

SAMA INSIDER

MAY 2018

Using chaperones during intimate patient examinations

Exceptional
Dr Senkubuge
leads the way
in Africa



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
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18/04/20



Diane de Kock
Editor: *SAMA INSIDER*

Practising medicine

This month we focus on the day-to-day challenges faced by a healthcare practitioner in SA.

On page 5, the use of medical chaperones is discussed, particularly in view of the "significant number of cases of inappropriate sexual behaviour by health professionals towards patients". Authors Bernard Mutsago and Selaelo Mametja encourage SAMA "to assume a catalytic role in enabling a formal chaperone policy in SA". As always, your feedback on this issue will be appreciated.

"Terminating the physician-patient relationship: Avoiding patient abandonment" is discussed in an article on page 7 by SAMA legal advisor Hanneke Verwey, from both the legal and ethical perspectives.

"While the positive aspects of social media should be recognised, practitioners should also be aware of the potential legal and ethical pitfalls," writes Hanneke Verwey in her article on page 10. A daily challenge for many, this article provides valuable background and advice in a constantly evolving field.

Defining an emergency consultation is clarified from a coding perspective in Rendani Tendani's article on page 12, after two codes were recently added to the Coding Manual.

The article on page 14 updates us on the PMB review, a process recommended by SAMA in March last year and which is currently underway. "SAMA has welcomed and eagerly participated in the current PMB process ... and we are eager to assist in improving the situation."

A continued point of contention and concern for SAMA members is the issue of supersession, as illustrated in the letter to the editor on page 18. An article on the same page seeks to address these queries and complaints.

Please keep us informed of your day-to-day challenges and we will attempt to assist in any way we can. Until next time ...

Cover photographs for *SAMJ*

The Health and Medical Publishing Group (HMPG) is calling on doctors who have high-quality images of themselves and/or colleagues in medical contexts to make them available for next year's *South African Medical Journal* covers. If you have images that you consider coverworthy, please send them to publishing@hmpg.co.za. All contributions will be acknowledged.

Editor: Diane de Kock
Chief Operating Officer: Diane Smith
Copyeditor: Kirsten Morreira

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The use and misuse of antibiotics



Dr Marina Xaba-Mokoena, SAMA president

I was moved by an article authored by my niece, Dr G T J Kali, a neonatologist at Tygerberg hospital, and her colleague at Red Cross War Memorial Children's Hospital, paediatric professor G Swingler. It is not a recent article, and appeared in the *Continuing Medical Education (CME)* journal, but it has been weighing on my mind, such that I would like to add to their thoughts. They dealt, of course, with conditions in children, but their argument pertains equally well, or even more so, to adults.

Globally, levels of antibiotic resistance are on the rise

Gugu (Dr Kali) wrote: "There is a common misconception among many people that antibiotics are necessary for common colds and their symptoms." This is indeed a major problem – generally healthy and well individuals may feel mistreated or undertreated when they have been to doctors and antibiotics have not been prescribed. The worst clientele in this category are healthcare workers themselves, in particular those who have worked in hospitals, or – to be precise – trained professionals.

There was a time when even rural persons with minimal knowledge about antibiotics felt that whenever they went to see a doctor, they should be given an injection. In fact, during my late father's time, in the early 1950s, the very size of the dispensed bottle of medication, its bitterness and also its laxative effect mattered a lot to the patient being treated. When medicines became more concentrated and syrup-like, and were poured into smaller containers, this

needed some explanation before people would understand and accept them.

Sore throats and upper respiratory infections are among the most common presenting complaints in general practice, especially in autumn and winter. Adults have about 2 - 3 such infections per annum, and children may have about five such bouts. And most of these are self-limiting, and caused by **viruses**. Yes, we do know and accept that 15% of sore throats are caused by haemolytic streptococcal infections, and here, the fear is always the development of rheumatic fever, glomerulonephritis or otitis media. The risk varies greatly with age and socioeconomic setting, as poor socioeconomic circumstances greatly increase it. Several randomised controlled trials and good-quality systemic reviews have been carried out, using sputum and nasopharyngeal swab cultures, and it is now regarded as prudent to treat with antibiotics children from poor socioeconomic circumstances who are at the age of greatest risk for streptococcal infection and acute rheumatic fever (5 - 15 years). However, it does not make sense to treat children under 3 years old, because rheumatic fever is very rare at this age.

It is not, however, convincing to argue that antibiotics have led to a reduction in rates of rheumatic fever, because in Denmark the incidence has steadily declined since 1900, and was largely unaffected by the arrival of antibiotics.

Nevertheless, an evidence-based approach does not replace clinical judgement. For example, an 8-year-old girl from an outlying area, presenting with fever and follicles on swollen, red tonsils, seems more likely to benefit from an antibiotic to prevent severe complications rather than to shorten the duration of the illness and reduce symptoms, which could equally well be effected by analgesics.

Do antibiotics cause harm?

Yes – gastrointestinal disturbances are 3 - 4 times more common in adults when taking antibiotics. Additionally, there is evidence of the development of bacterial resistance. Globally, levels of antibiotic resistance are on the rise, to an alarming extent. To mitigate antibiotic resistance, we need the judicious use of antibiotics, via making correct diagnoses; the appropriate prescription of drugs, and channels

for their distribution; and the involvement of all health professionals, for viable antibiotic stewardship. The fact that antibiotic-resistant bacteria are increasingly becoming part of our normal microbiota suggests the carriage and transmission of multi-drug-resistant bacteria at the population level from early in life.

We need new antibiotics, but we also need to preserve the existing ones

Questions arise about the burden of antibiotic resistance in apparently healthy individuals, and how this burden affects the formulation of strategies to minimise the spread of antibiotic-resistant bacteria. It is worthwhile to determine the burden and carriage of drug-resistant bacteria at the population level (Bessong/Guerrant).

I have a strong reaction to patients who not only demand, but even prescribe for the doctor themselves, the treatment that they want, either because an antibiotic once helped them, or because they have been advised by another patient or a relative who has not even examined the patient. There are, of course, doctors who give an injection to a patient, and then tell him or her, under false pretenses, to come back again to "take out the injection" with another one – and patients believe that! This is a misuse of drugs, and abuse of the patient too, in playing on their ignorance.

Ethically, this is immoral and should not at this time and point be practised any longer. There are also shortages of drugs. Some older drugs, such as benzathine penicillin G, are in short supply, as they offer little prospect of large profits. But experts argue that ensuring access to these medicines remains crucial not only for patients but also for tackling the spread of resistance. For instance, a shot of benzathine penicillin G is enough to treat syphilis in an expectant mother and her fetus, but shortages of the drug result in babies being born with the bacterial infection. A rheumatic heart disease patient has a lifelong disease that can only be managed with monthly benzathine penicillin G injections. We need new antibiotics, but we also need to preserve the existing ones because they can still save us.

Use of chaperones during intimate patient examinations

Bernard Mutsago, Dr Selaelo Mametja, *SAMA Knowledge Management and Research Department*

The significant number of cases of inappropriate sexual behaviour by health professionals towards patients has brought to the fore discussions on the use of medical chaperones. In view of several recent sexual violation cases implicating healthcare providers, and the rising numbers of such cases reported, there have long been calls for the routine use of chaperones during intimate patient medical examinations. Globally, there is wide variation in chaperone use among countries. In some states, the use of a chaperone is mandated by statute. In SA, there is no policy on chaperone use, despite the upswing in sexual assaults of patients by healthcare workers, including doctors.

A medical chaperone can be defined as a third-party, impartial observer present during a consultation between a doctor or an allied health professional and a patient. Intimate patient examination commonly refers to the examination of the breasts, male and female external genitalia, the female pelvis, and the anus in both men and women. The definition could also include any examination where proximity to, or contact with, the patient is necessary.

Research and recommendations by ethicolegal experts in both SA and other countries strongly suggest that a chaperone policy be officially and broadly implemented, as in the UK, where the General Medical Council (GMC) has published guidelines on chaperones and intimate examinations. Despite some controversy, the use of chaperones has benefits for both the patient and the examining professional. Firstly, providing chaperones is concomitant with key principles of ethics and law that uphold

patient autonomy, justice and the principles of informed consent. Secondly, chaperoning affords the examined patient trust, emotional reassurance, comfort, dignity and respect.

SAMA recommends that doctors who routinely conduct intimate examinations make use of chaperones

Thirdly, chaperoning protects patients (and less commonly health professionals) from sexual improprieties. Fourthly, it helps practitioners to maintain professional conduct during examinations, and avoid litigation. According to the Medical Protection Society, allegations of sexual impropriety are rarely made if a chaperone is present.

On the other hand, critics oppose the use of chaperone on a number of grounds. The most often cited of these are: additional staff costs; cultural or religious sensitivities; potential breaches of privacy and confidentiality by the chaperone; and the potential for preclusion of full disclosure by the patient. Rather than abandoning the option of chaperone use altogether, though, strategies could instead be employed to mitigate the impact of these challenges in the course of implementing chaperone policies.

