

SAMA INSIDER

AUGUST 2018

Bills address reforms in the public and private healthcare sectors

**Mandatory reporting
of child abuse:
The legislative
framework**



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

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Diane de Kock
Editor: SAMA INSIDER

Healthcare and law

Law can either help or hinder the delivery of healthcare. Our constitution affirms the fundamental right to healthcare, but there are serious flaws in the implementation of these rights.

This month, we focus on three new Bills that could potentially have a huge impact on healthcare in our country. On page 5, Henneke Verwey, Bernard Mutsago and Dr Selaelo Mametja unpack two long-awaited and controversial pieces of legislation: the National Health Insurance Bill and the Medical Schemes Amendment Bill, published in the Government Gazette on 21 June this year. Both Bills promise improvements in healthcare delivery, but implementation is once again a challenge. The article also outlines SAMA's concerns, which will be submitted to the Department of Health before 22 September.

Charlton Murove, from BHF Global, looks at whether there are opportunities if medical schemes and benefit options are consolidated (page 15). "The need for greater alignment between private healthcare funding, healthcare provision and broader policy reform cannot be overstated."

On page 4, SAMA president Dr Marina Xaba-Mokoena writes on the dangers of smoking, "a major cause of preventable premature death in our societies." Reinforcing SAMA's principles on tobacco, the new Tobacco Bill (see page 9) is viewed as a "watershed in the battle against tobacco-related epidemics in SA." "SAMA applauds the Bill for introducing tight measures ... to prevent the tobacco industry from influencing tobacco demand and public health in SA," write the authors.

Hanneke Verwey, on page 12, analyses the legislative framework in the mandatory reporting of child abuse for doctors. A study conducted last year by UCT and the Centre for Justice and Crime Prevention found that "of the young people interviewed in schools, 35.4% – one in every three young people – had experienced some form of sexual abuse at some point in their lives." A frightening statistic, which strengthens the role that doctors can play in reporting and prevention.

This month we also share a case report from the Medical Protection Society (page 18) that illustrates how the law can protect both doctors and their patients.

All three Bills are open for comment, and present an opportunity for engagement for all interested parties.

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Published by the Health and Medical Publishing Group (Pty) Ltd
Block F, Castle Walk Corporate Park, Nossob Street
Erasmuskloof Ext. 3, Pretoria

Email: publishing@hmpg.co.za | www.samainsider.org.za | Tel. 012 481 2069
Printed by Tandym Print (Pty) Ltd

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Emphasis on anti-smoking



Dr Marina Xaba-Mokoena, SAMA president

It was my greatest joy when former MEC for Health, Dr Nkosazana Dlamini-Zuma, at the start of our independence, not only stood up to endorse what I had promoted in my 1985 inaugural address presented at the University of Transkei (now Walter Sisulu University) on the dangers of tobacco smoking, but also saw to it that there was legislation passed on this topic. I shall repeat most of what I expressed in that address, with the hope that still more can be done to curtail this habit.

The most common causes of human resource waste that cripples manpower, or simply leads to absence from work, are secondary to and intertwine with preventable circumstances, such as:

- tobacco smoking and air pollution
- alcohol/drug abuse
- accidents – in particular, motor vehicle accidents.

These and their consequences are **preventable**. Tobacco smoking is a major cause of preventable premature death in our societies.

The history of the opium trade between the West and China in the 19th century has been told in many books and articles. So profitable was it that attempts to curtail the trade were met with the utmost resistance. One cannot help seeing a certain parallel between the opium trade of the Victorians and the promotion of tobacco smoking in the Third World today. Cigarette smoking claims more lives in 3 years than all US wars

combined. If the same number of people died from anthrax or smallpox, society would protest and demand immediate, effective action. Yet the toll exacted by the cigarette-smoking epidemic is concealed behind death certificates, which read heart attack, stroke or cancer. Cigarette smoking, even in the developed world, is the smallpox of our day, and society will be judged harshly in the future for not having dealt with this fact in a straightforward manner.

