

# SAMA INSIDER

AUGUST 2013

## National Development Plan 2030: An overview



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# CHANGING THE FUTURE OF HEALTHCARE

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## EDITOR'S NOTE AUGUST 2013



Conrad Strydom  
Editor: *SAMA INSIDER*

### An invitation to a new start

I suppose introductions are in order. As the new editor of the *SAMA Insider*, the mouthpiece of the South African Medical Association, my task is clear: gather information relevant to SAMA members and present it clearly and with concision. Not being a medical professional – I think ICU is a phrase that follows 'peekaboo' – or a manager in this organisation, my efforts to communicate the heart of SAMA's policies therefore rely greatly on you, the members and employees of SAMA. If there is a particular matter which you would like to be highlighted, or a suggestion that you think could improve this publication, go ahead and contact me directly on the number or email address listed below.

The South African government has committed itself to numerous development initiatives, many of which have direct implications for the health sector. In this issue we examine the National Development Plan (NDP) 2030, the brainchild of Trevor Manuel and the National Planning Commission, which has set very high standards for the development of healthcare in this country. We examine the specifications set by the NDP, courtesy of SAMA's resident health policy researcher, Bernard Mutsago.

Sometimes it is necessary to take a step back, if only to make room for a leap. It is therefore with some pleasure that I can announce that the issue of the *SAMA Insider* you currently hold in your hands will be the last one in the current format. Doctors lead lives that are exceedingly busy and often highly stressful. They cannot be expected to digest long articles of content which are often only of peripheral value to them.

We hope to bring you a brand new *Insider* in the coming month, one that directly addresses the topics both public and private sector doctors struggle with in their daily practices, and the role SAMA plays in caring for the needs of its members. The perception that SAMA does not do much to foreground its members' needs is an old one, and based largely on a failure to adequately communicate the organisation's efforts on their behalf. We hope to rectify this lamentable situation, starting with the upcoming September issue.

Until then, pleasant practice!

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## Serving the rural communities – An ongoing challenge



Prof. Zephne van der Spuy, President, SAMA

It has been recognised that many of our rural communities are under-served in terms of appropriate healthcare provision. This has been a source of concern within the National Department of Health and a challenge for provincial authorities.

Our universities have been encouraged to address the needs of rural health and there are now some programmes which are particularly proactive, supply considerable outreach and appropriate training for our students, making them aware of the requirements within our rural communities. There has been a move in the faculties of health sciences within South Africa to establish rural campuses which must ultimately benefit the communities in which these operate.

It is difficult to trace where our graduates move, but some research at the University of Witwatersrand indicates that almost 50% of graduates from 1960 to 1994 were working abroad and of the remaining graduates about 36% were working predominantly in the public sector. There is an ongoing concern about the shortage of full-time specialists in regional public hospitals and this is a further barrier to adequate healthcare provision.

Family medicine is the centre of good healthcare and these skills are essential to our health services. It seems that the factors which influence our medical students in determining their future career include the role models they meet during their training, their own origins, whether rural or urban, and their

personal motivation. All these influences play an important role as to where they eventually will practice. We recognise that recruitment by industrialised countries of health personnel from developing countries threatens the viability of crucial health programmes. Some countries depend extensively on overseas trained doctors to fill many of their vacancies and this must be an ongoing cause of concern.

Unless conditions of service within the developing countries are improved it is unlikely that this trend will be reversed. While there is an agreement that the Southern African Development Community (SADC) doctors will not be recruited to South Africa, this has not assisted in retaining expertise as these professionals have then often moved to industrialised countries and their expertise has been completely lost to Africa.

Our problem in providing good rural healthcare is not unique and it is interesting to look at the experience of countries such as Australia, Canada and the USA. In North America it seems that rural recruitment is enhanced by the presence of residency programmes in those areas, investment in undergraduate student support and these graduates then eventually returning to these communities, at least for a period after graduation. Canada has developed teams of family physicians who work together in group practices in isolated areas and who are given generous leave privileges, excellent support and specialist backup.

**There is an ongoing concern about the shortage of full-time specialists in regional public hospitals**

Similar schemes have been put in place in Australia in rural areas where community intervention and participation is perceived as important. This has not yet been attempted in South Africa. We are very conscious that in South Africa we do not retain our staff and there are

numerous reasons why clinicians are reluctant to work in under-served areas. On a personal level the facilities for education for their children or career prospects for their partner may impact on their decision.

In addition, the lack of facilities and clinical support, inadequate staffing in many rural hospitals and inadequate specialist support may also mitigate against commitment to rural work.

Given that over 60% of our medical graduates are women, their career choices are often different to their male colleagues and it may be more difficult for them to move into rural areas. The community service year has certainly not worked as a means of retaining doctors within South Africa and possibly needs to be revisited and restructured. Perhaps we should consider developing the Canadian example in our rural areas.

Family physicians there are offered higher salaries, many benefits within rural practice and, because redundancy is built into the practice, there is opportunity for generous leave and Continuing Professional Development (CPD) activities. If we wish to grow rural practices in isolated parts of South Africa, we need to be sure there is an "excess" of family practitioners in all services.

For example, if a hospital service requires three family practitioners, ideally we should have four or five. Generous leave privileges, recognising the need for easily accessed CPD and possibly the need to move to larger centres for updates and interaction may make the practice more attractive.

Undoubtedly the costs of such a service will be raised but the establishment of good centres for rural health will ultimately benefit public health. If we can involve the community, so much the better, but at the moment this is possibly not practical within our services.

Good access to healthcare in the rural communities is important. In addition we need to be innovative as to how we supply specialist services. We must develop partnerships and regular interaction. It is essential that the family practitioner, the core of these services is available and on site in rural areas. This is a challenge which we need to address fairly urgently.

There are inspiring examples of successful development of superior rural care. We need to examine these, replicate these models and expand them further.

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Thinking ahead

# Healthcare and the National Development Plan 2030 (NDP)



Bernard Mutsago, SAMA Health Policy Researcher

achievements are interlinked, hence the sibling topics of Education and Health, addressed in the NDP's Chapters 9 and 10 respectively, would be the main focus of any health establishment like the SAMA.

The greater part of the South African society seems to embrace the goals of the NDP, although the million dollar question being asked by many stakeholders is HOW the Plan will be implemented. The NDP has received a number of quite vicious criticisms from some quarters, including the labour movement.

## The twin national challenges

The NDP is explicit that the two large-scale challenges facing South Africa are poverty and inequity, and this need to be addressed. Despite gains made since Democracy, these two challenges persist as giant enemies of development and are factors in the health profile of the nation.

**The greater part of South African society seems to embrace the goals of the NDP, although the million dollar question being asked by many stakeholders is how the plan will be implemented**

Healthcare in South Africa unfortunately bears the ugly faces of both monsters, at a huge cost to social stability. Studies have clearly demonstrated that material deprivation perpetuates the poverty-ill health cycle.

It is indisputable that globalisation and market-led health delivery models have left the poorest of South Africans at the mercy of the health system.

Too many South African die unnecessarily from preventable and curable diseases because they cannot afford basic health care. In such national circumstances, calls for physicians and others in the health system to be 'attorneys for the poor' and defenders of the human right to health, have been heard.

