof can only be realised once the two major issues I have isolated have been addressed, not necessarily simultaneously. This is pivotal to this dilemma and nothing can be achieved before the above issues are resolved appropriately, especially the first one that involves the top officials.

A guest on a popular talk radio station quoted an old saying that goes "If you do not have a beautiful marriage, at least you must have a beautiful divorce". This advice applies very well to implementation of the two areas I have identified above. The second advice I may craft in an attempt to understand this quagmire is that if you do not like the make or brand of your car, it may be a waste of time and resources going around shopping for wheels and mirrors or even changing its colour as your major problem is the make of that car.

Since the announcement was made by the Minister, the CEO, the COO and the legal services manager still report for duty as if it's business as usual.

The fact that these officials were "shamed" in public and that disciplinary proceedings are pending implies that there is "a cloud hanging over their heads". This by no means implies that they have been found guilty of any wrong-doing but that their conduct is in question and as such they may be subjected to disciplinary procedures.

This is at the heart of our concern as ordinary members of SAMA. You cannot have officials whose future hangs in the balance reporting for duty. That alone renders them dysfunctional

and non-productive and it may also compromise investigations as the implicated officials still have access to and control over vital information within the HPCSA. That is a major problem.

## What should have been done?

I believe the process was handled incorrectly. The moment the Minister released the report the implicated officials should either have taken leave of absence or been suspended until investigations and disciplinary procedures are finalised. Acting officials were supposed to be appointed. That should've happened immediately. Not doing so removed the sting from the report.

**You cannot have officials whose future hangs in the balance reporting for duty**

Who suspends who? My understanding is that the registrar is appointed by the Minister. The Minister gives the notice to suspend to the registrar and then the HPCSA undertakes the process of appointing an acting registrar as approved by the Minister. This was supposed to be the first step and it is not too late to take this step.

The appointed acting registrar would then implement the other section of the recommendations involving the suspension of the other named officials and also conduct investigations accordingly.

The Minister and the HPCSA instruct the acting registrar to live up to the spirit of the report. The HPCSA itself which is comprised of the President and the other members of the professional boards cannot interfere with how the acting registrar conducts investigations against the COO and the legal services manager other than that of oversight. They can only ensure that the acting registrar has the necessary power to act.

We cannot fail in this regard. The above process must ensue.

## On the unbundling of the HPCSA

Again, this is a Ministerial competence. It is protracted as it involves repealing the law that brought the HPCSA into effect. The HPCSA cannot unbundle itself. A child cannot "unborn" itself.

The Minister needs to begin to look at the Act and see whether the Act needs to be amended, repealed and redrafted and then give effect to the separation of the conjoint twin. The HPCSA and all other stakeholders, especially medical practitioners, should be consulted throughout the process. This marriage was a forced marriage.

It is not a bilateral agreement to fuse medical and dental practitioners with the

rest of the other boards. They may be happy about what we are not happy about. It was never in the interests of the medical and dental profession. No wonder pharmacists and nurses found it apt not to be suffocated. They have their own councils while they are also health professionals.

What must be ensured is that, as the new other council is formed, we do not carry over the dysfunctionality that infests the current HPCSA as outlined elsewhere in the detailed report. The structure must show better and functional organisation.

I hope this well-thought statement is responded to constructively.

## Dr Mphata Norman Mabasa

- Limpopo MEC for Health and Social Development from 2012 - 2014
- President of SAMA from 2007 - 2008
- Chairman of SAMA from 2009 - 2012
- Human Resource task team member at the Department of Health
- Council member, University of Limpopo
- Chairman of the Society for General Practice
- Board member of SAMA

## The dispute resolution procedure in terms of the Labour Relations Act

Wandile Mphahlele, Legal Advisor: Labour Relations

*This is part one of a series of articles on this subject*

The Labour Relations Act (LRA) differentiates between dismissal based on operational requirements, misconduct or capacity on one hand, and on the other cases labelled as automatically unfair dismissals. The reference to this distinction is important as the process dealing with the two differs slightly.

The rationale for automatically unfair dismissals is to prevent or deter employers from infringing rights conferred on employees by the Act (e.g. the right to strike, a right to join a trade union). The sanction for infringing such a right is curbed at 24 months by the LRA, while the other forms of dismissals are curbed at 12 months. After conciliation of a dispute, an automatically unfair dispute must be referred to the Labour Court instead of

arbitration. Only the Labour Court can give the maximum compensation of 24 months.

After dismissal, the employee has 30 days to refer the dispute to the Commission for Conciliation, Mediation and Arbitration (CCMA) and in unfair labour disputes, the employee has 90 days to refer. The latter must appoint a commissioner who must resolve the dispute within 30 days. In circumstances where the dispute was referred out of the prescribed time period, a party must, when referring the matter, also file an application for condonation. This application must state the degree of lateness, reasons for lateness, and prospects of success and prejudice that may or may not be suffered by the other party. The CCMA will not have jurisdiction unless condonation is applied for and granted.

The main objective of conciliation is to assist the parties to settle or find a solution that is practical, cost-effective and which will maximise satisfaction to both parties. This the commissioner can do after hearing both sides of the story and advising the parties on how best to settle. The commissioner has no power to force the parties to settle and no matter how reasonable the proposal may be, she/he must complete a certificate of non-resolution and advise the parties on the next step.

No legal representation is allowed in conciliation proceedings. The Labour Court has held that even if parties agree to legal representation, the Commissioner has no discretion, she/he must refuse legal representation.



**SAMA Med-e-Mails will no longer be published daily. From the 1 March 2016 Med-e-Mails will be published weekly on a Friday morning. SAMA members are encouraged to check the SAMA website daily for news. [www.samamedical.org](http://www.samamedical.org)**

# GPPPC key deliverables for 2016

*General Practitioners Private Practice Committee*

The General Practitioners Private Practice Committee (GPPPC) has made a conscious decision to actively execute and deliver on their mandate to members. The Private Practice Unit (PPU) of SAMA has identified 2016 as the year of ensuring that our delivery machinery is aligned with the expectations of the membership.

