

SAMA INSIDER

JULY 2013

SAMA RWOPS Discussion Paper



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EDITOR'S NOTE JULY 2013



Zukiswa Nomnganga
Acting Editor, SAMA INSIDER

Legally correct...

There has been a lot of dialogue among doctors and the Department of Health regarding Remuneration of Work Outside Public Service (RWOPS), which has also fuelled the unsavoury reports in the media towards doctors and the profession. This is concerning doctors who are being accused of abusing the system which has had a bad reflection on those who are following the correct procedures.

The Minister of Health highlighted this issue in his budget vote speech and emphasised that a significant number of doctors were abiding to the rules set out for RWOPS and that there were still individuals who abuse the system and once caught, would be dealt with under serious measures. Furthermore he added, "The few individuals who are involved, are not only punishing patients, they are also destroying the medical training in the country because they leave medical students to their own devices. Even specialists in training are badly affected by being abandoned by people who are supposed to guide them in every step of their training".

In this issue we take a closer look at the acceptable and legal way of making use of the RWOPS system and the benefits thereof. SAMA has formulated a draft discussion paper on RWOPS where members are required to give inputs and comments. Once the document has been finalised, it will be an official document on RWOPS going forward. See this on page 8.

Only one month left before the long-awaited SAMA Conference, having looked at the line-up of speakers and topics to be covered, delegates can expect to be enchanted with critical and valuable information. Furthermore, the nomination deadline for the Doctors Awards has been extended to 12 July, to allow SAMA members to nominate their colleagues and peers who have contributed significantly to medicine and added to the esteem of the profession. Once again, entries for the 2013 SAMA/MPS Photography Competition are now open.

We welcome all contributions and articles from our readers to share with the rest of the SAMA membership and stakeholders. All contributions can be sent to the editorial contact details. Please note that editorial coverage will be at the editor's discretion.

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Who cares for the carers?



Prof. Zephne van der Spuy, President, SAMA

There are many challenges facing healthcare professionals in South Africa, both in the private and public sector.

Those in the public sector often have to provide services in under-resourced facilities, face growing patient needs and then there are the particular challenges within the clinical environment.

We have not met the Millennium Development Goals, we still have an unacceptable maternal mortality ratio and an unacceptable death rate among children under the age of five years. HIV/Aids continues to be a challenge and the emergence of multi-drug resistant tuberculosis has impacted on healthcare delivery.

"I would suggest that every maternal death needs a debriefing and discussion..."

In the industrialised world, there is an extensive system of support for healthcare practitioners. This includes counselling, education, intervention in crises and ongoing psychological input. While it is appreciated that the resources

in these countries obviously exceed those in South Africa and that the issues are somewhat different to our local healthcare facilities, we do need to ask who cares for the health professionals within our services.

"Staff should feel free to discuss adverse events and to ensure that they will get input and support in the future"

There are many different areas in which support is required. These include interns and community service doctors, registrars or sub-specialist trainees, established service providers at specialist and non-specialist level and colleagues within the private sector.

We are informed that regular mortality and morbidity (M&M) meetings and audits are essential, but there must be support offered for staff who are often dealing with an overwhelming clinical load and high mortality rates within their services. While audits of clinical events are important, support and backup for clinical staff is essential if they are to continue within the public service and it is also required within the private sector where adverse clinical events often generate enormous stress and concern.

Possibly the first level of caring for the carers is to ensure junior staff have adequate support and mentoring in the clinical environment. Too often one hears of reports of community service medical officers who do not have adequate senior input.

The same support is necessary for all levels of care. Both registrars and sub-specialist trainees need clinical input from their supervisors, and established service providers at both medical officer and specialist level need to be sure that there is a network of clinical support and information available to them.

While regular M&M meetings and audits of clinical outcomes are essential, there does not appear to be any audit of staff support following difficult clinical outcomes. I would suggest that every maternal death needs a debriefing and discussion with all the staff involved, as do many other adverse clinical events. I have been told by junior staff that they reach a breaking point after a difficult night on duty when they have signed repeated death certificates, for whatever reason, in their particular discipline.

It is therefore essential that we look at the health professionals, recognise that they are central to service provision within our country and ensure there are systems in place to give ongoing support to the whole multidisciplinary team. Counselling must be available for difficult events, but it is also essential that M&M meetings take place in a supportive and non-

"Without appropriate support, there is likely to be a loss of professional staff..."

acrimonious environment. Staff should discuss adverse events and ensure that they will get input and support in the future. It has to be recognised that in the public service working in under-resourced and often under-staffed areas, provides particular challenges that need addressing. In the private sector the challenges are slightly different but, once again, discussion and counselling may be very helpful.

Without appropriate support there is likely to be a loss of professional staff in the public sector and high rates of burnout and dissatisfaction. It is in everyone's interest – the patient, the healthcare professional and the service – that we put in place appropriate and ongoing assessments of how staff are to deal with stress and how multidisciplinary caring for carers is recognised as part of the general support system within every healthcare environment.

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SAMA calls for Gauteng MEC for Health to be reshuffled from his position

SAMA Communications

The South African Medical Association (SAMA) is gravely concerned about the tone and language that has been used by Hope Papo, Gauteng MEC for Health, to address doctors in the media. This language is unacceptable and intolerable. SAMA agrees and accepts that the issue of overtime by doctors needs to be dealt with properly; culprits need to be identified and dealt with accordingly.

However, SAMA takes serious exception to an approach that is obsessed with exaggerating the issue to a level of tarnishing the entire noble medical profession due to a few variant professionals.

Such an approach will only seek to achieve the myopic pseudo-euphoria of making headlines and reducing the medical profession to a political punching bag.

The consequences will be dire; this will irreparably tarnish and contaminate the sacred doctor-patient relationship, as all doctors will be seen as 'tsotsis', as labelled by the MEC in recent media reports. We, however, welcome the Gauteng Health

MEC's zeal to deal with fraud and corruption; it is upon his dedication that we pin our hopes that he will not only single out doctors as soft targets and defenceless professionals, but that he will leave no stone unturned, that is, to clean the entire department of the reported rampant corruption, failure to pay suppliers on time, poor equipment service programme and unreliable drug supply.

"The MEC's narrow focus unfortunately depicts the lack of leadership in the department. There are some 3 000 doctors working in the province's hospitals and he chooses to focus on a handful who appear to be abusing the system," says Dr Phophi Ramathuba, chairperson for SAMA's Public Sector Doctors.

It is also important to highlight that there are many doctors who work way beyond their paid overtime – is the MEC also willing to pay those doctors for their unpaid and thankless hard work and sacrifice owed to them over the years?

"The MEC conveniently ignores the obvious rootcause of this quagmire: the lack of leadership and prudent management in his department.

How was this issue allowed to occur in the first place? Where are the checks and balances that are basic in any industry to deal with such issues?" continues Dr Ramathuba.