On the other hand, inequalities in the broader South African society express themselves in inequalities in health. The nation experiences pervasive differentials in health outcomes, based on race and economic status. For example, nearly 20 years after the 1994 turning point, black South Africans have an average life expectancy that is 18 years less than that for whites.

The inverse care law is at play in South Africa; the majority of the underprivileged South Africans, being black, sick, poor and rural, are deprived of healthcare resources and rely on a failing public system, while a massive 80% of private health is lavishly funded by the wealthy. The grand plan also singles out the central health challenge of "a widespread disease burden compounded by a failing public health system", which, according to the plan, is one of the nine main challenges identified in the Diagnostic Report.

## Multi-sectoral approach

One of the most attractive features of the NDP is its multi-sectoral approach, an approach that is highly recommended for addressing health challenges. The plan address several complex issues, all of which have some direct and indirect linkages to health, such as: Demographic trends, the environment, education, technology, the economy, employment, infrastructure, human settlements, social protection, gender, corruption and globalisation.

The plan underscores the pre-eminence of addressing Social Determinants of Health, which are acknowledged internationally as drivers of health inequities. These determinants are shaped by a wider set of forces including economics, social policies, and politics. South Africa's National Service Delivery Agreement (NSLA) highly recognises

the importance of addressing the social health determinants.

## Health targets for 2030

The NDP sets out key targets for each sector. The targets for health, delivered under the overarching theme of "Providing quality healthcare for all", are set out below:

- I. By 2030 everyone must have access to an equal standard of basic health care regardless of their income.
- II. A life expectancy of 70 years by 2030, for both men and women.
- III. The under- 20 age group should largely be an HIV free generation
- IV. The infant mortality rate should be reduced from 43 to 20 per 1000 live births
- V. The under-5 mortality rate should be reduced from the current 104 to 30 per 100.
- VI. Maternal mortality rate should decline from 100 to 500 per 100 000 live births.
- VII. All HIV positive people should be on treatment

VIII. Reduce non communicable diseases by 28% and deaths from drug abuse, road accidents, and violence by 50%.

With specific reference to Human Resources for Health (HRH), the plan aims to achieve the following, among others:

- Accelerate the production of community specialists in each of the five specialist areas (medicine and surgery, paediatrics, gynaecology, psychiatry, and anaesthetics).
- Recruit, train and deploy 700000 to 1.3 million community health workers to implement community-based healthcare.
- Clear separation of policy making from oversight and operations.
- Link training of health professionals to future diseases, especially different categories of non-communicable diseases.

The above targets will be reached through a set of fundamental initiatives or actions, including: implementation of NHI; addressing the social determinants of health; reducing the burden of disease; strengthening the national health system; and building human resources for the health system of the future.

We have already begun to see some of the initiatives being implemented, e.g. overhaul of hospital management, implementation of NHI, reduction of maternal and child deaths, to name a few.

## Other highlights

- The NDP notes that "South Africa has the means, the goodwill, the people and the resources to eliminate poverty and inequality". In terms of healthcare, one sees that, as in Apartheid, the country has enough resources; the problem is failure to deliver. The system is riddled with so much corruption and inefficiency.
- The plan places much premium on a future health system based prevention and population-orientation to health care (primary health care)
- The importance of Public-Private collaborations. This is important in unlocking the power of collectivity in health delivery.
- The impact of the demographic transition on the health system.



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# Celebrating Women's Month with Dr Gwen Malegwale Ramokgopa, Deputy Minister of Health

Zukiswa Nomnganga, PR and Media Liaison Officer, SAMA



In the spirit of Women's Month, SAMA Insider (SI) conducted an exclusive interview with Dr Gwen Malegwale Ramokgopa (DM).

## SI: What does your role at the Department of Health entail?

DM: I'm the Deputy Minister of Health in South Africa. Overall, I support the minister in his function and there are also some areas that have been delegated specifically. The delegated functions are the non-communicable diseases, which include high blood pressure, diabetes, and for women specifically, such as cervical and breast cancer, among other cancers, as well as mental health.

Secondly, these functions include injury and trauma; thirdly the issue of pharmaceutical services; fourthly information systems including e-health (as we know, we are now in a digital world); research and development; and last but not least issues surrounding governance of the institutions that report to the Minister of Health.

As you can see I have a vast range of responsibilities, but we work very well with the Minister.

## SI: Has your previous experience as an activist contributed to the way you approach women's issues in the health sector?

DM: Most definitely, my experience as an activist does assist and it's important that we

acknowledge that the struggle for liberation in South Africa was centred around servicing our people and ensuring that people have a just and better life.

Therefore, the approach to health is to ensure that people have access to it and patients' rights are protected, and that we do everything possible and put in extra effort to extend services, and also extend the right to affordable care for those who do not have access to it. Another important part of what I do is to look at the underlying causes of why we cannot extend the rights of health, including reproductive rights, to most people and especially women.

One major underlying factor is that we come from a society which is patriarchal, and while the Constitution has guaranteed equality between men and women, and also among different races, we find that women, especially African women, still bear the greatest burden with gender-based violence, and those African women also bear poverty-related diseases like cervical cancer and don't have much access to healthcare.

The struggle that we waged is not yet complete, and so the approach from an activist perspective ensures that we don't just get comfortable in our boardrooms but we reach out to communities and stakeholders to work together to ensure that all South Africans enjoy this democratic society.

## SI: Do you think there has been any progress?

DM: Most definitely, there's been progress. The first thing is that we supported the Minister and the Presidency, as the Department of Health, was to reduce the burden of HIV/AIDS that was the heaviest in women. We have achieved great success which has been acclaimed by a number of United Nations forums, such as the World Health Organization (WHO) and UNAIDS, and many scientists are complementing South Africa for having made this significant progress.

For example, the mother-to-child transmission over 3 years was reduced from above 8% to 2%. All these efforts resulted in increased life expectancy.

There was a time when life expectancy of South Africans was hovering at around 49 years,

and with all that effort we have managed to increase it to 60 years. We need to do more and target 70 years as the National Development Plan envisions, but we have certainly made great progress. Secondly, we have also worked with the nurses – mainly women – who agreed to work with us where there were no doctors to help us with providing medication.

One approach is to think outside the box and to mobilise resources and also a willingness of South Africans to deal with challenges and that we were able to have more than 20 million people coming forward to test. An activist approach does help.

We have just identified a need to introduce a vaccine for the human papilloma virus (HPV) that causes cervical cancer and we have established a Ministerial Advisory Committee on cancer, overall, and that also focus on initiatives that target what affects women and men generally, but also to improve the lives of women, because even when there's a high disease burden, women primarily suffer and bear the burden as the biggest care-givers.

## SI: Why is that?

DM: It's the nature of women as they empathise and socialise more, and are able to focus on the needs of others, and it also could be because of nurturing. If we look at Nelson Mandela, who gave his life to the liberation of others, we can see that there are also men who are equally caring and we must continually mobilise all society to care for their neighbours and to take care of each other.

That is why it wasn't difficult for our nurses to say 'Count on us' when South Africans needed us to combat the high death rate caused by HIV/AIDS.