In the title of a leading article on a report about smoking, *The Lancet* went so far as to name this phenomenon “Third world smoking – the new slave trade”. The difference lies in the fact that the African slaves had no choice in their fate, while smokers do.

Smoking creates a major avoidable public health problem for countries least able to withstand it. This is added to the community health scene even before the problems of malnutrition and communicable diseases have been controlled. This tends to make nonsense any talk of “Health for All”.

“Third world smoking – the new slave trade”

Of course, governments benefit from “politically comfortable” tobacco taxes, but these do not increase the national wealth, and cannot offset the loss in production and the medical costs involved in treating sufferers of smoking-related diseases. This applies even more to us, as a developing country. Do we want to be swamped by an increasing flood of preventable diseases, or wait until the symptoms develop before heeding the arguments? **Health seems to come a poor second to wealth**, insofar as governments are concerned throughout the world. The smoke ring is the ring of defences that has kept the power of the tobacco industry intact for the past 50 years or more, despite its lethal products.

An article in the *British Medical Journal* suggests that “every time we doctors fill out a death certificate for a smoking-related disease, perhaps we should also write to the local MP stating ‘one of your constituents died before his time from smoking; what action do you plan to take about the smoking epidemic,

which kills 100 000 prematurely each year?’” Such action might be effective, for example, in ensuring that each political party has a section in its manifesto for the next general election on the control of smoking.

Nicotine is an addictive, potent drug. But it pays to stop smoking, in improving lung function, reducing the risk of coronary thrombosis, occlusion of other blood vessels, hypertension, asthma and emphysema.

Smoking-related diseases also include, *inter alia*, cerebrovascular diseases, oral, lung, larynx, bladder, stomach and pancreas cancers, cancer of the oesophagus, chronic obstructive airways disease, gastrointestinal tract and periodontal diseases, and sudden death. Women who smoke while pregnant are more likely to have small babies, and there is an increased risk of perinatal death in children born to smoking mothers.

Tobacco-smoking habits associated with an increased incidence of lung cancer are:

- inhaling the smoke
- taking a higher number of puffs per cigarette
- keeping a lit cigarette in the mouth
- relighting a stubbed-out cigarette
- smoking cigarettes that have a short butt length.

I hope that this is enough information to discourage smoking, especially among those of our colleagues who still enjoy the habit. It should not be a question of “Do as I say – but not as I do,” when giving advice on quitting smoking to patients. A helping hand with a course of “I quit” used to be offered at Wits Medical School, monitoring progress and providing support for those who wish to stop. Most disturbing is when a patient puts away the oxygen mask he is on, to go outside to smoke, and then returns to once again replace the oxygen mask.

There is a useful Arab proverb to remember, too (courtesy of the Heart Foundation):

“Smoking is good for you, because:

If you smoke enough you will **smell** so strong that dogs will not bite you.

If you smoke long enough you will **cough** even in your sleep, and this will deter robbers, who will think you are awake.

If you smoke as much as possible you will **die young**, thereby escaping the indignities and problems of old age.”

Two new Bills address reforms in the public and private healthcare sectors

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

June 2018 was an exciting month, as we saw the publication of two long-awaited pieces of legislation: the National Health Insurance (NHI) Bill and the Medical Schemes Amendment (MSA) Bill, which were published together in the *Government Gazette* on 21 June. The Bills are open for public comment until 22 September.

The aims of the Bills differ, but the relationships between the two are clear in several areas.

The stated aims of the NHI Bill are the establishment of a mandatory prepayment mechanism for health services in SA, the establishment of the NHI Fund itself, setting out a framework of active purchasing for the fund, creating mechanisms for the utilisation of the resources of the fund to meet the needs of users and limiting undesirable, unethical and unlawful practices in relation to the NHI Fund.