SAMA therefore calls for MEC Hope Papo to be recalled and reshuffled from his position as the Gauteng MEC of Health. The province deserves someone who is passionate and understands the health system in the country, and who will be able to deal with issues at hand.

Papo also fails to mention how many doctors (and other healthcare workers) are leaving his health system every day due to factors that he could control, but cannot manage – including medical supplies, equipment, queue management, patient pathways, clean institutions and providing an inviting work environment.

The country will certainly not thank him for aggravating this exodus by lambasting our professionals. Tiger Woods' response to Sergio Garcia's racist remarks succinctly describe SAMA's view on Papo's statement as "hurtful, wrong and wholly inappropriate."

SAMA/MPS Photography Competition

The SAMA and MPS Photography Competition is open for entries. The theme for this year is 'A Day in a life of a Doctor'.

The categories for entries are:

- Work Environment
- Emotions
- Nature

Doctors spend most of their time in hospitals or in their private practices enhancing quality of life and saving lives in surgery rooms; therefore this year we would like entrants to share a glimpse on some of the special moments and experiences with their patients, fellow doctors and nurses. Included as a sub-theme is an area of relaxation, which can feature nature and wild life.

The competition closes on 26 July 2013.

Cash prizes per category include:

Work Environment: R 4 000
Emotions: R 4 000
Nature: R 4 000

To enter, upload your photos to <http://www.samedical.org/events/photography-home.html>

For further information contact Zukiswa Nomnganga at SAMA head office on 012 481 2052 or email zukiswan@samedical.org.



SAMA / MPS Photography Competition 2013
A day in the life of a Doctor

SAMA Conference 2013: One month to go

Corné Engelbrecht, Events and Branding Officer

With just one month left before the 2013 SAMA Conference, there are limited seats available, so make sure you register and secure your seat to avoid disappointment.

The conference will take place at Birchwood Conference Centre from 15 to 17 August 2013. The theme will be 'Changing the Future of Healthcare', with a focus on clinical updates for practical guidelines, National Health Insurance (NHI) with emphasis on the roles of public and private sectors, funding and funders, as well as on human resources for health. Delegates attending the full conference will qualify for up to 23 CPD points.

An exhibition will run concurrently with the SAMA Conference and we encourage our delegates to make use of the allotted times to visit the exhibitors and gain insight into the latest products and services on offer.

Register online at www.samedical.org/sama-conference-2013.html

Nominations for the SAMA Doctors' Awards are also open and entries close on Friday, 12 July. The Awards Gala Dinner will

take place on 16 August at the OR Tambo Centre at Birchwood. The awards aim to recognise individuals who have contributed significantly to medicine in particular and healthcare in general, or have added to the esteem of the profession. Delegates attending the full conference can attend the gala dinner for free.

For more information, or to nominate a peer, please visit our website at <http://www.samedical.org/sama-doctors-awards-2013.html>

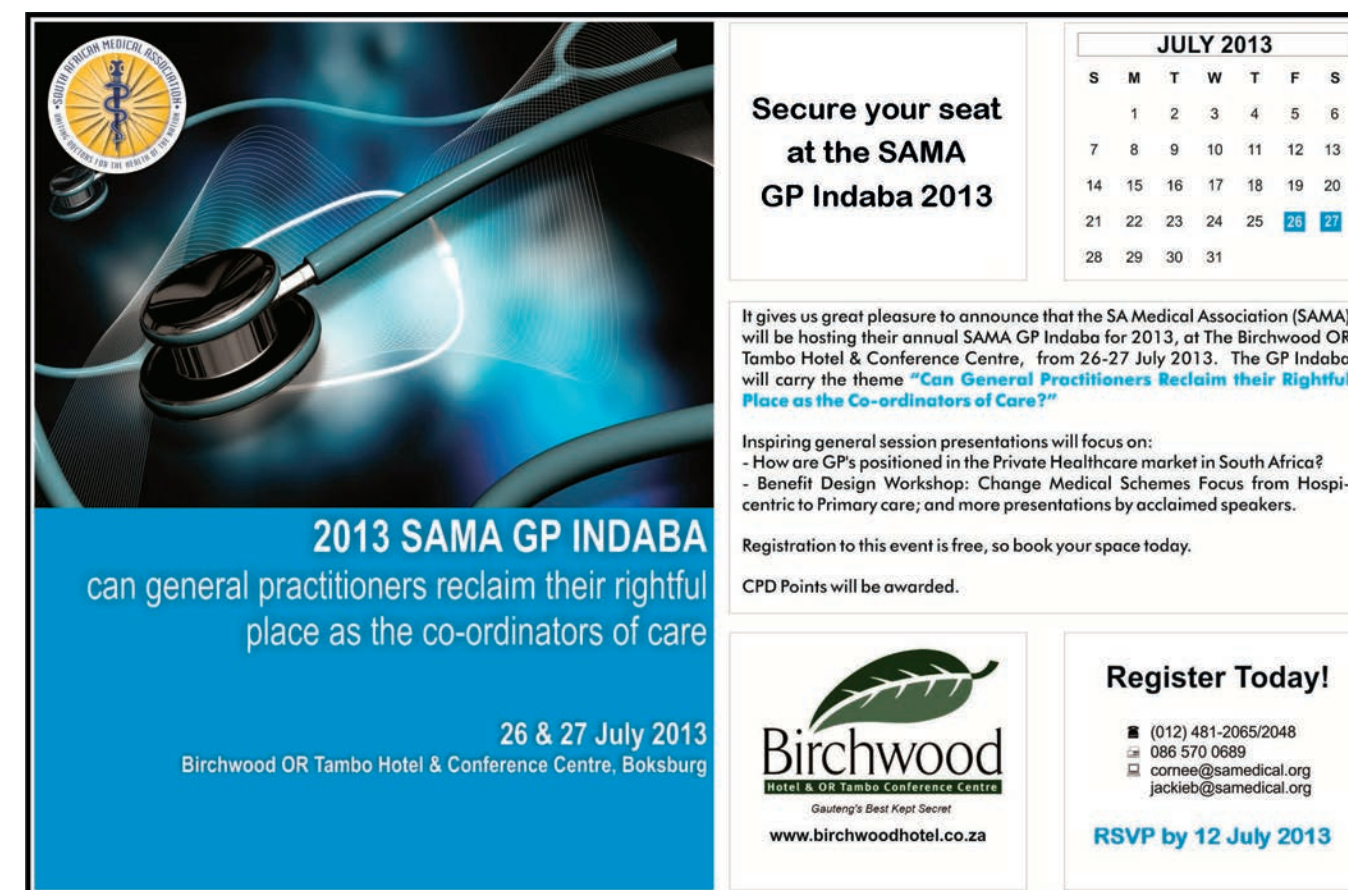
In addition to the conference lineup, a workshop on Professionalism in Practice will be held directly after the conference on Saturday, 17 August, from 13h45 to 17h30.