## SI: What is the role of women in health today?

DM: The role that women are meant to play is to be true to the legacy of the South African women that contributed to the country being free.

For example, Charlotte Maxeke was the first South African and African woman to graduate with a BSc, but came back to give her life to the service of South Africans.

Women like Mme Bec Maxowa, who was among the first women to serve in the health

committee in parliament and continued to mobilise society around South Africa and the health sector.

For instance, when I was a student there were other students who were being excluded because they were activists, but on one hand we had to be in the struggle and on the other hand we had to pass.

We adopted a slogan that 'passing was a revolutionary task of an activist' and that the country will need skills and therefore women alongside men in the healthcare sector need to look at the opportunities that are there and emulate people like Dr Nono Simelela, who was the first South African woman to qualify as an obstetrician and gynaecologist.

We need to make sure that young people do not drop out of school and that they do well at university, and that they realise that they have lots of opportunities that we didn't have and must not undermine these opportunities, for their own sake and the sake of our country. Also in health, we have bursaries and programmes like the training of medical students in Cuba, and we are also engaging with other medical schools to expand their training platforms.

There are lots of opportunities for young people in the health sector and we are proud that many young women are contributing to society and are also participating and not just having fun and waiting for men to be providers, but are alongside boys and men as healthcare professionals to make a contribution.

## SI: What are some of the skills and/or attributes required to fulfil this role?

DM: The important thing for young people is to be self-confident and know that as a human being they have a human right. If anyone feels that their rights are being ignored, they must break the silence and come forward so that they can be assisted.

They need to appreciate the spirit of *ubuntu* that 'you are, because others are', like getting support from your family, peers, community and professionally, and the support of your colleagues.

To have that sense of *ubuntu* helps you to be well-rounded, even as health worker. It's important for young people to be informed, listen to the news and to know of what opportunities and threats there are, as well as to read – we find that young people don't read books. Continuous development as a human being is also very important.

You are never too old to study and education is always the key, with this we can learn from history. We also need a spirit of innovation, what I learned from the ANC and the struggle is that we live in a world where there are always no answers and we must generate answers, we must innovate.

In this regard, we also managed to contain the AIDS epidemic through innovation and it's the first time that the world has seen such levels of an epidemic since the times of bubonic plague.

We need to invest in science and as a result we have established a Ministerial Advisory Committee on research and also announced a commitment to train a minimum of 1 000 PhD students over 10 years. Therefore, it's important to invest in innovation and research.

It's important that our generation appreciates the need to innovate and create new knowledge, new systems and opportunities to solve our problems, and also to contribute to knowledge on a global scale.

## SI: Has there been any progress in transformation relating to women in the medical profession?

DM: Most definitely, there has been a great transformation, but we have not arrived at our goal and we still need to do more. We still have a large male majority of health professionals, even in gynaecology, which is an area of women's health.

If you look at where we have a majority women, it's within nursing, which we need to sustain as well. In leadership we need to make sure that we see a lot of women, we need women to be researchers and we have opportunities that are opening.

We are strengthening programmes to support women who are survivors of gender-based violence and we are also working with other departments to reduce this in our society.

The department and the sector is heading in the right direction in terms of transformation and making sure that women's rights are respected as human rights.

Women should participate and be in leadership positions in important sectors such as science, research and education in medical schools.

If you look at Ms Malebona Precious Matsoso, Director-General of the Department of Health, she is a woman who is competent, skilled, adequate and experienced. I think the sector is changing but we still need to do more.

## SI: Do you have any advice for young female doctors?

DM: They must know that they have made it and must be proud that they have made it as young female doctors in a profession that was previously male-dominated.

## SI: In your view, what does the future hold for medical professionals in this country?

DM: In the medical profession, we are establishing the National Health Insurance and we need to understand that this system is there to promote health more as a primary intervention.

We need to be closer to communities and that is why we are re-engineering a primary healthcare system, and why we need lots of doctors to be available at a community level. We have also established district specialist teams in district and metro municipalities because we want to tackle illnesses at that level.

We are also concerned about the high burden of disease in our country, both on an individual scale and in society. We need to adopt a different outlook – that we shouldn't wait for someone to need a hospital before we can intervene.

We must promote health and we have instituted legislations to reduce 30 foods in the market, especially in the food industry, and to reduce salt since we have hypertension and heart attacks. Especially now it's no longer affecting just the elderly people, but also young people who are economically active.

We also want to ensure that we eradicate certain diseases that are vaccine-preventable so we are saying to the health sector that the National Health Insurance is about promoting health and reducing disease burden, but also that we practise evidence-based, quality care in hospitals and various facilities. We are geared up to promote the health of South Africans and to provide quality and affordable care in the public and private sectors.

We want to encourage healthworkers to take an interest in the journey that we are taking, which is further deepening our democracy and the Constitutional rights of South Africans with respect to health. I would like to add that in journalism and the promotion of health, female journalists take an interest in issues of health from a perspective of empowering the community with positive knowledge.



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## Free State SAMA Trade Union 2013: We have a vision



Dr Dirk Hagemeister, SEDASA

We have a vision of a health system that provides quality healthcare for everybody, a system where highly motivated healthcare professionals work in a safe environment to preserve and improve the health of their patients, a system where experienced senior colleagues take pride in leading and teaching their younger colleagues and where these younger colleagues mature into highly skilled professionals in a supportive team. We do, however, recognise that the current system is far from this vision. It will require hard work and probably a number of struggles to get closer to the realisation of this vision.

As a medical association, we acknowledge the shortcomings of our organisational structures, and the long walk that will be needed to put the structures in place to guide the improvement process, optimally utilising the skills and knowledge of our members.

SAMA is registered as a trade union under the Labour Relations Act, and as such it is the prime representative of the medical professionals in salaried positions. To run up to the expectations of our members, and to promote our vision of a better health system, we will need representatives at local level in the facilities. These representatives (shop stewards) will act as SAMA's eyes and ears in the health facilities, and they will help our members to find assistance from the industrial relations unit of SAMA if this should be required.

Our experience teaches us that in the current situation, even the health of the health professionals employed at facilities in South Africa is at stake.

There is often an utter disrespect for the responsibilities defined by the Occupational

Health and Safety Act and other relevant legislation. As a result, our members, and in particular the more junior 'frontline' staff is exposed to unacceptably high risks of disease transmission e.g. drug-resistant tuberculosis. If damage occurs or is threatening to occur (e.g. in the case of needle stick injuries), the system is anything but supportive to the victims, confidentiality is not protected and preventative as well as curative services for occupational diseases are not adequately available.

Other challenges and transgressions we recently encountered were the unilateral withdrawal of approval for Remuneration of Work Outside Public Service (RWOPS) during office hours by the Free State Department of Health and the attempt by the National Health Laboratory Services (NHLS) to unilaterally reduce the salaries of registrars in their service.

On both occasions, the respective employers tried to alter the existing status quo to the disadvantage of our members without prior consultation and ignoring due process.

