

SAMA INSIDER

AUGUST 2016

SAMA responds to NHI White Paper

The heavy burden of mental health



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

**SOUTH AFRICAN
MEDICAL ASSOCIATION**

An open letter to South Africa's healthcare service providers



Thank you...

As a healthcare professional, you protect the health and wellbeing of thousands of patients, and many of those whom you tirelessly care for are members of GEMS.

Thank you for the many new lives you have brought into the world and into the GEMS family in the past decade. Thank you for guiding and nurturing thousands of GEMS babies through their formative years and the childhood illnesses that are part of growing up. Thank you for being the helping hand that dispenses care to our older members in their twilight years. Thank you for being the voice that offers hope to those afflicted by dreaded diseases and terminal illness.

Our commitment to you...

As healthcare practitioners you are a scarce and precious resource, you are the backbone of our healthcare delivery system. Without you we could not provide accessible, affordable quality care to our members. We want you to know that we acknowledge and appreciate your tireless efforts in ensuring that our members receive quality healthcare.

If this describes you, you may stop reading now, unless you are so committed to your profession that you, yourself, would want to assist us to bring to book those who are bringing our proud profession into disrepute.

A word of concern...

It is with great concern that we have noted an increasing trend among a small group of seemingly unscrupulous healthcare practitioners who do not view healthcare as a precious resource, often using the funds that are at the disposal of our members in a wasteful and abusive manner. This is done without due consideration to the sustainability of GEMS or that of the broader South African healthcare industry.

There is a smaller group of individuals who do not uphold the values of their profession, do not care for our members as we do and do not uphold the sanctity of life. These are individuals who are motivated by greed. The sustainability of the South African healthcare industry carries little weight in their hearts and minds.

Tough action from GEMS...

In honouring the true ethos of this proud profession and the sacrosanct doctor/patient relationship, we caution the small minority of healthcare practitioners who are responsible for such wasteful practices. Those who abuse member and Scheme funds are guilty of the unacceptable practice of fraud.

For these reasons, in the coming months, the Scheme will be introducing a number of additional managed care and forensic interventions and will be taking a tough stance on waste, misuse of member benefits and particularly fraud.

In line with our values of honesty and transparency we thought it fair to alert those who are abusing GEMS's resources to desist from any practice that will endanger the sustainability of the Scheme, thereby harming our members, our valued healthcare professionals and the greater South African healthcare system.

Yours in health Dr Gunvant (Guni) Goolab Principal Officer: GEMS



GEMS108

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Diane de Kock
Editor: *SAMA INSIDER*

Resilient young doctors face frightening challenges

The challenges facing young doctors in South Africa are frightening, a situation highlighted in Prof. White's President's message this month (page 4) and in the article on page 15, "A praying criminal" by community service doctor, Dr Rambuwani.

The consequences of the Department of Health's 30-hour shift policy were emphasised recently by the death of medical intern Ilne Markwat, and have led to an outcry from within and outside the medical profession.

The Junior Doctors Association of South Africa (JUDASA), SAMA and Safe Working Hours (SWH) have recently joined hands to take up the plight of the overworked doctors: "If there ever was a time to join forces and push for change, it is now. It is only through pressure from within and outside the medical profession simultaneously that this archaic practice can be stopped," said SWH spokesperson Helene-Mari van der Westhuizen.

According to a recent University of Cape Town study a worrying number of doctors are not showing up for compulsory community service. But, on the positive side, the proportion of medical graduates intending to emigrate has fallen, and the overwhelming majority of these new young doctors believe they made a difference and experienced development during their community service year – this despite the fact that a shocking 64% had perceived a risk to their personal safety.

However, said Prof. Steve Reid of the University of Cape Town: "The most intriguing finding is that doctors' attitudes towards community service change for the positive through the course of the year, and this has become more positive over the past 15 years. This is despite the challenging nature of the public health services, and points to the resilience that South African doctors are known for."

In this issue of *SAMA Insider* we look at health from various perspectives: mental, our changing climate and our financial health. The first of a series of articles on the SAMA submission to the health minister on the NHI is published on page 5. Read about financial aid in the form of various support packages for undergraduate students on pages 8 and 9. Julian Botha unpacks the Protection of Personal Information Bill on page 10 and Wandile Mphahlele deals with dismissal for misconduct on page 11.

Once again, we are pleased to receive feedback from readers in the form of two letters from Drs Hardcastle and Erasmus on page 17 and look forward to hearing more from our readers in the future.

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Do no harm!



Prof. Denise White, SAMA President

The tragic death of 25-year-old Paarl Hospital intern, Ilne Markwat, has thrown the spotlight on the excessive hours junior doctors work.

According to reports, Markwat's death was related to extreme exhaustion. She allegedly fell asleep while driving home after working a very long shift at Paarl Hospital. Markwat started her medical internship at Paarl Hospital in January. She worked in the obstetrics unit, where last year interns had complained to the Junior Doctors' Association of South Africa (JUDASA) about continuously working excessive hours.

A concerned doctor writing in the *Cape Times* said: "There seems to be a failure on behalf of the government to take cognisance of the consequences related to medical doctors who work overtime. We know of doctors who make serious mistakes while working long hours."

Earlier this year, Safe Working Hours (SWH), a group of local doctors campaigning to reduce the hours doctors have to work, petitioned the HPCSA for a legal limit of 24 hours per shift. The organisation delivered a petition of 3 000 signatures. The Council allegedly did not respond to the petition. SWH spokesman, Koot Kotze, said: "Safe Working Hours also delivered the same petition to the Department of Health, again with no response or feedback."

In her blog, intern doctor "Barefoot Megz" said of the accident: "The number of consecutive hours – such as our 24-hour-plus shifts – gives rise to exhaustion so bad you might as well be drunk. I hate how I second guess my medical judgement when I've been working more than 18 hours. I hate driving home tired and I am afraid that I'll fall asleep."

JUDASA chairperson, Zahid Badroodien, said junior doctors were currently expected to work 40 working hours per week and up to 60 to 80 hours overtime. Badroodien said it was common for junior doctors to work continuously for more than 36 hours. "This results in an increase in medical errors, which can lead to poor patient management. We are a danger to our patients and to ourselves." He said young doctors were being bullied by senior medical staff who had the perception that "long slogs through the night are a rite of passage" and would make them better doctors. "We are held to ransom by the threat of not being approved for completion of a compulsory rotation necessary for obtaining HPCSA registration," he said.

Since the unfortunate death of this young colleague, there has been extensive media coverage and an outpouring of grief and public concern in reaction to our junior doctors' plight.

"There seems to be a failure on behalf of the government to take cognisance of the consequences related to medical doctors who work overtime"

The National Department of Health (NDoH) responded to the tragedy saying it plans to review the number of continuous hours medical interns are expected to work, and admitted that the public health sector is under-resourced and that more doctors are needed to cover the increasing service demands.

The NDoH's deputy director general, Dr Terence Carter, explained that currently interns cannot work in excess of 30 hours per shift. Regulations do not stipulate that they should work 30 hours, he said, but that they should not work more than 30 hours per shift.

Dr Beth Engelbrecht, head of the Western Cape DoH, admitted she is aware that the junior doctors are not happy with the prescribed working hours. At the start of the 2-year internship she said the department met with junior doctors and discussed the hard work they would be doing, and explained the support systems that were in place to assist them. "We tell them if you feel you cannot cope, there are systems, mechanisms and processes in place to give you assistance."

Working in the health sector poses a real risk to the mental health, clinical judgement and welfare of overworked doctors, in particular to those working in the under-resourced and stressful working conditions of the public sector. Following the tragic death of Markwat, the health authorities were quick to communicate intentions to investigate working hours and improve conditions.

My experience tells me that meaningful change is not going to happen any time soon! Tragic events evoke outrage and lip-service promises of remedial action, but once media headlines fade, action dissipates and nothing changes. Working our priceless young colleagues to the point of utter exhaustion and impairment poses not only risks of serious errors of clinical judgement, but also risks of malpractice litigation. That is to say nothing of the danger it poses to them. It is therefore a no-brainer that these irresponsible demands must not be allowed to continue.

In recent years the HPCSA's Health Committee has expressed grave concern at the rising trend of intern impairment, based on the increasing numbers of interns being reported to the committee for investigation. No intervention was ever made to investigate the root cause of the problem.

The profession must engage in a campaign of activism in support of the junior doctors' plight.

For meaningful change to occur to the working hours of interns, SAMA and JUDASA need to come up with a bold strategy that commands the attention of government and the public on the question of abuse and exploitation. No less do our senior public sector doctors need to throw their collective hats into this untenable ring.

Failure to act will perpetuate the harm!

An official response on the NHI White Paper

Diane de Kock

This is the first of a series of articles on SAMA's submission to the minister of health in respect of the White Paper for NHI.