In the past financial year (2015), SAMA GPPPC held an Indaba which adopted important resolutions. These resolutions serve to highlight the issues members regard as priorities, and will act as a blueprint on how to deal with them.

The GPPPC has outlined seven priority areas that require special focus.

These areas are:

## Co-ordination of care

General practitioners (GPs) are recognised as the embodiment of family and community health. They are highly skilled, and trained, and provide independent, high-quality clinical advice and general diseases management solutions.

**The GP is now firmly in the driver's seat and our members should prepare for better times ahead**

The GPs' level of experience and engagements with society's health challenges on a daily basis has enabled them to understand and appreciate the extent of the burden of diseases, and their implications, for communities.

It is becoming apparent that healthcare funders have realised the big role GPs play in the co-ordination of patient care. The GP is now firmly in the driver's seat and our members should prepare for better times ahead. But this will only happen if they have the knowledge and understanding of what care co-ordination entails. They

must also ensure that they are ready and equal to the task, given the responsibility that they have.

This entails continuing to take good history, thorough patient examination, producing patient reports, and prompt finalisation of diagnoses. This should act as a basis to provide effective clinical advice for directive intervention, which includes proper referral and eradicating unnecessary delays.

The subset to this plan is chronic diseases management. GPs, as the leaders of care co-ordination, should establish clinical approaches that prevent complications resulting from poorly managed chronic conditions.

This responsibility will go a long way to ameliorate dependency on hospitalisation and the associated costs thereof.

## Indaba resolutions

The GPs have spoken, and we now need to deliver on the requirements, and to report back at the next Indaba. Progress reports will be provided during planned roadshows throughout the country.

## GP up-skilling workshops

Roadshows as mentioned above will be two pronged. There will be a CPD evening, followed by an up-skilling workshop, on successive days. The workshops will be aimed at optimising GP income through up-skilling them with procedures that are intended for GP practices. Examples are programmes on how to perform procedures such as circumcisions, screening tests, and intra-articular injections. The workshops will be CPD accredited. We envision visiting twelve areas in 2016.

## Practice cost studies

An actuarial services company will be appointed to conduct practice costs studies. We have now stepped up efforts to put some science behind the cost studies. This will ensure that our members, and the industry, begin to understand the input costs that practices incur in delivering a service to patients. Apart from engaging actuaries, we will also be speaking with people involved in the GP value chain, to establish a credible and independent view on practice costs. It is anticipated that members

will have to support the investigations with their practice information.

## National Health Insurance (NHI)

The release of the White Paper on NHI has sent the industry into a frenzy. SAMA is busy putting together a submission to the Department of Health (DoH). GPPPC will ensure that your interests and views are safeguarded when engaging with the Department on NHI.

**GPPPC will ensure that your interests and views are safeguarded when engaging with the Department on NHI**

## MomConnect programme

MomConnect is a pregnancy management programme for pregnant women during the entire duration of their pregnancy, and up to a year post delivery. It is a DoH initiative aimed at providing guidance and support to pregnant women, using mobile technology. The initiative will need the support of GPs as this will help reduce maternal and infant mortality, an important component of the sustainable development goals. GPs should also be provided with a unique code, as is the case with all the government clinics. Negotiations are underway to have this arrangement in place.

## Communication

Poor communication remains a problem in many organisations. We have also not communicated as well as we should have. GPPPC is looking to improve this by ensuring that members are kept posted on all developments. But poor communication runs both ways; members sometimes do not respond to surveys, attend meetings, or provide important inputs, a situation that must also change.

We look forward to a successful 2016.

# Insubordination and characteristics to look out for

Keletso Makwe, *Labour Relations Advisor*

The Trade Union (SAMATU) has a duty to advise and/or assist members in dealing with insubordination and characteristics to look out for, which seems to be a general challenge in the workplace. This is also prompted by the number of grievances, complaints and disciplinary cases brought to our attention.

Insubordination is when the employee refuses to obey a reasonable instruction given to him/her by his/her immediate manager, or the employee continually challenges the authority of his/her immediate manager.

This helps both the employer and employee to understand what insubordination is (and what is not insubordination) due to the fact that it goes to the heart of the employer/employee relationship.

The employer has a duty to give lawful and reasonable instructions and not provoke employees in doing so. The following are examples of what is expected from the employer:

- The instruction must be capable of performance.
- The instruction must be lawful and reasonable.

**If an employee believes that an instruction is unreasonable, he should appropriately address it with the employer and not just blatantly refuse**

An instruction can be lawful but unreasonable. If an employee believes that an instruction is unreasonable, he should appropriately address it with the employer and not just blatantly refuse.

An example would be that of a medical practitioner expected to save a patient's life

without crucial equipment. It is not unlawful to expect them to save a life, but to expect that to be done without the resources is very unreasonable. The instruction must be capable of performance.

## Must fall in the ambit of the job description

Another argument would be that the instruction does not match the job description of the employee. It may not be in the employee's job description but if it's a once-off request, especially under certain special circumstances, refusing to obey would be unreasonable. In some cases tasks may not be outlined in written form but stated "between the lines". The best way would be to comply and complain when things have calmed down.

Some of the characteristics present in insubordination would be willful disregard of management authority, disrespect, rudeness, rebelliousness or disobedient gestures, manner or attitude, dismissive gestures, walking away, abusive language, knocking the written instruction or notification of enquiry from the senior manager's hand, or taking it and discarding it, addressing the senior manager or director or supervisor in a disrespectful manner.

Below are some examples of what employees should look out for:

## Addressing the senior manager, director or supervisor in a disrespectful manner

This includes writing rude emails, or SMSs and worse, copying in all to the rude correspondence. In one case the employee was charged for rude emails to the seniors. The employee only realised during our consultation meetings that the emails served as evidence and that they were indeed rude and wrong.