As a medical association and a trade union we have resisted these attempts, with or without support from other partners in the field, and we are prepared to continue opposing unjust treatment of medical professionals by their employers. As in the current disputes, we are aiming at constructive solutions, keeping the interests of our members at heart and the needs of our patients in mind.

Together with the Democratic Nurses of South Africa (DENOSA), SAMA has initiated a nationwide project aiming at Positive Practice Environment (PPE). It is up to us to fill this project with life, and we will need the help and collaboration of all our members to succeed in making the working environment safer and more sustainable. The focus for the first term is set on the safety at the workplace as well as at the compliance of the employer with the regulations about salary and employment.

For our province in the Free State, we as SAMA envision to use the coming months to establish the following:

Local representation or 'shop stewards' at the majority of the eligible facilities and structures in the province. This includes public sector hospitals, regional primary healthcare structures, NHLS regions etc. These representatives will be in contact with their respective management structures, and

will be supported by the SAMA structures at branch, provincial and national level.

An intense dialogue with the provincial management structures of the public sector employers (FS Department of Health, NHLS) about Occupational Health and Safety Plans, Staff Development Plans and the Human Resources Plans. With the support and active involvement of our members, it will be essential to interrogate these plans thoroughly.

As healthcare professionals, we are in a prime position to assist with the development and implementation of these plans. Our members will contribute their expertise on facility level: Are the Health and Safety Plans realistic? Are they being implemented? Are staff development projects realised? Do the members have their individual development plans? Is the staffing appropriate and are the health professionals in the correct posts and salary ranges according to their tasks?

Towards the end of the term (early 2014), the local representatives shall have an opportunity to convene on provincial level with the aim of providing training for their shop steward roles, reflecting on the challenges and advances in the province and to elect a new provincial leadership for the SAMA trade union and its sub-committees in the Free State.

As stated above, we are aware of the multiple challenges and shortfalls. The recent weeks have been dreadfully busy with controversies regarding RWOPS in the province and the salaries of NHLS registrars nationwide. On a daily basis we experience how the employers are taking advantage of our colleagues, and it is clear beyond doubt that we need to unite to empower the doctors of South Africa to deliver quality services to all in need in a safe and sustainable environment.

We will contact the facilities and areas in the province to organise local meetings and to identify local champions, but we will never succeed in this endeavour without your participation and engagement.

The future of the health care system in our country and that of the health professionals in this health system lies in your hands. Do not throw it away.

Together, we can make healthcare in South Africa a better workplace, and by ensuring a well-resourced, supported and sustainable workforce, we will improve the health of all those living in our beautiful country.

# Medical Protection Society: When normal is wrong

The Medical Protection Society shares a case report from its archives

Mr B, a 35-year-old businessman, consulted Dr L, a urologist, over the telephone requesting a vasectomy. Mr B had been married for 12 years and the couple had three children, aged seven, four and two.

Dr L explained the procedure briefly over the telephone to Mr B, stating that there was a slight risk of infection and bleeding from the procedure and a very slight risk of chronic scrotal pain. Dr L then sent Mr B the hospital admission form and the consent form, to bring back with him on the day of the operation.

Mr B was admitted to the ward and only met Dr Q, the urologist who would perform the operation, briefly before having his anaesthesia. In that short visit, Dr Q introduced herself to Mr B, checked his signature on the consent form, and told Mr B he should be out of hospital in a few hours' time.

On discharge later that day, Mr B was advised to get a sperm count organised by his doctor in 12 weeks' time. He claimed later that he was not given any practical advice on contraception, nor told that there was a risk that the vasectomy might not have worked.

Dr Q did not see Mr B after the operation; instead it was the nursing staff that discharged Mr B and gave him advice regarding his sperm count check.

GP Dr X saw Mr B in clinic and was surprised to hear about the operation but still requested a path lab test for his sperm, although he failed to label that it was post-vasectomy. Dr X advised Mr B to phone him for the result.

Mr B contacted the surgery but could not get hold of Dr X. The secretary mentioned that the report said 'normal', which Mr B interpreted as meaning that the operation had been successful.

Unfortunately, Mrs B became pregnant and only then it was made clear that Mr B's sperm count was normal. Mr B made a complaint against all three doctors involved. The case could not be defended and it was settled for a moderate sum.

## Learning points

Vasectomy is one of the technically simplest urological procedures and yet one of the most litigious. While the procedure might be simple, the consent process is not. Informed consent is best gained in person rather than



over the telephone and ideally should be performed by the person performing the operation. If it is gained a few days or more before the procedure, consent should be confirmed on the day of the procedure by verifying the patient's understanding of the procedure.

Going through the operative risks of the procedure is not sufficient. The failure rate of vasectomy, either due to failure to remove adequate sections of both vasa or recanalisation, albeit small, is of crucial significance, and must be mentioned and documented.

The patient must also be told that it takes around 12 to 14 weeks on average for the sperm to be non-motile or absent after vasectomy, and thus two separate sperm samples should be provided at these time intervals, and contraception used until the patient receives the 'all-clear' from these samples.

These sperm samples should be marked as post-vasectomy so the processing laboratory understands that the desired result would be to have no sperm or few non-motile sperm. If the patient's GP is expected to send these samples then a discharge letter explaining this plus the procedure should be sent to him/her, so that he/she is aware of the situation.

The results of the sperm samples should also be sent in writing to the patient's GP as well as the patient with a letter from the urologist who performed the procedure stating the 'all-clear' or otherwise. If viable sperm are still present, the patient should be advised to continue contraception and provide a further sample four weeks later.

Results should not be given over the telephone by non-medically-trained staff, to avoid potential miscommunications as happened in this case.

This case illustrates the commonest reason for medical claims – poor communication. There was poor communication at multiple stages: during the consent process, between urologist and patient after the operation, between urologist and GP after the operation, between GP and sperm laboratory, and between patient and urology secretary.

While each of these errors might appear small in isolation, together they added up to an undesired outcome.

*The original case report can be found in MPS's edition of Casebook Vol. 21 no. 2 - May 2013 at <http://www.medicalprotection.org/southafrica/case-reports-may-2013/when-normal-is-wrong>*

# Medical records: Retention and storage

SAMA Legal Department

All practitioners have an obligation to retain the medical records of their patients. This obligation exists for a variety of reasons. These reasons include ensuring the continuity of care of the patient and to serve as evidentiary record in the event of any litigious or professional dispute or complaint.

Because medical records contain confidential information of a patient's health status, they fall under section 14 of the National Health Act:

## 14. Confidentiality

- (1) All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.
- (2) Subject to section 15, no person may disclose any information contemplated in subsection (1) unless-
  - (a) the user consents to that disclosure in writing;
  - (b) a court order or any law requires that disclosure; or
  - (c) non-disclosure of the information represents a serious threat to public health.

This means that over and above the obligation on the practitioner to retain the health record, there is a statutory obligation to ensure that the confidentiality of the medical records is preserved.

These records must be kept in a safe place where they can be accessed only by persons who are authorised to have such access. Questions are, however often posed to us relating to the length of time records should be kept and the keeping of electronic records.