The stated aims of the Medical Schemes Amendment Bill include enhancing the governance of medical schemes, extending the functions of the Council for Medical Schemes (CMS), the founding of Central Beneficiary and Health Care Provider Registers, providing for new admission and cancellation of members, as well as making contributions payable on an age-related basis. It also declares the carrying on of the business of a medical scheme by a person not registered as a medical scheme to be a criminal offence.

Fund governance

Clearly, the establishment of a fund commanding as many monetary flows as are planned for the NHI Fund will require tight oversight over its governance and financial management, to ensure that the pooled funds are used in the most equitable, efficient and effective way.

In the NHI Bill, the fund is established as a juristic person and national public entity, as in the Public Finance Management Act No. 1 of 1999. The Bill declares that the fund is to be the single public purchaser and financier of health services in the republic, and will operate as a mandatory prepayment health services system.

Both Bills make room for chief executive officers (CEOs) to be appointed: one as the administrative head of the NHI Fund, and others to replace the principal officers of medical schemes. The CEO of the NHI Fund is to be selected by the NHI Board, and scheme CEOs will be appointed by scheme boards of trustees.

SAMA maintains its position in support of universal health coverage

The NHI board members will be drawn from a list of nominations received from the public, but vetted by the Minister of Health and Cabinet, and will be appointed for a period not exceeding 5 years. Both Bills lay out requirements for NHI board members and trustees that relate to the appropriate skills and qualifications required.

It may come as a surprise that despite the multiple duties assigned to medical scheme boards of trustees throughout the original Medical Schemes Act, very little detail is provided with respect to the specifics of the composition of the board, a list of duties or emphasis on issues such as conflicts of interest and remuneration. The new chapter 11 A in the MSA Bill aims to beef up all of these aspects in the Act. The requirements for appointment and the duties of the CEOs are also outlined in detail.

The NHI Bill likewise spells out the responsibilities and accountability of the CEO of the NHI Fund. The functions are extremely broad, but the CEO is to be assisted by several ministerial committees, the members of which will be appointed by the Minister of Health.

Information repositories and registries

Both Bills also put substantial emphasis on data repository and membership registry. The NHI Bill defines who exactly will be eligible as

beneficiaries of the NHI scheme, and outlines processes for the registration of, and the rights of, users of the NHI benefits.

Having a defined user base will require the fund to keep a detailed register of eligible beneficiaries, who, according to the Bill, will be all SA citizens and permanent residents of the country, dependents of such citizens and residents, children between the ages of 12 and 18 not otherwise registered, and all inmates, as defined by the Correctional Services Act No. 111 of 1998. Refugees and asylum seekers who have not been granted refugee status will have access only to a small set of pre-specified services.

On the medical schemes' part, the new Bill requires that the CMS establishes, maintains and administers a central beneficiary register. The stated aim of this register, which will contain a substantial pool of medical scheme members' personal information, is to allow the identification and assessment of risks within the medical schemes, as well as for the NHI Fund, and to better equip them to manage the rights and obligations of beneficiaries of the schemes.

Of particular importance to doctors is the fact that new sections in the MSA Bill also empower the CMS to acquire information from schemes pertaining to services rendered by healthcare providers, including practice numbers, HPCSA numbers, number of unique beneficiary visits or admissions, total amounts claimed by each healthcare provider and the amounts paid from risk and savings. The council can now also request the scheme to provide amounts paid to each provider.

Definition of benefits, and attention to equity and fairness

As the determination of NHI benefits is to be the job of one of the ministerial committees yet to be established in terms of the NHI Bill, this Bill is thin on detail of what benefits will and will not be covered in terms of the NHI.

The NHI Bill does, however, relegate the role of medical schemes to only covering

complementary benefits – that is, benefits that are **not** offered through the NHI.

The MSA Bill, in contrast, speaks of a set of predetermined “comprehensive” service benefits that are yet to be determined for the industry. It seems that these are to replace the current set of prescribed minimum benefits (PMBs). The aim is that as with the PMBs, these comprehensive services will be covered without co-payments or deductibles on the part of members.