Even if the employer may make a mistake when it comes to being reasonable, employees should not give them ammunition by being hasty in responding. Seeking advice from SAMATU before reacting or responding is the better option.

SAMATU had to intervene in a matter where the employee and the manager were always at loggerheads over many issues. Sitting in the meeting it became apparent that the employee was downright disrespectful and didn't even realise it.

There had to be stern advice from the Union to prevent the situation or grievance from escalating to disciplinary action by the employer. The intervention was crucial in calming the situation.

**Seeking advice from SAMATU, if the situation seems unbearable, is always the better option to prevent the situation from getting out of hand**

## Walking away/disobedient gestures

This happens a lot and what is of concern is that most employees involved see nothing wrong in the situation. An employee gets upset with the discussion in a meeting or gets into an argument with the manager and decides to walk out. This is a classic example of disrespect/insolence and can therefore justify disciplinary action for insubordination. It would be advisable to sit in the meeting and raise the concerns separately after the meeting.

## Disregard of management authority

One example of this would be refusal to clock in or sign an attendance register. If the employer decides that the signing process makes it easier to monitor and account for employees work attendance, it is not unreasonable to ask employees to sign in; refusal to comply could be viewed as disregarding management's authority. Seeking advice from SAMATU, if the situation seems unbearable, is always the better option to prevent the situation from getting out of hand.

## Conclusion

SAMATU is available for any assistance and intervention that may be required by members in dealing with the employer's unfair conduct that could provoke the situation.

## Support for stroke patients available

Diane de Kock

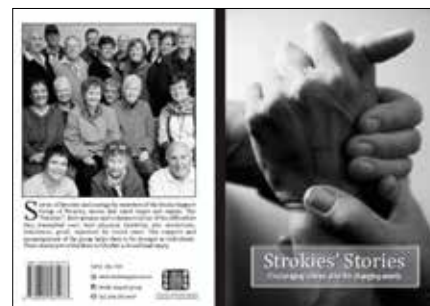
Once a patient has been discharged from hospital after a stroke, there is often a need for group support for both the patient and family. One such group is the Stroke Support Group (SSG) in Pretoria. Members of the group shared how their lives were changed as a result of a stroke or closed head injury in inspiring stories which were published in a book called *Strokies' Stories* (Strokies is the name that members of SSG call themselves).

The SSG is a registered non-profit organisation. In a city as big as Pretoria, with 2.9 million people (Census 2011), there would be approximately 52 200 people with a disability due to neurological causes.

The SSG markets their services, which are at a nominal annual membership fee, as much as possible. However, it is a constant

battle and an ongoing concern to remain viable. Members and volunteers grow old, become ill and pass away, or have another stroke. Pamphlets and bookmarks, visiting cards, exhibitions, and information are sent to professional groups, informative talks are given at clubs, etc. to raise awareness of the group. However, most new contacts are made via the website.

To inform people about the group and to inspire others, most, but not all, of the current members of the SSG contributed their stories to the book. These are stories of individuals and how they overcame their problems. They are stories of hardship and endurance and aim to inspire others to do the same. The intention of this publication is to aid in recruiting members, both "Strokies" and volunteers.



*Strokies' Stories* was launched in 2013. The book, compiled by Ingrid Vorwerk Marren, chairman of the SSG and edited by Anne Nash, can be ordered from the SSG website, both in printed version as well as in electronic format and is available in English and Afrikaans.

To order the book visit:  
<http://www.strokesupport.co.za> or  
 telephone 084 270 4507.

## Greening your office

Todd L Sack, MD, Editor, *My Green Doctor*

More than ever before, you need an environmentally sustainable office. This is because the skills that come with sustainability are the same skills that you need to thrive among the world's current healthcare challenges: decision-making by teams, continual process improvement, efficiency and flexibility.

"Environmental sustainability" in an office setting was defined in 1987 by the United Nation's World Commission on Environment and Development, as "meeting the needs of the present without compromising the ability of future generations to meet their own needs." The same sentiment was expressed by the American environmentalist, Robert F Kennedy Jr, in July, 2007, when he said, "We did not inherit this planet from our ancestors; we borrow it from our children."

Each of these statements embodies the ethical principles of awareness for the long-term implications of our actions and respect for the rights of others. These statements sound true to medical professionals because they remind us of the most fundamental ethical principal of healthcare, attributed to Hippocrates, the "Father of Medicine", in the third century BCE: "First do no harm".

As healthcare providers, we know that everything we do has the potential to harm,

even as we intend to heal. Just as our tests and treatments may harm some patients, our decisions produce small environmental damages that may, in aggregate, lead to injury to the natural environment that have consequences for human health of this or future generations. Our uses of energy, water, chemicals, and other resources all have ethical consequences.

Striving for environmental sustainability can be a part of every person's personal ethical principles. You can make this one of the values held by your medical offices, outpatient facilities, or entire company, together with other core values such as delivering quality care, respect for preserving life, respect for privacy, and non-discrimination.

So why more than ever before do you need an environmentally sustainable office? First, there is the obvious reason that man is exhausting precious, non-renewable resources such as clean water, stable climate, undeveloped spaces, and certain minerals. We have an obligation to not compromise the availability of these to future generations.

The second reason to adopt environmental sustainability in your medical office is that the processes needed for addressing sustainability are exactly what are needed to confront the urgent challenges facing

healthcare today. Modern medical practices, if they are to survive, need to bring together all the talents in the office and to harness the creative thinking of young people to find new ways of solving problems. These are the same skills promoted by medical office Green Teams in the pursuit of environmental stability:

- Employee participation and team building
- Office self-examination
- Process improvement
- Lowering business operating costs
- Supporting the values of employees who want to "make a difference" for others
- Creating a healthier work environment
- Achieving healthier patients and communities
- Improving the public's recognition and approval of the office.