The Health Professions Council of South Africa has published helpful guidelines in respect of the retention of medical records, "Guidelines on the Keeping of Patient Records" (second edition 2008) at paragraph 9 quoted below:

- 9.1 Health records should be stored in a safe place and if they are in electronic format, safeguarded by passwords. Practitioners should satisfy themselves that they understand the HPCSA's guidelines with regard to the retention of patient records on computer compact discs.

- 9.2 Health records should be stored for a period of not less than six years as from the date they became dormant.

- 9.3 In the case of minors and those patients who are mentally incompetent, health care practitioners should keep the records for a longer period:

- 9.3.1 For minors under the age of 18 years health records should be kept until the minor's 21st birthday because legally minors have up to three years after they reach the age of 18 years to bring a claim. This would apply equally for obstetric records.

- 9.3.2 For mentally incompetent patients the records should be kept for the duration of the patient's lifetime.

- 9.4 In terms of the Occupational Health and Safety Act (Act No. 85 of 1993) health records must be kept for a period of 20 years after treatment.

- 9.5 Notwithstanding the provisions in paras 9.3 and 9.4 above, the health records kept in a provincial hospital or clinic shall only be destroyed if such destruction is authorised by the Deputy Director-General concerned.

- 9.6 In addition to the time periods mentioned above there are a number of other factors that may require health records to be kept for longer periods, but no clear-cut rules exist in this regard. For instance, certain health conditions take a long period to manifest themselves, (e.g. asbestosis), and records of patients who may have been exposed to such conditions, should be kept for a sufficient period of time. The HPCSA recommends that this should not be less than 25 years.

- 9.7 A balance must be reached between the costs of (indefinite) retention of records (in terms of space, equipment, etc.) and the occasional case where the practitioners' defence of a case of negligence is handicapped by the absence of records. The value of the record for academic or research purposes, and the risks resulting from the handling or complications of the case, are additional considerations.

- 9.8 Where there are statutory obligations that prescribe the period for which patient records should be kept, a practitioner must comply with these obligations.

As we move ever further into the digital age, the storage of records and documents electronically is becoming more and more prevalent.

It is clear that there are continuous technological advances in the field of electronic data storage and that the above guidelines do not reflect these advancements. It is therefore important to extract the underlying principles and apply them to the practice of electronic storage:

1. The system should be secure and not accessible to any other person.
2. It should also ensure that no subsequent modifications can be made to the stored data.
3. There should be a separate back-up storage of the medical records

The retention of the medical records is the responsibility of the practitioner and therefore that practitioner must personally ensure that the medical records are secure, irrespective of any promises made by any service provider, and would be ultimately responsible should those records be lost.



## Management's duty to discipline balanced against the interest of an aggrieved employee



Keletso Makwe, SAMA Industrial Relations Advisor

When an employee walks into the manager's office to lodge a grievance, the last thing they expect is to have their grievance handled in a manner that suggests its being trivialised. It is therefore quite important that management is seen to be treating the matter appropriately. The challenge however is when the aggrieved employee remains unsatisfied after action has been taken and they view the punishment not severe enough to make up for their pain.

This is a case where the employer is caught between a rock and a hard place with two employees they value, need and cannot afford to lose. There has been many cases reported where employers have been accused of taking sides or not imposing sanction deemed harsh

enough to deter the conduct. An example would be that of an employee who was allegedly assaulted by her colleague for calling him derogatory names. She reported the matter to the employer and they were both summoned to a meeting where the colleague was instructed to apologise to her.

The accused employee apologised stating that he was provoked into committing the offence. The aggrieved employee was appalled by the decision as she felt the employer was too lenient to the offender and demanded that the employer dismiss the employee. The employer refused stating that discipline is managements function and that they would not be dictated to by the employee.

This was the beginning of problems for all parties as the employee turned to the police to open a case of assault against her colleague, on the other hand the accused employee was threatening to open a case of *crimen injuria*. The employer felt helpless as despite intervening and trying to talk to both employees everything seemed to have spiralled out of control.

The trade union was then roped in to mediate between the employees as they belonged to the same union. The matter was eventually resolved with both parties reaching a compromise. The relationship between the two remained hostile as they both felt they were failed by the employer whom they had bestowed their trust upon. The lesson learnt by the employees was that no matter how strongly they felt about their case, the least they could do was report the matter to management and hope that management

will handle the matter fairly and satisfactorily. The decision on the sanction to be imposed should be left to the employer to deal with.

On the other hand the employer can tarnish its name if it fails to handle problems between employees appropriately and fairly.

In an interesting case law *SATWU obo Finca v Old Mutual SA and another (2006)27 ILJ*, an employee had made racist remarks about her colleague in his absence. The employee who overheard the remarks confronted the supervisor. The supervisor downplayed the significance of the remark by justifying it and decided to warn the employee verbally.

On realising that the employer was not going to investigate the matter further, the employee took it upon herself to inform the affected employee who then informed his union. The union demanded that action be taken and that the employee be dismissed as this was a dismissable offence. The employer took action and dismissed the employee who subsequently appealed the sanction and was reinstated.

The union then approached the labour court for a recourse. The court ruled in their favour and the employer had to pay the employee R150 000 in compensation.

The company thereafter decided to dismiss the offending employee who also took them on for only dismissing her two years after committing the misconduct. In this case it was a losing situation for the employer for failing to act and protect the aggrieved employee. The principle therefore is: "Where an employer fails to protect an employee against abuse in the workplace, the employee can seek assistance externally."



## Risk management: Respect for patient confidentiality

SAMA Legal Department

There is a common-law duty to preserve professional confidence, it is usually thought of as an ethical issue. It is, but it is also a legal obligation:

- Employed healthcare workers are usually bound by a confidentiality clause in their contracts.
- There is a common-law duty to preserve professional confidence.
- The Constitution guarantees citizens the right to privacy, including the right to not have the privacy of their communications infringed.
- Rule 13 of the Council's Ethical Guide states that practitioners may only divulge confidential information without the patient's consent when specific circumstances apply. This does not apply in the case of a termination of pregnancy. Under the Choice on Termination of Pregnancy Act of 1996 there is no age or maturity test for a girl to consent to a termination.
- The National Health Act makes it an offence to divulge information about health service users without the user's consent. The only permissible exceptions are when the law or a court order requires disclosure, or if non-disclosure would represent a serious threat to public health.

The obligation of confidentiality goes beyond undertaking not to divulge confidential information; it includes a responsibility to make sure that all records containing patient information are kept securely. Confidential records should not be left where other people may have casual access to them and information about patients should be posted or faxed under private and confidential cover, with appropriate measures to ensure that it does not go astray.

Patients should be informed about the kind of information being held about them, how and why it might be shared, and with whom it might be shared. Patient information leaflets are a convenient way of notifying patients about this, but they are not sufficient in themselves. Bear in mind that few patients will bother to read the leaflets, and some may not be able to read them. It is especially important to inform patients – and to let them know that they have the right to withhold consent – if

you intend to use their personal information for purposes other than their immediate care, or to share it with non-medical agents such as welfare workers. In addition, be especially cautious about sharing information governed by specific regulations outlined in below.