Concomitant with the ethicolegal principle of informed consent, the need for **communication** is strongly underlined by

proponents of chaperone use. The GMC guidelines state that before conducting an intimate examination, the practitioner should clearly explain to the patient what the examination entails, and allow the patient to ask questions and to give or to refuse consent for the use of a chaperone. The guidelines recommend recording any discussion with the patient about chaperones, the identity of the chaperone if utilised, and whether the patient accepted or declined the use of a chaperone. The guidelines recommend offering chaperone use regardless of whether or not the practitioner is the same gender as the patient.

The wide variation in chaperone use is not just intercountry, but is also observed intracountry – among individual doctors or practices, between the public and private sectors, and across different health or medical disciplines, for example, in gynaecology vs psychology. Experts recognise that there is scope for the HPCSA to develop and implement guidelines on chaperones, especially in a country where sexual violations and medical litigation are on the rise. The GMC and other medicolegal bodies of knowledge widely recommend that a chaperone must ideally be a trained health professional, in contrast to, say, a family member, although a family member may be allowed in the room in addition to a chaperone. In many countries, including SA, a nurse is often used as a chaperone. Higher chaperone utilisation rates are reported in the USA and in Canada. SA should draw lessons from such countries. The dynamic promotion of chaperone policies, such as those of the GMC, the UK Royal College of Obstetricians and Gynaecologists and the American Medical Association (AMA), should stimulate bodies such as SAMA to assume a similar catalytic role in enabling a formal chaperone policy in SA, applicable to both public and private sectors. Local studies and work from the Steve Biko Centre for Bioethics show that such a policy is likely to be supported by SA healthcare practitioners. In the absence of such a policy, SAMA recommends that doctors who routinely conduct intimate examinations make use of chaperones.

References are available on request.



Exceptional Dr Senkubuge leads the way in Africa

SAMA Communications Department

Dr Flavia Senkubuge is a pioneer. A quick glance at her biography reveals as much: the first black woman in a senior leadership position at the prestigious Colleges of Medicine of SA (CMSA), and also the first black woman to be president of the World Conference on Tobacco or Health (WCTOH).

And that's only the beginning. Dr Senkubuge is a remarkable health professional, in every respect.

Dr Senkubuge obtained her MB ChB from the University of Pretoria in 2004, and her MMed (Community Health) from the same university in 2010. She is a medical doctor, public health medicine specialist and a global health advocate. She is currently completing her PhD.

Apart from the obvious workload which accompanies these positions, Dr Senkubuge is the current junior vice-president of the CMSA. She is the first black woman, and first public health medicine specialist, to occupy such a senior post in the institution's 63-year history.

In addition, she is a member of the Health Policy and Management track at the School of Health Systems and Public Health at the University of Pretoria.

And Dr Senkubuge's long list of current appointments doesn't end there. She is the

vice-president of the African Federation of Public Health Associations, the secretary of the WHO/Afro Region African Advisory Council on Research and Development (AACHRD), and the Executive Director of Public Health Africa, an Africa-led, globally supported, non-profit organisation.

Not surprisingly, Dr Senkubuge was elected as a Young Physician Leader in 2015 by the respected global Inter-Academy Medical Panel (IAMP), and selected again for IAMP's global reunion in Geneva in 2016. She is also a 2018 nominee for the prestigious Women of Stature, Woman of the Year Awards in the category Woman in Healthcare.

Earlier this year Dr Senkubuge again paved the way by becoming the first black woman to preside at the WCTOH. This is one of the largest policy conferences globally, which, for the first time in more than 50 years, was hosted in Cape Town from 6 - 9 March. Not only was she the president of the congress, she was instrumental in winning the bid for the congress to be held in South Africa.

In her welcome address to the congress, Dr Senkubuge noted the honour that was bestowed on her by being invited to preside over such an important gathering.

"I am so humbled to stand here because in my standing here, I do not stand alone



Dr Flavia Senkubuge

... this conference was born out of a conversation between myself and Ms Kellen Nyamurungi, two young black women. We had no idea this was going to be a first in Africa, and so be tenacious, be undeterred, be resolute in your conviction," she said.

Dr Senkubuge's tenacity is evident in everything she does, as a medical professional, a doctor and a humanitarian. But, perhaps most importantly, it is seen in her quest not to break a mould, but create a new one, and set an example for others, as a young, black African woman.

Ethics Alive Week discusses professionalism

Bokang Motlhaqa, Sarah Molefe, junior marketing officers, SAMA

The Wits Faculty Of Health Sciences and the Steve Biko Centre for Bioethics hosted the 11th annual Ethics Alive symposium from 12 - 16 March. The event took place at Wits Medical School and at various public sector hospitals in the Gauteng region, featuring Dr Volker Hitzeroth from the Medical Protection Society, unpacking the topic "Maintaining professionalism when resources are constrained".

Many attendees stated that Dr Hitzeroth's presentation was timeous, considering the recent increases in number of malpractice cases, and the Life Esidimeni tragedy. The basis of Dr Hitzeroth's talk was that, while

every hospital certainly has issues pertaining to resources, it still stays the responsibility of doctors to deliver impeccable healthcare to their patients. In his definition of professionalism, he referred to the connotative terms which are associated with the word, such as social responsibility, good judgement, professional duties, skills and knowledge. He emphasised the fact that doctors need to remember that patients do not pay attention to an institution's lack of resources *per se*, but to the service that they get from the health practitioner(s).

The event featured a special symposium for undergraduate students, held on 14 March, where Prof. Malegapuru Makgoba unpacked "The Ethics

of Life Esidimeni", contrasting the tragedy with the ethical conduct training that students receive as part of their medical education.

The main symposium of the Ethics Alive Week took place on 15 March, where Mr Pravin Gordhan, Prof. Malegapuru Makgoba and Prof. Elmi Muller tackled issues of justice, equity and health.

The Ethics Alive Week has as its objective reminding the medical practitioners of their responsibilities in terms of the oath that they have undertaken to deliver professional healthcare to the SA community, seeking to bring about transformation to the medical landscape.

Terminating the physician-patient relationship: Avoiding patient abandonment

Hanneke Verwey, legal advisor, SAMA

Physicians may accept or refuse patients as they see fit, except in the case of an emergency, or when the refusal is motivated by unconstitutional or discriminatory considerations. In this regard, there is no liability for mere omissions in SA law unless there is a positive duty to act, or the circumstances are such that society would regard the failure to act as unlawful. Furthermore, in terms of the principle of freedom of contract, private physicians are free agents who generally have the right to accept or refuse patients at will. However, once a physician accepts someone as a patient, a physician-patient relationship is created, in terms of which physicians owe patients a duty of care. In addition to the legal duties owed to patients, the physician-patient relationship also gives rise to several ethical duties. These duties are usually implied, and include the duty not to abandon patients.

Definition of abandonment

A patient is abandoned when a physician denies a patient necessary care by ceasing a course of treatment before the patient has terminated the relationship out of own volition or has fully recovered. Abandonment may occur in a variety of circumstances; however, in the context of the termination of the physician-patient relationship it usually refers to the termination of the relationship without reasonable notice, and/or without referring the patient to another healthcare provider.

Reasons for termination

Terminating the physician-patient relationship should be done for the correct reasons, and with the necessary sensitivity. Termination should be an option of last resort. The extent of the breakdown in the relationship should be of such a nature that the physician's continued involvement would not be in the patient's best interests – for example, if the breakdown of trust jeopardises the continued provision of good clinical care. The physician should be able to justify the decision to terminate the relationship. The reasons for the termination and the way in which it is handled will be instrumental in rebutting

any potential complaint emanating from the termination.

The termination of the relationship may never occur for unconstitutional reasons, or in the case of a medical emergency. Common reasons for terminating the physician-patient relationship include non-payment of or inability to pay fees, chronic non-compliance on the part of the patient, hostile patient behaviour and conscientious objections on the part of the physician. The aforementioned scenarios deserve further exploration due to their heightened potential for ethical transgressions.

Non-payment of or inability to pay fees

Although it is permissible to terminate the physician-patient relationship for failure to pay for services, SA law does not provide specific criteria outlining when it is appropriate to terminate the relationship in these circumstances. It is therefore recommended that physicians implement a uniform process and routine business policy for terminating the relationship in case of non-payment, irrespective of whether patients pay privately or through a medical scheme. For example, the policy could outline steps to allow patients a reasonable opportunity to set up a payment plan. It should then be explained to patients that failure to set up such a plan will lead to the termination of the relationship. Existing patients who can no longer afford to pay for treatment should be treated fairly, by taking into account their personal circumstances. For example, a physician may decide to treat a regular patient who has not paid her bills recently due to a temporary cash flow problem. Resource constraints constitute an acceptable reason to refuse expensive treatment, but patients should be treated as far as their limited resources allow. If necessary, such patients may be referred to a public health facility for treatment.