SAMA, in compiling an official response on the NHI White Paper, consulted members in their various categories. In addition to a member survey that was undertaken in December 2015, the various structures of SAMA were consulted on a continual basis. The following is an extract from the submission detailing SAMA's position on the NHI, the structure of the report and a brief summary of the first chapter:

SAMA's position on the NHI

SAMA commends the National Department of Health (NDoH) for championing the health system reform process in South Africa (SA), and for finally releasing the White Paper on NHI. The delayed release of the White Paper posed a threat to national dialogue, increased anxiety and created a negative impression of the NDoH. Nevertheless, the release of the White Paper for public comment is a massive step in the right direction for the improved access to healthcare for all South Africans.

As medical professionals, we are patient-centred in our view of any health system reform, as the practice of medicine demands that the patient's health and wellbeing is of foremost importance. When the idea of NHI was promoted in SA, SAMA voiced its official support for the principle of universal healthcare, a worldwide trend that should address many health inequities in the SA healthcare system.

If implemented properly, NHI should afford South Africans their right to access the best quality healthcare irrespective of their socioeconomic status, leading to better health outcomes and better quality of life for the majority. At the same time, a re-engineered health system would create a safe and enabling environment for health workers to deliver their best care with unhindered morale, having an excellent structural platform for delivery.

These enablers should encourage more of our doctors to stay in SA, thus stemming the ongoing exodus of health professionals.

Recognising that no health system can stand without health professionals, it is clear that NHI will be doomed to fail if the

health workforce is not satisfied with the NHI processes and proposals.

The procedure

Structure of the submission

This submission is structured according to chapters. We considered **eleven topical issues** as raised by our members, to be, from our standpoint, the core matters that deserve serious attention and which are determinants of the success or failure of NHI. Each chapter provides concrete recommendations to Government or any relevant stakeholders. We endeavoured as much as possible to base our recommendations on scientifically proven facts and information, in the spirit of evidence-based health policy development, while taking into consideration the views and expectations of our members.

The chapter describes two fundamental rights pertinent to the query, namely the right to freedom of choice, and the right to have access to healthcare

Ten chapters

This SAMA submission on the NHI White Paper consists of ten chapters representing, in SAMA's view, critical issues that need serious consideration for a successful reform of the health system in SA. In this submission, focus is placed on issues affecting the patient, as well as providers charged with caring for the patient, without both of whom there would be no health system to talk about.

While our submission rigorously examines key challenges to be overcome in implementing NHI, it does not ignore the sterling efforts and achievements by the

Government and the NDoH in addressing healthcare challenges facing the nation.

In particular, Government's keenness on wide stakeholder/public consultation on NHI is applauded, exemplified by the ongoing stakeholder meetings, as well as the gesture of extending the initial deadline for White Paper submissions. Other broader, progressive health system reform initiatives by Government congruent to the NHI roll-out process are significant milestones for the nation, such as the ideal clinics initiative, and the promotion of a new medical school in Limpopo. This is highly respected.

Chapter 1: Compulsory membership of the NHI

Chapter 1 addresses the constitutionality of mandatory prepayment to raise revenue for NHI by citizens (and permanent residents), as proposed under the NHI. The question addressed is: Does mandatory participation infringe on the rights of citizens? According to the White Paper, "NHI funding will be mobilised through mandatory prepayment. Individuals will not be allowed to opt out of making the mandatory prepayment towards NHI, though they may choose not to utilise the benefits covered by the NHI Fund".

The chapter describes two fundamental rights pertinent to the query, namely the right to freedom of choice, and the right to have access to healthcare. Drawing on key documents, viz. the Constitution of the Republic of South Africa (Act 108 of 1996), and the NHI White Paper, as well as a document by the World Health Organization (WHO), the chapter concludes that NHI mandatory prepayment will not, *prima facie*, infringe on these constitutional rights. Possible exceptions in this regard are explored in Chapter 10.

The NHI is likely to enhance certain rights, i.e. the right to access healthcare services, as the NHI ensures that citizens are able to access healthcare, irrespective of their socioeconomic status and ability to pay.

The full submission is available on the SAMA website: <https://www.samedical.org/links/nhi-exec-summary> OR

<https://www.samedical.org/links/nhi-white-paper>



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The heavy burden of mental health

Jolene Hattingh and Selaelo Mametja, *Knowledge and Management Research Department, SAMA*

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of a disease”. When symptoms of mental illnesses present themselves, they are associated with significant distress and impairment in human functioning, including learning abilities, working or family relationships and the ability to earn a living. Because of the low mortality rate associated with mental health, it is often placed low on a priority list; however, its comorbidities with other – often fatal – diseases are easily forgotten. Therefore mental health needs to be prioritised. Mental disorders are a risk factor for, and can even worsen, communicable and non-communicable diseases, as well as maternal and child health illnesses. Mental health has also been shown to increase work-related injuries, and prolonged exposure to stress has been shown to suppress the immune system.

Ranked third globally in terms of burden of disease, with 1 in 7 people suffering from some form of mental illness, South Africa (SA)'s most common types of mental disorder include anxiety, substance abuse and mood disorders. SA children suffer mostly from an inability to learn, not because of underlying biological problems, but because their environment is not conducive to learning or they have physical or mental illness.

Social determinants and economic impact

Some of the major risk factors for mental health illness include financial concerns, job stressors, high unemployment rates, poverty and family discord. Those who live with mental illness, in turn, have an increased risk of falling into poverty, due to increased health expenditure, loss of income, reduced productivity, loss of employment and social exclusion.

Poverty and mental health conditions have a mutual impact: the lack of financial resources to maintain basic living standards; fewer educational and employment opportunities; exposure to adverse living environments such as slum areas or dwellings without sanitation or water; inadequate access to good-quality healthcare, therefore increasing disability and early death; and people with mental health conditions unable to work because of their symptoms. This inability to work can be caused by discrimination, as some are denied work opportunities or lose employment. Many have no means to pay for needed



Jolene Hattingh

treatment or are impoverished when money is spent on costly mental healthcare.

Mental health problems have serious economic and social costs, including costs related to the provision of healthcare, and indirect costs, such as reduced productivity at home and work, loss of income and loss of employment. These costs have an impact on the mental healthcare user and their families' financial situation, as well as on the entire community. In the first nationally representative survey (The South African Stress and Health [SASH] study/survey 2002 - 2004) of mental disorders in SA, lost earnings among those with severe mental illness during the previous 12 months amounted to R28.8 billion, which outweighs the spending on mental healthcare for adults by approximately R472 million.

High prevalence in child mental health disorders, specifically those of conduct- and attention-deficit disorders, is one of the leading risk factors for future social determinants of health, as they hinder our future generations from excelling to their full potential to build a strong foundation for future economic growth. Some of the contributing causes leading to child mental health disorders include physical and sexual abuse, parental neglect and rejection, harsh discipline, lack of supervision, early institutional living, and frequent change in caregivers, as well as a family history of criminal activity and substance abuse disorders. Some of these risk factors can be largely attributed to the high prevalence of HIV/AIDS, as orphans of the early 2000s are now having children of their own, while lacking sufficient parenting skills, not to mention the high probability of suffering some form of mental illness or behavioural disorder of their own.



Selaelo Mametja

Limited resources and barriers to access

Most psychiatric care in government facilities has been structured in the in-hospital setting. Government lacks sufficient resources to screen and provide early counselling. Medication, although listed in the Essential Medicine List, remains unavailable on the clinic shelves. Patients suffering with early symptoms of mental health are left to fend for themselves until they present with more debilitating symptoms, and their care becomes complex and costly.

Private sector paints a similar picture, as diagnosis and treatment in accordance with the Medical Schemes Act (No. 131 of 1998) prescribed minimum benefits (PMBs) promotes hospicentring and expensive care. While anxiety and depression are very common in SA, PMBs do not cater for non-hospital medical treatment of such conditions, and members of medical schemes often face catastrophic expenditure as their benefits are exhausted before the second quarter of the year. With soaring prices and out-of-pocket payments for medications to treat, specifically, disorders such as attention-deficit disorder, most adolescents are acquiring their medication from their peers, leading to the abuse of medications such as Ritalin.

The **PR**ogramme for **I**mproving **M**ental **h**ealthcar**E** (PRIME) has conducted several research studies in SA with regard to mental illness, and found the following challenges in accessing quality of mental healthcare:

- A lack of referrals by primary healthcare nurses to counsellors for depression
- Underdiagnoses of alcohol use disorders
- Poor follow-up of counselling referrals
- A high default rate of patients receiving follow-up medications for mental illness at the primary healthcare clinics

- Poor uptake of the psychosocial rehabilitation intervention by caregivers of patients with schizophrenia.

Despite a good mental health framework, mental healthcare in SA still lags behind in terms of actual implementation. With the current difficult economic times, the SA population is experiencing higher volumes of

stress, leading to comorbidity with diseases such as heart disease, diabetes and HIV/AIDS – all top causes of mortality. By reaching our children early with preventive and educational programmes as well as affordable medications, we will be able to reduce difficulties and produce a more productive and healthy population. Integration of mental healthcare services at primary care levels will assist in

timely detection and facilitate early access to treatment. Population-based awareness and antistigma campaigns will reduce stigma faced by mental health patients and may lead to increased community participation in informal mental health services. We, as the individuals in the community, can make a difference; let us do our part in supporting those who need it most.