### Legislation stipulating confidentiality requirements for certain types of medical information

#### Choice on Termination of Pregnancy Act, 92 of 1996, section 7

The identity of a woman who has requested or obtained a termination of pregnancy shall remain confidential at all times. Records of termination of pregnancy must be made by the practitioner and the person in charge of the facility. The person in charge of the facility must notify the Director-General within one month of the termination, but the information should be de-identified.

"The identity of a woman who has requested or obtained a termination of pregnancy shall remain confidential at all times unless she herself chooses to disclose that information."

#### Children's Act, 28 of 2005, sections 12, 13, 133 and 134

Information about a child's virginity, HIV status and contraceptive use should not be divulged without the child's consent.

"Every child has the right to confidentiality regarding his or her health status and the health status of a parent, care-giver or family member, except when maintaining such confidentiality is not in the best interests of the child." In addition, the Act specifies that information about a child's virginity, HIV status and contraceptive use should not be divulged without the child's consent.

In the case of HIV status, the exception is if the child is below the age of 12 and lacks the maturity to understand the implications, in which case the parent or caregiver, a child protection organisation or the person in charge of a hospital may consent to disclosure

on his or her behalf. Confidentiality is not an absolute obligation – there are circumstances in which disclosure is permissible or even mandatory (see below)

#### Circumstances in which disclosure is either permissible or mandatory

- To meet the terms of a Statutory provision (e.g., notification of a communicable disease)
- To comply with a court order
- In the public interest (which includes, but is not limited to, "situations where the patient or other persons would be prone to harm as a result of risk-related contact")
- With the patient's consent.
- With the written consent of a parent or guardian of a minor under the age of 12 years
- With the written consent of the next of kin or the executor of the estate of a deceased patient.

### HPCSA, Confidentiality: Protecting and Providing Information (2001) par 3.2

#### Professional ethics

Confidentiality is considered to be central to the trust between doctors and patients and doctors are held responsible by their professional bodies for protecting personal information that patients share with them. An unjustifiable breach of confidentiality is taken very seriously by the Council; its booklet, Confidentiality: Protecting and Providing Information (2008), sets out detailed guidance on the circumstances in which patient information may be disclosed to third parties. The principles that should be applied are listed in below.

#### Principles of confidentiality

1. Patients have a right to expect that information about them will be held in confidence by health care practitioners. Confidentiality is central to trust between practitioners and patients. Without assurances about confidentiality, patients may be reluctant to give practitioners the

- information they need in order to provide good care.
- Where health care practitioners are asked to provide information about patients, they should:
    - Seek the consent of patients to disclosure of information wherever possible, whether or not the patients (b) can be identified from the disclosure; Comprehensive information must be made available to patients (c) with regard to the potential for a breach of confidentiality with ICD10 coding.
    - Anonymise data where unidentifiable data will serve the purpose; (e) Keep disclosures to the minimum necessary.
  - Health care practitioners must always be prepared to justify their decisions in accordance with these guidelines.

#### Tips to avoid confidentiality breaches

- Do not leave case notes lying around in publicly accessible areas.
- Resist the temptation to look up patients' records out of idle interest (eg, because you know the patient personally, or the patient is a celebrity). If you are not involved in the patient's care you have no more right than any other member of the public to access their records.
- Do not use information contained in the medical records for purposes other than patient care, unless consent has been obtained or the data anonymised.
- For research or audit, anonymise information about patients in such a way that they cannot be identified. If this isn't possible, obtain the patient's consent.
- If you write identifiable information about patients on scraps of paper, post-it notes or in a notepad, keep track of them – don't leave them lying around in your car or in your pockets, etc. When you've finished with them, dispose of them securely.
- Follow the hospital's policies on safe storage of records and their removal from the premises.
- If you download patient information onto a memory stick or flash drive, make sure it's encrypted and that the files are password protected. Keep the memory stick in a secure place.
- Change your computer password regularly, keep it secret, never let anyone log onto the system in your name, and never borrow someone else's ID to log on.
- If you are faxing confidential patient information, call the recipient first to check that you have the right number and to

tell them the fax is on the way. Ask them to notify you if it doesn't arrive. You might also consider using a cover sheet warning the recipient that the contents of the fax are confidential.

- Be aware that emails are not secure, so take care not to include identifiable information about patients in emails unless you are confident that the emails are being adequately encrypted.
- Even letters can go astray, so they should be marked "Confidential" on the envelope and care must be taken to ensure that the correct address is used. Consider using registered post for highly confidential letters.

#### Probity

"Probity requires that the doctor's conduct at all times justifies patients' trust and the public's trust in the profession." Segen's Medical Dictionary (2011) [www.medical-dictionary.thefreedictionary.com](http://www.medical-dictionary.thefreedictionary.com). The term "professionalism" is so widely applied nowadays that its currency has been debased. In many people's minds the word "professional" can be applied to any skilled worker, and "professionalism" to skilled work of any kind.

Your professional integrity is a measure of the degree to which your own professional reputation and credibility remain intact. However, for the older professions (with the possible exception of the oldest of them all), "professionalism" goes far beyond the mere exercise of skill; indeed, it extends beyond the workplace and into one's private life. A medical professional is expected, by his colleagues and society, to be a person who can be trusted to act with integrity at all times.

"Integrity is generally defined as wholeness, honesty and 'uprightness', being in sound and intact condition; undamaged, untainted. Your

professional integrity is a measure of the degree to which your own professional reputation and credibility remain intact. It is more than just clinical or technical excellence alone, since a major element of a person's integrity derives from the way in which they are viewed by others. Anything which has the potential to reduce a professional person's reputation in the eyes of another undermines their professional standing."

#### Examples of unprofessional conduct

- Making misleading or false claims about your practice
- Touting for business
- Succumbing to inducements to provide services to patients that are not clinically indicated
- Accepting perverse incentives
- Over-charging patients
- Fraudulently claiming for services that have not been rendered
- Lack of transparency to patients about financial interests in healthcare facilities or pharmaceuticals
- Impeding patients who wish to seek a second opinion
- Sexual impropriety, particularly with patients
- Involvement in criminal activities
- Continuing to practice when impaired
- Not reporting impaired colleagues
- Not reporting unethical behaviour on the part of colleagues
- Engaging in medical research without the approval of an ethics committee
- Anything that undermines public confidence in the profession
- Anything that undermines the reputation or standing of the profession

(List derived from HPCSA guidance)



## Member profile: Dr Amitabh Mitra



Dr Amitabh Mitra

In the popular imagination, art and medicine are usually strange bedfellows; one is an entirely creative endeavour, the other a distillation of the scientific method. Surprisingly, a long list of physicians have taken up pen or brush over the centuries, including such luminaries as Keats, Rabelais and Chekhov, who once remarked that "Medicine is my lawful wife, literature my mistress."

For Dr Amitabh Mitra, the balance is an easy one. A surgeon with a background in orthopaedic and aerospace medicine, Dr Mitra is the current head of accident and emergency care at Cecilia Makiwane Hospital in Mdantsane

and has been a SAMA member for the last 19 years. *SAMA Insider* spoke to him about his artistic side and the state of medicine in South Africa.

#### When did you take up poetry and art?

I started writing poetry with commitment somewhere between 1976 and 1979 – before then I had only dabbled in it. My first book, *Ritual Silences*, was published in 1980.