Non-compliant patients

Non-compliance is generally not a good reason for termination unless continued non-compliance leads to the irretrievable breakdown of the relationship. Physicians should first attempt to establish the reasons

for non-compliance. They should ensure that patients understand the risks if the condition remains untreated or undertreated. Physicians should try to identify any specific concerns or questions that patients may have regarding the treatment, any necessary lifestyle modifications, follow-up, etc. Adequate time should be allowed for this process, as the information conveyed to the physician may be invaluable for tailoring the approach to improving compliance. It is recommended that physicians consider involving a social worker and/or the patient's family to assist in these discussions. It is important that physicians document the fact that patients were informed of the potential consequences of non-compliance.

Hostile patients

Physicians have the right to refuse to treat patients who are physically or verbally abusive towards them, or who sexually harass them. Although the best interests of the patient should always enjoy first priority, the severity of the offending conduct may justify terminating the relationship without first issuing a warning to the patient. Enlisting assistance from other healthcare professionals or a social worker may be of some assistance; however, sometimes the only option is for the offending patient to be referred to another physician.

Conscientious objections

Physicians have a duty to ensure that their personal beliefs do not prejudice their patients' healthcare. Physicians will only be able to terminate a physician-patient relationship on the grounds of conscience in limited circumstances. The horizontal operation of the right to equality and the concomitant equality guarantee underlying the right of access to healthcare services preclude any arbitrary refusal of treatment, or refusal that is motivated by unfair discrimination. The context in which conscientious objection most often arises is the refusal of termination of pregnancy on the grounds of religious belief. In order to determine whether a physician may refuse to perform a termination of pregnancy, a balance has to be struck between the physician's right to freedom of conscience, religion, belief and opinion, and

the patient's right to access to reproductive healthcare services. A conscientious objection to performing a termination of pregnancy will generally amount to a justifiable limitation of the patient's rights, unless it is an emergency and the termination is required to save the patient's life or to prevent serious bodily harm. The right to conscientious objection may, possibly, also be more readily limited in rural areas where alternative facilities are unavailable.

Requirements and process

Physicians may only withdraw from treatment if an alternative source of care is available, and the appropriate avenue for securing the same is known to the patient. Patients should be referred to a public health facility or to another physician (or in the case of a specialist, the patient could be referred back to the initial referring primary care provider).

An orderly transfer of care should be facilitated, including the transfer of clinical records and the drafting of a referral letter. Patients should be assisted in the collection of copies of clinical records, or alternatively, copies of the records may be sent to the new physician. In the latter case, the patient's consent should be obtained. Physicians may

charge a reasonable fee for the copying of patient records. As the circumstances for provision of record copies may vary, however, physicians should evaluate whether a charge makes sense relative to the patient. If the physician intends to charge for the copying of the records, he or she should clearly state this in the termination letter or in discussions with the patient.

Reasonable notice should be given to the patient. The termination period should allow the patient sufficient time to secure alternative healthcare services. If the physician is the sole specialist in an area, or is practicing in a rural area, it may take longer to secure alternative care, and a longer notice period may be required. The timing of the termination might be critical in the defence of an allegation of patient abandonment. Terminating the relationship at a critical juncture is not recommended, unless there is no alternative. The physician should make him- or herself available to provide emergency and essential care during the transitional period.

Physicians should review the patient's records prior to termination to ensure that the documentation supports the decision to terminate the relationship. Depending on the reason for the termination of the relationship, these could include clinical notes confirming

that the patient was furnished with treatment education, clinical notes recording the fact that the patient was repeatedly warned about the dangers of non-compliance, notes regarding attempts made by the physician to resolve the matter, or a written record of the patient's abusive behaviour.

The process of termination should be clear, in order to avoid expectations of ongoing care. The communication should be non-confrontational and should not be punitive in tone. Physicians should make detailed clinical notes of these conversations and keep a copy of any written communication.

Conclusion

A poorly handled termination of a physician-patient relationship may lead to a complaint of unprofessional conduct. Physicians may also be held contractually liable for breach of contract, or delictually liable if a patient suffers harm as a result of negligent abandonment. The decision to terminate the relationship needs to be reached dispassionately, in order to avoid adverse consequences for both parties. Physicians are encouraged to seek legal advice, or advice from a senior colleague or someone versed in ethics, before terminating a physician-patient relationship.

Now we're Medtalkz-ing

SAMA Communications Department



Medtalkz is a new online service that gives medical professionals and medical students access to lectures and presentations they can't attend.

Doctors throughout the world share their knowledge on a variety of platforms: at conferences, symposiums, once-off lectures at institutions, evening events, and other academic gatherings. This knowledge is useful and can be of great value to others in the medical profession.

But all too often, these presentations are delivered once or twice and then forgotten: lost to anyone who did not attend the event. And, with the wealth of knowledge and experience in the health professions in SA, this loss of intellectual sharing means valuable learning material goes unnoticed, and cannot be used by others.

To counteract this loss, a new open-access platform has been launched to give health

professionals and medical students a way to stay up to date with the latest findings and research in the medical field, regardless of where they are based.

"Medtalkz is essentially an online medical library, and will carry presentations and lectures from medical professionals across all medical fields. Medtalkz is a non-profit initiative, and an important feature of the service is that it is freely accessible to doctors, nurses, allied healthcare professionals, and medical students. We are extremely excited about this programme, and the value it will bring to everyone in the profession," says Dr Brian Levy, one of the doctors behind the initiative.

Dr Levy says that although SA has an active continuing medical education landscape, those who would benefit the most from the information at conferences, lectures and symposia are often unable to access it due to resource, time or geographical constraints.

"We think by making this information available through this platform many, many healthcare professionals, and students, will benefit a great deal from the information which will be available, and, ultimately, our entire healthcare service will benefit," says Dr Levy.

All presentations and lectures available on the site are screened by abstract submission before being uploaded. Users (who register for free) are then able to search the content using the title, key word, field of medicine, speaker, date range or even the institution where the talk was delivered.

"A unique aspect of Medtalkz is that lectures and presentations are recorded live, to achieve a slide presentation with a synchronised voice over, and then stored on the platform in video format. To protect the presenter's intellectual property, these videos cannot be downloaded or saved," explains Dr Levy.

Another feature of Medtalkz is that societies and institutions can each have their own secure channel on which to record and upload educational information, thereby creating, and preserving, their own library of information. These channels can be society branded, with links to their own websites, and can be for the use of the society or institution. This service is available at no cost.

"I think the message we are sending is that there is important information out there, and we don't want it to be lost or forgotten. Through this platform, no matter what type of information it is, if it is of medical value to a broader audience, you will find it here," says Dr Levy.

Importantly, explains Dr Levy, revenue for the site will be generated through the placement of specific and focused advertising,

for which the societies will receive honoraria. "To avoid the site being 'used' for unethical purposes, commercial entities and products will not be directly linked to speakers or institutions, and all local and international advertising and marketing codes will be strictly observed," he says.

Medtalkz is available online at www.medtalkz.com.

Addressing the missing TB cases

Dr Margot Uys, *chair, 5th SA TB conference*



Find the missing TB cases! This seems to be the mantra dominating all national and provincial programmatic discussions relating to TB. And with good reason, as it is estimated that at least 100 000 - 150 000 missing cases are "out there" – not on treatment, mostly undiagnosed, and spreading the disease through the airborne transmission route, simply by exhaling, and especially when they cough, when they sneeze.

The Department of Health is on a mission to end TB, but to get there it is essential that we find these missing TB cases.

The 5th SA TB conference, organised by the FPD, with the overarching slogan "STEP UP – Let's embrace all to end TB", will contribute to the discussions and action plans for moving forward to eliminate TB. The conference will focus on different themes for each day of the 3-day long forum on TB. "Finding the missing cases" will be the theme of day 1; discussing the social and biological determinants impacting the TB cascade day 2; and dealing with drug-resistant TB, and finding solutions

for better and more efficient drugs is the theme for day 3.

The conference will draw national and international speakers from across the world of TB research and programmatic management. In many ways SA leads the way; we have first class researchers investigating new vaccine options, doing research on the molecular epidemiology, host genetics, clinical manifestations and optimal treatment of TB in conjunction with other comorbidities, and exploring the best options for drug-sensitive and drug-resistant TB.

The associated social stigma, and how this impacts both accessing treatment and therapy adherence, is another important theme that will be explored, as well as the plight of the healthcare worker, in view of infection control practices and shortcomings. The need for community participation and education will form yet another important theme of the conference.

The National TB Control Programme (NTP), under the leadership of Mr David Mametja, is focused on identifying the "missing" TB cases, especially among key populations, i.e. those HIV-infected, mothers and their children, farm workers, migrants, those living in informal settlements, those in detention, mine workers and peri-mining communities. Not actively identifying and treating these "missing" TB cases seems to fuel the epidemic.