My Green Doctor urges every medical office to discuss the concept of environmental sustainability, to adopt this as a core value for your organisation, and share this concept with your office staff, your families, and your patients.

Interested? Register today at [www.mygreendoctor.org](http://www.mygreendoctor.org) where you can take the Green Doctor Office Pledge, your first step towards sustainability. It's free, safe, and no passwords are needed.

Source: [www.mygreendoctor.org](http://www.mygreendoctor.org)

# NHI will work best when there is harmony

Bernard Mutsago, SAMA Health Policy Researcher and Analyst



Recently attending a high profile event called “The Thought Leader Dialogue on Healthcare”, organised by the *Mail and Guardian* newspaper in Johannesburg on 28 January 2016, I was gobsmacked by the divergence in philosophy and ideals on the long recognised giant in the room – the National Health System for South Africa (SA). The question began to simmer within me: “Why do healthcare stakeholders disagree so persistently”? One would assume that 20 years of national dialogue on health system improvement would by now have successfully ushered people to a shared understanding of key principles, the ills besetting our health system, as well as the right prescription to the maladies.

Now with the National Health Insurance (NHI) White Paper in our hands, opinions seem to be more diverse than ever! A few years of my participation in health discussion fora have proven that health stakeholders in general – and specifically certain health professional categories as well as the two health sectors – are not natural allies. Particularly in the period preceding and succeeding the NHI Green Paper release, the discussion hall immediately transformed into a mini “war zone” and antagonism is an inevitable reality. As a matter of fact one of the delegates at the aforesaid *Mail and Guardian* policy dialogue bewailed the entrenched binary mentality of “them and us” that has slowly but surely contributed to the decay of the SA health system.

At the above-mentioned dialogue, the SAMA president, Prof. Denise White, gave the welcome address, setting the scene for

vehement discourse by ten prominent industry specialists as well as the audience. The speakers included Dr Nicholas Crisp, Prof. Alex van den Heever, Prof. Ian Couper, Dr Solly Motuba (SAMA Private Practice Department), Dr Yogan Pillay, Dr Daygan Eager, and Dr Morgan Chetty, among others. Topics firing the debate were the deep pathologies characterising the SA health system: health reform dilemmas, poor quality of care, role of the private sector, challenges faced by the modern day GP, rural health, access to emergency services in SA, nutritional diseases, vaccines, suitability of the health workforce, and how to appropriately measure health outcomes.

“What’s wrong with our health system”? was one poignant slide title in the presentation by Dr Nicholas Crisp, which was entitled: “Why is SA not achieving better healthcare outcomes”? His presentation kindled stimulating deliberation as he dissected the behavioural problems of our health system and struck a note on specific “non-collaborative” healthcare players who insist on “doing their own thing”. His panacea was that “the whole health system needs to be pulled together” and that there is need to find some “common ground” focusing on how all players can contribute to the whole system (inputs, process, outputs and outcomes). Prof. Alex van den Heever underscored that emergency health services, for example, require a high degree of integration and co-ordination to protect patients and the quality of care.

The degree of privateness of a universal healthcare system has been a subject of violent controversy. Both sectors frequently have conflicting demands and expectations in a health system. Dialogue in the SA context has shown that there is no broad consensus on the role of the private sector in the health system, specifically the NHI. Cohesion is sadly lacking in the SA system, where the fragmented nature of the health system has led to provider defensiveness in both private and public sectors.

*Silo-ism* is the ghost that is haunting the SA health system. The professional tensions have historically been between two major health professional categories, but have recently gradually distilled to other professional groupings. In a recent journal article published in the *Asian Pacific Journal of Tropical Medicine*, entitled “Harmony in health sector: a requirement for

effective healthcare delivery in Nigeria”, the authors identify professional conflict in the health sector as the vicious cankerworm that is killing the system. The article notes the deplorable state of the Nigerian health system (despite having rising expenditure on health) and attributes this to, inter alia, lack of professional harmony. The publication also underlines the centrality of professional accord and teamwork in the success of multidisciplinary teams and networks, such as are envisaged in the SA NHI.

Not to say that healthcare players must agree on all points, but, as one presenter at the *Mail and Guardian* event put across, “if health stakeholders can have a caring ethos and sense of responsibility – not only to patients but also to the general community – we can easily find some **common ground** and have common vision/ goals, and aligned behaviours”.

**“There is consensus that change is needed if this country is going to be able to afford the healthcare it demands and deserves”**

So, why do healthcare players disagree? Nobody knows. There is no agreement on the answer! There is no consensus on a range of critical issues. One cannot agree more with Prof. Morgan Chetty that consensus only lies in one aspect: “There is consensus that **change** is needed if this country is going to be able to afford the healthcare it demands and deserves”. With a White Paper for the Transformation of The Health System in SA that perfectly idealises a harmonious system in such terms as “unified system”, “coherent”, “coordinated”, “inter-sectoral collaboration”, “common vision” “pooled public-private resources”, and “integrated”, who can argue with Dr Nicholas Crisp’s avowal: “It’s time for everyone to be a South African first and then whatever else they want to label themselves only secondarily; what’s the alternative?”

# SAMA mortality and morbidity guidelines for CPD accreditation

*Continuing Professional Development (CPD)*

The following guidelines are aimed at assisting hospitals to obtain CPD accreditation. A routine, structured forum for the open examination and review of cases which have led to illness or death of a patient, in order to collectively learn from these events and to improve patient management and quality of care.