The MSA Bill introduces an entire new chapter addressing contributions to medical schemes. The existing community rating of premiums is emphasised, so that members pay the same premiums regardless of health status or utilisation of health services.

New requirements are that medical schemes must determine contributions for mandatory benefits based on income, and that schemes should now determine different premiums for adult beneficiaries (30 years of age and over), young adult beneficiaries (18 to under 30) and child beneficiaries (under 18). The Bill also requires that a child premium be set at a maximum of 20% of that of an adult beneficiary, and that of a young adult beneficiary not more than 40% of an adult premium. Currently, schemes are free to determine ratios for children and adult dependents' premiums, which, within scheme options, may range from 20% to 100% of an adult beneficiary premium, dependent on the structure of the option and which demographic the option is trying to attract.

Schemes have also been encouraged to provide a uniform discount in their rules for members in a particular option who elect to have health services provided by a designated service provider. This discount is to be made clear in the contribution table for the medical scheme, and is to be approved by the CMS registrar.

Accredited and certified healthcare providers

Both Bills make reference to using the services of pre-selected providers, the NHI Bill referring to certified and accredited providers, and the MSA Bill to designated service providers (DSPs). Both speak to the fact that the NHI Fund and the medical schemes are expected to become more active purchasers of healthcare – requiring contracts and mechanisms for the evaluation of providers to be in place.

DSPs are now formally defined in the MSA, where a formal definition was

previously absent. A DSP now means “a healthcare provider or group of healthcare providers selected and formally contracted by a medical scheme as its preferred service provider or providers to provide relevant healthcare services to its members”. This definition is important as it requires that medical schemes have a contract with their DSPs – so it is clear that they cannot make the state health service their DSP without a contract in place.

In the NHI Bill, the accreditation of both public and private service providers is through certification by the relevant professional council, as well as certification by the Office of Health Standards Compliance (OHSC), and through proving that a provider is in compliance with a yet-to-be-determined range of health services, to ensure that they provide for the needs of the patients utilising their services.

There are a number of requirements that will apply for accreditation of NHI providers, including agreeing to adherence to prescribed treatment protocols and guidelines (including for medicines), adhering to specified referral networks, submission of information to what is to become the National Health Information Repository and Data System and adherence to the determined national pricing regimen for services.

Payment mechanisms for providers under the NHI Fund have yet to be determined, but it seems that risk-adjusted capitation will remain the preferred method at primary-care level, and that all-inclusive performance-based payments will apply to specialist- and hospital-level care.

Complaints and appeals processes

Several pages of both Bills are dedicated to detailing the processes to be followed in the case of complaints and appeals against the NHI Fund or medical schemes.

In the MSA Bill, it is clear that any member, or third party on behalf of a member, may lodge a complaint about a medical scheme. It is also required that the medical scheme deal with this complaint as soon as practically possible, through a predetermined process. It remains a requirement that before complaining to the CMS, a complaint must first be lodged with the scheme concerned. The timelines for the CMS in dealing with complaints are relatively short – requiring schemes to respond within 10 working days.

Timelines for complaints and appeals within the NHI environment are a little longer, with the NHI Fund having 30 days to respond to a complaint received from a user, service provider, health establishment or supplier. The fund has to afford the complainant the opportunity to make representations relating to any decision it takes about a complaint, as well as providing reasons for any decision taken with respect to the complaint.

In both cases, there is a detailed appeals process that applies should a party not be satisfied with the outcome of a complaints process in either environment.

Impact on, and of, other legislation

The proposals in the MSA Bill may impact and be impacted by both the Consumer Protection Act No. 68 of 2009, and the Protection of Personal Information Act No. 4 of 2013 (POPIA). The Bill has, in one section, clearly carved the medical schemes environment out of the Consumer Protection Act with reference to matters governed by the Medical Schemes Act, but does not make reference to POPIA, despite the intention to collect the personal information of healthcare providers and medical scheme beneficiaries. SAMA is still in the process of examining this.