In addition, and for the first time in history, the UN General Assembly will have a dedicated session focusing on TB in September 2018, to assist with the international drive to find the missing cases and end TB. All high-burden countries will have to make presentations. The hope is

that SA will have identified at least 60 000 additional TB cases by then. As always, the challenge is making sure that all presumptive TB patients (people with symptoms) are diagnosed and started on treatment at the first contact session with the healthcare provider – which was not the experience of Ms P M. Aged 24, unemployed, a single mother of two young children (6 and 10 years old), she presented to her nearest public clinic in Tshwane with a complaint of not feeling well: she had been coughing for some time, with chest pain. Despite these telling symptoms, and a further visit to the clinic with an additional tell-tale complaint – significant weight loss (4 kg) since the first visit – it was not until 6 weeks later (on hospital admission) that sputum was eventually collected to initiate an investigation for TB. Finally, Ms P M was diagnosed with TB and started on treatment. In the meantime, she was coughing her lungs out at home and spreading the TB bacilli in the air of their small dwelling, thereby exposing her children to this million-year-old bacillus, a disease efficiently spread by the airborne route.

TB, a fully treatable disease, is still the top cause of mortality in this country. SA ranks among the top 10 TB-burden countries – after India, Indonesia, China, Nigeria and Pakistan. SA noted a total of 244 053 TB cases in 2016, but the *WHO Global TB Report*



2017 estimates are much higher, at 438 000 cases. Taking these estimates into account, there may be at least another 90 000 (range approximately 60 000 - 190 000) undiagnosed TB patients “out there” who are not being identified, are incorrectly diagnosed with pneumonia or flu, etc., are not being investigated despite tell-tale symptoms, or are affected by stigma-related factors influencing both healthcare worker and patient behaviour. Some patients’ inability to access healthcare services, as a

result of time constraints, poor services and/or transport problems, raises a further barrier to treatment.

TB has been named by some as one of the “scarlet pimpernel” diseases, (because of it being here, there and everywhere, and the difficulties in making a definitive diagnosis). Clinicians need to have a high index of suspicion and tenacity to point them in the direction of TB. Symptoms can be misleading, vague and general for a long time, but with a history of cough and weight loss, the diagnosis

becomes easier. However, testing sputum for TB is not the end of the journey. Once treatment has been started, it is very important that the patient complete the 6-month course of daily pill-taking to prevent relapse and/or the development of drug resistance.

The 5th National SA TB Conference will be held in Durban from 12 - 15 June 2018 at the International Convention Centre. Registration is open, and more information regarding the conference and the programme is available at www.tbconference.co.za.

Healthcare practitioners, social media and ethics

Hanneke Verwey, *legal advisor, SAMA*

Social media is a great information equaliser, and has radically transformed the way people communicate around the world. In a healthcare context, social media can be used to enhance professional networking, promote patient rights, promote the profession, enhance patient education and share health information rapidly and directly. While these positive aspects of social media should be recognised, practitioners should also be aware of the potential legal and ethical pitfalls around its use.

What is social media?

The definition of “social media” is broad, and constantly evolving. The term generally refers to websites and applications that enable users to create and share content, or to participate in social networking. Examples include social networking sites such as Facebook, Google Plus and Twitter. It also includes professional networking sites, media-sharing platforms, content-producing blogs and gaming environments.

Potential ethical pitfalls Patient confidentiality

In terms of the National Health Act (NHA) No. 61 of 2003, information concerning a patient, including information relating to his or her health status, treatment or stay in a health establishment, is confidential. This is consistent with and gives effect to the right to privacy in the SA Constitution, in a healthcare context. Similarly, the ethical rules of the HPCSA provide that practitioners may divulge information regarding a patient only if this is done in terms of a statute, a court order, in the public interest,

with the express consent of the patient, with the written consent of a parent or guardian of a minor under the age of 12 years, or with the written consent of the next of kin or the executor of the deceased’s estate in the case of a deceased patient. Although the entire act is not in force as yet, certain breaches of patient confidentiality will also constitute an offence in terms of the Protection of Personal Information Act (POPI) No. 4 of 2013. The POPI affects all private and public organisations that deal with the processing of information such as names, addresses, health information, employment history, etc. This includes private and public healthcare facilities and individual practitioners. Failure to comply with the provisions of the POPI could lead to complaints, civil claims for payment of damages, or criminal prosecution subject to a fine or prison sentence, or both.

A practitioner’s duty to keep a patient’s personal information confidential applies online as well as off. Social media platforms have the potential to be viewed by many people, and there is an increased security risk of unauthorised access to such platforms. Personal information disclosed online is also subject to the unique privacy risks associated with electronic communications, including the fact that electronic storage devices make it easier to store and transport, but also to lose, multiple records. The WHO recommends that practitioners should study and understand the privacy provisions of social networking sites, bearing in mind their limitations.

While practitioners may discuss their experiences in non-clinical settings, the WHO recommends that practitioners should ensure

that no identifiable patient information is posted on social media platforms. Revealing an isolated piece of information may not in itself breach patient confidentiality; however, the sum total of published information could identify a patient. Practitioners should not discuss real patients, their illnesses or any of their personal information on social media platforms, unless with the explicit and informed consent of the patient. Breaches of confidentiality will constitute a violation of the patient’s Constitutional right to privacy, national legislation (including the NHA and the POPI) and the ethical rules of the HPCSA.

Blurring professional boundaries

Social media can make it difficult for patients to distinguish between a practitioner’s personal and professional life. As such, there should be a clear distinction between the practitioner’s professional and personal opinions. Personal social media profiles should be kept separate from professional profiles. Practitioners may accept patient requests to connect to professional accounts, but should avoid accepting “friend requests” from patients to connect with the practitioner’s personal accounts. The WHO provides that practitioners have a duty to maintain appropriate boundaries in the doctor-patient relationship online in accordance with professional ethical guidelines, just as they would in any other context. All patients should receive a copy of the office’s online communications protocol and social media policy so that boundaries are not crossed. Practitioners are also encouraged to use stringent security and privacy settings

with respect of their personal accounts, in order to control who can find them online and to limit the number of unwanted friend requests. The WHO also recommends that practitioners should consider their intended audience, and assess whether it is technically feasible to restrict access to content to predefined individuals or groups.

Maintaining professional reputation

Online posting may contribute to the public perception of the profession. Practitioners do not only represent themselves, but also the profession, and so should always act professionally in order not to bring the profession into disrepute. These same principles apply to online behaviour, and professional bodies can sanction practitioners if they deem online behaviour to be detrimental to the reputation of the profession as a whole. Practitioners should keep in mind that any content published on social media may be regarded as in the public domain, which means that it may be published in other media, including the national press. Practitioners should therefore be very careful about what they post online, including photographs, comments, likes or shares, and causes or organisations liked or followed. Content that could be perceived in a negative light should be avoided, even if meant in jest or as satire. The WHO recommends that practitioners routinely monitor their own internet presence to ensure that the personal and professional information on their own sites, and, to the extent possible, content posted about them by others, is accurate and appropriate. The WHO similarly recommends that practitioners should provide factual and concise information, declare any conflicts of interest and adopt a sober tone when discussing professional matters.

Online medical advice

If practitioners are approached online for clinical advice, it is best to only answer general health-related questions. Practitioners may therefore engage with patients about healthcare online, but should avoid engaging in a doctor-patient relationship, as practitioners will then owe a legal duty to such a patient. If a patient asks specific questions about his or her health, it is advisable to request the patient to book an appointment, and inform him or her that this is necessary in order to protect privacy and ensure good clinical care. Practitioners should carefully consider every post, as the distinction between providing general advice and personalised medical advice may not necessarily be very clear. If a practitioner dispenses general advice online, it would also then be incumbent upon such a practitioner to regularly review online notices and messages. All information posted online should be credible, up to date, evidence based, factually accurate and suitable for the intended audience. Practitioners should restrict themselves to their level of expertise. They are furthermore encouraged to publish a disclaimer on social media platforms stating that the posted information is for educational purposes only.

Advertising and solicitation of business

Practitioners should consider the ethical rules of the HPCSA regarding unethical advertising when conducting themselves online, in particular when posting content about their practices to their professional profiles. Practitioners are not prohibited from advertising online or elsewhere, provided that the advertisement is not unprofessional, untruthful, deceptive or misleading, or causes consumers unwarranted anxiety that they may be suffering from a health condition. Furthermore, advertising may not unfairly

promote the practice of a particular practitioner or healthcare facility for the purpose of financial gain or other valuable consideration. Although a detailed analysis of the meaning of touting, canvassing, endorsement and promotion falls beyond the scope of this article, practitioners are encouraged to familiarise themselves with the meaning of these terms as they appear in the ethical rules of the HPCSA, as such conduct is prohibited online. In order to avoid accusations of unethical conduct, practitioners should keep online information regarding their practices concise and factual.

A conservative approach to online advertising should be adopted, and practitioners should avoid any comparisons or claims of superiority when describing themselves or their practices online. Practitioners should furthermore adopt a prudent approach when inviting members of the public to be added to their social media pages, or when recommending such pages to members of the public. There is no reason why existing patients of the practice should not be invited to join or like a practitioner's professional page; however, sending out bulk friend requests to the public in an attempt to advertise the practice should be avoided.

