

SAMA INSIDER

DECEMBER/JANUARY 2017

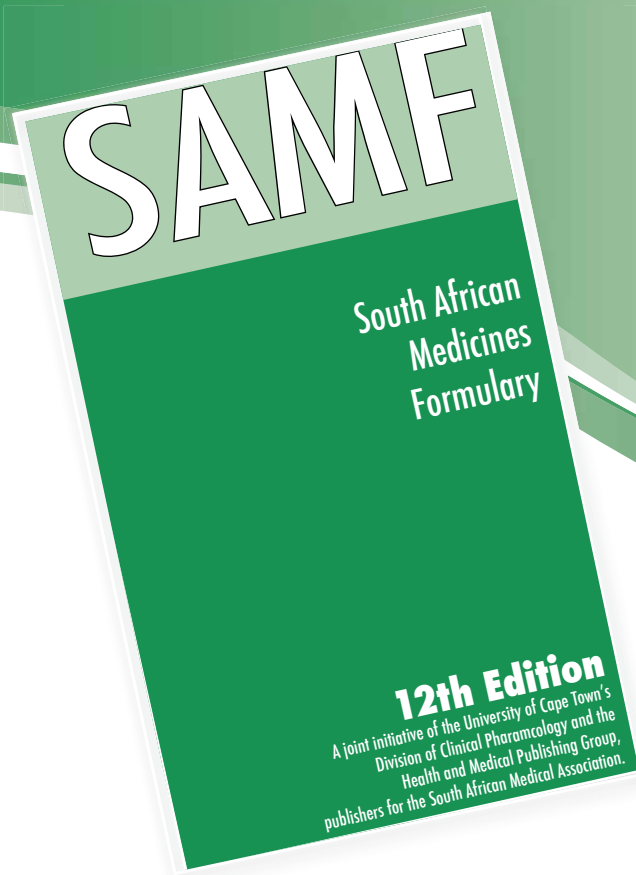
SAMA conference highlights universal access to healthcare

Refusal to treat – is it ethical?



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Diane de Kock
Editor: SAMA INSIDER

Ending the year well

For SAMA the year 2016 has been packed with challenges, change, communication, climate change and camaraderie among members. The SAMA conference this year highlighted universal access to healthcare, a vital issue in South Africa, and was an apt and successful end to the year.

Read about the conference on page 6 where the need for NHI was again emphasised by Dr Olive Shisana, former Department of Health director general. On page 4 Prof. Ncayiyana, in his President's Message, challenges his colleagues with the question: "Are we doling out too many drugs and performing too many unnecessary procedures?" Dr Mark Sonderup, on page 9, pays tribute to Prof. Denise White, outgoing president of SAMA. On page 10 Selaelo Mametja treats us to her impressions of the 67th WMA General Assembly in Taiwan and looks at the NHI system in that country.

Wendy Massaingaie, on page 13, tackles the contentious issue of direct payments to medical practitioners – the common practice of medical aid schemes not making direct payments to medical practitioners for services rendered.

"The determination about whether a medical practitioner can refuse to treat a patient, circumstances in which it may be deemed appropriate, and the patient's right to refuse to be treated, have been a conundrum for the medical profession through the ages," says Marli Smit in her article on page 16, which tackles the question: Refusal to treat – is it ethical?

On a happy note, two pages of branch news end this, our final magazine for 2016. Until we meet again in February 2017, may your 2016 end as you would like it to.

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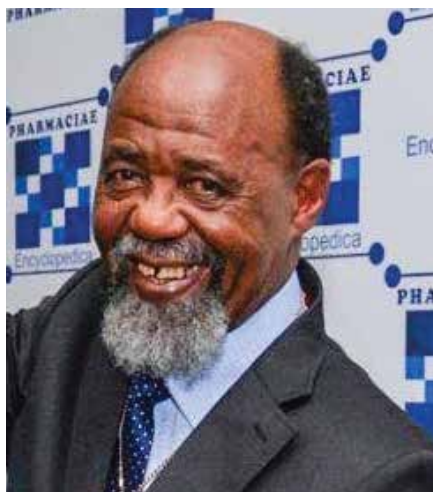
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Are we doling out too many drugs and performing too many unnecessary procedures?



Prof. Dan Ncayiyana, SAMA President

Well, how was your visit to the doctor today? my grandmother quizzed my aunt, who had just returned from a medical consultation when I was a youngster growing up in the KwaZulu-Natal countryside about 50 years ago. "Not good", my aunt replied. "The waiting room was full. It took a long time until it was my turn. And then he didn't even give me an *umjovo* (injection). "What? No *umjovo*?" My grandmother was incredulous. In those days, rural patients placed a high premium on injections, regarded as the ultimate – almost magical – cure, no matter what the ailment. A "good" doctor always gave you one, and doctors almost always indeed obliged, even if with a vitamin B or saline solution injection.

Medical practice has evolved exponentially since those days, in tandem with decades of massive advances in medical science, pharmaceutical discoveries and medical technology. But the phenomenon of patient expectations and the desire of (or pressure on) practitioners to satisfy them has remained the same.

The antibiotic conundrum

The public has come to expect and often demand a pill for every ill, and antibiotics for every sniff. This public attitude, along with aggressive pharmaceutical marketing tactics, has contributed to the indiscriminate use of antimicrobials over the last few decades. This, in turn, has led to the development of unacceptable levels of antimicrobial resistance for which the medical profession must accept

ultimate responsibility as the final gatekeepers. Antimicrobial resistance has become a huge worldwide phenomenon, with low- and middle-income countries bearing the brunt. Resistance to new-generation cephalosporin, for example, is highest in India at 75%, and lowest in Scandinavia where the rate of resistance is well under 5%. SA's rate lies somewhere in between at just over 25%.

Global initiatives have been established at national and international levels that seek to contain the problem through research, monitoring, education and helping shape policy. The Washington-based Center for Disease Dynamics, Economics and Policy (CDDEP), which has for some years been engaged in the effort to combat this problem, has observed how "addressing antibiotic resistance is difficult because patients, physicians, hospitals, pharmaceutical companies, and agricultural users have insufficient incentives to act in ways that would conserve antibiotic effectiveness." CDDEP has sponsored the Global Antibiotic Resistance Partnership (GARP) with the mandate to monitor and document antibiotic use and to track antibiotic resistance in the human and animal populations in every country. GARP then collates the national data at the global level in order to track the resistance patterns across the world. SA is one of the panel of five core nations in this initiative, and is a leading contributor to the work of GARP.

Futile procedures and drugs that kill slowly

Turning now to medical procedures and drugs in general, Peter C Gotzsche, a Danish researcher and leader of the Nordic Cochrane Centre in Copenhagen, asserts – with reference to Western countries – that "general practitioners have no idea that they on average kill one of their patients per year" through their prescribing practices. While this may seem like a rather bold overstatement, there is no gainsaying the fact that patients across the globe do die from side-effects of medication and medical procedures whose risks turn out to far outweigh the benefits.

Recent years have seen an explosion of new drugs, diagnostic technologies and therapeutic procedures for all kinds of medical conditions, the benefits of some of which are either controversial or unproven. Then there are drugs and procedures that offer minor potential bene-

fit relative to their potential risk for harm. There has also been an explosion of medical journals and published articles that often present ambivalent, contradictory or flatly false findings on treatment modalities. This is one reason the "evidence-based medicine" or EBM movement was born, which gained considerable traction in the 1980s to date. EBM sought to empower physicians to identify and only apply research findings at the bedside that had been proven to be valid. But EBM in its pure form is, in some ways, too academic and theoretical for application by practitioners in busy practices and, in any event, EBM has had its detractors as well. Separating the research chaff from the grain has become very difficult, and one can, at some level, understand doctors' vulnerability to pharma propaganda and patient demands.