The NHI Bill recognises a significant impact on several other pieces of legislation, including necessary changes to multiple others to enable the introduction of the NHI, which will be the focus of what is to be “phase 2” of this introduction, to take place from 2017 to 2022.

SAMA's concerns relating to the MSA Bill

While SAMA is very supportive of several aspects of the Bill, we have some concerns which we will be addressing in our submission to the Department of Health:

- **Abolishment of co-payments:** Supposedly, PMBs have always been understood not to attract co-payments, which as we know, has not been the case in practice, because of tariff differences, DSP arrangements and various other mechanisms employed by schemes. In pursuit of national objectives, SAMA would support the abolition of co-payments on the premise that the agreed tariffs are appropriately pegged to realistically cover the costs of healthcare, and will ensure that practitioners are adequately remunerated by schemes.

- **Changes to conditions for brokers:** In contrast to what Minister Motsoaledi announced when the Bills were published (that brokers would be abolished), the MSA Bill still makes mention of and provision for brokers within the medical scheme environment. The Bill contains three changes, however, defining the role of brokers, broker fees and broker services. SAMA hopes that this will improve current practices in this area.
- **Replacement of PMBs with comprehensive service benefits:** The shift from the current diagnosis-based PMBs to a comprehensive service-based package is significant. The Minister of Health has promised that the comprehensive service benefits will include primary healthcare services such as family planning, vaccination, screening and wellness services. However, the ministry and the CMS must recognise that secondary, tertiary and quaternary (specialised) services are equally essential, and that improved primary healthcare will also potentially create higher demand for specialised services, as conditions will be detected earlier.
- **Unfair and unequal benefit options:** Section 33 of the current Medical Schemes Act has been substituted. However, we are concerned that the proposed substitution will not achieve the fairness and equity objective. The provisions in the current Act are prescriptive and protective in terms of registration of benefit options. Mandatory provision of PMBs offers health and financial risk protection. Therefore, to protect the health of beneficiaries, all benefit options registered by CMS should include the newly proposed comprehensive service benefits.
- **Establishment of a central beneficiary registry and provider registry:** At present, medical schemes are unwilling to share information on beneficiaries or providers. The provider registry seeks to register all providers, and gives CMS powers to ascertain monies paid to them. SAMA is examining Section 32 of the MSA Amendment Bill to understand the impact of this on professionals.
- **Introduction of income cross-subsidies:** This is a solidarity principle that SAMA supports, as it will reverse the regressive cross-subsidising currently occurring, i.e. the middle-income plans cross-subsidising the elite plans. Even with this new measure in place, vigilance

must still be maintained, as medical schemes' design of benefit options can disproportionately attract and favour a particular socioeconomic class.

- **Compelling medical schemes to pass back savings if a member uses DSPs according to the rules of the schemes, and discounts:** We support this intervention, with its potential to provide relief to scheme beneficiaries in the form of affordable or lower premiums, through clear and transparent discount mechanisms.

While SAMA is very supportive of several aspects of the Bill, we have some concerns

- **Cancellation of membership and waiting periods:** SAMA welcomes the waiving of general waiting periods. However, we are concerned about the expansion of the definition of a condition-specific waiting period to include a further condition where a primary cause is the specified condition. This would be particularly difficult to determine where a secondary condition is of multiple causality.
- **Governance of medical schemes:** We welcome the provision for governance of schemes. However, we feel that improved governance provisions must also apply to managed care organisations and administrators. Managed care organisations make health decisions at population level, and their decisions can therefore have huge impacts on society. Employees of managed care organisations should possess professional qualifications and be subject to professional regulation.

SAMA's concerns relating to the NHI Bill

SAMA maintains its position in support of universal health coverage. However, major causes for concern in the NHI Bill revolve around:

- **Quality of care:** There is no plain assurance that the intended right to broadened access refers to access to high-quality care. Furthermore, to achieve its full goals,

the NHI must not result in quality of care lower than that currently experienced by medical scheme beneficiaries. Instead, the NHI should seek to raise the quality of care of those not covered, to that enjoyed by medical scheme beneficiaries.