Conclusion

Social media remains a new and constantly evolving phenomenon, and much still needs to be learned regarding its use and effectiveness in achieving health outcomes. New media and communication channels also come with new risks. Practitioners need not, however, be dissuaded from using social media, provided that they have familiarised themselves with the possible legal and ethical pitfalls and taken steps to mitigate against any potential professional risk or patient harm.

Immediate treatment = emergency

Rendani Tendane, *medical coding consultant, SAMA*

As of 1 January 2018, the Medical Doctors' Coding Manual contains a new item. Code 0126 has been added for **unscheduled** consultations/visits at the doctor's home or rooms, while the wording of item 0146 has been amended to limit its use only to **emergency** consultations/visits at the doctor's home or rooms.

This amendment and the addition are the result of disputes and confusion between healthcare practitioners and funders for the code description for code 0146, which previously included both emergency and unscheduled consults.

Section 2(5) of the National Health Act No. 61 of 2003 states that "A healthcare provider,

health worker or healthcare establishment may not refuse a person emergency medical treatment." However, the only legal definition of a medical emergency in the country is in the Medical Schemes Act No. 131 of 1998, which defines an "emergency medical condition" as "the sudden and, at the time, unexpected onset of a health condition that requires

immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a body organ or part, or would place the person's life in serious jeopardy".

Some conditions may have a sudden onset but not require emergency medical care. In an instance where a patient sees a practitioner unscheduled, for a condition that does not meet the criteria for an emergency as defined in the Medical Schemes Act, this would constitute an unscheduled visit. In this instance, scheme rules apply.

According to the Council for Medical Schemes (CMS Script Issue 6 2012 - 2013), the following factors must be present before an emergency and its prescribed minimum benefit can be established:

- There must be an onset of health condition.
- This onset must be sudden and unexpected.
- The health condition must require immediate treatment (medical or surgical).
- If not immediately treated, one of three things would result: serious impairment to a bodily function, serious dysfunction of a body or organ, or death.

For a medical condition to qualify as an emergency, therefore, a diagnosis is not enough: immediate treatment must be required. Diagnosis in any case comes at a

later stage for any treatment to save the patient's life or bodily function, or the use of a body part.

Item 0146

This item only covers an **emergency** consultation/visit at the medical doctor's home or rooms, and not cases where a consultation is unscheduled, but not an emergency.

- ADD only to the consultation/visit items 0190 - 0193, items 0161 - 0164 or items 0151 - 0153, as appropriate. Note: Only one each of items 0145, 0146, 0126 or 0147 may be charged, and not combinations thereof:
- Only one of items 0145, 0146 or 0147 may be added to a consultation/visit item, (as appropriate) and not combinations thereof
- To be added to items 0190 - 0193 (as appropriate) for emergency or unscheduled consultations in rooms
- To be added to items 0190 - 0193 (as appropriate) for consultations by doctors normally using 24-hour emergency facilities
- The patient is responsible for the payment if his/her medical scheme does not grant benefits for this service (not applicable to Compensation Fund cases)
- Applicable to Compensation Fund cases for after-hours emergency only (refer to Rule B)

- Rule P is only applicable to emergency travel to a place where the doctor does not normally perform voluntary services, such as making a hospital visit.

Item 0126

This code is used for an **unscheduled** consultation /visit at the doctor's home or rooms.

- ADD only to the consultation/visit items 0190 - 0193, items 0161 - 0164 or items 0151 - 0153, as appropriate. Note: Only one of items 0145, 0146, 0126 or 0147 may be charged, and not combinations thereof:
- Item 0126 may only be added to the appropriate consultation/visit (item 0190 - 0193, 0161 - 0164, 0151 - 0153) for an unscheduled consultation/visit at doctor's rooms or home
- Not appropriate to add to items in the case of confinements in after-hours periods, where a global obstetric fee is charged
- Not appropriate to add to items 1204 - 1210
- The patient is responsible for the payment if his/her medical scheme does not grant benefits for this service
- Practices where no bookings or scheduling of appointments are done, and patients are seen on a first-come, first-serve basis, may not use item 0126.

Launching CODOSA, new medical organisation

Dr Jody-Joseph P Mbuilu

Doctors with foreign qualifications from the Democratic Republic of Congo (DRC) launched a professional organisation, Congolese Doctors in SA (CODOSA), on Saturday 24 March 2018. Recording currently 435 members, all of whom qualified in the DRC, more than 200 delegates from all nine SA provinces participated in CPD activities sponsored by SAMA, PPS/Quantum, Nestlé and Novartis, before embarking on an afternoon of policy debate and voting.

The chairman of the new organisation, Dr Thierry Ngoyi, launched CODOSA, which aims to enhance ethics and professionalism among members, while serving as a medium for solidarity initiatives in response to specific

socioprofessional problems encountered by this group of doctors.

The first general assembly of CODOSA opened with early registration, with guests and delegates arriving at the Sheraton Pretoria Hotel. The morning meeting was essentially dominated by presentations on scientific issues, as seen from the topics covered: vaccination in adults with HIV, presented by Dr Baraldi (Sanofi); burnout management, by Dr Kazadi (psychiatrist); men's health issues, by Dr Polycarpe Makinga (family physician); communication with your patient and disclosing information, by Dr Julius Kunzmann (SAMA); and the role of protein in metabolic programming, by Ms Keamogetswe Seshabela (Nestlé).

Dr Balenda, president of the Wound Healing Association of Southern Africa, introduced the launch ceremony around 12h00, marked by the speech of the CODOSA chairman, in the presence of many generations of doctors with Congolese qualifications, who have been practising in SA for as many as 25 years.

The afternoon was dedicated to a closed administrative meeting, where delegates and members of the new association debated and agreed on the long-term organisational goals. Among them are to continue to strengthen and enhance ethics and professionalism; to offer specific skills-development opportunities; and to improve socioprofessional solidarity in response to lifecycle events affecting the members.



From left: Dr S Lumeya (national general secretary), Dr T Ngoyi (national chairperson), Dr H Nadia (deputy national chairperson), Dr J Mbuilu (public relations officer) and Dr P B Tshikuluila (deputy national secretary)

The majority of CODOSA's members are, firstly members of SAMA. They serve different communities in SA, particularly rural communities. In his opening remarks, the moderator of the day, Dr Jody Joseph Mbuilu, mentioned that "doctors with qualifications of Congolese origin are estimated to approximate 2 000 medical practitioners in SA. They are contributing in different areas and medical specialties within the SA health system. In the past

10 years, more than 80 million clinical encounters were conducted by those doctors, ranging from administrative consultation, primary care consultations, specialised care, HIV and TB care, perinatal and maternal care and nuclear medicine." Their work has contributed to the current improvement of life quality and lifespan in SA. A few of those doctors are also found in cities, in private practices, and in academic institutions as lecturers and professors.

As well as facing the challenges commonly seen within the medical community, doctors with foreign qualifications in general, and those from the DRC in particular, experience specific challenges that have motivated the creation of CODOSA. These challenges range from factors related to DRC current and near future political uncertainty "holding an entire nation hostage", Southern African Development Community (SADC) and regional policies affecting the free movement of peoples, SA immigration and labour laws, HPCSA interpretation and implementation of certain policies, and more. Some challenges extend to the local communities and work places where these doctors practice. These have motivated the creation of CODOSA alongside the many initiatives already begun within SAMA and other organisations.

On World TB Day, members of CODOSA sent a message of hope to the SA communities where they work and live: that they will continue to be on their side, offering their dedication and professional skills, together with the government and health professional colleagues from SA, in order to continue to help curb the burden of disease in general, and TB in particular.

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Life Esidimeni judgment a scathing indictment

SAMA Communications Department

SAMA applauded the judgment by retired Deputy Chief Justice Dikgang Moseneke into the Life Esidimeni deaths, saying that it must lead to action by professional statutory bodies such as the HPCSA and the SA Nursing Council (SANC).

The association also labelled the ruling a scathing indictment of government that raises serious issues of culpability that warrant full processes by bodies such as the HPCSA and the SANC.

Justice Moseneke's ruling was handed down on 19 March, following public hearings that began in October last year. These came after revelations that 144 mental health patients who were moved from Life Esidimeni to outside facilities died because of improper and negligent care. A further 44 patients are still unaccounted for. The remaining 1 418 patients who were also moved are likely to be indefinitely traumatised.

The arbitration hearings were part of an agreed-to alternate dispute resolution process, instead of approaches via individual claims or class-action lawsuits.

"All these would have taken an inexorable amount of time, hence the process followed has been done in an open, transparent and fair manner, but, importantly, also within a reasonable timeframe," said Dr Mzukisi Grootboom, chairperson of SAMA.

He said, however, that the process raised two issues that must be explored.