SAMA's Bursary and Scholarship Programme

Dr Mergan Naidoo, *Education, Science and Technology Committee, SAMA*

SAMA is fully committed to supporting doctors to bring health to the nation. SAMA acknowledges the funding challenges undergraduate students from disadvantaged communities face when attempting to get a high-quality education at tertiary institutions. SAMA also recognises the need to grow academic medicine in South Africa (SA). In an attempt to support doctors and prospective doctors, SAMA has introduced various financial support packages. A brief description of the offerings is listed below.

Supporting medical education in SA

The SAMA medical education bursaries are intended to support SA citizens who live and attend medical schools in SA. The bursaries will only be used to fund studies in the field of medicine (MB ChB, MB BCh or equivalent).

The SAMA medical education bursary will be offered yearly to undergraduate students from the first year of study and will be paid into the student's account at the university. The bursary will be non-exclusive (i.e. if the student obtains additional bursaries, this bursary will continue). The continuation of this bursary will be conditional upon satisfactory progress and will terminate should the student fail any academic year. Additional undergraduate bursaries are also offered to deserving students who are already registered towards an MB ChB or equivalent degree, have good academic records, but find that due to financial pressures they are unable to continue with their studies. These bursaries will also be paid into the student's account at the university. The bursary is also non-exclusive and continuation will be conditional upon the satisfactory progress of the student, and will terminate should the student fail. It is incumbent on the recipient to forward exam results to the bursary committee as soon as they become available so that the monies may be disbursed.

To be eligible to receive an undergraduate bursary from SAMA the applicant will have to be:

- a South African citizen
- in receipt of a letter of acceptance into an MB ChB programme or equivalent from an approved SA tertiary institution which could be conditional, pending final acceptance **OR**
- currently registered as an undergraduate medical student in SA with a good academic record but dire financial needs proven by supporting documentation.

The SAMA Bursary Committee will give preference to candidates who:

- display an excellent academic record
- are from historically disadvantaged groups
- show evidence of leadership qualities
- provide proof of previous prizes and awards received
- are supported by recommendations from referees

Scholarship-holders are allowed to hold supplementary bursaries, grants or emoluments with unlimited values; however, should the applicant receive supplementary funding during the duration of the scholarship, he/she will need to declare this to the SAMA Bursary Committee.

Method of payment

- Payment will be made directly to the medical school at the university.
- Once approved for a bursary, a medical student will be paid the full amount of the bursary in January of each year or as soon as possible thereafter.
- Payment for the second and subsequent years of study will be made only after submitting proof of successful completion of the previous year of study and proof of enrolment in the next sequential year of study.

Applications close on 30 September in the year preceding the year for which funding is being sought. Completed applications must be received by this date. Applications must include:

- full name, address, telephone and email contact information

- copies of documents to demonstrate SA citizenship (e.g. copy of ID or passport photograph page, birth or citizenship certificate)
- a resume outlining education and volunteer experience (maximum length two pages)
- copy of letter of acceptance to an SA medical school (this document may be provided at a later date).

Complete applications with copies of all required documents, must be received at the address below on or before 30 September of the preceding year.

SAMA Medical Education Bursary Committee
P O Box 74789, Lynnwood Ridge 0040 **OR**

Emailed to graceb@samedical.org

Download the application form from:

https://www.samedical.org/about-us/student_bursary

SAMA Research Masters Supplementary Scholarship

The scholarship aims to encourage postgraduate research and foster the development of research competencies in medical practitioners to promote academic medicine in SA. The research Masters may serve as a prerequisite for doctoral studies.

The requirements for the successful completion of a general Master's degree are as follows: Masters degree by dissertation or publication; a single advanced research project, culminating in the production and acceptance of a dissertation or other forms of publication as indicated below. This **excludes** the professional Masters degree, such as the Masters in Medicine done as a requirement for specialist training. Master's degree graduates in general must be able to reflect critically on theory and its application. They must be able to deal with complex issues both systematically and creatively, design and critically appraise research, make sound judgements using data and information at their disposal and communicate their conclusions clearly to specialist and non-specialist audiences, demonstrate self-direction and originality in

tackling and solving problems, act autonomously in planning and implementing tasks with a theoretical underpinning and continue to advance their knowledge, understanding and skills.

The research component or components of a general Master's degree should be commensurate with the characteristics of the discipline and field, as well as the purpose of the programme, and in addition to a dissertation or treatise may take the form of a technical report, one or more creative performances or works, or a series of peer-reviewed articles or other research-equivalent outputs.

Purpose of award

The supplementary scholarships are intended to encourage medical practitioners to embark on a research master's degree at a recognised SA institution of higher learning.

Selection criteria

The scholarships are open to medical graduates of any university within SA who have started their research masters study within 1 year of application. Only SA citizens will qualify. The main selection criteria are the academic quality of the research proposal and the suitability of the project for the SA environment. Preference will be given to researchers whose research topics are of relevance to SAMA.

Number of awards offered

The SAMA Research Masters Supplementary Scholarship will be made available to one new student per year.

Value

R50 000 award distributed in equal amounts over 2 years.

Tenure of award

This scholarship will be awarded annually, must be applied for annually, and will not necessarily fund the same Masters student for 2 consecutive years. The scholarship will be non-exclusive, but will be conditional upon positive progress reports received from the tertiary institution.

Closing date for applications

30 September of the preceding year for which funding is sought.

Application documents

To be arranged in the order mentioned below:

- Completed application form with a passport-size photograph attached
- Typed copy of curriculum vitae (maximum of 2 pages)
- Title of project and short abstract of research project (~500 words) detailing the

background, aims and objectives, research question and methods

- Proof of registration with an academic institution
- One reference from the supervisor of the applicant. The referee's title and academic status should be clearly indicated (with official rubber stamp). This should be confidential (in sealed envelope) and should be recently dated or may be emailed by the supervisor.

The SAMA PhD Supplementary Scholarships

The scholarship aims to encourage postgraduate research, one objective being to build up a strong research and development interest in SA. The scholarships are awarded on academic merit and are open to all medical practitioners.

Purpose of award

These supplementary scholarships are intended to encourage doctoral studies by physicians.

Selection criteria

The scholarships are open to medical graduates of any university within SA who have started their PhD study within 1 year of application. Only SA citizens will qualify. The main selection criteria are the academic quality of the research proposal and the suitability of the project for SA's research programme.

Number of awards offered

The SAMA PhD Supplementary Scholarship will be made available to up to two new students per year.

Value

R100 000 stipend plus tuition fees per individual per annum.

Tenure of award

These scholarships will be awarded annually, must be applied for annually, and will not necessarily fund the same PhD student for 2 consecutive years. The scholarship will be non-exclusive, but will be conditional upon positive progress reports received from the university.

Closing dates for applications

30 September of the preceding year for which funding is sought.

Application procedure

To apply for SAMA scholarships, you will first be asked to fill in and submit our online application form (Doctoral) and to upload the following documents by the given closing date:

- Completed application form together with a passport-size photograph (electronic submission should include colour copy scan of ID photo if possible)
- Abbreviated curriculum vita (maximum of 2 pages)
- Title of project and short abstract of research project (~500 words)
- Letter of intent (explaining motives for applying)
- Letter of recommendation by two supervisors
- Brief outline of the methodology you will use (including a budget if possible)
- Proof of registration with academic institution.

How and when do students learn of the decision?

Offers of SAMA Masters/PhD scholarships will be made approximately 6 weeks after the closing date in the year of application. Because some applicants may decline the offer of a scholarship with the result that further offers have to be made, it is possible that some applicants will not be finally notified of the success or otherwise of their applications up to 3 months after application. If you are unsuccessful, you will be notified of this, and if you are on the reserve list, you will also be notified by email, so it is essential that the correct contact details are given in the application.

What conditions are attached to acceptance of this award?

Scholarship recipients and supervisors shall be required to provide yearly reports.

Once the period of tenure of a scholarship has commenced, the Scholarships Committee may, at its sole discretion, grant a scholarship recipient a deferment of their scholarship for a period not exceeding 1 year. In most cases such a deferment will coincide with a formal suspension from their Masters/PhD degree enrolment.

A scholarship shall be terminated if a scholarship recipient ceases to resume the aforesaid programme of research within 1 month of the last day of the period of the deferment. If an award is made to an existing Masters/PhD candidate the tenure of the award will be reduced. SAMA will need to be acknowledged in the thesis or publications arising out of the research.