The workshop will address the gap in current knowledge on core ethical values and medical law with the objective of keeping the doctor out of trouble.

For more information on the SAMA Conference 2013, the SAMA-Bonitas Housecall Doctors' Awards, or the Professionalism in Practice Workshop, contact Corné Engelbrecht at comee@samedical.org or tel: 012 481 2065.

The delegates can expect quality and influential speakers lined up for the conference. To name a few:

- Prof. Tim Noakes: Weight management – a practical approach
- Dr Sean Chetty: Managing chronic non-malignant pain
- Dr Phophi Ramathuba: NHI – Human Resources for health
- Dr Marmol Stoltz: The roles of the public and private sectors now and in the future
- Prof. Hoosen Coovadia: HIV and children
- Dr Harlem Gongxeka: Interpreting chest and abdominal X-rays

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Secure your seat at the SAMA GP Indaba 2013

It gives us great pleasure to announce that the SA Medical Association (SAMA) will be hosting their annual SAMA GP Indaba for 2013, at The Birchwood OR Tambo Hotel & Conference Centre, from 26-27 July 2013. The GP Indaba will carry the theme "Can General Practitioners Reclaim their Rightful Place as the Co-ordinators of Care?"

Inspiring general session presentations will focus on:
- How are GP's positioned in the Private Healthcare market in South Africa?
- Benefit Design Workshop: Change Medical Schemes Focus from Hospicentric to Primary care; and more presentations by acclaimed speakers.

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SAMA RWOPS Draft Discussion Paper: Proposed criteria for the performance of RWOPS

Purpose of the discussion paper

- 1.1 To serve as an initial basis for the subsequent drafting of a uniform Remuneration of Work Outside Public Service (RWOPS) policy for all provinces.
- 1.2 The paper consists of general principles, and does not contain the extensive details that will be included in the draft policy document.
- 1.3 The continued existence of RWOPS is under threat due to statements by officials who hold positions of authority at national, provincial and institutional levels, the perceptions created in the public eye and doctors who are abusing the system as it is presently administered.
- 1.4 It is therefore essential to draft a policy that is acceptable to doctors who work in the public service, the Ministry of Health and Department of Health, as well as the Committee of Medical Deans. This policy will have to be adopted uniformly throughout the country as a National Policy to ensure that there is both transparency and fairness.
- 1.5 The fundamental principle underlying this discussion document and the subsequent draft policy is that the privilege of being granted permission to perform RWOPS has no negative impact on service delivery and is not, in any way, detrimental to the health care of patients treated in state facilities.

Preamble

The performance of RWOPS is an entrenched part of the conditions of service of employees in the public service. It is provided for in the Public Service Act and Regulations and has been regulated in terms of various provincial policies. Permission to perform RWOPS is granted to employees subject to their adhering to certain conditions.

1) Criteria for performance of RWOPS

Each provincial head of department for the Department of Health may grant permission for RWOPS to medical practitioners employed by the Department of Health in terms of the Public Service Act and Regulations. Such permission should not unreasonably be withheld and the following conditions and



criteria should be applied in the granting and supervising of RWOPS:

- (a) The performance of RWOPS must not impact negatively on service delivery, teaching and training (where applicable), nor be detrimental to the health care of patients treated in state facilities.
- (b) The approval of RWOPS will be subject to the continued performance of all the contractual obligations of the applying medical practitioner as contained in their employment contract.
- (c) RWOPS may be undertaken during designated working hours as prescribed by the conditions of service. This may be done on condition that the institution can ensure that the service delivery requirements of the institution are adhered to.
- (d) The distribution of RWOPS hours must be clearly indicated in the work plan as discussed and agreed to with the line manager. The agreed work plan, including the approved RWOPS hours must not impact negatively on service delivery nor be detrimental to the health care of patients treated in state facilities. The responsibility for the supervision of the performance of contractual obligations vests in the line manager.
- (e) A medical practitioner granted permission to perform RWOPS may not utilise this

time to operate a solus GP practice. Medical specialists may operate their own private practice. Practitioners may form part of a registered group practice or be employed on a part-time basis by a practice registered in the name of the practitioner who is not a full-time employee of the State. Proper records of the hours worked in the private practice should be kept and be available should they be requested. Applicants should clearly indicate on the prescribed application form how their accounts will be submitted.

- (f) RWOPS may only be undertaken within state facilities where:
 - It can be shown that there is a benefit to the Department of Health.
 - Such facilities have been clearly designated for use by the private sector.
 - The management of these facilities can monitor the use of the facilities.
 - A facility fee can be billed by the institution for the use of such facilities
- (g) RWOPS may be undertaken outside public facilities where it is not possible to utilise public facilities.
- (h) All hospitals, CHCs, district offices, and institutions must set up a RWOPS committee that will deliberate on applications for RWOPS and renewal of applications to perform RWOPS.

Such committee must further deal with disputes arising from the performance of RWOPS as well as investigate and adjudicate upon allegations of abuse of RWOPS. The committee must comprise of the following members:

- The CEO / Head of Institution
 - Head of Clinical Services
 - Head of Nursing Services
 - Head of Institution Human Resources
 - Line managers
 - Trade union representative of the medical practitioners performing RWOPS
- (i) Permission to perform RWOPS must be applied for in advance, and RWOPS may only be performed once approval has been obtained. In terms of the Public Service Regulations, an application to perform RWOPS must be dealt with within 30 days. If the application is not dealt with in this period, the application will be deemed to be approved. In the event that approval is declined, reasons for such refusal must be furnished in writing to the applicant. Inability to monitor RWOPS activity is not a valid reason for refusal.

- (j) If there are allegations that the conditions of RWOPS are violated by a medical practitioner of RWOPS, such allegations must be properly investigated by the RWOPS committee. If after the investigation and subsequent hearing, it is established that there has been a violation of the conditions for the granting of RWOPS, the RWOPS committee may recommend to the Provincial head of department that approval for RWOPS be withdrawn.
- (k) Unless the Provincial head of department agrees otherwise, permission granted to perform RWOPS will be granted for one calendar year, commencing on 1 April of each year, but the permission will be reviewed whenever an individual is promoted, transferred to another health institution or the post is upgraded.

Where there is an operational requirement to terminate RWOPS, the affected doctor must receive sufficient (three months) notice of such termination.

- (l) After approval is granted, a certificate confirming the medical practitioner to

perform RWOPS will be issued to that medical practitioner. The certificate will indicate the period for which approval to perform RWOPS has been granted to the practitioner.