- **The intention to "contract both public and private" must not end as lip service:** Strategic purchasing must be impartial (**not** biased towards the public sector), but must draw on the full capability of the private sector. The private sector has the capability to increase competition and improve quality of care, especially if reimbursement mechanisms emphasise and reward performance. Involvement of the private sector will assist the government to progressively realise the right to healthcare.
- **The emphasis on "gatekeeping":** Appropriate use of lower levels of care must not unduly restrict higher levels of care for patients who genuinely need secondary, tertiary and quaternary services.
- **Services at the "lowest possible price":** The Bill encourages providers to provide services at the "lowest possible price". SAMA reiterates that providers will accept the imposed tariffs only to the extent that such tariffs are reasonable and consistent with realistic costs of service provision. Price determination must be evidence-based, transparent and procedurally fair. The omission of medical professional associations from the Benefits Advisory and Stakeholder Committee (Section 25) is ill considered.
- **OHSC capacity:** The OHSC needs to be capacitated to assess and accredit all the public and private sector facilities. We believe this function to be a critical one, and that the office will only be able to provide the necessary services to the health system with a substantial level of independence afforded to it.
- **Complementary medical scheme cover:** This will only be fair if the NHI Fund purchases healthcare in both the public and private sectors, and consistently provides good quality of care. At the moment, the state has not proven that it can provide good quality of care, and there is no certainty that the NHI Fund will be able to contract services with private providers. This may necessitate duplicative medical scheme cover to avoid violations of rights to healthcare.

Dr Trudy Thomas – a tribute

SAMA Communications Department

Dr Trudy Thomas, a SAMA member for 17 years, passed away on 10 June. The following is a tribute from SECTION27, a public interest law centre that seeks to achieve substantive equality and social justice in SA, and the Eastern Cape Health Action Crisis Coalition (EHCAC).

We are sad to share the news of the passing of Dr Trudy Thomas, a long-time friend of EHCAC. *Lala ngoxolo qhawekazi!*

Dr Trudy Thomas may not have been big in physical terms, but she was big in presence, voice and impact. Her death will renew our determination to do all we can to bring a better health system to the people of the Eastern Cape, something for which Dr Thomas fought for most of her life.

Dr Thomas practised medicine for more than 35 years, the majority of which were spent in the Eastern Cape, in both rural and urban areas.

In 1994, she became the first MEC for the Eastern Cape Department of Health and Welfare

(renamed the Eastern Cape Department of Health in 1997), a position she held until 1999.

Dr Thomas spoke to SECTION27 on many occasions about the pain she felt at witnessing the progressive deterioration of the province's health system and services over the years.

However, Dr Thomas always believed that the situation could be reversed, and this optimism will serve as an inspiration to us as we work to improve the health system, and more specifically, emergency medical services.

"My experience tells me it is possible to reverse the course and begin, once again, to improve the quality and availability of health services in the province," Thomas told SECTION27 in 2013.

She also reminded us that success is not measured in monetary terms only: "Once there are nearly enough nurses in the clinics, and medicines in the pharmacy; when ARVs don't run out, and TB patients start fattening up; when dehydrated babies sit up and smile as a drip starts putting back life into their little



shrunk bodies – then sully, stolid nurses will start bustling and smiling, and injecting much more service into the system for the same money."

Failure was never an option for Dr Thomas, and we will carry this spirit forward. *Lala uxolo, Trudy Thomas.*

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New Tobacco Bill: A watershed in the battle against tobacco-related epidemics in SA

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

SAMA is delighted by the release of the Draft Control of Tobacco Products and Electronic Delivery Systems Bill, which was published on 9 May 2018. The Bill repeals the Tobacco Products Control Amendment Act No. 23 of 2007. SAMA recognises the huge potential of this Bill to affect the use of tobacco and related substances in this country, and ultimately tobacco-related deaths.