Do you prescribe statins? According to *BMJ* blogger David Gillespie, statins are "the single most profitable drug ever made" and are being handed out "like lollies at the school fete", yet they have no proven benefit of reducing the likelihood of a fatal heart attack among healthy individuals with no previous history of a heart attack. Conversely, they have serious side-effects that include type II diabetes, muscle damage, memory impairment, and liver and sexual dysfunction. The efficacy v. harm of many other drugs has been questioned, including antidepressants, non-steroidal anti-inflammatory drugs (NSAIDs), and long-acting beta-2 agonists for asthma.

Overservicing by way of laboratory tests and radiological examinations is rife. The Academy of Medical Royal Colleges is urging medics to choose wisely and not dole out prescriptions or refer patients for tests simply because they feel under obligation. Their "Choosing Wisely" campaign recently published a list of 40 interventions that the various royal colleges consider unnecessary, including chemotherapy in terminal cancer, routine prostate-specific antigen (PSA) screening tests and X-rays for lower back pain.

Gotzsche advises doctors to "[m]ake fewer diagnoses, prescribe fewer drugs and tell the patients to read the package insert . . . Then they might never take the drug." He goes on: "Many years ago I did research on naproxen and when I read the package insert and realised in how many different ways this drug could kill me, I decided never to take an NSAID."

An official response on the NHI White Paper

SAMA Communications Department

This is the fifth 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 a brief summary of the eighth and ninth chapters of the submission:

Chapter 8: Moral hazard

Chapter 8 describes the dilemma of potential moral hazard within NHI. The White Paper identifies the risk of moral hazard (paragraph 137) from both the users and providers' side, and recognises some of the possible mitigating interventions against moral hazard (paragraphs 138 and 325). The meaning of moral hazard is explained.

This chapter evaluates the merits of such interventions against international literature and best practices. From the NHI beneficiary's side, patients are incentivised to overuse NHI services or indulge in health risk behaviours (such as smoking), knowing that they are not paying directly for the costs. From the suppliers' side, health professionals are likely to overservice for their own interests. (However, underservicing is more likely under a capitation system.) Both types of moral hazard drive up costs.

SAMA supports the use of treatment guidelines and protocols, which must be evidence-based and cost effective

To reduce hospital and professional moral hazard, SAMA supports the use of treatment guidelines and protocols, which must

be evidence-based and cost effective. To reduce user-side moral hazard, two standard mechanisms are propounded:

- **Co-payments** – In congruence with the White Paper, SAMA does not support this as it may reduce access to care and may entrench inequalities.
- **Gate-keeping** (paragraph 128) – SAMA supports this intervention with the GP as the central figure. However, the envisioned bypass fees (paragraph 148) must be properly defined. What proportion does the patient pay? Fees must be set in such a way that inequities are not promoted, i.e. high socioeconomic strata continually accessing unnecessary specialised care because of ability to pay.

Chapter 9: Corruption

In considering NHI as a new funding system for SA, SAMA members identified corruption as a serious risk for successful and sustainable NHI. The NHI White Paper acknowledges the threat of corruption, noting that the NHI Fund itself may fall prey to the temptations of corruption (paragraph 375). Chapter 9 turns the spotlight on corruption, recognising it as the vicious cankerworm that is eating away at our health system and posing a serious threat to the achievement of health outcomes.

General corruption and corruption in the health sector is a global problem; there is increasing concern worldwide about the adverse effects of corruption on the developmental agenda in terms of attainment of Millennium Development Goals (now Sustainable Development Goals).

In Africa, big scandals involving officials and leaders in both government and private circles have been reported. SA is no exception, where grant corruption is reported in common media and by advocacy groups such as Corruption Watch. Recent international data categorise SA among countries perceived to have serious corruption, ranked 61 out of 170 countries and with a corruption score of 44 (100 being perfect and 0 being completely corrupt). A unique aspect in the SA context is the

question of trustworthiness of government. It is recognised that trust must be earned. This chapter strongly points out that the apparent societal (SA) suspicion of (and diminishing confidence in) political leaders and/or government institutions has relevance in the search for right solutions.

Corruption . . . the vicious cankerworm that is eating away at our health system

Corruption is not just about money. Systemic corruption rampant in our health sector and the SA health sector in general, takes many forms: contemptible so-called "tenderpreneurship", cronyism, kickbacks, theft of time (absenteeism), bribery, medical scheme fraud, and theft of medicine, among other things. Besides being severely costly to the system, corrupt behaviour is unacceptable and puts anyone who practises it – health workers included – at odds with ethical expectations of good professional practice.

By way of recommendation, this chapter emphasises the need to strengthen transparency and control, as well as prosecution. Absenteeism of state employees can be addressed by measures such as better working conditions, including better management of remunerative work outside the public service (RWOPS), establishment of a Commission of Inquiry to interrogate state sector absenteeism, and better remuneration, including performance bonuses for clinicians.

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

SAMA conference highlights universal access to healthcare

SAMA Communications Department

SAMA recently held its annual conference at the Sandton Convention Centre from 21 to 23 October. The event was attended by more than 330 doctors from across the country who gathered for the chance to hear health experts, and leaders in the health sector, speak on a range of topics.

The theme of the conference was "Universal Access to Healthcare". In line with this, the former Department of Health director-general, Dr Olive Shisana, spoke of the need for NHI. Dr Shisana stressed the importance of the system. She said much planning has gone into developing a system that is

both equitable and available to all South Africans.

Dr Shisana admitted that while it is the goal of the government to implement an accessible system, there are still challenges to overcome to achieve this objective.

Apart from the NHI, the conference delegates also heard from experts on topics ranging from breast cancer and prostate cancer screening to diabetes and integrative medicine in private practice. The worldwide problem of the Zika virus was also discussed with Dr Lucille Blumberg of the National Institute for Communicable Diseases, with the local risks highlighted. Dr Blumberg noted that while globalisation has played a big part in the spread of the disease, SA is at low risk of an outbreak, although she warned that vigilance is necessary to maintain this status.

In addition to the medical topics discussed, the conference had presentations on the wellness of doctors, the management of private medical practices, issues relating to the Road Accident Fund (RAF), and the role medical schools need to play to respond to the health challenges in SA. Important legal matters facing doctors, and the health profession generally, were also reviewed, along with issues on medical aids and how they interact with the medical profession.

Speaking after the conference, SAMA chairperson Dr Mzukisi Grootboom noted that it was an important conference dealing with matters doctors have to grapple with daily.

"This conference not only provides a forum to discuss important medical issues but brings together experts in a range of specialties that are related to the medical profession. These provide an extra dimension to the conference because they give the delegates a little extra information they need to be more effective managers, as well as more effective medical professionals," he said.

A highlight of the conference was the annual Doctor's Awards that were presented to recipients on Saturday evening. The winners of these awards were: Dr Heike Geduld (Gender Acclaim Award), Prof. Linda Gail Bekker (Fellowship in Art



Dr Grootboom opens the conference



Recipients of the annual Doctor's Awards

and Science of Medicine Award), Prof. Delawir Kahn (Extra-ordinary Service to Medicine Award), Prof. T E Madiba (Lifetime Achievement Award), Dr Andrew J Ross (Spirit of Medicine Award), Dr Nastassja Koen (Young Leaders Award: Research), Dr Allan-Roy Sekeitto (Young Leaders Award: Healthcare), Dr Loganathan Naidoo (Community Service Award), Dr Neil Comley (Service Excellence in the Private Sector), and Prof. Denise White (SAMA Award of the Year).



The SAMA stand



At the gala dinner



The product most recommended by doctors for scars and stretch marks.



SAMA award recognises SADAG's 20+ years of helping patients

SADAG recently received a SAMA award recognising their outstanding contribution to society

The South African Depression and Anxiety Group (SADAG) is the largest patient advocacy organisation in southern Africa. SADAG is now in its 23rd year, and our commitment to raising awareness about mental health issues only deepens. SADAG engages in a number of projects and services, including a call centre, a mental health journal, awareness campaigns, rural outreach programmes, school talks, corporate wellness days, and advocating for patient rights in the public and legal sectors.