Application forms may be downloaded from the SAMA website from 1 August via www.samedical.org -> About us -> Bursaries & Scholarships and posted or emailed to:

The SAMA Scholarships Committee, P O Box 74789, Lynnwood Ridge, 0040 **OR** emailed to karlienp@samedical.org

Download the application form from: https://www.samedical.org/about-us/sama_phd_supplementary_scholarship
Contact telephone number for enquiries is: 012 481 2097

POPI – medical records and health information

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

For many the spectre of POPI (Protection of Personal Information Bill) looms large on the horizon like an impending Highveld thunderstorm. The POPI Bill, when enacted, will be a rather onerous regulatory change. Non-compliance with its provisions could lead to criminal sanctions, including significant fines and even imprisonment.

This article does not presume to be an all-encompassing guide to assist in navigating this storm; rather it is intended to give a sense of the requirements involved.

In our previous article we dealt with the responsibilities of medical practitioners in respect of medical records, which responsibilities stem from ethical rules and guidelines to applicable health legislation. These obligations are well known to practitioners and they provide a good start on the long journey to POPI compliance, but by no means do they get one close to the finish. One cannot be lulled into a false sense of security and assume that the measures already in place to protect existing confidentiality obligations are sufficient for adherence to POPI.

It is important to bear in mind that POPI extends further than merely maintaining confidential information. It adds the obligation that the data (medical records) should be protected against loss or theft, and that the data contained in medical records be used only for the purpose for which consent was given by the patient (data subject).

POPI refers to concepts of various role-players in the processing of data, and it is important to understand who these role-players are, as well as what is understood by the term “personal information”.

- **The data subject:** This is the individual whose personal information is being processed. In the context of the medical practice this would refer to the patient. However, legal entities are also considered data subjects and therefore any data from such an entity that is processed through the medical practice would also enjoy protection.
- **The responsible party:** This is the individual who decides what to do with the information/data and is responsible to ensure that all personal information is processed in terms of the requirements of POPI.
- **The operator:** This is the person or entity that processes the personal information on behalf of the responsible party.
- **Personal information:** In terms of POPI, personal information is defined as follows: “personal information means information

relating to an identifiable, living, natural person, and where it is applicable, an identifiable, existing juristic person, including, but not limited to -

- (a) information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and birth of the person;
- (b) information relating to the education or the medical, financial, criminal or employment history of the person;
- (c) any identifying number, symbol, e-mail address, physical address, telephone number, location information, online identifier or other particular assignment to the person;
- (d) the biometric information of the person;
- (e) the personal opinions, views or preferences of the person;
- (f) correspondence sent by the person that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence;
- (g) the views or opinions of another individual about the person; and
- (h) the name of the person if it appears with other personal information relating to the person or if the disclosure of the name itself would reveal information about the person.”

As one can see from the above, personal information is an incredibly broad concept in POPI. It gets no easier for medical practices. Medical or health information is regarded as “special personal information”. POPI places a prohibition on processing this special personal information unless proper consent is obtained from the data subject (patient).

“26. Prohibition on processing of special personal information.

A responsible party may, subject to section 27, not process personal information concerning: (a) the religious or philosophical beliefs, race or ethnic origin, trade union membership, political persuasion, health or sex life or biometric information of a data subject.

27. General authorisation concerning special personal information

(1) The prohibition on processing personal information, as referred to in section 26, does not apply if the -

(a) processing is carried out with the consent of a data subject referred to in section 26.”

The consent referred to in section 27 of POPI is not the same as the consent that a practitioner is required to obtain from the patient in terms

of section 14 of the National Health Act (No. 61 of 2003) but should rather be regarded as an additional requirement (although there may be certain overlapping aspects).

In obtaining the POPI consent, the responsible party must inform the data subject (patient) who the responsible party is, precisely what information (health-related or otherwise) is being collected, what it is going to be used for, and for how long that information will be kept. In addition the data subject must be told who will have access to the information. The patient must be informed what the purposes of the processing are, and such purpose must be lawful, e.g. transmission of patient personal information to medical schemes. The consent obtained from the patient/data subject must be in writing, voluntary, explicit and unequivocal.

Retaining patient personal information – medical records

In terms of POPI, personal information may not be retained for longer than is necessary to fulfil the original purpose for collection unless the data subject consents thereto or where retention of records is required by law. In terms of medical records, the requirements to retain such records for certain periods are already prescribed by legislation (in the case of occupational health records) and HPCSA guidelines.

Data processing in medical practices

In medical practices, it is the medical practitioner who is the responsible party. Should the practitioner make use of the services of an external company for support data services (claims switching, accounting and billing), that external company is regarded as an operator. The ultimate responsibility (and liability) vests in the responsible party for the correct processing of data – this responsibility is not transferred to an external company providing the service.

It is imperative that, when selecting or assessing service providers, you are assured that their processing of data is in compliance with POPI.

As mentioned previously, the purpose of this article is not to serve as an encyclopaedic reference source for POPI compliance. It serves merely to provide information on POPI and how it will impact upon the way medical records and health information are dealt with in medical practices. Although POPI is not yet in effect, it is advisable to get into the habit now and to put systems into place to ensure that when POPI becomes a reality, you will be ready.

Dealing with dismissal for misconduct

Wandile Mphahlele, Legal Advisor: Labour Relations Unit, SAMA

Section 188 (2) of the Labour Relations Act (LRA) (No. 66 of 1995) states that any person considering whether or not the reason for dismissal is a fair reason or whether or not the dismissal was effected in accordance with a fair procedure must take into account any relevant code of good practice issued in terms of the LRA.

The code of good practice in the LRA, although a guideline only, serves as an important tool for employers to deal with misconduct in the workplace. In fact, the Commission for Conciliation, Mediation and Arbitration (CCMA) guideline states that where there is no disciplinary procedure the code of good practice must be strictly followed. It is trite that for a dismissal to be fair; it must be procedurally and substantively fair. The procedural aspect of misconduct is dealt with in item 4 of the schedule, while the substantive part of it is dealt with in item 7.

In terms of item 7, in order to determine whether an employee committed misconduct, the employer will have to make sure of the following: (i) was there contravention of a rule regulating conduct in the workplace or of relevance to the workplace?; (ii) is the rule reasonable and valid?; (iii) was the employee aware of the rule or could s/he be reasonably expected to have been aware of it?; (iv) has the rule been consistently applied?; (v) was dismissal an appropriate sanction for the rule?

A rule is accepted as legitimate and valid if it is lawful and can be justified with reference to the operational requirements of the employer. A rule is unlawful if it forces employees to perform actions which are prohibited by law. The code also requires that the rule must be well known. In the case of *Matshoba v Fry's Metal* the court held that dismissing employees for failure to work overtime was unfair because the employer had never dismissed anyone before. Establishing whether a rule has been breached is a twofold enquiry: firstly, the rule must be interpreted and its elements explained, and the second stage entails determining whether the employee's conduct breached the rule as interpreted.

Closely linked to the breached rule is the appropriate sanction. In *Woolworths v Mabija*, the Labour Appeal Court held that the outstanding bad conduct of the employee would warrant a sanction of dismissal without the employer leading evidence that the relationship had broken down. However, employers are cautioned about using this *Edcon* principle because courts will not

always accept that the rule breached is serious enough to warrant dismissal. In *Department of Home Affairs v Ndlovu* the Court held that there was no evidence that the misconduct complained of had resulted in irreparable harm to the employment relationship, and further, that in such cases, the employer must show evidence of such harm.

On offences that are regarded as a zero tolerance offence by the employer, the courts have ruled that employers cannot contract outside of fairness of the law, and that not all infractions will be regarded as a no-go area without proper determining of the matter. The commissioner is allowed to rule that the sanction of dismissal was unfair despite the fact that the offence is said to be a zero tolerance offence.

On consistency, in *Gcwensha v CCMA*, the Court held that: "Disciplinary consistency is the hallmark of progressive labour relations that every employee must be measured by the same standards."

The courts have made a distinction between historical and contemporaneous inconsistency; the latter is when the employer has in the past not imposed the same sanction for contravening a certain rule; in such a case, an employee faced with that charge will expect to be treated the same. The latter also applies when two or more employees commit the same offence but only one is disciplined, not all of them. However, inconsistency in applying different sanction is not per se unfair; at times the employee's situation can justify the inconsistency, e.g. previous warnings and years of experience. The employer must show a valid reason. Previous warnings, even those that have lapsed, may be taken into account when determining fairness of a dismissal.

The employee has a duty to alert the presiding officer to the inconsistency during proceedings, the allegation must not be general but concrete, and the case of inconsistency must be spelt out with details of the people involved.

In certain instances when employers have reached a point where they will no longer accept a certain offence as minor or have amended the disciplinary policy to capture certain conduct as a dismissible offence, they must inform the employee notices of such change. In certain cases, however, the Labour Courts have accepted that decisions made in error cannot be perpetuated, even without notice to employees on the basis of consistency, especially cases of gross dishonesty, as it is trite that such cases

attract dismissal as a sanction. Section 193 of the LRA permits the arbitrator who finds the dismissal of an employee to be substantively unfair to reinstate, re-employ or compensate the employee; whichever remedy is given, the commissioner must give reasons.