- (m) Heads of Clinical Departments/Clinical Heads of the Institution should be able to locate/reach medical practitioners at all times at service points as indicated on the work programme.
- (n) Each head of a clinical department/clinical head must certify that the private work allocation in terms of the work roster will not negatively impact on the service delivery to State patients and that she/he supports the application. Please note that this is a discussion document. SAMA would like to invite members to send their inputs and points for possible inclusion and addition to the SAMA RWOPS Policy.

Please note that this is a draft discussion document, kindly send your inputs to Adv. Daniel Madiba: danielm@samedical.org; tel: 012 481 2075; fax: 012 481 2100.



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A doctor's right to earn

This is an abridged version of an article that was written in 2011 by Dr Carol Funeka Madikiza, who was then a member of the SAMA Human Rights Law and Ethics Committee. The article constituted part of the SAMA submission on the NHI Green Paper. Recent developments around Remuneration of Work Outside the Public Service (RWOPS), have necessitated a revisit of the arguments of this article.

The medical profession is one of those professions which is held in high regard in society and tends to get most of the attention in terms of rights, law and ethics compared to other professions. This may be attributed to the fact that health professionals work with people, and in that empathy should be at the top of their list when it comes to care. A doctors' ability to earn and be wealthy also seems to be under scrutiny. True, as it may be, it is also reasonable for society to realise that there are huge costs involved in the long training and subsequent responsibilities associated with the profession after qualifying.

Some of these expectations tend to border on an assumption that doctors should have limited access to wealth and its visibility because of a perception that their wealth comes from the proceeds of practice and care of patients only. Often, at times, the misconception is that doctors are supposed to charge low fees. Below are some of the reasons doctors need to earn high salaries/incomes, whether they are self-employed or otherwise:

- To pay back study loans and other debts.
- To finance their expensive insurance covers – personal, professional and business.
- To start families and educate children.
- To meet housing costs e.g. bond repayments
- To start up business practices while also working in government, so that sessional work can supplement their income.

How much do doctors make and how many hours do they work?

There are widespread views that doctors earn large amounts of money and are automatically rich. This profile is changing, especially as we understand the costs of medical schools in terms of both time and money, the average wage of

doctors, and the high costs of maintaining medical practice insurance. Moreover, doctors often work long hours of up to 60 hours a week depending on the speciality, work load, size of population and environment. All this at the expense of their families at times. Some of the highest paid physicians are those who specialise in anaesthesiology and surgery.

These specialities can require up to seven years of additional training prior to becoming board certified. Some of the doctors who earn the highest also trained the most, and may have completed ten to eleven years of training after graduating from college with a four year degree, thus a total of fifteen years worth of preparation.

In a 2007/8 study done by Steven F Koch and Jean Slabbert, entitled *Analysis of specialist surgeons and their practices in Gauteng* and published in April 2011 with assistance from the SAMA/Foundation of Professional Development (FDP), it was reported that a great number of doctors left South Africa to go overseas, mostly to America, Canada and United Kingdom.

In this study they noted that it is the new patients and procedures that bring in more money as the costs are higher than repeats and follow up patients.

Employment contracts – RWOPS, rights, law and ethics

In most countries, after qualifying, doctors have to work in government institutions as part of professional training requirements. In South Africa it is for a minimum of three years before they can go into private practice or decide the route they want to follow in the medical profession. The majority of doctors remain in government employment for a while to gain experience before moving to the private sector. Some doctors choose to remain in the government academic environment for further studies, while others remain in the academic environment for teaching and research pursuits.

In any contract, there are employment conditions agreed upon by both parties. For doctors, this includes the number of hours to be spent seeing patients. Due to overcrowded public health facilities, doctors are forced to work longer hours. This leads to ethical and legal questions being raised against doctors who engage in sessional work as they are seen to be neglecting public patients and student doctors. In the past few years the South African government permitted extra work by public

doctors to supplement their meagre salaries. This is called RWOPS and has been most beneficial to some doctors (e.g. cardiac catheterisations, gastroscopies, etc.) and those involved in rare procedures which are not performed regularly, if at all, in government facilities.

RWOPS is optional to a doctor, and if needed should be arranged with the head of the specific unit for accountability purposes. Unfortunately this system has been abused by some unscrupulous doctors, attracting the attention of the Ministry of Health and the media.

Occupation Specific Dispensation (OSD) was implemented in 2009 to adjust salaries in order to try and retain health professionals in the public sector. However, despite the roll-out of OSD, doctors still find it necessary to do RWOPS and unfortunately this has attracted criticism including by the Ministry of Health. This raises the question of a doctor's right to earn a living.

As people have different needs, each individual, including a doctor has the right to work as hard as they wish and exercise the right to earn in order to be able to experience their desired lifestyle. Of course this does not excuse doctors from the duty to give care and support to patients and student doctors.

Frequently the need arises for some doctors to seek to improve skills in the private sector (e.g. for certain procedures such as gastroscopies, cardiology procedures and radiology) where the public sector environment, primarily lack of equipment, cannot allow this. It becomes understandable and expected that doctors should make arrangements with private institutions that have these necessary facilities.

However, notwithstanding the need to acquire skills and income, it would be illegal and unethical for doctors to leave the hospital without proper arrangements and sacrifice the patients and students for more money. This case scenario is common in most government hospitals where there is a lack of equipment and few skilled people to perform certain procedures as most specialists are in private practices with equipment and skilled doctors.

References

1. *Analysis of specialist surgeons and their practices in Gauteng (2007-2008) published April, 2011, by Steven F Koch and Jean Slabbert*
2. *The Bill of Rights Handbook by Iain Currie and Johan de Waal, chapter 22, section 22.3 pg 491*
3. *Common law right to earn a living by Timothy Sandeur.*

Requirements of acting in higher positions in the public sector



Vuyo May, Industrial Relations Adviser, SAMA

Section 32 of the Public Service Act 103 of 1994 read together with, Chapter I, VII, B.5 of the Public Service Regulations of 2001, as amended, provides guidelines for appointing public service employees to act in higher positions other than those ordinarily assigned to them. It is these provisions that gave rise to Resolution 1 of 2002 of the Public Health and Social Development Sectoral Bargaining Council (previously referred to as Public Health and Welfare Council). The resolution provides a framework for compensating employees acting in higher positions in the health and social development sector.

According to the resolution, an employee appointed in writing to act in a higher grade than the grade of an employee by the HOD or his/her delegate at provincial or national level shall be paid an acting allowance provided that certain conditions are met. The first requirement for this acting allowance is an appointment **in writing** by the HOD or his/her delegate. It is becoming common that the employer, through his/her delegates, requests an employee to act in a higher position with the promise that a letter of appointment will follow.

More often than not, the employer turns around and refuses to remunerate employees acting in higher positions for longer than the prescribed period without such appointment being confirmed in writing. This in turn leads to a dispute on whether there was a contract for the employee to act on in the first place; is it fair for an employer to do that? Section 32 (2)(a) of the Public Service Act stipulates

that an employee may be directed in writing to act in a post subject to such conditions as may be prescribed, it does not say that the appointment must be in writing, but what effect does an unwritten contract have on parties to the contract?