SADAG runs 16 dedicated toll-free lines, which offer free telephonic counselling to callers throughout the country. This includes the only suicide crisis line in SA. The helplines offer counselling, referrals, information and support to patients, loved ones, family members, teachers, colleagues, etc. These helplines provide free telephonic counselling 7 days a week, including public holidays such as Christmas Day and over the Easter weekend, from 08h00 to 20h00, with access to a 24-hour emergency helpline, all of which are answered by trained SADAG counsellors. SADAG counsellors also receive and respond to over 50 emergency SMSs on average per day. Examples of the SMSs received include: "Help", "Urgent, please call back", and "Suicidal, need help".

Through these helplines patients have access to our extensive referral guide of psychiatrists, psychologists, clinics, hospitals, support groups, free counselling centres, trauma centres, other NGOs and organisations. If necessary, counsellors offer other relevant referral information that would help or assist the patient in their treatment programme, including self-help tips, relaxation tools, mood diaries, online resources, etc. The call centre receives over 400 calls a day, showing that the service SADAG provides is of the utmost importance. Mental illness is among the chief causes of disability and lack of productivity, as well as negatively impacting quality of life.

In a developing country such as SA, there is a definite lack of access to help and support services for many people, especially those in historically disadvantaged communities. Therefore, it is a matter of great urgency to raise awareness and procure access to services for patients in need, through continual campaigning and advocacy. The stigma that is still faced by those with mental health problems is significant, and normalising the experience of patients and their families is very important for a future where mental health is taken seriously.

One way in which SADAG does this is through the continual training and main-

taining of support groups. SADAG is currently affiliated and involved with the training and running of over 200 support groups across all nine provinces. The aim of these is to utilise the power of the community, in mobilising people who are willing to help, and bringing those in need together. They can share their experiences, learn from each other, and begin their journey back to health in a safe and non-judgemental environment.

SADAG is immensely proud of being recognised by SAMA for the work that we do. The award was given to "an individual or organisation which has made outstanding contribution to society", and SADAG will continue to strive for patient rights in all spheres of mental health. We will continue to give voice to those who are often silenced due to stigma and taboo, and we will continue to fight for patients who are among the most vulnerable in our society.

As chairperson of SADAG, Dr C Linde states: "Everybody needs access to mental health services and treatment. From a community perspective everyone is equal. The word community is the most important, and everyone should be treated equally. Community is wider than just you and me, it is everyone in the country. SADAG is for everyone. We touch the whole country and beyond."



Dr K Spencer, Gauteng branch chairperson (left) and Prof. L Green Thompson, branch president (right) present the award to Dr C Linde and Dr F Korb

Tribute to Denise White, 2016 SAMA President

Mark Sonderup, SAMA

Denise Ann Campbell White was born in New Zealand and moved to SA at a young age, going on to study medicine at the University of Cape Town (UCT) and later qualifying as a psychiatrist at Groote Schuur Hospital and UCT. I came to know Denise as a registrar at Groote Schuur, where she was already the longstanding chairperson of the hospital's Fulltime Practice Doctors Committee (representing doctors in the public sector). The relationship between doctors and province was always a little strained, so it made for interesting interaction with provincial Department of Health (DoH) management. Groote Schuur doctors embarked on a major legal challenge regarding overtime and other payments to doctors at senior level. An immediate legal fund was set up and the challenge was eventually successful.

In 2003, the provincial DoH decided to unilaterally alter the terms of commuted overtime for doctors – an issue that remains problematic to this day. Conveniently, the context and history of the implementation of commuted overtime is somehow forgotten by authorities. Major criticism was levelled by Denise (and I, on behalf of registrars at that time) both at a national level and provincial level. This struck a chord and a doctors' meeting, to be addressed by the then chair of SAMA, and attended by media, was disallowed by provincial and hospital authorities.

She remains an example of what it means to serve

Thanks to Denise's quick thinking, she obtained immediate permission from the then head of psychiatry to have a meeting in the Psychiatry Department at Groote Schuur. Technically this was on "UCT" property but wholly within the hospital, and the meeting simply relocated and continued, very successfully. Plans to tinker with the commuted overtime process were eventually withdrawn, directly due to the firm and decisive leadership that Denise demonstrated. Denise was never loud or populist; her approach reflected the very essence of who she is – humble, principled, quiet, yet determined and unshakeable.

After serving as the academic doctors' representative on the Fulltime Practice Committee of SAMA, Denise was later elected as the chair of that committee, and in 2007 was elected as the vice-chairperson for SAMA. 2009 was an eventful year. In January 2009, the SAMA chairperson was recalled by a special National Council and Denise immediately became acting chairperson of SAMA. As tough as it was, she took it in her stride. In June 2009, the first-ever national doctors' strike erupted around the occupational specific dispensation (OSD) issue reflecting years of doctors' frustration with the way we are treated. Denise dealt with a very difficult situation the only way she knew – she led from the front and put herself on the line. Just prior to the 2-week doctors' strike, Denise led a doctors' march on Parliament to hand over a memorandum to Government. In front of Parliament, on the back of a flat-bed truck, Denise rallied doctors in a show of defiant unity and a stand against the intransigence shown around dealing with the OSD negotiations.

Later in 2009, she stepped down as chairperson at the scheduled National Council, unfortunately not being allowed the opportunity to see out the Council meeting. This decision, incorrectly, was made in an acrimonious atmosphere that should never be allowed to happen again. Doctors have the uncanny ability to treat each other with a degree of vitriolic intent, something we as SAMA need to guard against. Her exit from SAMA at a national level was gracious and coincided with her retirement from the public sector. She, however, remained committed to the Cape Western Branch, regularly attending meetings. She went on to serve as honorary president of the branch.

Retirement allowed her to do some locum time and she returned to New Zealand to work. Although I have never quite established the facts, rumour has it that she organised and unionised doctors in the hospital where she worked as she felt they were being treated unjustly. Denise, in her indefatigable way, told me how unfairly she thought New Zealand doctors, and even psychiatry patients, were being treated. True to form, she stood up for what she believed was unjust and unfair.



Prof. Dan Ncayiyana, presents a bouquet to Prof. Denise White

It was therefore very fitting that the National Council elected her to serve as SAMA president for 2015/2016. Even more fitting was her being the 2016 SAMA Award of the year recipient. Denise served her tenure as president very ably. She was a sounding board for advice and her expertise in the public sector structures of SAMA were available at an apt moment in the Association's history. Denise, I think SAMA should leave you alone now – more we cannot ask or expect from you. You have given more than most to the profession and the Association. For this SAMA is truly grateful. Recently the Chief Justice, Mogoeng Mogoeng, said at the OR Tambo Memorial Lecture, "We must avoid becoming positional leaders; you can be an effective leader without occupying any position". This in my view sums up Denise – she remains an example of what it means to serve.

The 67th WMA General Assembly in Taiwan – looking at National Health Insurance

Selaelo Mametja, *Head of Knowledge Management and Research Development, SAMA*

I attended the 67th WMA General Assembly in Taiwan. Dr Tzou-Yien Lin, Taiwanese minister in the Ministry of Health and Welfare, impressed me with his talk titled “The Roadmap for Better Healthcare in Taiwan”.

The first thing that grabbed my attention was that the Taiwanese National Health Insurance (NHI) is only 22 years old, but covers more than 99% of the population and has a sizeable surplus. The services are predominately provided by the private sector, and all Taiwanese citizens have equal access to care and a choice of professional and level of care. I was quite gobsmacked that such a young NHI scheme has achieved so much in such a short period of time.