The first is the issue of "compensation". Each family who lost a loved one will be awarded approximately ZAR1.2m.

"The principle of compensation is undisputed, as it forms part of a case of (medical) malpractice. In this instance, the malpractice was medically, but also socially, abhorrent, and the quantum of the award has been determined by Justice Moseneke as being proper," explained Dr Grootboom.

He said that the second aspect that warrants comment is that of "culpability". In effect, 144 people, perhaps more, died after being entrusted to the care of a provincial health department. Many, such as the former MEC for Health in the province, Qedani Mahlangu, claimed a lack of foresight regarding the consequences of their decision. This was wholly rejected by Judge Moseneke.

"In our view, culpability in this instance has two components: professional and criminal. Professional culpability warrants the full processes by the relevant statutory bodies of the professionals involved, including the HPCSA and the SANC. Why these bodies have been slow to act to date, especially in such a publicised hearing, is inexplicable.

"One would hope that the HPCSA, for example, will be as fervent in pursuing the matter as they have been about a certain medical practitioner's activity on Twitter. Given the volume of information available from the hearings, exhaustive processes are surely not warranted," noted Dr Grootboom. According to him, criminal culpability was also alluded to in the judgment, which suggests that the South African Police Service (SAPS) should investigate the matter. A full record of the proceedings has been provided to them and they, along with

other organs of the justice system, need to do their job and provide a prosecutorial docket to the NPA for consideration.

Dr Grootboom said, "If government can set aside resources for the hearings, resources must be provided for the justice system to conclude its investigation. The intriguing question to consider is whether, given the rejection of the lack of foresight argument by several key players, a charge of murder, *dolus eventualis*, is apt?

"Intent, in the manner of *dolus eventualis* – or legal intention – is considered when the perpetrator objectively can foresee the possibility of their act causing death, and they persist regardless of the consequences. This is a question that warrants consideration in court."

He added that if the test of culpability fails, what happened at Life Esidimeni is doomed to be repeated.

Dr Grootboom said an important take-away from the hearings is the dispelling of the notion that cost-cutting is cost-effective.

"We were told the reason for moving the patients in the first place was to save costs, or because the Gauteng Department of Health was pressured from the 'Auditor-General'. Expedience in healthcare cost lives, and cost-cutting and cost-efficiency are two very different notions. One affects quality, while the other shouldn't. In our current climate of austerity, let us remind ourselves of the victims of cost-cutting, and practitioners need to remember that their only responsibility is to the wellbeing of patients," concluded Dr Grootboom.

PMB review well underway

Shelley McGee, SAMA Private Practice Department, Dr Selaelo Mametja, Bernard Mutsago, SAMA Knowledge Management and Research Department

In SAMA Insider of March 2017, we wrote about the Council for Medical Schemes (CMS)'s intention to review the existing set of prescribed minimum benefits (PMBs) to which medical scheme members are entitled. At that time, SAMA had just completed and submitted comments and suggestions in response to the announcement (Circular 83 of 2016), and we were in full support of the need for a review process, as well as of many of the principles which the CMS had

proposed to apply in consideration of the review process.

SAMA also recognised the limitations and problems that our members experience with the current PMB legislation, including opaque PMB-qualification requirements for patients, non- and partial payment of PMB claims, flawed managed-care processes, and many completely illogical scheme benefit designs, which have been influenced by the nature of the current list of PMB conditions. We

also emphasised that there are several other challenges and failings within the current Medical Schemes Act (No. 131 of 1998) legislation, which influence poor quality of care but may not be adequately addressed by a PMB review.

The Medical Schemes Act requires that the PMBs are reviewed every 2 years, specifically to address:

- inconsistencies or flaws in the current regulations

- the cost-effectiveness of health technologies or interventions
- consistency with developments in health policy
- the impact on medical scheme viability and its affordability to members.

SAMA continued to engage with this important review process throughout 2017, and is now part of the elected multistakeholder PMB Review Advisory Committee, made up of representatives from the National Department of Health, specialist and general practitioners, allied health professionals, medical schemes and administrators, patient advocacy groups and medicine and technology suppliers.

This review committee will begin, in early 2018, to define the principles and lay down the rules of engagement and participation in the PMB review, which the CMS currently views as a complete overhaul exercise of the existing set of benefits.

This process culminated in the publishing of CMS *Circular 6* of 2018, requesting public commentary on the proposed PMB review framework. SAMA submitted comprehensive commentary on the PMB review in March 2018, with the assistance of the Private Practice Committees and comments submitted directly from the membership.

The PMB proposals

The envisaged reviewed PMBs will no longer be disease-based, but should take a service-package-based approach. This represents a major departure from the current situation where some medical conditions are fully covered, while others are not covered at all.

The CMS has defined the goals of the PMB review as follows:

- Reduce the burden of disease: The package should prioritise interventions that will address the burden of disease of the country.
- Ensure financial protection: The package should include services which protect patients against catastrophic/impoverishing expenditures.
- Improve quality of care: The package should improve quality of care through adequately defined services.
- Ensure equitable use of services: The package should reduce the gap between need and utilisation by prioritising vulnerable groups.
- Improve efficiency: The package should cover a cost-effective mix of services, to maximise health gain at the appropriate level of care.
- Facilitate transparency: The package should be drafted in such a way that the population clearly understands their entitlements and obligations.

- Ensure sustainability: The package should outline mechanisms that should be put in place to ensure sustainability.

Achieving all of these goals at once through the PMB benefits review will be a tall order indeed, and the CMS envisages utilising the skills of all the stakeholders who they serve to try and achieve this.

The CMS has proposed service categories, which will consist at a very high level of:

- maternal and neonatal services
- child health services
- preventative services (including education, screening for diseases and family-planning services)
- communicable and non-communicable diseases (including early treatment, management of complications, pathology and radiology, specialised geriatric care and specialist referral where necessary)
- mental health services
- rehabilitation
- palliative services
- emergency services (including immediate management, radiological studies, laboratory tests and referral and transport).

As a clinician looking at this list, one can immediately recognise that there is much detail yet to be thrashed out within these proposed categories, before a decent benefit can be defined for patients.

Yet the CMS has allocated very little time to the whole process – the latest project plan published by the council, in December 2017, gives less than a year to complete all the necessary consultation, and for the committee to make a recommendation on a final, costed benefits package. This is perhaps SAMA's greatest concern if we are to successfully overhaul the current benefits. The PMB review process is envisaged as consisting of several clinical advisory subcommittees, which will debate and decide on the appropriate clinical content of the new PMB package.

In addition, a costing committee has been appointed by the CMS to formulate and conduct costing of the eventual benefit framework, to ensure that the principles of affordability, sustainability and cost-effectiveness are adhered to in the final benefit design.

Response to Circular 6

SAMA has welcomed and eagerly participated in the current PMB review process – there are many challenges and limitations to the current PMBs, and we are eager to assist in improving the situation.

SAMA noted a number of concerns regarding the current PMB review, including

expressing unease at the fact that the review seems to be being undertaken in parallel with the NHI processes, and the fact that the reforms proposed and the scope of the review are so broad as to potentially completely reform the current system, instead of just “reviewing” it. SAMA feels that the proposals are too onerous to be undertaken in a single review process.

SAMA has also identified a number of other regulatory issues that will not be addressed by reforming the PMB package – for example, the fact that schemes do not comply with the current PMB regulations. We do not feel that amending the package content will assist with the enforcement of medical scheme compliance with the regulations.

The proposed revised benefit package also remains very vague at this stage – SAMA included several suggestions for improvement, as well as other aspects of care to be considered for the proposed package.

SAMA has recommended that the PMB review be based on an Oregon-like comprehensive range of both primary healthcare and hospital services, which are well defined, with evidence-based exclusions and inclusions. The Oregon list was also used to guide the original PMBs developed in the 1990s, although at that time, the expectation was that the public sector would be responsible for primary care for the whole country – hence the PMBs were designed to be more hospicentric.

We have also urged the CMS to wait for the findings and recommendations of the ongoing Competition Commission Health Market Inquiry (final report due April 2018), before proceeding with some of the aspects of the review.

Way forward

By May 2018, the PMB advisory committee should have insight into all the public comments submitted in response to Circular 6, which may well complicate the current proposals even further. Lessons from the PMB benefit-definition process, in which SAMA was also involved in 2017, are that this is a painstakingly detailed process of interrogation and debate, involving multiple clinical disciplines, as well as medical scheme clinical and financial advisors, and patient advocates. It is near impossible to have everyone in agreement as to what patients' PMB entitlements should be, and even in cases where definitions have been published as finalised, the balancing act between clinical needs and costs leaves many dissatisfied with the results.

SAMA has representation in both the specialist and GP subgroups, and we hope that our inputs can assist in a transparent, fair and informed review with positive outcomes for private healthcare in the country.