The doctrine of quasi-mutual assent provides for a contractual liability based on the parties' subjective intentions. It refers to the surrounding circumstances that determine the intentions of the disputing parties. In this case we would need to determine whether there was a need and an intention to appoint the employee to the position and whether the offer was accepted by way of performance of duties by the employee.

If it is found that the surrounding circumstances suggest that the intention was to enter into a contract and that the employee had accepted the appointment by undertaking all the responsibilities of the acting position, then the contract would have a binding effect on both parties.

The Supreme Court of Appeal in *Pillay v Schaik 2009 4 SA 74*, however, stated that a contract that is not in writing will have a binding force, unless the parties agree beforehand that writing constitutes a formality. The collective agreement on acting allowances stipulates that only those employees who have been appointed in writing to act in higher positions will be eligible for an acting allowance. If that is the case, what legal effect do collective agreements have on parties to the agreement?

Section 23 of the Labour Relations Act 66 of 1995 provides that a collective agreement binds the parties to the collective agreement and sub-section 3 states that where applicable, collective agreement varies any contract of employment between an employee and an employer who are both bound by the collective agreement.

What this provision means is that even if the parties may decide not to observe the requirements of the collective agreement when entering into a contract, when there is a dispute about the performance of a duty by one of the parties or both, or the existence of a contract, the contract will be nullified by the conditions specified in a collective agreement.

In addition to the requirement of appointment in writing, the conditions

prescribed in the resolution are that, an employee will be eligible for an allowance if the acting post is vacant and funded; the period is longer than six weeks; the appointing authority is a level higher than the acting appointee; and the employee must accept the appointment.

The resolution does not specify how the mode of acceptance should be in respect of the latter requirement but the Labour Court in *Jafta v Ezemvelo KZN Wildlife (2008)* specified legal requirements for an acceptance of an offer and it stated that:

- (a) The acceptance must be clear, unequivocal and unambiguous;
- (b) The acceptance must correspond with the offer;
- (c) It must be made in the mode prescribed by the offerer; and
- (d) The offeree has to communicate acceptance of the offer to the offerer.

These provisions mean that it may be difficult to prove existence of a contract when appointing an employee to the acting position if there is a collective agreement in place that requires that the appointment should be in writing and there is no written appointment in place. It may be even more difficult to prove that the appointment was accepted if there is nothing in writing to prove the appointment and also no documented evidence to prove that services were actually rendered in the acting position.

Whether it is acceptable for an employer to hide behind absence of an appointment letter where services in the acting position have been rendered is a topic for another day. It will be interesting to see how the arbitrators in two different provinces will find on two acting allowance matters that SAMA has taken to the Council for determination where the employer is denying any existence of a contract due to the absence of the appointment letter as prescribed in the resolution.

It is advisable to contact SAMA for advice if the acting period exceeds the six weeks prescribed period and there is no appointment letter in writing.

The industrial relations advisors can be reached on the following numbers: 012-481 2028/2047/2096 or at labour@samedical.org.

First provincial PPE launch – Northern Cape

Sibongiseni Delihlazo, *Communications Manager, DENOSA*

The South African Medical Association (SAMA) and the Democratic Nursing Organisation of South Africa (DENOSA) successfully held the first provincial launch of the Positive Practice Environment (PPE) campaign at Tshwaragano Hospital in Kuruman, Northern Cape, on 10 May 2013. The launch was joined by the Provincial

Department of Health, local councillors, hospital board, church and traditional leaders as well as more than 500 members of the community. The Junior Doctors Association of South Africa (JUDASA) Northern Cape representative, Dr GE Mashele also attended the launch together with DENOSA general-secretary, Thembeke Gwagwa.

General-secretary Gwagwa, unveiled the eight pillars that make up a positive practice environment in an institution, namely: safety, payment, resources, equipment, supplies, training, support and respect. The main event was held at the hospital where all health workers attended with the political leaders of the province.



Successful Limpopo PPE launch

Zukiswa Nomnganga, *PR & Media Liaison Officer, SAMA*

A second successful PPE launch by the South African Medical Association (SAMA) and the Democratic Nursing Organisation of South Africa (DENOSA) was held in Limpopo at the Makweng Hospital on 12 June 2013. The launch was honoured by the Treatment Action Campaign (TAC), South African Council of Churches and the Retired Nurses Forum. SAMA chairperson for Public Sector Doctors, Dr Phophi Ramathuba and

the Academic Doctors Association for South Africa (ADASA) secretary, Dr Sizaka Maweya, joined hands with community members and nurses in a call for a safer and conducive environment in the province and healthcare facilities for health professionals and to recuperate patients. Dr Ramathuba unveiled the eight pillars that constitute the positive practice environment in any health institution and

urged the health professionals present at the launch to work together in improving the health system in their province. She stressed that SAMA and DENOSA needed every health stakeholder, including Public Service Administration, Nursing Council, the Health Professions Council of South Africa (HPCSA) and the Department of Health, in the transformation of the public health system.





JUDASA launches medical male circumcision project



Dr Thabo Maleka, National Deputy President, JUDASA

The Junior Doctors Association of South Africa (JUDASA) in the Limpopo province successfully launched a massive Male Medical Circumcision (MMC) project on 1 June 2013 at Mankweng Hospital in Polokwane. This crucial initiative serves as an extension of the service provision of the current MMC programme in the province.

JUDASA acknowledged the prevalence of HIV/Aids in this rural province. It is known that male circumcision only provides partial protection, and therefore should be one of the elements of a comprehensive HIV prevention package that includes: the provision of HIV testing and counselling services; treatment for sexually transmitted infections; the promotion of safer sex practices; the provision of male and female condoms and promotion of their correct and consistent use.

In an attempt to augment the current existing strategies, JUDASA organised the special MMC drives across the five districts in the province. The main goal is to accelerate the prevention of HIV transmission through the provision of safe, free and accessible

male circumcision services as part of a comprehensive HIV prevention strategy, and to explore the possibilities of establishing a central circumcision centre in the province.

The programme was officially launched by the honourable MEC for Health and Social Development, Dr Norman Mabasa. In his opening remarks, he hailed the campaign and praised JUDASA for such a wonderful project. Saddened by the recent death toll of initiates at traditional schools in both Limpopo and Mpumalanga provinces, the MEC reiterated the need for support toward the campaign from his department, which was symbolised by his signature when he performed the first circumcision of the project.

Dr Phophi Ramathuba, performed the second circumcision of the day. She congratulated and encouraged the young 'lions' to continue to roar relevantly within the context of our society.