To be honest, I was envious. These issues are central to our own NHI debate. Our target period is 14 years. I am anxious about the 14-year target, given the developments in the pilot project, and the service delivery platform has not been defined. Will it be public, private or both? Will NHI cover both primary healthcare (PHC) and hospitalisation in both sectors? To date, only provision in the public sector has been piloted. Will we be able to cover the entire population? What is the package of care? Free of charge at point of care? How about moral hazard? So we think gatekeeping is a good rationing strategy; how did the Taiwanese Ministry of Health manage to curb moral hazard for overuse without any gatekeeping system? Naturally, his talk caused me anxiety, depression, and excitement all at the same time, but prompted me to read further on the Taiwanese NHI, hence this write-up.

Taiwanese NHI system

Taiwan is country with a land area of 35 801 km². The country is made up of a main island, offshore islands, and mountainous regions. In 2010, its population reached 23 million. It has an ageing society that encompasses about 10.7% of its population. Taiwan's birth rate has steadily declined over the years and currently is one of the lowest in the world, at 0.895%. The life expectancy rate is 76 (male) and 83 (female). The GDP is USD18 588 per capita and the national health expenditure in GDP is 6.9%. Taiwan experienced an annual

economic growth averaging 6.4% between 1960 and 1980. The government managed to avoid wide income gap distributions often associated with economic growth.

The healthcare in Taiwan is provided mostly by the private sector (70% of beds). Before adoption of NHI, only 57% of the population was covered by insurance. This insurance covered farmers, government, and private sector workers. Most of the GPs were practising independently, and there was a high out-of-pocket payment.

The NHI was instituted in 1995, consolidating all the insurance schemes. It is a single-payer, compulsory social insurance plan that centralises the disbursement of healthcare funds. NHI is financed through premiums via payroll tax. Government subsidy and out-of-pocket payments supplement NHI. The government and employers subsidise a portion of the premium. The government contributes the entire premium for the unemployed, and a portion for low-income earners. The insurance premium rate for 2016 is 4.69%.

We should not be aiming for a Rolls Royce when we can afford a skedonkie

The NHI premiums are determined by the Executive Yuan (parliament). Often the parliament is resistant to increasing premiums, in order to maintain popularity. Except in the first 3 years of implementation, NHI expenditure exceeded the revenue collection. In 2013 Taiwan adopted the second generation of NHI, where a supplementary 2% premium was imposed on high-bonus, professional-practice income, and interest, dividend, rental and part-time job income. The reform has enabled the NHI to not only cover its annual healthcare expenditures but also to eliminate accumulated deficits from prior years. The NHI operates with a sizeable surplus.



The Palace Museum in Taiwan

Service delivery platform and reimbursement mechanism

Services are provided by both public and private sectors. On implementation, fee-for-service was used, and soon the fund ran into problems due to overservicing. To curb overservicing and threats to sustainability, the global budgets were introduced. By setting a global budget, government gained some control over healthcare expenditures and can plan for revenue needs. This was changed to global payments, with management of service providers and doctors. Healthcare delivery is dominated by the private sector. The global budget threatened quality of care as it incentivises profit maximisation at the expense of quality care. For example, by “cherry-picking” the healthiest patients most likely to perform well on selected measures, physicians were able to play the system and potentially reap the rewards of higher pay-for-performance payments without actually improving the care of all of their diabetic patients.

Benefit package

The Taiwanese system has a comprehensive package which spans from uterus to grave. The package includes Western and Chinese medicine (yes, ginseng and acupuncture are included), dental care, optical care, PHC and hospitalisation. The long-term care plan was added in 2007 to provide care and support to the ageing population.

Moral hazard

The Taiwanese system allows for a wider choice of professionals and service pro-

vider; however, co-payments are levied. These co-payments are generally low. Ranging from TWD50 (equivalent to ZAR21) for PHC to TWD210 (equivalent to ZAR90) for a specialised centre. An extra 60% of the normal co-payment is charged in local hospitals and 70% in regional hospitals and medical centres to promote the referral system. Veterans, those on low incomes, people from remote mountain areas and outlying islands, those suffering from major illness and injury, and women undergoing child delivery are exempt from co-payment. Follow-up visits are also exempt from co-payment. The characteristics of ambulatory care in Taiwan differ somewhat from those in other countries. Utilisation is extremely high; patients average approximately 13.5 visits per year, primary care workloads (the number of patients seen per day) are also relatively high in Taiwan compared with other countries, and the duration of patient visits with the physician is very short – often 2 - 5 minutes. There is a large amount of “doctor shopping” – where a patient sees many doctors for the same problem, compromising continuity of care.

My conclusion

The NHI success was due to rapid economic growth, very low unemployment rate, and improved social determinants of health (and probably a healthier nation), which uplifted the living conditions of the Taiwanese. Unfortunately, in SA, NHI implementation has coincided with slow economic growth, high unemployment rate, high inequalities in income, and inequalities in education.

Taiwan is truly an egalitarian state; equal access is for all. The income is equally distributed among citizens. The current SA NHI debates are centred around socio-economic class with opponents of NHI arguing that the State should focus on the poor and the private sector should focus on the rich. SA has gone down this road before. In 1948 Gluckman recommended universal coverage, and his recommendations were not implemented because of racial policies. In my view any policy that promotes segregation is likely to fail.

The Taiwanese government uses its power as a single purchaser to determine prices and set global budgets; this enables purchase of healthcare from the private and public sectors and controls expenditure. Our

Ministry of Health should leverage on the monopsonous power proposed in the White Paper to negotiate access to the private sector, especially general practitioners.

While the free choice of hospitals and health professionals is appealing to the covered population, it may affect continuity of care. I think an average of 14 consultations per capita per annum is very high. Maybe the Taiwanese could learn one or two things about integrated healthcare, aka the “supermarket approach” practised in the public sector by PHC professionals.

It is clear the fee-for-service plan did not work for Taiwan. We know fee-for-service has not worked for private medical schemes, and it is something we should avoid like the plague. I am quite attracted to the pay-for-performance idea; it seems fair, and the fund and taxpayers would be getting value for money. However, I am concerned about the SA government’s monitoring performance. This is something that we could start implementing, or rather should have implemented in pilot sites.

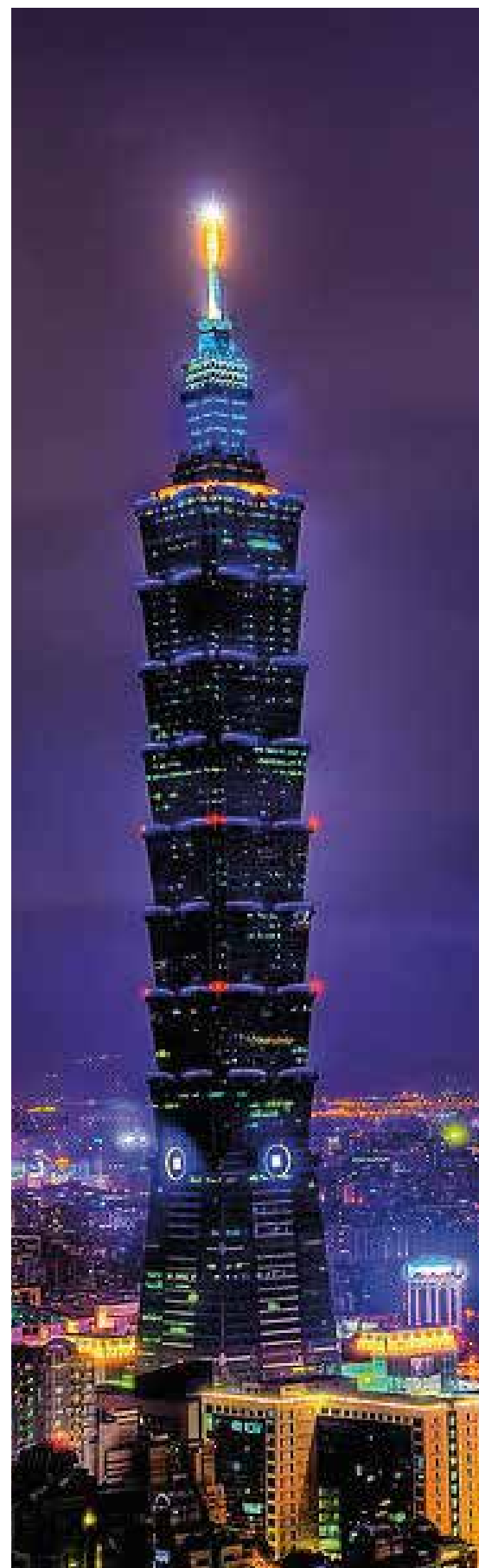
Exempting the vulnerable from co-payment ensures improved access to healthcare. In order to promote PHC as gatekeeper, the SA NHI White Paper recommends co-payments. This caused anxiety in specialist clinics serving vulnerable populations; one such is psychiatric patients who often have to refer themselves to hospitals. The health minister could also consider exempting the vulnerable populations who self-refer to hospital.