Similarly, my paintings were a hobby until eight years ago, when I started exhibiting and selling them professionally.

#### Is it difficult reconciling your roles as an artist and a physician?

Not really. As a doctor, I have access to a different field of experiences than most people. Doctors develop a unique perspective on life, and this can be very helpful in one's life as a poet. Poetry and art also hold valuable lessons for physicians; they force us to think outside of the box and look at the world as human beings, not objective scientists.

#### Do you think more doctors should take up art?

I believe more doctors should do what they are passionate about. I have met many doctors

who are passionate about music, politics or any number of other fields. I say: go for it. Be yourself. See it as a holistic approach to your own survival.

#### How does our healthcare system match up to India's?

Actually, healthcare in South Africa is generally of a very high standard. It is difficult to compare our system to India's, since their conditions are so different – over a billion people live in India, after all! Many of my friends from India congratulate me on our health system whenever they visit.

There is something I would like to get off my chest, though: in India, the right to engage in private practice is a basic right for all doctors, and it should be a basic right for South African ones too. Our healthcare system is losing doctors to other countries because we don't take care of our specialists.

Ask yourself: what does a specialist want? It isn't money. We can't attract specialists to disadvantaged areas like Mdantsane with cash; we must address their need to advance in their profession. Send them overseas for conferences, or provide them with further training; develop a package deal. This is how we should be retaining our public doctors. Instead, we are condemning them for engaging in private work.

## Medunsa students visit Hyperbaric oxygen chambers

Dr Andre Marais, SAMA Gauteng North Branch Councillor

Hyperbaric medicine is something not commonly used in everyday medicine due to the high costs and limited facilities available. In fact medical schools in general dedicate very little time, if any, in their undergraduate curriculum to this complimentary field of medicine.

Hyperbaric Oxygen Treatment (HBOT) provides the body with extra oxygen under high pressure. The patient breathes 100% pure medical oxygen in a special chamber at increased atmospheric pressure, thereby increasing the oxygen supply to all body. Hyperbaric oxygen therapy can be used in a variety of medical conditions including air or gas embolism, burns, crush injuries or compartment syndrome, diabetic ulcers,

carbon monoxide poisoning, sport and soft tissue injuries to name but a few. There are currently only 10 Southern African Undersea and Hyperbaric Medical Association (SAUHMA) accredited treatment facilities in South Africa, five of them being in Gauteng of which Eugene Marais Hospital and Steve Biko Academic hospital serves the Pretoria-North region.

The University of Limpopo – Medunsa campus gives each medical student in their fourth year the opportunity to participate in a non-curricular activity of their own interest in their own time. For the past two years the Department of Pharmacology and Therapeutics have been facilitating a selective in Sports medicine which includes Diving and hyperbaric medicine.

After their academic contact time and exposure to the theory and history of hyperbaric oxygen therapy, the students are taken on a field trip to visit, and experience the uniqueness of a hyperbaric oxygen chamber.

This year the interest grew from eight students in 2012 to 25 students currently. They are entertained by the passionate and charismatic Dr Gregory Weir, a vascular surgeon and head of the Eugene Marais Hyperbaric Unit with his unmatched knowledge on the subject matter. Brave students are also given the opportunity to experience the feeling of entering the chamber (without the pressure and oxygen obviously) The aim is to raise awareness and expose students to this exciting avenue in medicine.

## GP and Specialist Network Contracts – red flags to look out for

SAMA Private Practice Department

At the outset, it must be said that the contracts that we have reviewed are not unlawful but that almost all contain obligations placed on the participating doctor that may induce such doctors to act incorrectly. It is not practically possible for us to analyse each contract for every one of our members individually. However, we have identified certain provisions which occur in almost every contract we have reviewed. We have compiled the following checklist of problem areas to which we wish to alert our membership. Every doctor is free to enter into any lawfully contract the wish to, but we want our membership to have all possible information available to them when they make their decision. If one sees any of the following clauses in the agreement that you are considering, please take the following information into account.

### 1. Promotion and marketing of your practice as a “preferred provider” by the medical scheme.

Although this may sound beneficial to your practice in respect of increasing your patient base, SAMA is of the opinion that this is in direct contravention of Ethical Rule 3(2) which prohibits canvassing and touting of medical practitioners.

### 2. Appointment as a Designated Service Provider

Most Preferred Provider/Network contracts contain a clause that states that you will, in addition to being a preferred provider or network doctor, also be a DSP. If you do not wish to be a DSP then you cannot sign the contract. If you wish to be a DSP you should check the

provisions of the contract that describe the rate at which you will be reimbursed. Many of these contracts state that you will be reimbursed as a DSP at “the scheme rate” for PMB conditions. This is in contravention of Regulation 8 of the Medical Schemes Act which states that DSPs must be “paid in full” (i.e. at the rate they would normally charge, not at the scheme rate).



### 3. Practice Profiling

The vast majority of contracts impose “practice profiling” on the doctor. Essentially this practice profiling is a tool to measure the financial performance of the doctor. Simply stated, where the doctor saves the scheme money, they receive preferential reimbursement rates. While it is acknowledged that doctors should strive to ensure cost-effectiveness, this should not be an inducement not to render optimal care to the patient.

### 4. Information Sharing

Carefully consider clauses that oblige the participating doctor to participate in “information-sharing”, “disease management” and “clinical review” processes as well as implementing resulting recommendations from the IPA foundation or scheme’s Managed Care Organisation (MCO). This has the effect that participating doctors probably will have recommendations imposed upon them by the scheme, without necessarily participating in the process.

### 5. Treatment Protocols and Formularies

Take note of clauses that enforce adherence to the scheme’s medicine formulary “where required and clinically appropriate” – this leads to the interpretation that the scheme will exercise control on what medicines the participating doctor prescribes or dispenses.

### 6. Clinical/Treatment data

Beware of clauses that require that the participating doctor provides the scheme with treatment data in terms of what is agreed between the IPA foundation/MCO and the scheme (again the participating doctor is not a party to this agreement and would be unaware of the terms of such agreement).

Although the scheme does undertake to obtain the requisite informed consent from the beneficiary concerned, this does give rise to the question whether or not this data will be used for any other purpose than that which is stated in this contract.

## Compensation Fund manager suspended

SAMA Communications

The plot thickened in the ongoing Compensation for Occupational Injuries and Diseases Act (COIDA) saga this month with the suspension of the Compensation Fund manager tasked with improving the fund’s unpaid backlog crisis. SAMA and the Compensation Commissioner had previously reached an agreement concerning the backlog and were eagerly expecting the implementation of this scheme.

At a 25 June meeting between representatives of SAMA and the Office of the Public Protector, a number of resolutions were passed to ensure that the agreement between the two parties would not be derailed.

Besides appointing a different manager to oversee the implementation process, the meeting also resulted in a renewed effort on the part of the Compensation Fund to address the concerns of the hundreds of

thousands of South Africans who await COID reimbursements.

The COIDA scandal has caused a great deal of upset among South Africa’s medical community. While the recent burst of activity on the part of the Compensation Fund and the Department of Labour are generally welcomed as encouraging, many medical practitioners have adopted a wait-and-see approach to any such attempts.