As stated earlier, item 4 deals with the procedural aspect of dismissals. Accordingly, it states that to comply with procedural fairness: (i) the employer must conduct an investigation about the allegation; (ii) the employer must notify the employee about the allegations using form and language accessible to the employee; (iii) the employee should be allowed to state his/her case in response to the allegations (this includes calling his/her witnesses); (iv) the employee should be allowed reasonable time to prepare for the hearing; and (v) be allowed the assistance of a trade union representative or fellow employee. The employee must be allowed to cross-examine witnesses of the employer. After the enquiry the employee must be furnished with a written outcome and be advised of any steps s/he can take if dismissed, i.e. appeal or approach the CCMA.

The procedural aspect of dismissal does not entail the need for the process to be formal; these proceedings may be informal. According to the *Avril Elizabeth Home for the Mentally Handicapped v CCMA*, the Court held that:

"the conception of procedural fairness incorporated into LRA is one that requires an investigation into any alleged misconduct by the employer, an opportunity by an employee against whom any allegation of misconduct is made, to respond after a reasonable period with the assistance of a representative, a decision by the employer, and notice of that decision."

The Court held that the purpose of this approach is to avoid protracted delays caused by legalities.

The CCMA guidelines stipulate that disciplinary procedure must be tested against the code and contract between the employee and employer unless the employer can justify departure from this procedure. However, if the contract imposes more burden than the code, then the code must be followed.

The presiding officer, upon finding the employee guilty, must give him/her a chance to submit mitigating factors and the employer to submit aggravating factors. The employee must state factors such as his personal circumstances, long service to the employer, etc., while the employer will provide factors such as previous warnings.

Discovery conducts employee wellness tests

SAMA Communications Department

On 4 July 2016, Discovery Health conducted employee wellness tests at the SAMA offices in conjunction with the corporate wellness week, observed from 1 to 5 July, with the aim of urging businesses across South Africa (SA) to look after employees, as well as to promote healthy living among their workforce. Among other screening tests, SAMA employees were made aware of their blood pressure, cholesterol levels, weight and body mass index (BMI).

"We want to urge businesses to set up comprehensive employee wellness programmes that sustain healthy habits and experiences among employees, such as taking stairs instead of lifts, eating healthy food and providing an accommodating working environment. These facilities should be made available to all employees, while damaging habits such as negative employment relationships, smoking and alcohol use are discouraged," commented Dr Mzukisi Grootboom, chairperson of SAMA.

Although most companies still view employee wellness as a light issue, it is not. Research has confirmed that SA loses between R16 and R19 billion annually due to work absenteeism, unproductivity and bad employee morale. Amid efforts to ensure profitability and maintain the existence of organisations, the most significant priority of companies should be the promotion of employees' health. Organisational effectiveness and employees' physical and psychological wellbeing



One of the SAMA employees being tested

should be equally important; nonetheless, the wellness of employees is directly proportional to productivity.

Dr Grootboom amplified that working inordinately long hours without breaks is unfortunately the fate of some professions and industries.

In general, healthy employees will be happy and productive, so it is the ongoing task of employers to ensure that health-promotion efforts are in place that will not only provide for basic needs and assist impaired employees, but also facilitate optimal growth and health.

Still robed – retired Justice Dikgang Moseneke joins Steve Biko Centre for Bioethics

SAMA Communications Department

Former deputy chief justice of the Constitutional Court, Dikgang Moseneke, has been appointed honorary professor of bioethics in the Steve Biko Centre for Bioethics, Faculty of Health Science at the University of the Witwatersrand.

Moseneke is one of South Africa's leading jurists, who retired from the Constitutional Court in May this year after 14 years of dedicated service. He is also the chancellor of the University of the Witwatersrand, a position he has held since 2006.

Prof. Ames Dhali, director of the Steve Biko Centre for Bioethics, says Moseneke has had a deep impact on the judiciary and beyond the courts, and it is this legal authority as well as his intellectual and ethical integrity that will be invaluable to the Centre in its efforts to further the discipline of bioethics.

"For a jurist of the calibre of Justice Moseneke – honourable, principled and righteous – and because of his commitment to justice and social change, a professorship at the Steve Biko Centre for Bioethics is without question.

"His combination of qualities as a jurist and a scholar of the highest acclaim would support further growth and development of the Centre and its many activities. We look forward to working closely with him and benefitting from the valuable guidance and advice he will impart to us when grappling with the many ethical dilemmas which form part of our day-to-day work," says Dhali.

Prof. Moseneke joined the Centre from 1 June 2016. "I am humbled to be associated with the Steve Biko Centre for Bioethics and the Faculty of Health Sciences. I am not unmindful of what honour the honorary professorship bestows on me and hope to add value to the deliberations of the Centre in some modest way," says Moseneke.

About Dikgang Moseneke

Moseneke obtained his BA degree in English and Political Science, as well as his B Juris, while jailed on Robben Island after being convicted and sentenced to 10 years imprisonment for participating in anti-apartheid activity in



Dikgang Moseneke

the 1960s. He later completed his LLB and started practising as an attorney in 1978. He was admitted to the Bar in 1983 and practised as an advocate. He is a founder member of the Black Lawyers' Association and of the National Association of Democratic Lawyers of South Africa. He was appointed justice of the Constitutional Court in November 2001.

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Aesthetic Medicine Congress a huge success

Dr Cobus van Niekerk

This year the Aesthetic Medicine Congress of South Africa (AMCSA) held their annual congress on the weekend of 19 - 21 May 2016 at the CSIR ICC in Pretoria (Tshwane). This is an AAMSSA (Aesthetic and Anti-ageing Medicine Society of South Africa)-endorsed event. AAMSSA is a SAMA-affiliated society.

Attracting delegates and speakers from all around the world, this was the 10th congress in South Africa.

The pre-congress workshops kicked off on 9 May with an introductory course into the world of aesthetics and anti-ageing medicine, discussing topics like botulinum toxin, fillers, chemical peels, microdermabrasion, skin needling, skin threads and nutraceuticals, as well as ethical advertising and the ethical behaviour of doctors, beauticians, advertisers and the like.

The second pre-congress workshop on 19 May was a masterclass in skin threading techniques, by local speakers Chris Giezing, Allistair Clarke and Gerhard van Niekerk, as well as non-surgical rhinoplasty techniques by Dr Radaelli (Italy). Both pre-congress workshops were well attended and well received.

The Congress attracts hundreds of doctors a year with a special interest in aesthetic medicine and this year was no exception. The lectures are always interactive and practical sessions are well attended.

The final day ended with a well-attended and interesting ethics workshop. Prof. Ames Dhali, head of the Steve Biko Centre for Bioethics at the University of the Witwatersrand, was our keynote speaker and she and Dr Cobus van Niekerk entertained extensive discussions regarding ethical considerations when pursuing a career in this young, exciting and growing field of medicine.

The 11th AMCSA will be hosted at the CSIR ICC in Pretoria from 4 to 6 May 2017 and will be the most practical congress to date. Our focus for this congress is to address the needs of doctors in this industry to enhance their practical skills. The congress has been an all-important mark on the calendar of both trade and doctors involved in aesthetic and anti-ageing medicine over the past 12 years (including our excellent world congress in 2013).



Prof. Ames Dhali at AMCSA 2016



Dr Kate Golding from the UK



Dr Cobus van Niekerk (front) and colleagues

AMCSA remains a pivotal event attended by doctors involved in:

- general practices
- aesthetic medicine
- weight-related fields of medicine
- anti-ageing, preventive and hormonal medicine
- dermatologists
- plastic surgeons
- dentists
- other medical specialists.

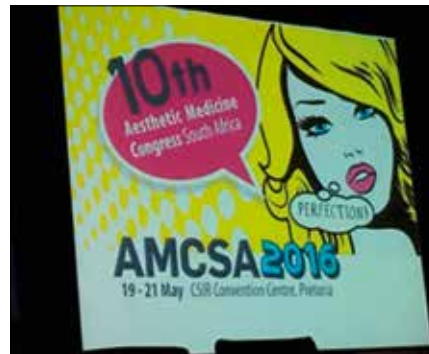
The focus of the congress remains to educate doctors in a high-quality scientific programme on the latest teachings, research, updates and skills to practise aesthetic medicine as well as anti-ageing medicine. The highly regarded programme is complemented by practical workshops and a trade exhibition where the



Dr Jenni Irving



Dr Phillip Petit from France



The banner advertising the conference

leading companies showcase their products and devices. The large, beautiful trade exhibition features all the leading companies, distributors and products in the industry.

AAMSSA is a non-profit organisation. You can join the society at www.aestheticdoctors.co.za

AMCSA is the Aesthetic Medicine Congress of South Africa and their website is: www.aesthmed.co.za

Our health and today's changing climate

Laurie Kirkland, *My Green Doctor website*

The Earth's climate is changing and already our health is threatened. This article offers some suggestions as to what those of us who work in healthcare can do about it. We can help slow climate change to help protect our patients from the effects. We have a responsibility to do this because we care about our patients; our influence can be significant because we are role models in our communities.