Cape Medical Museum, a hidden gem

SAMA Communications Department



The Cape Town Medical Museum

The Cape Medical Museum, which lies on the doorstep of the V & A Waterfront in Cape Town, in a beautiful, over 100-year-old home, is a great place to visit if you are interested in the history of medicine, particularly as it emphasises both western and traditional medicine in the Cape.

It is located in the precinct of New Somerset Hospital and the old City Hospital for Infectious Diseases, which was originally built by Sir George Grey, then governor of the Cape, in 1859. Currently located in the superintendent's residence, it will soon be relocated to the adjacent old City Hospital administration building.

Founded by a group of enthusiasts in the 1980s, led by J C ("Kay") de Villiers, professor of neurosurgery, who remains its enthusiastic chairman, the museum was proclaimed a Provincial Museum on 24 September 1981, in proclamation 299 of the Government Gazette, and opened its doors to the public in 1986.

The museum houses a most important collection of historical medical artefacts, and emphasises the unique contribution of the indigenous people of the Western Cape as well as the medical practice of the Europeans who settled there. Its collections are unique, priceless and irreplaceable. There are turn-of-the-century reconstructions of consulting



rooms, a dispensary, a dentist's room and operating theatre, and an exhibit of bones used by sangoma's.

History of medicine in SA

Western medical practice started at the Cape in 1652 with the arrival of Jan van Riebeeck.



Initial makeshift hospitals were built, and with time, more permanent structures were erected. In 1818 the first civil hospital, the Somerset Hospital (not to be confused with the New Somerset Hospital, which followed later), was built.

At this time, Western European medicine was in an empiric phase, and diseases were classified

and treated according to the symptoms. Early medication relied heavily on remedies mixed by Dutch apothecaries. Healthcare was influenced by contact with the indigenous San (hunter gatherers) and the Khoekhoe (semi-nomadic herders), who used the abundant flora and fauna for treatment in their religious and medical customs, and who shared their knowledge of indigenous medicinal plants and substances with the new arrivals.

The Malays – slaves, free bondsmen and political prisoners – brought their own culture, which also impacted on the young community.

Nguni traditional medicine was later introduced by the Xhosas who migrated from the Eastern Cape. A unique system of healthcare and folk medicine developed.

Scientific medicine, which employed ether anaesthesia, only reached the Cape during the 19th century, while the first medical school was only set up in 1912 at UCT.

Dental surgery

Jan van Riebeeck was a trained barber-surgeon, and therefore the first “dentist” at the Cape, although he never practised this trade here.

For centuries, surgeons, barbers and in fact anyone who could handle forceps could be called in to draw teeth or treat dental ailments. According to James Chapman (1849 - 1863), strange remedies were used in the interior. For example, a mixture of pulverised dog's teeth and honey was applied to a baby's gums during teething. “Quacks” were rife: in the

1880s, a quack called Sequa travelled around Free State towns in his coloured wagon, dressed as an American Indian, offering his “painless dental services”.

The situation had improved somewhat by 1891, when Cape legislation recognised dentistry as distinct from other medical disciplines. The profession achieved autonomy during the 1920s.

The museum offers guided tours, slide shows, educational programmes, lectures and presentations and archival material. It is also used as a venue for medically related functions.

Take a virtual tour:

<http://www.virtualsouthafrica.travel/capetown/tours/capemedicalmuseum/index.htm>, or contact the museum at capemedicalmuseum@gmail.com.

Recovery of monies unduly paid to an employee in public service

Simon Buthelezi, *industrial relations advisor, SAMA Employed Doctors Sector*

Often, employees find that their employer has unilaterally deducted a portion of their salary without their knowledge. This is done to recover monies erroneously paid to an employee who does not deserve such payment, or without any reason justifying such payment. An employer might have paid the employee for commuted overtime, only to realise afterwards that the employee did not in fact work such overtime, nor was on annual leave that allows the payment of commuted overtime without actually working for it. Or, perhaps, the employer has paid a newly appointed employee at a higher scale than the one he or she should be paid at, only to discover later that such an error has occurred.

The provisions that empower the employer to make deductions

When in a hurry to recover such monies, the employer relies on section 38(2)(b)(i) of the Public Services Act No. 103 of 1994 (PSA), which gives the employer the right to deduct money from the employee if it has been paid erroneously:

“(2) If an employee contemplated in subsection (1) has in respect of his or

her salary, including any portion of any allowance or other remuneration or any other benefit calculated on his or her basic salary or salary scale or awarded to him or her by reason of his or her basic salary, (a) been underpaid, an amount equal to the amount of the underpayment shall be paid to him or her, and that other benefit which he or she did not receive, shall be awarded to him or her as from a current date; or (b) been overpaid or received any such other benefit not due to him or her, (i) an amount equal to the amount of the overpayment shall be recovered from him or her by way of the deduction from his or her salary of such instalments as the relevant accounting officer may determine, if he or she is in the service of the State, or, if he or she is not so in service, by way of deduction from any moneys owing to him or her by the State, or by way of legal proceedings, or partly in the former manner.”

Invalidity of deductions

The labour court has repeatedly decided against the employer in such cases. In a very well-known judgement in Public Servants Association of South Africa on behalf of Olufunmilayo Itunu Obogu v Head of

Department, Department of Health, Gauteng, in which the applicant challenged the power of the state to make such deductions, in the alternative, the applicant sought a declaratory order to have the empowering provision declared unconstitutional. This meant that the entire section quoted above was placed under serious legal scrutiny.

The labour court, in terms of the Constitution, is a court of similar status to a high court. It may therefore make an order of the constitutional invalidity of an act of parliament, although such a declaration will have no force unless it is confirmed by the Constitutional court. This was confirmed by Judge Nkabinde, who was one of the judges handling the matter.

In confirming the invalidity of section 38(2)(b)(ii) of the PSA, Judge Nkabinde stated: “The deductions in terms of that provision constitute an unfettered self-help – the taking of the law by the state into its own hands and enabling it to become the judge in its own cause.”

One can only feel saddened by the unabated continuation of the state in making these unconstitutional deductions, despite numerous judgements against the practice.



Letters to the Editor

The Letters to the Editor page aims to give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare, which you feel should be shared with your colleagues and fellow readers.

Please email contributions to: Diane de Kock, dianed@hmpg.co.za. Our thanks to Dr van Wyk for the contribution printed below.

Communication in our profession?

So much is being said about ethics. For some or other reason I never see an article about communication in our profession.

Whenever I refer a patient, I always write a referral letter with all the necessary information about the case. In approximately half of the cases, I **never** receive feedback – not even a phone call. Patients die or have major surgery and I am not informed!

This I interpret as rude, disrespectful, bad manners and unethical.

Feedback is about the patient's wellbeing and care.

In the past this never happened!

How must we handle this?

Regards,

Dr A L van Wyk
Riversdal

Please see the article on Supersession (right), which answers Dr van Wyk's query from a legal/ethical perspective. We would like to hear what you think – please see above for contact details. Ed.

Supersession complaints persist

Hanneke Verwey, SAMA Legal and Governance Department, **Shelley McGee**, SAMA Private Practice Department

SAMA has written about the issue of supersession in the past, but nevertheless, we continue to receive queries and complaints from members concerned about supersession, and complaining that a colleague has “stolen” a patient. In a profession where collegiate relationships form one of the cornerstones of practice, the violation of trust implicit in supersession is considered a grave contravention of professional ethics.

Definition

One should not lose sight of the fact that supersession has a very specific legal-technical meaning. It is therefore important to understand the concept of supersession before accusing a colleague of acting unethically and unprofessionally. In a healthcare context, Prof. David McQuoid-Mason and Dr Mahomed Dada, in their *A-Z of Medical Law*, describe supersession as “the practice of taking over the patient of another doctor without informing the other practitioner in situations where the patient has not terminated the other healthcare provider's services”.

Underlying rationale

The rule against supersession is intended to ensure continuity of patient care. A patient's treatment may be compromised if the full benefits of the first practitioner's initial findings and investigations are not transferred. Poor communication might also give rise to a claim for damages due to medical negligence. If an adverse event occurs, and a lack of medical history is shown to have been a proximate cause of the damages, the superseding practitioner could be held liable, provided that the practitioner acted negligently in failing to obtain the history. The prohibition against supersession also recognises the duty of collegiality that practitioners owe one another. The initial practitioner should be notified about the transfer of care for the sake of professional courtesy. Lastly, the rule against supersession protects patient autonomy, albeit indirectly. Practitioners should honour the patient's rights to self-determination and to making his or her own informed decisions. The prohibition against supersession does not limit patient autonomy, but rather reinforces

the patient's right to choose, while placing certain obligations on the “new” practitioner to ensure safe transition of care.

Legal context

Although there is no law regulating supersession, it is recognised as improper or disgraceful conduct in terms of the HPCSA's *Ethical and Professional Rules*. Rule 10 reads as follows:

“10. Supersession

A practitioner shall not supersede or take over a patient from another practitioner if he or she is aware that such patient is in active treatment of another practitioner, unless he or she –

(a) takes reasonable steps to inform the other practitioner that he or she has taken over the patient at such patient's request; and

(b) establishes from the other practitioner what treatment such patient previously received, especially what medication, if any, was prescribed to such patient, and in such case the other practitioner shall be obliged to provide such required information.”