## Implementation of the 2013 ICD-10 Master Industry Table (MIT)

SAMA Coding Unit: Private Practice Department

SAMA has now included the official edition of the 2013 ICD-10 Master Industry Table (MIT) for the convenience of our members in the eDBM file. We also have an ICD-10 Browser product available, however some additional work will be done to make the product user friendly.

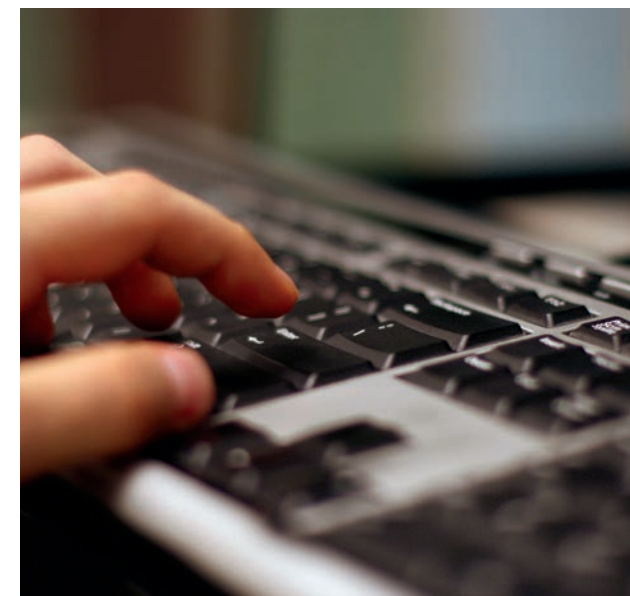
From time to time the World Health Organisation publishes corrigenda to the ICD-10 information, these includes amendments, deletions and additions. The ICD-10 Task Team has taken those changes and added them to the Master Industry Table. The previous version of the MIT was published in 2007 and an update for this information was crucial.

It came to our attention that some medical doctors and/or their practices use a website, ([www.ICD-10data.com](http://www.ICD-10data.com)), however, we would like to point out that this is a structure used by the American healthcare industry and based on the clinical modification of ICD-10. It specifically states 2013 ICD-10-CM Medical Coding Reference. This is the coding structure to be introduced in America from October 2014. This is not the official South African ICD-10 Master Industry Table (MIT) and to code from this information without verification of the information against the MIT will not guarantee correct coding. The MIT is part of our 2013 eDBM product or available as a separate product, or the 2013 ICD-10 MIT from the National Department of Health.

If you want to use this website, you have to verify the information with the MIT. This product has extensions to codes up to 7 characters – while in the MIT the highest specificity is 5 characters for some codes, mostly only up to 4 characters and some 3 characters only.

SAMA is developing an ICD-10 Browser that will be available shortly where the common descriptions will be added which will make look-up of diagnoses easier and more efficient.

*Should you have any queries about ICD-10 please contact the SAMA Coding Unit on [coding@samedical.org](mailto:coding@samedical.org) or 012 4812073*



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## Prizes awarded in SAMA survey

The South African Medical Association prides itself on the additional benefits that it offers its members. The marketing division at SAMA entered into strategic partnerships with various companies who in turn offer value added services including discounts for certain products if a person is a SAMA member. To improve the quality of this service, SAMA recently conducted a member benefit survey in order to determine how easily accessible these benefits are.

The purpose of the survey was to engage with members in order to gather feedback and look at ways of improving the quality of the current additional benefits. Members participated through an online survey or completed a questionnaire at two CPD functions: Johannesburg and Vereeniging.

Seven hundred and eighty-four members participated through the online survey and

49 members through the CPD meetings. Two lucky winners were chosen and each won a hamper sponsored by V-Professional

Services and Tempest Car Hire. SAMA would like congratulate Dr Natasha Gloeck who won the hamper for the online survey.



Jeanette Snyman, marketing officer at SAMA, awarding a hamper to Dr Natasha Gloeck at the Eersterust Clinic in Pretoria.

## SAMA/MPS Photography Competition: Deadline for entries extended

We are happy to announce that the deadline for the SAMA/MPS Photography Competition has been extended to 4 August 2013. The theme for this year is 'A Day in a life of a Doctor'. Entries are welcomed for three categories, namely, work environment, emotions and nature.

Prizes include R4000 per category. Doctors spend most of their time in hospitals or in their private practices enhancing quality of life and saving lives in theatre; and this year we would like entrants to share a glimpse on some of the special moments and experiences with their patients, fellow doctors and nurses.

Included as a sub-theme is an area of relaxation, which can feature nature and wild life. To enter, upload your photos to <http://www.samedical.org/events/photography-home.html>.

For further information contact Zukiswa Nomnganga at SAMA head office on 012 481 2052 or email [zukiswan@samedical.org](mailto:zukiswan@samedical.org).

## Trade union chair elected CMA treasurer



Dr Phophi Ramathuba, chairperson of the SAMA Trade Union

At a recent congress of the Commonwealth Medical Association (CMA), SAMA's very own Dr Phophi Ramathuba was elected as the association's treasurer.

Dr Ramathuba, a clinical pharmacologist and current chairperson of the SAMA Trade Union, was one of a number of appointments at the congress that saw Dr Solaiman Juman of Trinidad and Tobago elected CMA president. She will serve as treasurer for a three year period.

The CMA is a conglomeration of national medical associations from the former Commonwealth states and currently includes 42 member associations.

Since the establishment of the CMA in 1962, it has become renowned for its efforts

to uplift and support the healthcare systems of its members.

Besides taking a leading role in health research, the CMA is also noted for its advocacy initiatives, something Dr Ramathuba is sure to be comfortable with.

Her election has been welcomed by the South African healthcare sector, with the Democratic Nursing Association of South Africa (Denosa) describing it as "an opportunity for the southern and central regions of Africa to showcase to the world the ability to lead the fight against the burden of diseases."

Dr Ramathuba has advocated the Positive Practice Environment concept during her tenure with the CMA and has received much praise for her success in this regard. SAMA congratulates her on her appointment.



# Additional Member Benefits



**Alexander Forbes | Herman Steyn**  
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[steynher@forbes.co.za](mailto:steynher@forbes.co.za)

Offers SAMA members a 20% discount on motor and household insurance premiums.



**Automobile Association of South Africa (AA)**  
**Kevin Deyzel**  
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[SAMA@aasa.co.za](mailto:SAMA@aasa.co.za)

AA offers 12.5% discount to SAMA members on roadside assistance packages.



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[pklostermann@legacylifestyle.co.za](mailto:pklostermann@legacylifestyle.co.za)

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We are pleased to offer SAMA members 18% discount. The discount however only applies to new additional contracts and also when the user is due for upgrade. Discount will not apply to International Roaming and Dialling, SMS and Data packages. Please note that this is extended out to the family and the discount is on VOICE packages only as well. Monthly Service Charge: less 18% discount. Usage Charge: less 18% (eighteen percent) discount (excluding international calls, international roaming, SMS, MMS and Data Usage Charges).



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