Firstly, you can become part of the solution by acknowledging that climate change is real and by encouraging others to do so as well. The more we discuss this openly, the better prepared our societies will be to respond to this threat.

Second, make choices in your life and in your office that help prevent climate change. Here are a few options that will help save your family money and help the environment:

Appliances

Purchase only home and office appliances with the Energy Star rating. Look for these ratings when you shop for large or small kitchen appliances.

Home heating and air conditioning

Change your home and office air filters according to the manufacturer's recommendations, use programmable thermostats, and perform regular maintenance on these machines. A programmable thermostat lets you set the temperature and change the temperature depending on the time of day. You can programme your thermostat to cool or heat your home less when you are away from home. This saves energy, which is good for the planet and lowers your costs. You can purchase a programmable thermostat at a hardware store or home improvement store. Be sure machines are properly maintained so that they function at peak efficiency. Buy Energy Star-rated machines

Reduce/re-use/recycle

My Green Doctor's seven workbooks describe ways to reduce your use of resources, and how to re-use and recycle.

- Reduce your use of chemicals, paper products, office supplies and medical supplies. Consider carefully before buying. Try to avoid buying environmentally costly plastic and polystyrene products.
- Reduce your water use, both at home and for landscaping.
- Reduce home and office use of electricity by turning lights off when leaving a room, installing motion detectors to turn the lights off (this is almost always cost-effective), and turning off electrical items or putting them in sleep mode when not in use.
- Re-use sheets of paper when possible and avoid buying disposable supplies.
- Recycle whenever possible.

My Green Doctor is a free website that offers more than 140 steps that you can take to save money and reduce greenhouse gases.

Register at www.mygreendoc.org.

A praying criminal

Dr L Rambuwani, *Community Service Medical Doctor*

I'm a community service medical doctor working in a peripheral hospital in Limpopo Province. I thought my profession was the best thing to happen to this world. It was a profession associated with the good. As the religious ones would say ... holy. I just did not realise when I signed my employment contract with a pseudo-high salary notch decorated by rural allowance and hostage overtime that I was getting into bed with the devil.

I am a criminal ... I operate on a female patient without informed consent. Simply because I never tell the patient that before the caesarean section starts we need at least 4 doctors (2 surgeons, an anaesthetist and a paediatrician). I go into theatre with a medical officer and perform the operation with a nursing sister as a surgeon assistant. An anaesthetist doubling as a paediatrician. And then I wonder what will happen if under general anaesthesia the mother complicates from the anaesthesia side, while opening a tap of blood in the area of surgery, and the distressed neonate is gasping? For that reason, I say I'm a praying criminal.

I am a criminal ... I'm so ruthless that I fill in psychiatric admission forms to admit a psychotic, aggressive, violent patient in an open ward which is not equipped with the infrastructure of psychiatry. And in doing so, I do not care that I'm putting the nursing staff, fellow patients, patient

and myself in danger. For that reason, I say I'm a praying criminal.

I am a criminal ... I'm so vigilant that I admit a cardiac patient, and say with confidence that I can predict the electrocardiogram (ECG) readings by using my stethoscope, even if the ECG is not working or doesn't have paper. Still I say, I'm a praying criminal.

I am a criminal ... I detect fetal distress with a cardiotocograph (CTG) without paper and the toco part. I am a praying criminal.

I am a criminal ... I confidently respond to a ward call for resuscitation whereas I know that we don't have oxygen on the walls. We have one oxygen tank which is being used by an oxygen-dependant patient. So I ask myself, do I pull out the oxygen from the dependant patient and try to save the gasping one, even though I know very well we don't have resuscitation equipment and drugs? So, on top of being a criminal, I now play God and decide who lives and who doesn't. Still I say, I'm a praying criminal.

I am a criminal ... I consider myself on call with a medical officer performing the work of six doctors, and do it without hesitation. But still I wonder how I will save the day if all these emergencies happen at once, and who will I choose to save, since I'm playing God on earth?

Am I really a criminal? Last time I checked, I found that I am an employee who was equipped

with the knowledge from medical school, and I was told that the employer would provide all the things that the healthcare service needs, me included.

Ok, still I'm a criminal ... Because if any high-profile mortality happens with no investigation and introspection from the employer, I'll get crucified in the media, being called a murderer, which is a crime, right? Oh, by the way, this is the fastest healthcare service patients will get from the employer. Because they will take a chopper asap and come and receive their accolades of public sympathy by calling me an overpaid, lazy, negligent doctor.

Oh, what the heck? Who's the real criminal here? My knowledge is in my brain and skills drilled in by competent professors. I know nothing about finances, where to stock up for pharmaceutical drugs, who employs how many doctors, who buys infrastructure? So who's the real criminal here? I'm probably a pawn in an incompetent system simply because I signed my profession away to the devil that portrays itself as a saviour to the masses so that I get crucified.

As I said, I'm a praying criminal. So I pray that patients never find out about this and the HPCSA never make a visit to my work place because if they do, not only am I going to jail but I'm heading straight to hell for actively participating in this crime. I rest.

Your financial health

Gert Viljoen, *VPROF*

VProfessional Services (VPROF) is a medical practice administrator, medical bureau and professional accounting firm that is dedicated to supporting the business activities and patient care of independent medical practices around South Africa. Gert Viljoen keeps us up to date on developments:

Bitcoin: Learn about it now – it is here to stay

Bitcoin is a digital currency which has grown rapidly since its introduction in 2009. Recently the UK issued an e-money licence to a finance house and Barclays Bank has become part of this process.

What is Bitcoin?

It is a digital currency whereby you can, say, pay anybody in the world without an intermediary (a bank) involved. It is thus much cheaper than using a bank and potentially just as effective.

Main features and advantages

The founder of Bitcoin (still anonymous) built a robust system:

- The number of Bitcoins is limited to 21 million. This helps ensure that the intrinsic value of Bitcoins rises and is a hedge against inflation.
- The system is controlled by no one and is completely transparent. Therefore, anybody can check all transactions at any time. This is called the blockchain. The system is thus self-regulating.
- Sophisticated cryptography protects the integrity of transactions. It is not possible to issue the same Bitcoin twice. If you do, your system will be out of line with other users.
- It is done on open-source software which is not difficult to follow, is free and accessible.
- The system is easy to use.

What is the risk?

Like with any online system it is possible for cyber criminals to hack into the system. The value of Bitcoins is also subject to volatility, so there is no guarantee of value although it has recently appreciated against the dollar (after dropping sharply in 2014). There is also

no legal protection for Bitcoin (as there is for example with "legal tender" like the rand) so you use it at your own "sole and independent risk" (that's a quote from the South African Reserve Bank). Users can hide their identity so the potential exists for income tax fraud and evading exchange controls – which could bring unwanted attention from governments.

Applications in Africa

In Africa it has the potential for widespread use. The fact that Africa has many unstable currencies and has limited infrastructure means Bitcoins could be a "leap technology" that enables the continent to fast-track economic growth, especially considering the widespread use of smartphones in Africa.

Bitcoins are here to stay and many commentators are calling them the next financial/banking disruptor. **Don't risk losing out – learn all about them now!**

Employers: Is it pay discrimination to differentiate on length of service?

In the Employment Equity Act (EAA) (No. 55 of 1998) there is a wide definition of unfair discrimination which lists gender, race, religion and so on. Recently a phrase was tagged onto this discrimination clause which says "... or on any other arbitrary ground".

Recently, this phrase was relied on in a case of unfair discrimination against an employer. The employer paid newly employed workers 80% of the full wage for the first 2 years of employment. Thereafter they moved up to the full wage.

Some newly employed staff (via their union) took the employer to the Commission for Conciliation, Mediation and Arbitration (CCMA) and alleged unfair discrimination in that they did exactly the same work as other employees who had been there 2 years or more. The employees won their case at the CCMA but this was reversed on appeal to the Labour Court, which held that: "The differentiation complained of was not irrational; was not based on an arbitrary unlisted ground; and was not unfair."

What must the complainant prove?

The judgment set out what a complainant must prove to establish pay discrimination:

- The work performed by the complainant is equal or of equal value to that of a more highly remunerated comparator; and
- such difference in pay is based on a prohibited ground of discrimination.

To show unfair discrimination on an arbitrary ground, the complainant, held the Court, must identify the arbitrary ground, prove that it is the reason for the disparate treatment and show that:

- the conduct complained of is not rational;
- the conduct complained of amounts to discrimination; and
- the discrimination is unfair.

The judgment gave weight to the government's Code of Good Practice on Equal Pay/Remuneration for Work of Equal Value, which states that it is not unfair discrimination if the difference is fair and rational and based on "the individual's respective seniority or length of service". It also specifically recognises length of service as a factor justifying differentiation in pay.