We South Africans should start working together for a better health system and successful NHI. The odds are against us, but I believe, united we can overcome. As a medical student once said, NHI is a vehicle for healthcare, what we can afford becomes a vehicle. We should not be aiming for a Rolls Royce when we can afford a *skedonkie*. We must, however, uphold the principle of solidarity by pooling our financial and health risk.

Right now I can afford my healthcare; what happens if I live beyond 65? Who will pay for my healthcare when I am 80? With no answers, I thought relocating to Taiwan might be a solution for my old-age poverty. The entire talk was based on their strategy to look after the elderly; I am sure they would cater for me as a refugee.

Xie Xie (Thank you in Chinese)

References available on request.



Taiwan 101, the tallest building in Taiwan

Social determinants of health: Role of the SA medical profession

Bernard Mutsago, SAMA Health Policy Researcher and Analyst

As we are currently witnessing, SA society and the science community are increasingly awakening to the harsh reality of social determinants of health (SDH) in our society, and the growing international movement on this theme.

The WHO defines social determinants of health as *"the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."* These conditions and forces include a range of social, political, economic, environmental and cultural factors, including human rights and gender equality. Evidence attests that in many societies unhealthy behaviours follow the social gradient: the lower people are in the socioeconomic hierarchy, the more they smoke, the worse their diet, and the less physical activity they engage in.

In SA, poverty and inequality are the main SDHs. The incorporation of SDHs in the National Development Plan 2030 is a positive indication of the growing recognition of the merits of a social determinants approach. This is of great relevance in SA, given the high inequality that has existed pre- and post-

apartheid. The acknowledgement of SDHs in the NHI White Paper is also encouraging. Universal health coverage and SDHs are complementary: both are essential to population health.

A growing body of evidence supports the realisation of health as a social phenomenon. The WHO definition of health as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* weaves a social strand through the definition and experience of health, and places a premium on social context of health. Heeding the compelling evidence of the social effect on health, the WHO established a Commission on Social Determinants of Health in 2005 to champion a global movement to realise equality in health by tackling the inequitable distribution of power, money and resources, among other interventions. In 2008 the WHO released its famous report entitled *Closing the gap in a generation: Health equity through action on the social determinants of health*. The Rio Political Declaration on Social Determinants of Health was adopted during the World Conference on Social Determinants of Health on 21 October 2011.

On 23 and 24 February 2017 SAMA, in collaboration with the University of the Witwatersrand (Wits), will host an international Summit on Social Determinants of Health, where the renowned, London-based Sir Michael Marmot will be the keynote speaker. Several delegates from other countries, mainly African states, will also attend the Summit. The Summit comes at a time when SA is confronted with cruel evidence of inaction on SDHs – poor quality of education, high disease burden, poverty, low quality of life – and mounting pressure to address them.

Aptly themed *"Addressing health inequalities: Whose responsibility?"*, the upcoming 2017 SAMA/Wits Summit recognises – in line with international evidence – that the *"upstream"* factors that influence health (such as housing, education, employment, food security, early childhood development) lie outside the health sector itself. Therefore, **addressing SDHs is the responsibility of multiple players/sectors**, i.e. intersectoral collaboration is necessary. This is the essence of the WHO's *"health in all policies"* (HiAP) approach. While the primary obligation to deal with SDHs rests on Government, major international health bodies such as the WHO and the WMA have advocated for the increased role of health professionals in reducing health inequalities through action on the social determinants of health.

The WMA's 2015 Declaration of Oslo on Social Determinants of Health recognises that *"the medical profession can be advocates for action on those social conditions that have important effects on health"*. SAMA, as a member of the WMA, encourages its doctors to embrace the agenda of population-level preventive healthcare and the SDH approach. SAMA seeks to promote greater understanding of SDHs among the medical profession and recognises that this calls for a paradigm shift from the traditional biomedical view of medicine. In the spirit of health for all South Africans, SAMA wants to work with Government to ensure that the multisectoral/whole of Government/whole of society approach is practically effected in SA. Where necessary, the health and medical fraternity will/should exert pressure on Government to realise this.

Addressing health inequalities: Whose responsibility?



Conference dates: Thursday 23 February
and Friday 24 February 2017

Venue: Resource Centre
Wits School of Public Health Building
27 St Andrew's Road
Parktown
Johannesburg

For further information:
Contact: Dr Sumaya Mali
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Direct payments to medical practitioners

Wendy Massaingaie, Legal Advisor, Governance and Legal Department, SAMA

The matter at hand deals with the common practice of medical aid schemes not making direct payments to medical practitioners for services rendered. Upon receiving an account, medical aid schemes make payments to their members, as opposed to paying the medical practitioners. This practice creates difficulties when medical practitioners have to collect the amounts from the members. It is common cause that in most cases, once members receive the funds from the medical aid schemes, they use the funds for other purposes and the medical practitioners are left without receiving the payments.

Research

In addressing this query, I consulted the Medical Schemes Act 131 of 1998; Medical Schemes Act 131 of 1998 Regulations; and the *Sechaba Medical Solutions & others v Sekete & others* (216/2014) [2015] ZASCA 8 (11 March 2015) case.

Information obtained

The Medical Schemes Act

Section 26 of the Act deals with the effect of registration; it reads:

"(1) Any medical scheme registered under this Act shall -

(a) become a body corporate capable of suing and being sued and of doing or causing to be done all such things as may be necessary for or incidental to the exercise of its powers or the performance of its functions in terms of its rules;

(b) assume liability for and guarantee the benefits offered to its members and their dependants in terms of its rules."

Section 59 of the Act is concerned with charges by suppliers of service; it provides:

"(2) A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.

(3) Notwithstanding anything to the contrary contained in any other law a medical scheme may, in the case of -

(a) any amount which has been paid bona fide in accordance with the provisions of this Act to which a member or a supplier of health service is not entitled to; or

(b) any loss which has been sustained by the medical scheme through theft, fraud, negligence or any misconduct which comes to the notice of the medical scheme;

(c) deduct such amount from any benefit payable to such a member or supplier of health service."

It is undeniable that medical aid schemes have been interpreting the Medical Schemes Act to mean that they have a discretion as to whether to make direct or indirect payments, which interpretation was incorrect

The Medical Schemes Act Regulations

Regulation 6 deals with the manner of payment of benefits; it reads:

"(2) If a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform both the member and the relevant health care provider within 30 days after receipt of such account, statement or claim that it is erroneous or unacceptable for payment and state the reasons for such an opinion.

(3) After the member and the relevant health care provider have been informed as referred to in subregulation (2), such member and provider must be afforded an opportunity to correct and resubmit such account or statement within a period of 60 days following the date from which it was returned for correction.

(4) If a medical scheme fails to notify the member and the relevant health care provider within 30 days that an account, statement or claim is erroneous or unacceptable for payment in terms of subregulation (2) or fails to provide an opportunity for correction and resubmission in terms of subregulation (3), the medical scheme shall bear the onus of proving that such account, statement or claim is in fact erroneous or unacceptable for payment in the event of a dispute."