Despite being in the vanguard of the anti-tobacco battle over the past two decades, SA became one of a majority of African countries that did not meet the standards of the individual articles of the WHO Framework Convention on Tobacco Control (FCTC).

Notably, the Bill's ushering in of plain packaging, 100% smoke-free indoor places, tighter regulation of advertisement and the regulation of e-cigarettes are breakthroughs in the tobacco fight in SA. This Bill is an important step in putting SA on the right trajectory in the fight against smoking – i.e. lowering uptake of tobacco use, reducing the country's currently high smoking rate of 20%, protecting the public from second-hand smoke, arresting market expansion for the tobacco or related substances industry, and, most importantly, aligning SA with the WHO FCTC.

Despite a decrease and plateauing in the smoking rate in the past two decades in SA, the uptake and prevalence of smoking is still high, here and on the African continent, courtesy of the tobacco industry's rapid promotion and market-expansion efforts. Nearly 17% of the adult SA population smokes tobacco. About 44 000 South Africans are killed by tobacco-related diseases annually. Smoking prevalence among the youth is a persistent challenge. In excess of 55 000 SA children aged 10 - 14 years old use tobacco daily. This makes SA unlikely to meet the World Health Assembly goal of a 30% reduction in tobacco use by 2025. According to the WHO, an estimated 7 million people die from tobacco use annually, and an alarming 890 000 of these deaths are of non-smokers exposed to second-hand smoke.

SA's TB incidence is ranked the sixth-highest globally, at over 450 000 new TB cases annually; about 90% of new and relapse TB

cases are pulmonary TB, which is positively associated with smoking. The other major smoking-related conditions are heart disease, chronic obstructive pulmonary disease, lung cancer and stroke.

SAMA's principles on tobacco are in line with the principles of the WMA

SAMA's principles on tobacco are in line with the principles of the WMA, an international medical professional body of which SAMA is a member. The WMA has a number of tobacco and tobacco-related policies, namely:

- Resolution on Implementation of the WHO Framework Convention on Tobacco Control (first adopted 2005; revised 2016)
- Statement on Health Hazards of Tobacco Products and Tobacco-Derived Products (first adopted 1988; latest revision 2011)
- Resolution on Plain Packaging of Cigarettes (adopted 2012)
- Council Resolution on Trade Agreements and Public Health (adopted 2015)
- Statement on Electronic Cigarettes and Other Electronic Nicotine Delivery Systems (adopted 2012).

The WHO and WMA strongly advocate for the regulation of tobacco, nicotine and more recently, electronic nicotine-delivery devices (e-cigarettes). In pursuit of the national public health commitment to strengthen a public health approach to morbidity and mortality in the country, SAMA has recently entered into a partnership with the Public Health Association of SA (PHASA) to forge a strategic collaboration on public health and policy issues, including joint advocacy.

While the Bill is an impressive policy breakthrough in itself, there are strong calls among the public health community for breaking the current silos by having **coherent** policy and regulation of **all** commercially driven, harmful commodities, namely, tobacco, alcohol and food substances (salt, sugar, fat), rather than controlling each substance separately. These substances are

the culprits behind the "industrial epidemics" that are major killers in SA, such as obesity, heart disease, diabetes, cancer and TB, among other diseases.

For the Bill to be effective in cutting tobacco-related deaths, its interventions must be complemented by other measures in other local policies, such as the new value added tax (VAT) Bill. **Sin taxes must be increased significantly.** While the tax on tobacco products has significantly reduced usage rates in SA since its introduction, unfortunately, tobacco excise-tax increases have become less effective in decreasing tobacco consumption since 2010, because the excise-tax pass-through to consumers lowered from pre-2010 levels. Since 2006, excise tax and VAT, combined, have remained unchanged, at about 50% of the retail price of cigarettes. SAMA strongly supports evidence that calls for tobacco excise levies to account for **at least 70%** of the overall retail price of tobacco products, as this will encourage current users to quit the habit, and dissuade younger people from starting.