## Set-up

- Roles and responsibilities should be clearly defined and accreditation obtained by the SA Medical Association: [cpd@samedical.org](mailto:cpd@samedical.org)
- Meetings should have a chair or facilitator
- One person should be responsible for co-ordinating the meetings
- All members should be encouraged to contribute their views
- Regular, organisationally convened meetings, predominantly involving medical practitioners (but increasingly multi-disciplinary) who gather to discuss selected cases for the purposes of clarifying medical management and to provide a forum for teaching and system level learning – focusing on patient safety and quality improvement, including the identification and reporting of errors
- Identify key events resulting in adverse patient outcomes
- Foster open and honest discussion of those events
- Identify and disseminate information and insights about patient care that are drawn from individual and collective experience
- Reinforce system level and individual accountability for providing high-quality care
- Create a forum which supports open and honest discussion through the provision of a just, patient-centred culture
- Contribute to clinical governance processes.

## Content of the meetings

- Mortality and morbidity meetings (MMs) should occur onsite. MMs should be chaired by a senior doctor who takes responsibility for the process and in doing so has an ability to engage with clinical colleagues and to facilitate change at the patient care level. This may be the medical director,

unit/department head or delegate. Where possible, MMs should be regularly scheduled to maximise participation. Members of other clinical disciplines and junior medical staff should attend. Cases for discussion should be identified by:

- senior doctors raising specific cases
- referral from other MM meetings.
- In order to provide sufficient time for adequate discussion no more than two cases should be discussed per hour, although aggregating cases with similar issues into a “block” discussion may be appropriate.

## Cases must never be discussed in the absence of the senior doctors with primary responsibility for care of the patient

- Senior doctors and other clinicians actively involved in the care of the patient to be discussed must be made aware of the intention to discuss the case at least 72 hours prior to the case and must be made aware of the date, time and place of the meeting. If they are unable or unwilling to attend the meeting where the case is to be discussed, the case should be referred to the appropriate medical lead for further investigation or action. Cases must never be discussed in the absence of the senior doctors with primary responsibility for care of the patient.
- Cases should be presented in verbal format in a de-identified fashion, describing only the facts of the case including any confounding factors.
- The major issues should be identified during the presentation, with the chair providing further clarification if required
- The chair should ensure that following the presentation, the key discussion points are agreed. These should always include:

- What went wrong (or right)?
- How did it go wrong (or right)?
- Why did it go wrong (or right)?
- What could we do differently in future?
- What are the key lessons for the organisation?
- A consistent approach to problem-solving should be used to discuss the case.
- The chair should ensure that any discussion relates to the facts of the case and not to personal issues. This is not a meeting to attack or openly criticise individuals who have contributed to patient care – doing so impedes the development of a “just” culture.
- If major performance issues relating to an individual senior doctor become apparent at any stage during the discussion, the chair should immediately halt the discussion and refer the issue to the relevant medical lead (medical director, unit head or equivalent), who should then initiate the organisation’s usual performance development processes. Discussion around other matters pertaining to the case may continue.
- At the completion of the discussion, action points should be agreed and prioritised by all present in the meeting. Responses to these issues should be presented at subsequent meetings.
- Minutes should be kept – patient and doctor details should be de-identified.
- An action list and appropriate accountabilities should be generated and circulated to all participants and to appropriate organisation level clinical governance structures should be given.
- Evidence-based guidance to correct/prevent future incidents

For further information on CPD accreditation please contact: Lisa Reid on 012 481 2082 or [cpd@samedical.org](mailto:cpd@samedical.org)

Minutes of the meeting must be sent through every 6 months to your accreditor for auditing purposes.

Please note that medical professionals whose job descriptions involve hosting MMs should not accumulate CPD points for attendance or hosting.

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# Moot Hospital healthpost sets the pace in NHI

SAMA Communications Department

The government has been planning to introduce National Health Insurance (NHI) since 2012, in what it says is a major step in delivering quality healthcare to all South Africans. Dr Angelique Coetzee says she is extremely positive about the system and feels that others need to become involved.

NHI has, however, met with resistance. Doctors say the system will not be financially viable, and that they will suffer losses as a result.

But one doctor at the Moot General Hospital in Pretoria is pressing ahead with a pilot implementation of Community Oriented Primary Care (COPC), effectively a pilot NHI site.

Dr Coetzee says the "healthpost" in the Moot is about bringing public and private healthcare together to work specifically with people in the community. She says the purpose is to do comprehensive care in the community by creating a ward-based team of community health workers and a nurse teamleader to be integrated with the private general practice.

**The purpose is to do comprehensive care in the community by creating a ward-based team of community health workers**

"The GP, or family practitioner, is, essentially, the centre around which the practice is built. There are various other healthcare and community health workers drawn from the community who work with me. In the Moot we have two social workers, and a highly trained sister," she explains.

Dr Coetzee says the sister, for instance, is able to do home visits, assist with patient care and examinations, especially to those in

most need. If there are more complex cases, she can discuss these with her (Dr Coetzee). The patient can be seen by the doctor and referred to the clinic or district hospital if necessary.

"In cases where the patient is not covered by a scheme, chronic medication is dispensed through the Department of Health. Acute medicine still needs to be sorted out with the department, but we are working on getting this resolved," Dr Coetzee says.

The Moot healthpost officially started on this model in February but, as Dr Coetzee explains, it's been in the pipeline for 4 years. She says the essence of what they are doing is to streamline the processes of doctors to ultimately benefit patients.

"Yes, I think it's going to work, I really do. The idea is not that doctors see more patients but that they act as the centre of a practice, to a large extent co-ordinating care for the people in the community. It's about doctors using their knowledge in an advisory, consultancy capacity," she says.

Dr Coetzee says the progress of the implementation of this system will be reviewed in 6 months' time.

"But the review is not about how much money we made or didn't make. It's about how we can care for people in need, make the system to more effective, and close any gaps we identify. It's about looking at this system and seeing where the problem areas are and fixing them, and looking for ways to involve the private sector in finding a solution," she says.

## Criticism

Dr Coetzee acknowledges that there will still be many doctors who criticise the system, and opt out before they've even considered the implications.