Sechaba Medical Solutions & others v Sekete & others (216/2014) [2015] ZASCA 8 (11 March 2015)

The case set a new precedent in the manner in which medical aid schemes have been interpreting the Medical Schemes Act. In addition to the above, the judgment in this case makes it clear that medical practitioners should be paid directly by medical aid schemes. The judgment emphasises that the purpose of receiving pre-authorisation from the medical aid scheme is to confirm that they shall be liable for payments connected with the services rendered by the medical practitioner.

The judgment re-emphasises that the intention of the Medical Schemes Act was not for medical aid schemes to use their discretion in deciding whether to pay the member or the medical practitioner; it reads:

"[25] It seems to me that when a member obtains medical services and arranges for the service provider to submit their account to the medical scheme, they are authorising the medical scheme to pay the service provider and not the member. The position is different where the member pays the service provider directly and seeks reimbursement. That is the alternative contemplated by s 59(2), namely payment to the member."



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Medical Schemes Appeals Committee: Pay v SAPS Medical Scheme (April 2016):

3.4.1. The Medical Appeals Committee confirmed the ruling in the *Sechaba Medical Solutions & others v Sekete & others* case; the Committee stated:

"7. Thus, the registrar's finding that the scheme is, in the absence of a contractual relationship between the service provider and the scheme, not obliged to pay the provider directly for services rendered to the scheme's member, is no longer good law."

"13.1. It is declared that the scheme's conduct in refusing to pay the appellant's claims directly to her after rendering services to the scheme's members is inconsistent with section 59(2) of the MSA."

Recommendations

Medical aid schemes should be urged to take cognisance of the judgment in the *Sechaba Medical Solutions & others v Sekete & others* case, as it was delivered by the Supreme Court of Appeal, the second highest court in SA.

"4.2. As stated in Regulation 6, medical practitioners can resubmit their accounts to medical aid schemes for payment of same, and the medical aid scheme shall bear the onus of proving why the payment cannot be made.

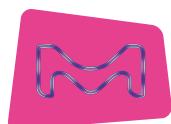
4.3. Dialogue with the Council for Medical Schemes, so that medical aid schemes can apply the correct interpretation of the Medical Schemes Act."

**It is clear that medical aid
schemes are
obliged to compensate
whoever rendered
the account**

Conclusion

From the above, it is clear that medical aid schemes are obliged to compensate whoever rendered the account. For instance, where the member pays the medical practitioner directly, they can claim the amount from the medical aid scheme; however, where the medical practitioner renders the account directly to the medical aid scheme, the medical aid scheme should make the payment directly to the medical practitioner.

It is undeniable that medical aid schemes have been interpreting the Medical Schemes Act to mean that they have a discretion as to whether to make direct or indirect payments, which interpretation was incorrect. As outlined above, in cases where the payments were not *bona fide*, the scheme can withhold or retract payments.



MERCK

SEDASA touches base with colleagues at grassroots

Dr Ayodele Aina, SEDASA National Chairperson

The Senior Employed Doctors Association of South Africa (SEDASA) made random provincial support visits in order to touch base with colleagues and members at grassroots.

This initiative was applauded. Members vociferated: "We need firm, highly visible interactive leaderships in SEDASA (and SAMA), while we acknowledge and appreciate the different dynamic styles of leadership in SEDASA and the mother body [SAMA]."

Noting the above empathy from members, as SEDASA national chairperson, I am committed to give feedback to the current leadership of SEDASA, work around a progressive and sustainable strategy within the SEDASA leadership team and engage with higher SAMA organisational structures if need be.

The efforts of all SEDASA members who engaged during the provincial support visit are hugely appreciated, and your commitment for passionate membership participation is on record. SEDASA leaderships, your daily

relentless sacrificial dedication in service is not unnoticed, I thank you!

SEDASA wishes all colleagues who newly voluntarily completed SAMA membership (recruitment) forms during the provincial support visits, existing members, leaders, and SEDASA/SAMA extra-milers a cheerful and exciting festive season.

SEDASA leaders - If your actions inspire others to dream more, learn more, do more and become more, you are a leader. A leader is one who knows the way, goes the way, and shows the way. Ultimately, leadership is not about glorious crowning acts. It's about keeping your team focused on a goal and motivated to do their best to achieve it, especially when the stakes are high and the consequences really matter. It is about laying the groundwork for others' success, and then standing back and letting them shine. - Chris Hadfiel



Dr Aina in Cape Town

Expansion of the NAPPI code to 7 digits

Private Practice Department

The National Pharmaceutical Product Interface Code (or NAPPI® code as it is commonly known) is an intelligent, unique national coding system for all pharmaceutical, surgical and healthcare consumable products available in the SA private healthcare sector.

NAPPI codes have successfully enabled reliable and efficient electronic claims processing for almost 30 years in SA and there are currently almost 300 000 active NAPPI codes in the industry.

NAPPI codes will be expanded to a length of 7 digits to continue meeting the requirements of all industry stakeholders. The implementation date for this change will be

1 March 2018, allowing sufficient time for all users of NAPPI codes to cater for this change.

The implementation date for this change will be 1 March 2018

Please note that it is the responsibility of each organisation affected by the changes

to evaluate the impact of this change, and then plan and implement their changes by the abovementioned implementation date accordingly.

Since this change will also affect how organisations interface with each other, each organisation will need to co-ordinate with their interfacing parties to ensure changes are tested and implemented by the implementation date.

For further details of this implementation, please refer to the Technical Guidelines document published on the MediKredit website: https://www.medikredit.co.za/index.php?option=com_content&view=article&id=93&Itemid=213

Refusal to treat – is it ethical?

Marli Smit, Senior Legal Advisor, SAMA

The physician-patient relationship is the cornerstone of medical practice and therefore of medical ethics. This relationship is not one which can (or should be allowed to) be influenced by any one rule or ideal, other than the best interests of the patient, which must always remain the guiding light in decision-making that directly affects the patient's health and, subsequently, their quality of life.

The Declaration of Geneva requires of the physician that: *"the health of my patient will be my first consideration"* and the International Code of Medical Ethics states: *"a physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her"*.

The traditional interpretation of the physician-patient relationship as a paternalistic one, in which the physician made the decisions and the patient submitted to them, has been widely rejected in recent years, both in ethics and in law.

Since many patients are either unwilling or unable to make decisions about their medical care, patient autonomy is often very problematic.

Equally problematic are other aspects of the relationship, such as the physician's obligation to maintain patient confidentiality in an era of computerised medical records and managed care, and the duty to preserve life in the face of requests to hasten death.

Patient's Health Charter

According to the National Patient's Health Charter, patients have the following rights:

- Healthy and safe environment
- Participation in decision-making
- Access to healthcare
- Knowledge of one's health insurance/ medical aid scheme
- Choice of health services
- Treatment by a named healthcare provider
- Confidentiality and privacy
- Informed consent
- **Refusal of treatment**
- A second opinion
- Continuity of care
- Right to complain about health services.

Respect and equal treatment – where did the patient's right to refuse begin?

All patients are deserving of respect and equal treatment – this is a belief which is recent (when considering its place in the timeline of history) and links directly to the eradication of slavery in European countries and the USA in the 19th century. Shockingly, slavery still exists in parts of the world today.

This belief was led by two opposing ideologies, namely:

- new interpretation of the Christian faith (following the American Revolution and the subsequent drafting of the US Bill of Rights);
- anti-Christian rationalism (e.g. French Revolution).

Under the influence of these two ideologies democracy gradually took hold and began to spread, and the concept of equality became established. This has had a direct influence on the rights each patient has to make determinations about his/her own health and the subsequent right to either accept or refuse treatment.

Conflicting views in the medical profession on patient equality

According to the Declaration of Geneva, medical practitioners have been told not to: *"permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient."*

However, medical practitioners have also in recent years claimed the right to refuse to accept a patient, except in an emergency.