Based on the aforementioned definition, taking over a patient from a colleague is permissible, provided that the requirements contained in rule 10 have been met. As such, taking over a patient's care from a colleague will only constitute supersession, and therefore unprofessional conduct, if practitioner B fails to take reasonable steps to inform practitioner A that he or she has taken over the patient at such patient's request, and/or fails to establish from practitioner A what treatment the patient previously received.

Merely providing a patient with a second opinion does not constitute supersession. In terms of the HPCSA's *National Patients' Rights Charter*, patients have the right to a second opinion. Similarly, rule 11 of the *Ethical and Professional Rules* states that a practitioner may not impede a patient (or in the case of a minor, the parent or guardian) from obtaining the opinion of another practitioner, or from being treated by another practitioner. However, once the patient expresses a desire to change practices and/or the practitioner who was approached for the second opinion takes over the patient's care, he or she has to comply with the requirements contained in rule 10.

Supersession in the medical schemes environment

SAMA is occasionally approached by members who query whether medical advisors at medical schemes (who are usually healthcare practitioners themselves) are committing supersession when they decline to grant authorisation for treatment and/or medication for a medical scheme member, usually on the basis of scheme benefits or clinical entry criteria. However, this is not supersession, as the advisor is not taking over the care of the scheme member. Instead, he or she is applying the scheme rules on the granting or refusing of authorisation, in terms of the contract between the member and the scheme. As frustrating as this may be for the healthcare practitioner concerned, it does not constitute a contravention of rule 10.

Concerns have also been raised as to whether medical schemes' use of designated service providers or network arrangements, whereby patients who do not make use of medical scheme-elected service providers may face co-payment penalties, is a form of supersession. In terms of the Medical Schemes Act No. 131 of 1998, medical schemes may appoint designated service providers. The HPCSA's guidelines on undesirable business practices furthermore provide that in an ideal healthcare system, choice should be maximised, as this enhances competition. The guidelines, however, acknowledge that restrictions on the choice of providers may be necessary in the interest of access to healthcare services, provided that quality of care is not sacrificed, and a point-of-service option is offered to patients, even at additional cost, to allow them to consult a provider of choice. Provided that the patient may still elect to consult with a practitioner of his or her choice, even at an additional cost to the patient, patient choice and autonomy

will not be limited unreasonably. If a patient transfers his or her care to a scheme-elected service provider, the provider will naturally have to comply with rule 10.

Occupational health practitioners

Patients sometimes consult with onsite occupational health practitioners instead of their GPs. This is often motivated by considerations of convenience and costs. Provided that the occupational health practitioner has not permanently taken over the patient's care, rule 10 does not apply. However, if the patient expresses a desire to change practices, it is advisable for the occupational health practitioner to comply with rule 10.

Group practices

In a group practice, patients are often allocated to practitioners by reception staff. This is a possible breeding ground for supersession and a contravention of the ethical rules relating to touting and canvassing. It often happens that receptionists offer patients an appointment with another practitioner, especially when the historical provider is on leave. Patients then sometimes choose to transfer their care to the new practitioner permanently. Patients' wishes should be respected, and it may be that the patient has, for whatever reason, simply found a better fit. However, the new practitioner then has a duty to comply with the provisions of rule 10. Reception staff are not bound by the ethical and professional rules, but this is no excuse for the superseding practitioner to flout rule 10. It is also impermissible to "tout" for patients, or have someone tout on your behalf. If the reception staff direct patients towards a particular practitioner (and away from others), it may be that the staff are acting as touts for that practitioner. Provided

that he or she is aware of the receptionists' conduct, this would constitute a breach of rule 10 on the part of the new practitioner.

Specialists

In the case of referral by a GP to a specialist, a process for the sharing of information should always be in place, and patients should be referred back to their GP for general treatment. It is not appropriate for a GP to refer a patient to a specialist, only for the specialist never to be heard from again. If a patient attends at a specialist's practice without a referral, the specialist should take reasonable steps to inform the patient's GP, and to obtain the relevant medical history.

Hospitalisation

Patients often switch providers following hospitalisation. For example, a patient may be admitted on an emergency basis at a hospital where their own practitioner does not have privileges. The admitting practitioner may then recommend that patients follow up with them after discharge, rather than returning to their original practitioner. However, practitioners may only take over a patient's treatment from a colleague at the request of the patient, and should not initiate such a takeover themselves unless there are extremely compelling reasons to do so. Regardless of whether or not the transfer was patient initiated, the superseding practitioner has a duty to notify the initial practitioner, and obtain the patient's medical history.

Conclusion

Supersession usually happens quite innocently, and may take place along a continuum of normal practices. As such, it is important for practitioners to familiarise themselves with the content of rule 10 and the meaning of supersession, lest they find themselves either the unintentional perpetrators or the victims of supersession.

SEDASA AGM addresses key issues

SAMA Communications Department

Leadership structures and task teams were appointed at the Senior Doctors Association of SA (SEDASA) AGM, held on Saturday 24 March 2018.

As one of the biggest SAMA interest groups, SEDASA represents both the Employed Doctors in Public Service (EDIPS) and the

Employed Doctors outside Public Service (EDOPS). Representatives from all provinces and SAMA branches were invited to attend the AGM, to address burning issues affecting members in their day-to-day interactions with employers, and healthcare in general. Task teams to investigate commuted overtime,

e-disclosure, the SEDASA constitution and other relevant issues, and to interact with SAMA, SAMA subsidiaries, the Department of Health and other role players, were appointed to ensure an active role in decision-making, and the implementation of such decisions, on issues relating to SEDASA members.

Successful CPD meetings

The KZN Midlands branch recently hosted three well-attended and successful CPD meetings – two in Pietermaritzburg, and one in Kokstad.

The topics were “Cannabis for medicinal (and other) purposes: A holistic view for doctors”, by Shelley McGee from SAMA Private Practice Department at head office, and “Informed consent and medical confidentiality”, by Tessa Brennan from Sanlam.



Shelley McGee (SAMA head office), Dr Brett Graig (Kokstad Private Hospital), Mandy Hattingh (branch secretary)



Tessa Brennan, second from left, with branch members and the Sanlam team

Medical indaba helps to equip doctors

The Lowveld branch held a medical indaba at Bundu Lodge in White River on Sunday 25 March 2018 for an audience of 55 private and public sector doctors and their billing administrators.

Dr Hlombe Makuluma, author of *The Business of Healthcare – Managing your Private Practice*, spoke on the business aspects of operating private practices, law and ethics and the role of the health professional.

The purpose of the day was to empower health practitioners with knowledge tools to assist them in operating the business aspects of a health practice, within the framework

of ethical systems, to reduce potential medicolegal challenges.

The indaba took the doctors through the legal and ethical guideline framework provided by the HPCSA.

The emphasis was on ensuring that doctors understand their medicolegal risks, and how to reduce them, as well as the principles of the “law of contract”, which is commonly known as informed consent.

Great presentations, outstanding catering with pretty decorations, and generous sponsorships made this day a success for all who attended.



Left to right: Dr Bruce Malumane (council chair), Dr Josephine Ngomane, Dr Bongki Baloi (council representative for private practices)



Dr Badenhorst retires

A long-time member of the SAMA Goldfields branch, Dr W J Badenhorst, a GP in Welkom, retired from active practice at the end of March 2018.

He became a member of SAMA in 1971, and had practised in Welkom since 1974. He was also the president of SAMA's branch council in 1983.

The branch wishes him and his wife, Hanti, the best of luck in their new surroundings in Cape Town.

Psychotropics in psychiatry

The Griqualand West branch hosted a CPD meeting on Thursday 22 March 2018 at the Garden Court, Kimberley. The topic discussed at the meeting, which was presented by Dr N K Kirimi, was “Psychotropics in psychiatry”.

Dr Kirimi qualified as a doctor at the University of Medunsa in SA, and went on to qualify as a specialist psychiatrist. He currently works full-time in the public health sector in Kimberley, and is the HOD of the Department of Psychiatry at West End Hospital. His clinical interests include child and adolescent psychiatry.

In Dr Kirimi's presentation, he used journal articles to lead an interactive discussion with the group on how to deal with/treat issues that arise from clinical practice work.



Dr M J Ngundu (chairperson, Griqualand West branch) handing over a gift to Dr N K Kirimi for an excellent and informative CPD presentation

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Why is building things that last, so last century?

There's a light bulb in a fire station just outside San Francisco that's been burning for 117 years, over a million hours and counting. Which makes you think, if we can make things that last, why don't we? And shouldn't we? Especially in a time when the world needs it most. At Sanlam, we still believe in this way of thinking. That's why, for the last 100 years, we've been hard at work building financial futures, lasting legacies and a better world for others to inherit.



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