"A big part of why I'm involved is to help others. I know not everything government does is perfect, but then neither is everything the private sector does. If I don't take a chance, government is going to implement a system without input from doctors, and that will be a sad day."

Dr Coetzee says she is extremely positive about NHI but says it has to be implemented in the right way with the



Dr Angelique Coetzee

involvement of all sectors and people involved in healthcare provision.

**"The idea is not that doctors see more patients but that they act as the centre of a practice, to a large extent co-ordinating care for the people in the community. It's about doctors using their knowledge in an advisory, consultancy capacity."**

"My message to doctors who are looking at what we are doing, and I think many are going to be following our progress, is that we have a great opportunity here. We can make healthcare better for the community, and we must stop criticising the system, we need to give it a try," she concludes.

# Oh by the way, doctor

Medical Protection Society

Mrs R was a receptionist in a local estate agent's office. One evening, she noticed that her 11-year-old son, Y, was limping as he walked towards her in the kitchen. Y was overweight and had been grumbling to his mother about his left knee hurting intermittently for the previous month.

On this occasion, when she asked why he was limping, Y told his mother he had slipped in the playground earlier in the day. The fall had caused his leg to be sore. He had pointed at his thigh and said his knee was hurting again. The following day, Mrs R was booked to visit her GP, Dr G, to review her contraceptive medication. She decided to bring her son along with her, without an appointment.

At the end of her consultation, Mrs R asked the doctor if he would take a look at her son. She explained what had happened yesterday and told Dr G that Y had been limping at home. There was a computer record of the consultation with Mrs R, but not with Y. Mrs R reported that Dr G carried out a cursory examination of Y, while Y was sitting in the chair. She said that the doctor told them this was most likely a hip sprain, but to come back if the pain did not settle.

**Remember the importance of contemporaneous record-keeping. Good documentation is the basis of good medical practice, and can help to defend a claim**

Dr G remembered Mrs R attending for a review of her medication, and then asking for her son to be seen at the same time. He recalled feeling



rushed and that Mrs R was quite insistent that Y be examined. Dr G could not remember carrying out the examination and thought he had asked Mrs R to rebook an appointment for Y. As there was no formal record of this, there was therefore no note of such a request, or an examination being performed.

When they returned home, the boy continued to complain of pain in his leg. Mrs R decided to bring Y to the local emergency department three weeks later, where a doctor requested bilateral hip X-rays and subsequently diagnosed slipped upper femoral epiphysis (SUFE). The case was discussed with an orthopaedic surgeon and Y was admitted immediately for internal fixation.

After his treatment, Y's legs were of unequal length and one year later, he still walked with a persistent limp, which he found extremely distressing. The family had learnt it was likely that Y would require an early hip replacement in the future.

Mrs R made a claim against Dr G. As there were no records of the consultation, experts found it difficult to make a definitive assessment of the case, but they did find that Dr G's management had not been appropriate. The case was settled for a high sum.

## Learning points

- Remember the importance of contemporaneous record-keeping. Good

documentation is the basis of good medical practice, and can help to defend a claim. Even if Y's problem was mentioned by Mrs R as a "by-the-by", Dr G should have made a clinical record of the events.

- If you are going to assess a patient, even in someone else's appointment, the history and examination should be carried out appropriately. Had Dr G done it at the time, he may have realised that there was a significant problem with the child's leg. Otherwise, Dr G should have asked Mrs R to wait until the end of surgery for Y to be seen if urgent, or rebook an appointment for Y at a later date, when a more thorough history and examination could be carried out, if the problem could wait. Dr G should have made a record of this discussion.
- A limp in a child can have multiple aetiologies: Perthes' disease/trauma/transient synovitis/septic arthritis/osteomyelitis. Slipped upper femoral epiphysis usually affects boys aged 10-15 years old. Incidence is 1:100 000 and is bilateral in 20% of cases. It occurs more frequently in obese children with delayed secondary sexual development and tall thin boys.
- Remember referred pain to the knee as an early clinical symptom of SUFE.
- Examine both hips and check for restricted movement, particularly internal rotation.

## Letters to the Editor

Our thanks to Dr HR Smit and Dr Erik van Dijk for submitting the letters below for publication. The **Letters to the Editor** page aims to give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare which you feel should be shared with your colleagues and fellow readers.

Please note that letters:

- should be no longer than 300 words
- can be published anonymously, but writer details must be submitted to the editor in confidence
- subject matter must be pertinent to healthcare delivery
- should be submitted before the tenth of the month in order to be published in the next issue of *SAMA Insider*.

Please email contributions to: Diane de Kock, [dianed@hmpg.co.za](mailto:dianed@hmpg.co.za)



### To the Editor

Congratulations Doctor Lingham on your letter "Professional Ethics"! I can't agree with you more!! We as rural GPs in Namibia experience the same scenario daily.

As far as I am concerned, the problems are:

- Specialists started to see patients "from the street" e.g. without a referral from the relevant GP. That leads to duplication of expensive special investigations etc., and unnecessary referrals.

- Private hospitals started to rent suites free of charge to specialists with the off-the-record agreement to admit and treat patients at that specific hospital. I believe that they also get a slap on the wrist when the turnover is not high enough.

What happened to the fact that GPs are the gatekeepers of medical aid funds? When you look at the divisions of the pay-outs of the medical aid funds there are only three main

players: private hospitals, specialists, medicine. In basic, all three are run by the same people behind private hospitals.

We as a medical fraternity became puppets of unscrupulous people. As long as they can blame the GPs they will get away with this unscrupulous behaviour. "Long Live Ethics"!

**Dr H R Smit**

Gobabis, Namibia

### Dear Editor

I wish I could congratulate Dr Phalane myself on his article in the *SAMA Insider* September 2015 issue. At least somebody is thinking of us. I have been a GP for 19 years and I cannot say it is going better.

With everybody else in the industry it seems it is just going better.

I hope it is not just words and that there is some action going to take place from SAMA's point of view; just start fighting for us for a change!