This creates contradictory views which, in practice, can cause much confusion and distress to medical practitioners faced with decisions based on one view or the other, as neither view is always correct or incorrect; it often depends completely on the circumstances surrounding the patient's clinical profile, clinical history and other important influences, such as religion.

What are considered legitimate grounds to refuse to treat a patient?

The following may be considered legitimate grounds:

- a full practice
- lack of educational qualifications and specialisation
- a breakdown in the relationship with the patient, e.g. when there is a serious disagreement about the proposed treatment, and the medical practitioner wants to refer the patient to another treating practitioner or to refer the patient for a second opinion from another specialist.

Medical decisions made for patients who are incapable of making their own

As mentioned above, many patients are either unwilling or unable to make decisions about their health and want to relinquish that responsibility to another person.

This responsibility would, in historical times, have automatically fallen upon the medical practitioner, as the person who has the relevant training, expertise and knowledge to best assist and evaluate what the options are with regard to diagnosis and treatment of the patient.

This has changed substantially, through the creation of so-called "substitute decision-makers", who are empowered by the patient to make the relevant decisions based on the information at their disposal, and with which they are to inform the medical practitioners of their choice. This is often not based on medical knowledge or experience, but on factors such as religious beliefs and other convictions which the patient or substitute decision-maker might have.

Principal ethical issues relating to beginning and end-of-life decisions

Beginning of life:

- contraception
- assisted reproduction
- prenatal genetic screening
- abortion
- severely compromised neonates
- research issues.

End of life: This remains a contentious issue with personal religious beliefs and other personal convictions playing a huge role in how these decisions are viewed and made by individuals or their substitute decision-makers.

Two main end-of-life decisions, viz. euthanasia and living wills, are prominent in the current social sphere, and have been the topic of many conversations, social media discussions, media articles and court cases.

- **Euthanasia** – means knowingly and intentionally performing or providing a person with the knowledge, or means, or both, required to commit suicide, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs.
- **Living will** – competent patients have the right to refuse treatment, even when the refusal will result in disability or death.

Does the right to access to healthcare prevent refusal to treat a patient?

- Principles of beneficence and non-maleficence require doctors to do good and not to harm their patients. This is consistent with the provisions of the Declaration of Geneva, the International Code of Ethics and the HPCSA rules.
- Except in emergencies or for unconstitutional reasons, doctors may legally accept or refuse patients as they wish.
- However, once legally accepted, the doctor enters into a **contractual relationship** with the patient.
- The terms of the contract are usually implied in the relationship, except perhaps regarding payment of fees, which should preferably be spelled out in advance.

It is therefore important for medical practitioners to understand the type of relationship which is established, whether or not they decide to accept a patient into their practice for treatment.

This is further complicated by the expectation the patient tends to have in this regard, where effective communication is extremely important. Sometimes a barrier to the understanding and comprehension of information as given by the medical practitioner remains, whether it is language, culture, religion, prejudice, etc.

The right to access to healthcare services is a fundamental one. A practitioner can only refuse to treat with referral of the patient to another practitioner; continuation of care must be established at all times. In this regard, refusing treatment does not take away or

restrict the patient's access to healthcare. It is also extremely important to remember that emergency treatment can't be refused under any circumstances.

Terms and conditions agreed to between medical practitioners and patients

It is often taken for granted, but the signing of an informed consent document by the patient constitutes so much more than just the fact that the patient agrees that the medical practitioner may treat him/her for whichever ailment they seek medical advice or treatment.

The signing of this document establishes a relationship between the medical practitioner and the patient, which brings with it certain terms and conditions of which both parties should be aware.

Notably, most patients do not understand that there is not only an obligation upon the medical practitioner to provide a certain level of service, but also an obligation upon them as patients to adhere to certain requirements in order for the treatment by the medical practitioner to be effective and successful.

Terms which **doctors** agree to in a doctor-patient contract include to:

- diagnose and treat complaints
- treat complaints in an acceptable manner
- obtain informed consent before treatment
- respect patients' confidentiality
- treat patients personally unless referral to a third party is necessary
- treat patients with reasonable skill, competence and care
- not abandon patients until they are cured or other arrangements for treatment have been made.

Conditions which **patients** agree to in a doctor-patient contract include to:

- make themselves available for treatment
- carry out the doctor's instructions
- keep appointments – they may be liable for fees if they fail to give proper notice of cancellation
- return for follow-up treatment
- pay private doctors' accounts or arrange for their medical aid to do so.

Conclusion

The determination about whether a medical practitioner can refuse to treat a patient, circumstances in which it may be deemed appropriate, and the patient's right to refuse to be treated, have been a conundrum for the medical profession through the ages.

Legislation and other applicable guidelines

- Health Professions Act, No. 56 of 1974
- The South African Constitution, Act No. 108 of 1996
- The National Health Act, No. 61 of 2003.
- WMA: *Medical Ethics Manual*
- HPCSA: *Guidelines for Good Clinical Practice in the Health Care Professions*

Patient rights, especially with regard to equality, bring an added obligation to ensure their rights are protected; however, the rights of the medical practitioner regarding choice to treat or refuse to treat a patient can't be ignored – each person has their own belief or conviction and lives by their own moral code, which must at all times be respected within the boundaries created through legislation, rules and guidelines with regard to human rights, as well as what is ethically acceptable or not.

This is an ethical question mainly based on a moral assessment made by each medical practitioner individually, based on the circumstances they find themselves in at any given time.

The most important point of reference is to ensure that no patient is refused emergency treatment or abandoned without continuation of care being ensured.

Each situation must be evaluated on its own merit and then in line with the HPCSA guidelines, which provide some guidance on how to deal with ethical dilemmas.

Medical practitioners are encouraged not only to understand their duty towards their patient, but also to explain to the patient what their obligation is towards the medical practitioner to ensure they take control and responsibility for their own health.

Patients have been left too long with the understanding that only their rights count and that they have no obligations when it comes to their own health.

Yes, they can refuse to be treated, but medical practitioners have a right to refuse to treat as well.

It is in finding the balance between these rights, that the golden path to transparency and advancement in the dilemmas with refusal of or to treatment might be discovered.

It will however, require more open and transparent communications between medical practitioner and patients alike.

Transfusion confusion

The Medical Protection Society shares a case report from their files

Mrs Y, 38, was admitted to hospital under the care of specialist physician Dr F for treatment of anaemia due to excessive menstrual bleeding. A sample of her blood was taken for grouping and cross-matching, for the purpose of a blood transfusion; a pack of compatible A-positive donor blood was sent to the ward for this purpose.

After the transfusion began, Mrs Y asked about the blood grouping, telling the nurse that she thought she might be A-negative. The nurse immediately stopped the transfusion and reported this to the laboratory technician – by which time, three to four drops of blood had already been transfused. However, the technician replied that the cross-matching was compatible, and advised that the transfusion should continue while he rechecked the cross-matching.

A short time later, the technician informed the nurse that Mrs Y was in fact A-negative and that the transfusion should stop; by this time, another six to seven drops of blood had been transfused. A blood sample was taken from Mrs Y and she was immediately administered dextrose saline and hydrocortisone intravenously.

Upon clinical examination and observation, Mrs Y's condition was normal. Both the pre- and

post-transfusion blood samples had been tested for haemolysis and antigen-antibody reaction (Coombs test), and both tests were negative for any reaction. A day later, Mrs Y was referred to a consultant obstetrician and gynaecologist for a full review of her menorrhagia, and a vial of anti-D was administered. The following day, Mrs Y was discharged from hospital.

When Mrs Y attended the hospital 2 weeks later, her condition was found to have improved – her haemoglobin level had increased, she was feeling less tired and there were no more palpitations. Mrs Y was asked to attend a further follow-up a month later, but did not attend. She later made a claim against both Dr F and the hospital for the errors in her blood transfusion, alleging pain and suffering, and emotional stress and psychiatric injury.