More than one hundred males between the ages of 12 and 35 have enrolled in the programme, however only 50 of them were circumcised on the day. All boys, together with their parents, received group counselling on what circumcision and HIV/Aids entails before they all went for individual HIV counselling and testing. It was encouraging and great

to learn that after a rapid test that 100% of the boys were HIV-negative and none of them had any symptoms or signs of sexually transmitted diseases.

More than 10 junior doctors supervised and two medical officers joined hands in ensuring the young men remained safe at all times. The nursing staff of Mankweng Hospital, who were involved in the project, were on point from the onset of registration through to counselling and screening, testing and the actual procedure.

JUDASA would like to thank the Centre for HIV and Aids Prevention Studies, which provided all the MMC packs and the technical support for the team.

The journey does not stop in Mankweng; the programme will run over a two-month period. The Waterberg and Voortrekker districts will shortly follow in the month of June. The rest of the districts will follow one after the other.

JUDASA would like to thank everyone who has made this project successful. We hope to enjoy similar support from our consultants, heads of departments, clinical managers and the staff in making this dream come true for those members of the community who value our services.



SARA's stand on RWOPS: Is the refusal of RWOPS among doctors a case of DoH cutting off its nose to spite its own face?

Dr Mary Adams, Treasurer and Marketing, SARA

The over-expenditure in health services with persistently poor health outcomes has been government's greatest challenge. Various options have been looked at to handle this matter. It appears human resources that are due to report for duty but are nowhere to be found are the first priority at curbing over-expenditure. The manner at which this was approached has caused a great deal of dissatisfaction among medical professionals across the country.

Like any other activity in life, there will always be those who abuse the loopholes. However, this does not justify placing an entire group of professionals in bad esteem. This is unfortunately the manner in which medical doctors have been handled.

Compensating a salary in the medical fraternity – often referred to as Remuneration of Work Outside Public Service (RWOPS) – is legal. The problem is healthcare workers who exploit the system. The perpetrators need to be identified and disciplined accordingly as opposed to the general non-negotiable stance that has been adopted by government.

“The problem is healthcare workers who exploit the system. The perpetrators need to be identified and disciplined accordingly...”

The reduction of the specialists' salaries has been seen as an unsavoury attack on the hard-working public servants to date.

The truth is that the specialists have sacrificed the majority of their lives to study, and master

the skills that would benefit the communities of South Africa, Africa and the globe at large. Our government, however, continually fails to acknowledge this critical fact.

The South African health system has generated much interest and focus for many internationals wanting to study medicine in this country. The array of vast complex conditions, trauma and HIV/Aids research has been driven by our very own specialists.

The interest in our medical training institutions comes at a pivotal time of health reform. Those who utilise our training institutions not only contribute to our human resources but also increase our highly skilled specialist base once they have completed their training. However, due to poor financial management of major hospitals like Charlotte Maxeke Johannesburg Academic Hospital in Gauteng and the Department of Health in the Free State, the coffers are empty and the driving force behind medical excellence has to pay the price.

The need for specialists to extend their expertise in private practice and to gain valuable wisdom in technology and science, which is not available in the public sector, while increasing their revenue has now been frowned upon.

A unilateral decision by government to abruptly end RWOPS and to reduce the overtime earned by consultants/specialists showed the lack of concern that our government has toward its doctors. The misconception of doctors "earning their money at leisure" could possibly be the reason behind such a poorly thought-out decision.

What many non-clinicians fail to acknowledge is the number of hours spent by the specialists away from their families to make a living that equals their years of sacrifice while training.

The majority of the specialists are teaching, preparing articles, overseeing exams in different parts of the country, collaborating with major universities across the world on latest treatment modalities, writing award-winning books, and at the end still providing for their families. The reduction in salaries of the consultants has resulted in the exodus

of specialists in academic hospitals such as Charlotte Maxeke Hospital. The Department of Anaesthesiology and a threatening team from Obstetrics' and Gynaecology have left us wondering whether these office-bound decision makers have made an educated recommendation.

“Specialists have sacrificed the majority of their lives to study and master skills that would benefit the communities of South Africa”

This significant brain drain has many implications for the forecast of future specialists. A lack of consultants will result in a decline of supervisors. This will undoubtedly impact on the training of registrars and will inevitably impact negatively on government's goal of public health sector reform.

Surely the pressure on the registrars from the excess workload will result in their opting out of the training programme. Those who remain behind may end up not meeting the Health Professions Council of South Africa specifications for specialist training.

We agree that the wrongdoers need to be identified and brought to book, however, a dysfunctional healthcare system should not negatively affect the future outcomes of our medical fraternity. The ultimate goal of registrars, specialists and administrators is to ensure equity in healthcare for all South Africans. We strongly feel that a consultative process to resolve this challenge will reap better rewards than the present inconsiderate decisions that have been taken.

Medical records: Definition and ownership



Julian Botha, senior legal advisor, SAMA

The importance of keeping proper, comprehensive and organised medical records cannot be overstated. Such records are often the only defence available when a doctor must respond to complaints or allegations that patients, medical schemes or even other doctors may have.

This is becoming even more important as the South African society is becoming ever more litigious and doctors are increasingly in the firing line of such litigation. In this series of articles, we will deal with the various issues relating to medical records in order to refresh memories and to clarify certain misperceptions.

In order to continue, we must first understand what is meant by the concept ‘medical records’. The medical record of a patient is the ‘umbrella term’ for any documentation or other media that relates to the diagnosis, treatment and care of the patient. It therefore includes clinical notes (irrespective of whether these are handwritten or electronic), reports from laboratories, radiological images and reports, sonograms, audiovisual material (e.g. photographs and video or voice recordings) and printed readings from medical devices. Medical records are sometimes referred to as ‘health records’ of the patient.

The Health Professions Council of South Africa utilises ‘health record’ in its guideline document, ‘Guidelines on the Keeping of Patient Records’ (second edition 2008). This document provides the following definitions of a ‘health record’: “A health record may

be defined as any relevant record made by a healthcare practitioner at the time of or subsequent to a consultation and/or examination or the application of health management.

“A health record contains the information about the health of an identifiable individual recorded by a healthcare professional, either personally or at his or her direction.”

These guidelines provide further information regarding what would form part of the health record:

1. Handwritten contemporaneous notes taken by the healthcare practitioner.
2. Notes taken by previous practitioners attending healthcare or other healthcare practitioners, including a typed patient discharge summary or summaries.
3. Referral letters to and from other healthcare practitioners.
4. Laboratory reports and other laboratory evidence such as histology sections, cytology slides and printouts from automated analysers, X-ray films and reports, ECG traces, etc.
5. Audiovisual records such as photographs, videos and tape recordings.
6. Clinical research forms and clinical trial data.
7. Other forms completed during the health interaction such as insurance forms, disability assessments and documentation of injury on duty.
8. Death certificates and autopsy reports.