**Erik van Dijk**

#### *Dr Phalane responds:*

It is with the highest level of seriousness that I respond to your letter. Thank you very much for taking the time to write to us. We have read with serious concern your honest plea for real action, and not just empty rhetoric. I could not agree with you more, I am tired of empty talk. Talk is not just cheap, but it is actually free.

You state in your letter that "at least somebody is thinking of us. I have been a GP for 19 years and I cannot say it is going better". That is the reality for most of us as doctors.

Our philosophy, structure, systems and way of doing things need to change, urgently. We cannot continue to do things the same way. It is not sustainable to work three or more jobs

just to afford a decent house, quality education for our kids, and to buy health insurance for our families. We cannot always strive to barely cover our debts. We put our lives and those of our patients at risk. We cannot afford to live quality lives. We are always in a struggle for survival.

We have to accept that our knowledge and attitude on money and health economics never worked for us. One example is the pharmaceutical industry. It will take a doctor to be the real and original person to invent or discover a medical condition. That diagnosis through thorough research will lead to laboratory research to make biochemical diagnosis, followed by pharmaceutical or clinical trials to treat such a condition. Unfortunately the doctor, who is the real inventor of this whole process, will not enjoy the financial benefits that the pharmaceutical company will for 20 years of exclusive patent rights. Why? It does not make sense to me that the real inventors work like slaves, barely make it in life financially, while those who use their hard work and intellectual property earn billions. The same argument holds in medical technology, it will always be a doctor who will identify the need to get imaging to diagnose broken bones, or pregnant uterus, or to diagnose diseases such as HIV, or TB. The story is the same with medical aids, they are to a large extent no longer aiding but ailing

the doctor's ability to practise medicine, and to earn a living. This has to stop.

Dr van Dijk, I personally invite you and those who believe in the principles we are raising to urgently: Convene a doctors "tell all and do all" action oriented gathering. Not another talk shop. We have no choice but to change our models; we need to start our own businesses. Why don't we own our own hospitals, medical aid schemes, pharmaceutical companies and other businesses that will generate us good profits? Running a medical practice, no matter how busy it can be, is never a sustainable business.

We should unite, unconditionally, and speak with one voice and act with one purpose to liberate ourselves from professional and financial slavery. It is time we think out of the box and liberate ourselves financially. That will enable us to practise medicine the way it should be.

Thank you, Dr van Dijk for your response, there is never a more perfect time than now to change the course of events towards total disaster. A poor doctor is a dangerous doctor. It can never be right for a hard working and highly qualified doctor to be poor. No one else but the doctor can change this situation. Everyone else enjoys it when the good doctor is apathetic, ignorant and divided. Let us "be the change we want to see".

## Dealing effectively with snakebites

SAMA Communications Department

Snakebites can be deadly, and effective treatment is vital to proper care. It is especially important for doctors in areas where snakebites are common, to be aware of the dangers, and how to deal with them.

On 30 January, snake expert Vic Boshoff presented a comprehensive snakebite lecture worth five CPD points, to the SAMA's Lowveld Branch at the Bundu Lodge near White River.

"The aim of the lecture was to inform the doctors about snakebites and the administration of antivenom. I used photos to identify snakebites and to show the difference in cytotoxic and neuro-toxic bites," explained Boshoff.

He says it is important for doctors to know when to administer antivenom as well as understand the treatment of anaphylaxis as a result of the administration of antivenom. He says doctors also need to use adrenaline (epinephrine) instead of solucortef, and/or aminophylline as prophylaxis in preventing allergic reaction.

"Part of the presentation also helped those tell the difference between a dry bite and a full bite, and we also spoke of the importance of administering antivenom within one hour of the patient being bitten," he said.

An important aspect of the presentation was to look at the distribution of snakes throughout South Africa, and the problem doctors in rural areas, where they have no access to ventilators during the administration of antivenom, are faced with.

"We want to be part of the solution whenever someone is bitten so I told the doctors they can SMS me the snakebites for quick identification. This extends to spiders and scorpions, and is a service we render free to assist doctors identify and treat bites," said Boshoff.

Vic Boshoff is not new to snakes. He has been working with them for 30 years, and is the chairman of the Limpuma Herpetological Association in Mpumalanga.

"I spend a lot of time removing snakes and assisting the MidMed Hospital, and



Victor Boshoff

provincial hospitals in the area, identify and treat snakebites," he said.

In addition to assisting with snakebites, Boshoff also lectures frequently in conjunction with the Mpumalanga Parks Board.

To get in touch with Mr Boshoff, contact him on 083 628 4902 or 082 697 9954.

## Learning to celebrate ourselves

Dr James Burger, SAMA Eastern Province Branch

As we continue to attempt to have some semblance of a life outside of medicine, the Port Elizabeth (PE) Public Hospitals' Social Committee, with the help of SAMA, Standard Bank, Mercedes and Sanlam, pulled off a spectacular night, quite befitting of a year worth commemorating.

This year's End-of-Year-Ball was held in December at the majestic Nelson Mandela Bay Stadium and attended by over 130 hospital staff and partners, all looking as stunning as the Fire & Ice themed décor. Numerous awards were given out, with new PE branch councillor, Dr Julian Basson, winning the prestigious Intern of the Year Award, voted on by the doctors of the three hospitals.

We danced the night away with colleagues and friends, celebrating the relationships which will undoubtedly last for years to come. One cannot think of a more memorable farewell for those to whom we were saying goodbye.

Over the last few years, the social committee has grown its social calendar to include a vast variety of thoroughly-enjoyed events; from the annual meet-and-greet party, to spring parties at the bowling club, party buses, rooftop picnics, wine-tasting events, among others, and culminating with the Annual End-of-Year Ball.