Expert opinion

Although there had been a clear breach of duty in the error made during the blood transfusion, the experts for both MPS and Mrs Y disagreed over causation. Although Mrs Y had suffered no adverse reactions as a result of the transfusion, and had been administered with the necessary remedial measures, she alleged psychiatric

injury; the experts instructed by Mrs Y's legal team stated that she was indeed suffering from major depressive disorder with psychosis, as a result of the erroneous transfusion.

The expert instructed by MPS, a consultant psychiatrist, said that the 17-month period between the blood transfusion and the alleged diagnosis of major depressive disorder was rather prolonged for a connection to be drawn between the two incidents.

MPS denied any liability on the part of Dr F in the claim, stating that although he ordered the blood transfusion and had overall responsibility for the care of Mrs Y, he could not be held accountable for the mistake of the hospital's laboratory technician.

The allegations against Dr F were subsequently dropped and the hospital accepted full liability for the incident and Mrs Y's psychiatric injury, settling the case for a low sum.

Learning points

- Being open about errors following an adverse event is important.
- Listen carefully to the history given by the patient, and don't hesitate to query a course of treatment even after it has started.

SAMA Cape Western Branch hosts CPD in Worcester

SAMA Cape Western Branch, in collaboration with the SAMA Private Practice Department (PPD), and Marketing Department, hosted a CPD function in Worcester on Thursday 10 November 2016 at Damas Conference Centre and guesthouse.

Dr Solly Motuba, head of SAMA PPD presented an update of current issues affecting the practitioners in private practice and what has been achieved by SAMA in addressing these issues. Advocate Yanush Singh presented on "Medical confidentiality", followed by the Aesthetic Medicine Association representative in the Western Cape, Dr Wade Merchant, who spoke on a very informative topic: "A GP's guide to aesthetic medicine". The very popular SAMA CPD programme has been offering SAMA members and medical practitioners situated in more rural areas the opportunity to obtain access to high-quality presentations and CPD points otherwise not readily available to them.



From left: Dr Jacques Botha (PPD Strategic Account Manager), Emily Nel (SAMA Cape Western Branch Secretary), Vernon Kinnear (SR Marketing Officer), Chenienne Gericke (SAMA Cape Western Branch Secretary), Dr Solly Motuba (head of PPD)

Hosting a CPD meeting in Beaufort West

SAMA hosted a CPD meeting in Beaufort West on 3 November 2016. The topics of the CPD were "Financial wellness for the professional", presented by Keith Floyd from Sanlam and "Health information: Informed consent, disclosure and impact of POPI", presented by Julian Botha from the SAMA Private Practice Department.

This event was attended by doctors, dentists and other health professionals from Beaufort West and surrounding areas, and was hosted at the Wagon Wheel Country Lodge. The general consensus among attendees was that the presentation on financial wellness should be given to professionals much earlier on in their careers, as it addresses issues such as trusts, legality of wills and even makes provision for retirement planning and important aspects relating to equity and financial planning.

The National Health Act, sections 14 to 16, and other related documents were discussed in the "Health information: Informed consent, disclosure and impact of POPI" presentation. This also covered information that must be disclosed by a healthcare provider, privacy violations and breach of confidentiality.

BMW ride and drive

Jeanette Snyman

BMW invited SAMA members to a ride and drive event on Friday 23 September. All the guests had the opportunity to drive these remarkable cars and experience first-hand the definition of performance, refinement and innovation.

In addition to a scenic journey undertaken in luxury, guests enjoyed the dealership's hospitality. We drove to Riviera on Vaal and enjoyed a wonderful brunch while overlooking the beautiful Vaal River.



Gosiane Leballo looking the part, as a BMW X3 driver!

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EP branch: Men's and women's health

Dr James Burger

Our last of a series of successful CPD talks was held on 29 September at one of our regular venues, the ever-hospitable Elizabeth Place. With Cancer Awareness Month as well as the month of "Movember" almost upon us, we decided on a talk shared between two important topics under the umbrellas of men's and women's health. While each of these topics can justify their own extensive talks, the EP Branch chose to focus on two important cancer-related topics for one night packed full of interesting information.

Prostate cancer is the most common cancer in South African men and we were lucky to have Dr Jörn Malan explore the new advances in prostate cancer.

As pointed out by Dr Malan, at age 50 one has an approximately 42% chance of developing prostate cancer, but only a 2.9% chance of dying from it, resulting in significant debate regarding the benefit of prostate cancer screening. This necessitates our pursuit for a way to balance the benefits of earlier, potentially curative treatments with the concerns regarding slow growth and exposing patients to unnecessary side-effects to treatment. This debate is complicated because of conflicting data from different trials regarding outcomes for patients who are screened or not screened.

The American Urological Association has advised, in light of these concerns, that men aged 55 - 69 should be screened, as they are more likely to benefit, and not to screen

men above 70 years who are not expected to live 10 - 15 years. However, this is not without its own grey areas, as estimating life expectancy is an undeniably difficult task.

Dr Malan outlined prostate cancer's carcinogenesis, grading systems, clinical presentation, and diagnosis and staging, before tackling the treatment of this common cancer.

Treatment, he emphasised, is always a combined decision that is individualised and based on the stage, as well as the age of the patient and their fitness, with either curative (radical) or palliative (symptomatic) intent.

The management of prostate cancer is rapidly evolving. He explained the various options such as docetaxel and cabazitaxel, as well as the multiple proven second-line options in metastatic castration-resistant prostate cancer, such as abiraterone. With further research and development, we will hopefully continue to improve in this area and determine the most appropriate sequencing of these new agents in order to improve survival, reduce morbidity and prevent side-effects.

We were lucky to have Prof. Mfundo Mabenge, head of department and principal specialist at Dora Nginza Hospital Obstetrics and Gynaecology Department, give us a talk on his area of expertise. Cervical cancer is a very common gynaecological cancer in SA, with lack of proper screening resulting in the vast majority of patients presenting in advanced stages. Prof. Mabenge outlined the findings of some of the local research



Guest speaker, Dr J Malan

available, and the study he quoted by Herbs and Snyman (2013) explained that only 41% of those who presented to healthcare services with the onset of symptoms had had a gynaecological examination on initial contact. He also pointed out that late presentation was because of this lack of a gynaecological examination (a point to remember for all of us who might try to justify not completing this part of the examination).

During his informative talk he discussed the pathogenesis, Bethesda terminology for reporting and the progression of each category, their management, and the management of invasive lesions. Prof. Mabenge also discussed the vaccines available, which generated a number of questions from the audience and stimulated some good debate.

Thanks, once again, to Mariana Johnstone from EP Branch for co-ordinating the talk and getting two of the experts in their fields to pass on some very valuable information.

Presidential and awards dinner in Gauteng

This year the Gauteng branch combined their awards dinner and presidential dinner. The event was held on 3 November 2016 at the Wits Club. The evening was attended by representatives from both the public and private sectors and the branch was pleased to welcome SAMA president Prof. Ncayiyana.

The evening was an opportunity for the branch to thank the outgoing branch president Dr Saner for his contribution and to welcome the current branch president Prof. Green-Thompson.

This year the branch had five awards to present. The award for the member or society who

has made an outstanding contribution to society went to the South African Depression and Anxiety Group (SADAG). The medical student award went to Ms Stephanie van Straten. The allied health award was presented to Prof. Patricia de Witt. The young colleague award went to Dr Sivuyile Madikana and the colleague award was presented to Prof. H Saloojee. Congratulations to all the award winners and congratulations also to all the nominees.

In between the proceedings and at the end of the evening the entertainment was provided by a Wits student band called The Blast Effect.



The Award winners (left to right: Dr C Linde, Dr S Madikana, Prof. P de Witt, Prof. H Saloojee, Ms S van Staten) with (far left) Dr K Spencer (branch chairperson), Prof. L Green-Thompson (branch president) (third from right) and Prof. D Ncayiyana (SAMA president) (far right)



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