Ownership

There is often confusion and subsequent disputes regarding the ownership of medical records in private practices. Simply stated, the general principle is that the private practitioner is the owner of the medical records. However, there are certain important factors that must be borne in mind.

The medical record of the patient belongs to the doctor, but the patient should not be prevented from accessing these records or obtaining copies of the records. The doctor can charge a reasonable fee for requested copies.

In the event that the doctor refuses access to the records or declines to make copies available, the patient has the remedy of formally requesting same in terms of the Promotion of Access to Information Act. It is clearly preferable to provide the access and/or copies when the patient asks for them in

the first place, as this will reduce acrimony and possible litigation. Where a patient has paid for a portion of the record, for example X-Rays or computed tomography (CT) scans, then the patient should retain these records unless it is agreed with the patient that the records be retained by the doctor for monitoring purposes. As the patient has paid for these particular records, he/she would enjoy ownership of them.

The ownership of the medical record does not vest in a doctor who is an employee of a private practice, as a professional assistant, but rather in the private practice itself. However, it would be unreasonable for the private practice to withhold copies of the medical records in the event that there is any compliant or claim against the professional assistant concerned, and should therefore make such copies available to allow that doctor to mount his defence.

In our next article, we will deal with the retention and transfer.



SAMA trademarks registered

The Governance and Legal division is pleased to announce that the registration of a number of SAMA trademarks has been concluded. See the list of trademarks below:

TRADEMARK	CLASS
Quick code	16
The Foundation for Professional Development logo	41 & 42
SAMA	42
South African Medical Association logo	42
Health Advantage	42
SA Medical	38
SAMJ - South African Medical Journal	16
South African Medical Journal of Psychiatry	16
South African Medical Journal of Obstetrics and Gynaecology	16
Doctors' billing manual and device	16
Doctors' billing tables and device	16
South African Medicine Formulary (SAMF)	16
By Doctors For Doctors	16
South African Medical Journal (SAMJ)	16
Continued Medical Education (CME)	16
CME Logo	16
SAMJ Logo	16
SA Journal for CPD	16
SAMA Insider	9 & 16
SAMA Logo (in black and white)	9 & 16
SAMA Logo (in colour)	9, 16 & 42
Uniting doctors' for the health of the nation	9, 16 & 42
SAMA Logo and words (in colour Pantone Blue)	9, 16 & 42
SAMA Logo and words (in colour Pantone Blue and Yellow)	9, 16 & 42
HMPG Logo (in black and white)	16

We are awaiting registration of applications for the following trademarks:

TRADEMARK	CLASS
SAMA Merit Awards	41 & 45
South African Medical Association Annual Conference	41 & 45
SAMA Annual Conference	41 & 45
South African Medical Association Merit Awards	41 & 45
UJAMBI Logo (in black and white)	9 & 16
SAMA Logo and words (in black and white)	9 & 16
HMPG Logo (in black and white)	16
CPD - South African Journal for Continuing Professional Development	16
Electronic Doctor's Billing Manual logo (in black and white)	9 & 41
eDBM	41

Any unauthorised use of these trademarks represents an infringement of SAMA's rights and members are encouraged to alert us to any potential unauthorised use of these trademarks.

ADASA AGM 2013

SAMA affiliate group, Academic Doctors Association of South Africa (ADASA), held their 2013 AGM on 31 May 2013 at the SAMA head office in Pretoria. Discussion points were on RWOPS, NHI, joint appointments and Five Flagship Tertiary Hospitals to be built.



PIRA talk – learning how to better manage chronic pain

The Gauteng North Branch facilitated a talk on learning how to manage Chronic Pain together with Pain Interventions (PIRA) and Regional Analgesia. The PIRA talk was held at the CSIR, Pretoria on 11 May 2013.



Albert Sisulu Executive Leadership Programme in Health launches in Cape Town

Zukiswa Nomnganga, PR & Media Liaison Officer, SAMA



Image supplied by the Department of Health

The National Minister of Health officiated the launch of the Albert Sisulu Executive Leadership Programme in Health (ASELPH), which honours the lifelong contributions of Albert Sisulu in the health sector. ASELPH was founded in a partnership by the University of Pretoria, the University of Fort Hare, Harvard University represented

by the Harvard School of Public Health, South Africa Partners and the Department of Health. The programme is aimed at strengthening health policy transformation and service excellence in South Africa as well as the skills competencies and experiences of senior health leaders and managers.

ASELPH will also aim to strengthen the human resources capacity in the health system needed to deliver high-quality, cost-efficient services through strengthened, executive-level training of health leaders and managers. Initiatives supported by the executive health programme will be the training of district and hospital managers who will be responsible for services related to the National Health Insurance; strengthen management capability of current and emerging, and district health-related leaders responsible for the implementation of NHI and the re-engineering of Primary Health. This will also include the advancement of sustainable, educational and training capacity for health executives responsible for the management of large public health programmes such as HIV, STIs and TB. ASELPH also organises and hosts university forums, policy seminars and round tables to address key policy debates, as identified by the National Department of Health, which will present the greatest challenges to implementation. The programme will offer an integrated approach in a form of short courses, certificates and diplomas based on the specific needs of participants and needs identified by the National Department of Health.

Submission of online medical insurance reports offers benefits to doctors and customers

Old Mutual has launched a new software capability, iMeds, which enables its preferred providers to submit medical insurance reports online. The online submission effectively reduces the processing time for a patient’s medical report by up to eight days. While there are huge benefits for the customer, there are several benefits for participating doctors:

- iMeds has built-in validation to ensure all the required information is complete before it can be submitted, so doctors will not be asked to provide additional or missing information.
- Medicals or accompanying forms cannot go ‘missing’ during the submission process, which often results in medicals having to be repeated.

- iMeds is PPI compliant – the information submitted via iMeds is confidential and secure.
- iMeds-enabled providers are a natural first choice for intermediaries, as they offer a more efficient and faster service.
- There is an opportunity for iMeds-enabled providers to grow their practice through new customers and referrals.
- Providers who bank with Nedbank will receive payment on the same day that Old Mutual receives the medical via iMeds. If a provider banks with another bank, payment will reflect within two days. This removes the need for any upfront payments or guarantees.
- iMeds-enabled providers are listed on Old Mutual’s online directory of preferred medical providers, which can be accessed by all their distribution channels.

Old Mutual offers software training and has a dedicated help facility should there be any problems using iMeds. The iMeds software can also be used by other insurance companies should they develop an online capability. “We currently have 298 iMeds-enabled providers operating in South Africa. Feedback from our providers and intermediaries has been very encouraging and we aim to have 500 iMeds-enabled providers by the end of June 2013,” said Dr Peter Bond, chief medical officer at Old Mutual. If you are interested in medical underwriting and joining Old Mutual’s network of preferred providers, please contact Old Mutual Medical Division on 021 509 7713/4.