Sundowners at the End-of-Year-Ball (left to right): Julian Basson, Marlise de Jager, Ramona Titus and partner, Shannon Muthukapan and partner

Despite being a lovely little city and a great place to gain experience, PE had previously gained a reputation of having a few departments that overwork interns. With the backing of SAMA, a few individuals managed to change the working environment in these departments and reclaim the Pretty Easy's crown as the king of the Eastern Cape from Slummies (in my completely unbiased opinion).

As healthcare practitioners, we are under heavy stress in our working lives as we try to ensure that our patients receive proper care. It is sometimes difficult not to let our work consume us and without an adequate balance, we are headed towards the dire situation of burnout. There have been a number of articles circulating on social media recently regarding the derogatory

way in which doctors treat each other. In an environment where curt replies and the blame-game can so easily become the norm, we need to focus on interacting positively with our colleagues, juniors, and seniors. It is not something which necessarily comes easily in a fast-paced, high-stress setting, but the difference that a good working environment makes is undeniable. Without wanting to come across too lovey-dovey,

or sounding like a Miss Teen America contestant, we have to learn to celebrate each another and our accomplishments.

With a couple of new young branch councillors and the reinvigoration of the way things are done, the SAMA PE Branch, working closely together with the PE hospitals' social committee, is challenging this mentality. With this shift of focus to where we continually strive to improve the working environments

in our hospitals, we can help keep our doctors, nurses, and rehabilitation practitioners healthy and in a good state of mind, prepared to handle the difficult circumstances which they face every day.

As the "father of western medicine" said: "to cure sometimes, to treat often, to comfort always".

Isn't it about time that we learn to comfort our fellow doctors?

## Lowveld branch hold successful CPD meeting

The SAMA Lowveld branch kicked off the year with the first CPD event on 30 January at Bundu Lodge, Nelspruit. Global Laboratory Services, Kiaat Hospital and ProtoMed were the sponsors who made this event successful. Victor Boshoff had exceptional feedback from his lectures on snakebites (see page 19).

Dr Nkuna from Kiaat Hospital represented the Kiaat Ridge Hospital 'vision and mission' with expert services offerings to the public and private sector.

Prof. Chetty from Port Elizabeth gave the audience an astonishing and outstanding presentation on ethics.

The Lowveld branch would like to express gratitude to all the members who attended the day and invite them to the next CPD event planned for June 2016



*Prof. Chetty's presentation looked at the Ethics of healthcare reform*



*Victor Boshoff from PhotoMed talked on snakebites*

## News from the Free State

The Free State branch held their first branch council meeting on 27 January this year. We are grateful that everyone returned safely from their holiday.

The branch AGM is scheduled to take place on 2 April and will be followed by

a formal dinner and dance. The final year medical students from the University of Bloemfontein will also be invited to this event and over 100 delegates are expected to attend this prestigious evening with keynote speakers addressing the audience.

Watch this space for a detailed report and photographs on the AGM in the May edition of *SAMA Insider*.

On a more personal level, we are grateful for the little bit of rain and remain hopeful that the drought will soon be over.

## Border Coastal welcome 52 newly qualified doctors

The East London hospital complex welcomed 52 newly qualified doctors as they began their internship at the complex on 1 January 2016.

The Border Coastal branch (BCB) presented an introductory overview of SAMA and its purpose to them at the Intern Orientation Programme.

Goody bags, which included a SAMA information brochure, a notice "Remuneration and Associated Issues", from SAMA TU Department, a SAMA membership application/update form, list of names and contact details of BCB branch councillors, local tourism information and street maps, tourniquets and SAMA pens, were given out.

Sixteen completed membership application forms were handed in at the

close of the meeting. We look forward to welcoming these "newbies" to the SAMA BCB fold.

Then on 8 January, an intern welcoming function was held right on the beautiful Nahoon beach front. Catering and music was arranged, including "braai masters" to allow everyone to mingle and socialise. The event was a huge success and besides allowing the hospital doctors to get to know each other, also served to introduce the personal side of SAMA BCB to the new doctors and encourage them to get involved in the SAMA mission of serving our local medical community.

In summary then, we can confidently say that new arrivals to the Border Coastal Region have been fully SAMARISED.



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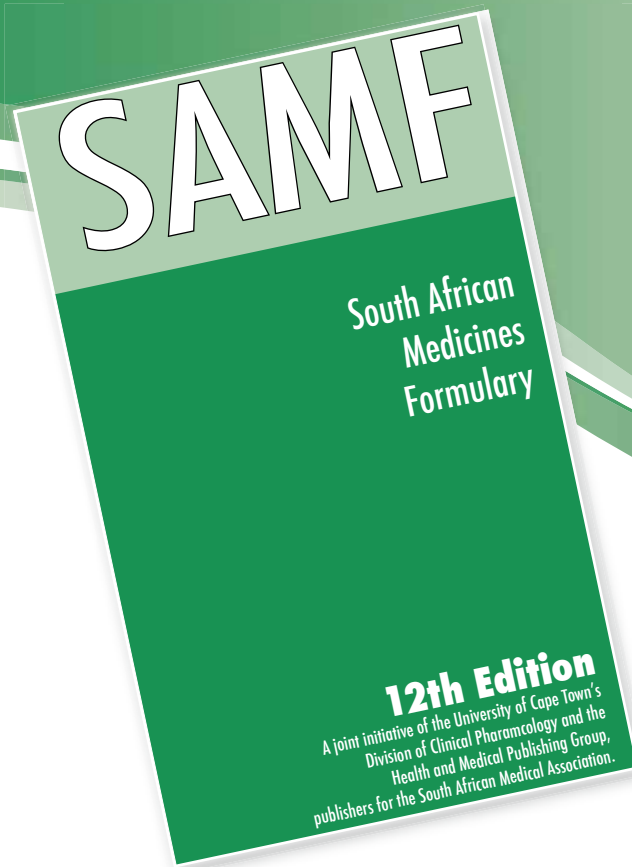
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