Therefore, in appropriate circumstances it is permissible to pay your staff based on their period of employment. As always, however, take full advice on your particular circumstances – our labour laws are complex and the consequences of non-compliance severe.

Your tax deadlines

The period for individuals to submit tax returns for the 2015/2016 period begins on 1 July. Important dates to remember for the 2015/2016 tax year are:

- 23 September 2016: the due date for manual and postal income submissions
- 25 November 2016: eFiling if you are a non-provisional taxpayer. If you plan to submit from a SARS office this is also the due date for filing (non-provisional)
- 31 January 2017: provisional taxpayers via eFiling.

If in any doubt ask your accountant for advice – the penalties for non-compliance are severe.

Letters to the Editor

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
- must be on subjects 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. Our thanks to Dr Hardcastle and Dr Erasmus for their contributions printed below.



Other reasons to refuse J88

I read the comments from Marli Smit (*SAMA Insider*, June 2016) with interest. There are indeed other reasons to refuse a J88. The way the Act (Criminal Procedure Act) is phrased, it requires “medical report writing” on request of a police officer (on the SAP308 or equivalent document). The J88 is often given to the patient by the police to bring to the Emergency Department or the general practitioner, with no officer in attendance – the doctor is then asked to complete this and return it to the patient. This breaches the “chain of evidence” rule and in this case (no officer present to receive the completed forms) the doctor may justifiably refuse to complete the form at that time, but must do so if a police officer is present and the patient is being discharged. Obviously if there are critically ill patients, then patient care takes preference.

There is another scenario of importance, namely patients seen at larger facilities who are subsequently admitted (after trauma) and who may

undergo procedures – a common occurrence. These patients should not be provided with the completed J88 as this only assesses the initial injuries and does not detail further care – for patients admitted to hospital the doctor can again justifiably refuse the J88, but should instead complete an “Affidavit of Treatment”, detailing all treatment, operative procedures and the eventual outcome. This should again be requested on a police letterhead and returned via the chain of evidence (not to the patient). This is standard practice in the academic hospitals, where typed reports are provided.

I feel these are pertinent additional points, which could add to the practice of every practitioner.

Dr Timothy Hardcastle

Head, University of KwaZulu-Natal Trauma Surgery Training Unit
Deputy Director: Inkosi Albert Luthuli Central Hospital, Trauma ICU

Regarding the article about the J88 forms in the *Insider* of June 2016, it was unclear how the J88 form can have an effect on both the patient and the attending doctor, and it also stated that the J88 was to be completed in the doctor's own handwriting. Surely there should not just be a burden forcing doctors to fill in the form, but there should also be clear guidelines to protect the rights of doctors? Allow me to summarise two cases that have made me turn away all future patients with J88 forms.

In the first case, a family suffered a farm attack. Having previously been a district surgeon for many years, I filled in the J88 – I want to state that my handwriting has always been very legible as I don't scrawl in the much-joked-about “doctors' handwriting”, as I print when I write. Months later, before the start of the court case, the prosecutor sent a police officer to my rooms with the forms and demanded that I type out the J88.

I phoned the chief prosecutor and asked why she suddenly wanted the form typed, pointed out that up to then it had never been requested, and asked whether she had specific problems with my handwriting. She ignored this and threatened to subpoena me and have me sit and wait for days until I was called to read my form to the court, thereby losing days from my practice and losing income.

Recently I saw a patient who alleged that members of the police had beaten him, and I completed a J88 form for him. Months later I

received a subpoena to testify in a court that is 70 km away from our town. The subpoena was from the plaintiff's attorneys, but I was never contacted by his lawyer to request my testimony and to negotiate a fee for leaving my practice for a whole day, or to arrange to come at a certain time to be called to testify so as to minimise disruption. All attempts to contact the lawyer who had subpoenaed me failed – he was never available when I phoned and never called back. The telephone lines to the area where the court and police station are situated had been stolen a year previously and never replaced, so I could not contact the magistrate or any other official at the court to get more details. By phoning a police official who gave me the cell number of a friend in the area who gave me the cell number of a court official who passed me on to another friend who ... I was able to reach a person working in that court on the morning of the case, only to hear that the case was not being heard on that day in that court. This was minutes before I was about to close my practice for the day! Imagine if I had travelled there only to find that nothing was going to happen, thereby losing a working day without any compensation! To this day, the lawyer has not contacted me to let me know where and when the case will be heard and to arrange a fee for closing my practice for a day.

My feeling is that doctors have no protection at all and can be abused when filling in a J88

form. It is a very one-sided affair because you have to go to court if subpoenaed and nowhere is it stated that you have to be contacted beforehand to arrange compensation for loss of income. Advice from a lawyer was that you had to attend and then try to get a fair compensation. If the plaintiff is not financially able to pay for your time, you still have to go. There is no law that states that it is a prerequisite that you have to come to an acceptable arrangement before having to go to court. You cannot stay away because you had not been contacted about arrangements with regard to compensation beforehand. If you do stay away, you can be arrested and held in contempt. In my case, the burden was on me to struggle to contact the lawyer who had subpoenaed me! Inevitably it is the patients who will be losing out because I will not see potential litigation cases in future. I would also like to point out to colleagues that it is not only after completing a J88 form that you can be called to testify. Every patient that was seen by you can have you subpoenaed to testify, so in actual fact, you will have to turn away every patient with an injury where someone else was involved!

As South Africa is becoming a more litigious country, it is imperative that rules and guidelines protecting doctors are propagated, as abuse of doctors will become more prevalent.

Dr Daniel E Erasmus, Hluhluwe

Pulled in all directions

Medical Protection Society

Mrs J, a 32-year-old female patient, had a long history of neck pain following a road traffic accident. The pain was localised to the left side of the neck and left shoulder, with only very occasional paraesthesia in her left hand. Despite regular analgesics and exercises, the pain was still troublesome and she was keen for a specialist opinion. Mrs J was referred to Dr M, a pain specialist.

Dr M noted slight restriction in neck movement on the affected side and elicited tenderness over the left C5/6 and C6/7 facet joints. Imaging revealed fusion of the C3 and C4 vertebrae and some loss of normal cervical spine curvature, but the vertebral bodies and spaces remained otherwise well preserved.

Dr M recommended C5/6 and C6/7 facet joint treatment and told Mrs J that there was a 50% chance of getting long-term pain relief. He suggested two diagnostic injections with local anaesthetic followed by radiofrequency lesioning if benefit was felt. Dr M went through the risks of the procedure with Mrs J, including lack of benefit, relapse of pain, infection and damage to nerves. Mrs J returned for the first of the two diagnostic blocks. The block was performed in the lateral position and Dr M injected a mixture of 0.5% levobupivacaine and triamcinolone. The block provided good pain relief and Mrs J felt it was easier to move her neck.

Mrs J later returned for the second diagnostic injection. Mrs J was placed in the prone position and local anaesthetic infiltrated into the skin. Using biplanar fluoroscopy, 22G spinal needles were inserted toward the C5/6 and C6/7 facet joints. Dr M then attempted to inject a mixture of lignocaine and triamcinolone at the lower level.

Unfortunately, as soon as Dr M started the injection, the patient jumped with pain and her left arm twitched. The procedure was abandoned.

Despite a normal neurological examination immediately after the procedure, the patient later the same day developed numbness in her left arm and right leg. She also complained of headache when sitting up, as well as pain in her left neck and shoulder. As she felt dizzy on standing, Dr M decided to admit Mrs J for overnight monitoring and analgesia.

The next morning Mrs J was no better. She felt unsteady on her feet and complained of a burning sensation in her right leg, as well

as weakness and shooting pains in her left arm. Dr M decided that a second opinion was required and referred Mrs J to a neurosurgical colleague. An MRI was arranged, which unfortunately demonstrated signal change in the cord at a level consistent with the intended facet joint injection.

Over time, the MRI changes improved but Mrs J continued to suffer from severe neuropathic pain. It affected many aspects of her daily life and she found it difficult to return to work as she was not able to sit for any length of time. A spinal cord stimulator was inserted by another pain specialist to try and help with the pain, but this was largely unsuccessful and was later removed. Mrs J subsequently lost her job and, following that, decided to bring a claim against Dr M.

Expert opinion

The case was reviewed for Medical Protection by Dr F, a specialist in pain management. Dr F was of the opinion that the initial assessment and management plan were entirely appropriate. She was somewhat critical of the approach used by Dr M for the diagnostic injection as it was not consistent with the planned approach for the radiofrequency lesioning and, in her opinion, more likely to be associated with the possibility of damage to the spinal cord. She also felt that the use of triamcinolone in the diagnostic injections could be criticised, as injection of particulate matter into the spinal cord is known to be associated with a higher risk of cord damage.

Dr W, an expert neuroradiologist, was concerned about the images he reviewed from the second diagnostic injection. He concluded that neither needle was within the respective facet joint and that the lower needle tip was within the spinal canal at the level of C5, less than 1 cm from the midline. Dr W also confirmed that the MRI abnormality corresponded with the position of the lower needle tip.