Branch news

Annual General Meeting 2013 – Eastern Province Branch

The 2013 Annual General Meeting (AGM) of the Eastern Province SAMA Branch was held on 14 May 2013. The main guest speaker was Dr Phophi Ramathuba, who addressed the branch on SAMA's role in addressing public sector doctors' issues and her speech was enthusiastically received. The AGM proved most enjoyable and socially successful.

New Branch Councillors

Outgoing president Dr Jeff Govender inducted Prof. C Grobler as new president for 2013/14.

Awards

Dr Pierre FM du Toit received the branch award for meritorious services over the past 42 years as member of the Branch Council, starting as treasurer, secretary, chairman, president on two occasions and federal councillor.

Dr Du Toit is currently enjoying retirement and celebrated his 88th birthday on 15 May 2013.

Dr Ronald Benson also received a branch award for meritorious services over the past 41 years on the Branch Council.



Dr Jeff Govender, outgoing President congratulates newly appointed President Prof. C Grobler

2013 Branch elections

SAMA Gauteng Branch – Elected Branch Councillors

The newly elected SAMA Gauteng branch – barely into its new term – has hit the ground running with an emergency intervention into the Charlotte Maxeke Johannesburg Academic Hospital's (CMJAHs) doctors' commuted overtime crisis. Besides crisis management, the branch has other various activities planned for the year. After a long process of branch nominations and electing the new branch councillors, the Gauteng branch is happy to announce its leadership.

Branch Councillors

1) Branch president – Prof. Martin Veller, presently head of the Vascular Surgery unit at the CMJAH and head of the Vascular Surgery division of the Department of Surgery, Wits University.

2) Branch chairperson – Dr Kalli Spencer, medical officer in the department of surgery at CMJAH.
3) Branch vicechairperson – Dr Martin Brand, general surgeon at Chris Hani Baragwanath Hospital (CHB).
4) Prof. Ken Boffard – head of the Department of Surgery at Johannesburg Hospital and the Wits University.
5) Honorary treasurer – Prof Abdool-Carim, adjunct professor at Wits University. Prof Abdool-Carim is a vascular surgeon practising in both the public and private sector.
6) Honorary secretary – Dr Mark Human, orthopaedic surgeon in private practice at Olivedale Hospital.
7) Trade union representative – Dr Gary Reubenson, paediatrician at Rahima Moosa Mother and Child Hospital.

8) General practitioner representative – Dr Virginia Wilson qualified at Guy's Hospital in London.
9) Specialist representative – Dr Frans Korb, psychiatrist in private practice.
10) Marketing/projects co-ordinator – Dr Kyle Wilson, ex-physiotherapist, currently completing his second year internship at Helen Joseph Hospital.

Branch members without portfolios

11) Prof. Ames Dhali, director and head of the Steve Biko Centre for Bioethics.
12) Dr Alison Bentley is a world-renowned sleep specialist.
13) Dr Sindi van Zyl, the SAMA Gauteng branch chairperson 2012-2013. Dr Van Zyl, has a passion for primary healthcare and HIV.

Branch councillors 2013



Providing education and training to physicians on the art and science of Aesthetic Medicine

ABOUT AAAM™

AAAM is dedicated to the teaching of Aesthetic Medicine to licensed physicians who have a scientific and clinical interest in exploring and expanding the aesthetic medical facet of their practice. Regardless of specialty and experience level, AAAM membership and course participation are open to a wide variety of medical specialties: family and general practice physicians, obstetricians/gynaecologists, emergency medicine, cosmetic surgeons, dentists, and aesthetic medicine physicians, to name a few.

AAAM Board Certification in Aesthetic Medicine

AAAM Board Certification Courses are open to all licensed physicians, regardless of specialty. The courses are offered in three parts described below, culminating in your Board Certification. Each level must be completed in order and none may be skipped, regardless of knowledge or experience level. AAAM Board Certification is good for 10 years.

2 - 4 August 2013
17 - 19 January 2014
CERTIFICATE IN
AESTHETIC MEDICINE

3-DAY COURSE/ LEVEL 1

INTRODUCTION TO AESTHETIC MEDICINE:

- Skin Conditioning and Chemical Peelings
 - Skin Conditioning Program and classification
 - Chemical peeling agents and selection
 - Prevention and management of complications
- Botulinum Toxin and Fillers
 - Indications and consent
 - Patient selection
- Lasers, physical peelings and other technologies in aesthetic medicine
 - Lasers and their physics
 - Laser skin resurfacing
 - Body contouring medical devices

Live patient workshops

15 - 19 January 2014
DIPLOMA IN
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5-DAY COURSE/ LEVEL 2

COMPLETION OF AAAM LEVEL 1 REQUIRED

ADVANCED AESTHETIC MEDICINE:

- Pigmentary disorders
- Acne management
- Hair loss management
- Loco-regional anesthesia
- Nutrition & Hormones in Aesthetic Medicine
- Aesthetic Medicine & Phlebology
- Advanced Botulinum Toxin and Fillers
- Advances in Chemical Peels
- Small surgery for office procedures & acne

Live patient workshops

3 August 2013
BOARD CERTIFICATION
IN AESTHETIC MEDICINE

1-DAY EXAMINATION/ LEVEL 3

COMPLETION OF AAAM LEVEL 1 & 2 REQUIRED

6 months interval required after completing Level 2.

WRITTEN AND ORAL EXAMINATION:

Part 1: Written Examination (2 hours)
Part 2: Oral Examination (30 minutes)

Upon passing both exams, written and oral, graduates receive a Board Certificate and may refer to him/herself as a 'AAAM Board Certified in Aesthetic Medicine'.

MASTER COURSE IN HAIR TRANSPLANTATION SURGERY

5 - 7 September 2013

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- Workshop training demonstrations to teach latest techniques in Hair Transplantation.
- Workshop training.

Course for Nurses, Doctor's Assistants & Surgical Assistants

- Lectures & workshops using simulation techniques.
- Workshop training demonstrations on artificial Hair Graft preparation.
- Workshop training in Hair Graft Dissection and Graft Placement (using artificial tissue and live observation).



Registration Fees

BOARD CERTIFICATION IN AESTHETIC MEDICINE

	LEVEL 1	LEVEL 2	LEVEL 3
AAAM Member	ZAR 19 500	ZAR 33 600	ZAR 29 200
Non Member	ZAR 21 300	ZAR 35 400	ZAR 31 000

HAIR TRANSPLANTATION SURGERY FOR MEDICAL DOCTORS

AAAM Member:	ZAR 53 500
Non Member:	ZAR 55 300

HAIR TRANSPLANTATION SURGERY FOR NURSES / DOCTOR'S & SURGICAL ASSISTANTS

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