Dr F concluded that insufficient images were taken to satisfactorily position the needles. She also noted that only 40 seconds had passed between the images taken for the first and second needle insertions, inferring that the procedure had been carried out with some haste.

MPS then instructed a causation expert to comment on Mrs J's progression of symptoms. Professor I concluded that the development

of neuropathic pain in the right limb was understandable, although the disabling effects were more than he would have expected. While the patient did have a history of neck pain, the patient's symptoms were consistent with a lesion affecting the spinothalamic tract on the contralateral side of the cervical spinal cord. The case was considered indefensible and was settled for a high sum.

Learning points

- Although it is commonplace for a doctor to assume multiple roles, this case highlights the risks during an individual procedure. Dr M was acting as an anaesthetist providing sedation, analgesia and reassurance, while at the same time carrying out the facet joint injections.
- Although Dr M warned the claimant about the possibility of nerve damage, this does not mean that a defence can necessarily be made. Both the expert pain consultant and radiologist concluded that neither needle was positioned as intended prior to the injection, and that the lower needle tip was clearly within the spinal canal and thus potentially within the substance of the cord.
- The experts were of the opinion that a pain medicine consultant should be confident in interpretation of live radiological imaging, including needle trajectory, and accurately determine needle trajectory and position prior to performing the procedure. It is important to allow the necessary time regardless of other pressures and to follow guidelines published by professional societies/bodies, e.g. International Spinal Injection Society. There is a body of opinion that advises against the use of particulate steroid injections in the cervical area.
- When an elective procedure or service has been offered to a patient, practitioners may feel an obligation to fulfil this, even when they may not be entirely confident about doing so. Where there is any doubt or concern, it is far better to abandon the procedure or seek a second opinion, particularly where a mistake may lead to a serious complication.

Border Coastal honour two local heroes

Border Coastal Branch held their AGM and annual dinner at the East London Golf Club on Friday 13 May 2016. There were 100 attendees, including partners. Two local heroes were honoured at the meeting: Dr Kim Klopper received a distinguished service award, and Dr Bavamma Thomas, a rural lifetime service award.

“She has always shown huge commitment to her patients, and has been willing to learn and take on new responsibilities”

The guest speaker was “Div” de Villiers, a professional conservationist for 33 years who has published numerous articles about fishing, hunting and conservation. Since 2007 he has been director of law enforcement with the Eastern Cape Department of Economic Development, Environmental Affairs and Tourism.

Chairperson of the branch, Dr Kim Harper, chaired the meeting and delivered the branch reports. Leftover food from the dinner was donated to The Manor House Old Age Home.

Dr Bavamma Thomas

Bavamma retired at the end of March, after more than 20 years working in the small

rural hospital of SS Gida in many disciplines, including paediatrics.

“She has always shown huge commitment to her patients, and has been willing to learn and take on new responsibilities, managing the ART program at the hospital from its inception. Even with many years of clinical experience and expertise she is still humble, and not afraid to call for advice to ensure that her patients get the best possible level of care,” said Dr Harper.

Her dedication extends to her hospital staff, and she would make every effort to ensure good working conditions for her nurses and doctors. Her hard work has been unflagging – she is always available to patients and doctors and involved in all aspects of the functioning of the hospital.

Bavamma has been the lifeblood of SS Gida and will be sorely missed by patients and staff alike. She completed her medical degree at Christian Medical Mission College in India, and after retirement will be returning to her home in India. Her contribution to healthcare in Keiskammahoek cannot be measured.

Dr Anthea Klopper

Anthea is no newcomer to the Eastern Cape. In 1995, she, her husband and children relocated to East London from North London in the UK. She is recognised for her insightful, inventive leadership and dedicated service to the medical community in the Eastern Cape. She leaves the city to join the Red Cross War Memorial Children’s Hospital in Cape Town.

Anthea started off working at Frere Hospital and at Cecilia Makiwane Hospital

(CMH) where she was responsible for two neurodevelopmental clinics. At CMH she managed a social medicine ward for abandoned, abused and disabled children and raised funds for a recreational facility for her patients there. In addition, she managed a clinic for abused children and was used extensively as an expert witness at court. During this time she conducted in-house training for medical staff at CMH on the management of child abuse, and ran workshops for the provincial Department of Health in training medical staff, social workers, psychologists, police officers and others.

She is recognised for her insightful, inventive leadership and dedicated service

In 2003, Anthea jointly launched an all-women-doctor family practice, which has three associates.

She qualified in the field of paediatric neurodevelopment, obtaining a Masters degree from the University of the Witwatersrand. This is an area which she is passionate about. Being in private practice has enabled Anthea to work with children and adolescents who have a variety of neurodevelopmental and mental health problems.

Her commitment to SAMA has ranged from advocacy on behalf of medical doctors (collectively and individually) in the Eastern Cape, working together with the Eastern Cape Health Crisis Action Coalition, facilitating professional development for medical associates, to arranging some unconventional AGMs for SAMA members.

Says Anthea of SAMA’s role in the Eastern Cape: “Doctors in both the private and public sectors need to present a united voice in advocating for better health services for their patients and better working conditions for doctors and other health professionals. SAMA provides the necessary vehicle for this and with the commitment and involvement of all members can achieve much.”



Dr Kim Harper presented the rural lifetime service award to Dr Bavamma Thomas



Dr Anthea Klopper received a distinguished service award from branch chairman, Dr Kim Harper

Healthcare professionals, social media and ethics

Jeanette Snyman, Senior Marketing Officer, SAMA

SAMA, in association with the West Rand Branch, arranged a hospital talk on 24 June 2016 at the Leratong Hospital. The topic was "Healthcare professionals, social media and ethics", presented by Marli Smit, Senior Legal Advisor from SAMA Head Office.

As with the business industry, social media is a well-recognised tool that may be used effectively to enhance professional networking, education, organisational promotion, and patient care, as well as public health within the health industry. Participation in social media by the general public has increased tremendously

over the years, and healthcare professionals need to use this to their advantage.

However, the question of ethics, more than in any other business, is a pressing issue within the health industry. Healthcare professionals need to apply an absolute censorship in terms of what they post on social networks so as not to contravene the patients' right to privacy. Healthcare professionals also need to be the gatekeepers and ensure that healthcare matters are published to keep the public well informed.

The attendance was satisfactory and SAMA made a few recruits. The attendees



Marli Smit presents her talk "Healthcare professionals, social media and ethics"

found Marli's presentation stimulating and the branch received positive feedback about the presentation.

Introducing newly appointed junior marketing officers

SAMA has pleasure in introducing Bokang Motlhaga and Sarah Molefe, newly appointed junior marketing officers in the Marketing and Communications Department.

Bokang is a second-year student pursuing BA Communication Science, and holds a diploma in media studies and journalism. He brings on board his writing and event management skills.

Sarah has vast experience in organising CPD and corporate events. She has years of experience in the marketing and communications field, as well as a strong client network base to her advantage.

Both candidates have shown enthusiasm in making invaluable contributions to



Bokang Motlhaga

the marketing and communications department that will take SAMA to elevated heights – the sky is only the beginning!



Sarah Molefe

SAMA congratulates and welcomes them aboard; we wish them a fruitful association with SAMA.

JUDASA doctors join Tygerberg Boland branch

Recently SAMA Tygerberg-Boland had various interactions with Stellenbosch University students, including a donation of R1 000 towards a meeting room for the Junior Doctors Association of South Africa (JUDASA) members working at Tygerberg Hospital. A plaque, recognising SAMA as a donor, will be attached on the outside of the venue.

The branch also made a contribution to a students' *Financial Day* fundraiser held on campus, and has since received a heartwarming letter of gratitude from the students. On this occasion 160 final-year medical students from the university joined SAMA after Dr Zahid Badroodien had addressed them on the importance of joining the organisation. Mrs Sandra Ferrone was in attendance at a special SAMA stall.



Chairman of JUDASA in the Western Cape, Dr Zahid Badroodien (left) and JUDASA member, Dr Michael van Niekerk (right) with Dr Wynand Goosen, branch chair of SAMA Tygerberg-Boland

Goldfields branch hold Mediclinic presentation

SAMA Goldfields branch held a presentation in June at Mediclinic Welkom under the supervision of Dr Piet Janse van Rensburg, Clinical Manager, on "Strategies to prevent the colonisation, infection and spread of multi-drug resistant organisms in healthcare facilities".

The following subjects were covered:

- Hand hygiene video and glitter bug demonstration

- Most prevalent micro-organisms, basic microbiology and resistance
 - Quality specimen collection methods
 - How can we prevent cross-colonisation and infection?
 - The management of chronic medication
 - The roll of the nurse/caregiver in antimicrobial conservation
 - How to prevent pressure ulcers in health- and geriatric-care facilities.
- The event was well attended.



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