The tobacco industry is a major obstacle to anti-tobacco legislation and efforts in the country. SAMA applauds the Bill for introducing tight measures (such as a ban on financial support from the industry, the regulation of e-cigarettes, etc.) to prevent the tobacco industry from influencing tobacco demand and public health in SA. The sting of the tobacco-industry tactics has been felt far beyond SA, for example, in Sierra Leone, Kenya and Uganda, where the industry successfully challenged or delayed anti-tobacco efforts. The June 2018 Australian lawsuit victory against the multinational tobacco companies, however, illustrates that tobacco-industry tactics and deception are not beyond challenge. This victory should send a sombre message to the tobacco industry, and is likely to pave the way for similar confrontations of the tobacco industry by anti-tobacco policy makers and lobbyists in many parts of the world. Similarly, there is widespread anticipation that this victory will also inspire public health resistance against other industries such as alcohol, salt, fat and sugar.

JUDASA – the revival

Dr Theresa Mwesigwa, chairperson, JUDASA national executive committee

The first weekend of June 2018 was an uncharacteristically exciting time – for football lovers across the globe, it marked the start of the official countdown to the FIFA World Cup in Russia, for healthcare providers and commentators, the much-protracted wait for the Medical Schemes Amendment and National Health Insurance Bills seemed to be drawing to a close, and in an unassuming conference room in a hotel not far from OR Tambo International Airport, the wheels of change were set in motion for the historically vibrant and radical Junior Doctors' Association of SA (JUDASA).

For the first time since 2015, JUDASA held an AGM where delegates from the re-formed and, in some instances, newly formed provincial executive committees came together to discuss the most pressing issues facing junior doctors today. Unsurprisingly, the issue that took precedence was that of internship/community-service placements, and this was addressed by the newly-appointed Chief Director for Human Resources in the Department of Health himself, Dr Gavin Steel. He delivered a thorough presentation that highlighted some of the changes that have been designed for and integrated into the online application and placement process for the 2019 cycle, to remedy the catastrophe that unfolded last year and to ensure that it is never repeated. The presentation ended with the planting of ideas for the future of the process, most notably, a reversion to the 1-year internship of pre-2005. The idea elicited mixed reactions, and sparked vigorous discussion and debate. To say that delegates were left wanting more following Dr Steel's presentation would be a gross understatement – delegates were willing to sacrifice lunch for the opportunity to ask more questions and gain greater clarity from Dr Steel.



At the AGM

There was no shortage of learning and wisdom to be gained as we settled into a talk by the president and chairperson of the executive committee of the HPCSA, Dr Kgosi Letlape, who skilfully navigated a number of topics in his presentation, ranging from the role of the HPCSA as a regulator of health services in SA to the role of junior doctors in maintaining the standard and quality of the health system, and finally, the importance of maintaining a high degree of professionalism and upholding ethical standards at all times, as health professionals.

The first day culminated in the election of a national executive committee (NEC) comprising bold, intelligent, dynamic and fearless individuals ready to rebuild and redefine the role of JUDASA, both within SAMA and within the broader health system. As discussions and proceedings continued into the night, it became ever clearer that the future of the organisation is bright, and that we will be well led.

It is often said that the mark of a great leader lies not in the answers that they are able to offer, but in the questions that they are able to ask.

Based on the questions from delegates, and indeed from the newly elected members of the NEC, it is clear that the calibre of the current leadership will do justice to the organisation, to junior doctors nationwide and to the health system and citizens of this country.

The weekend concluded with a brief but vital shop-steward training session, where we were armed and readied for our most important task: advocating for junior doctors at facility level. The weekend was a productive one that confirmed many truths, the greatest one being this: the future of healthcare in SA is in safe and capable hands.

We harbour no delusions that the road ahead will be an easy one to walk, or even that there will always be consensus on the work that needs to be done or the direction to be taken. However, it is clear from the incumbent leadership that the organisation that is to be rebuilt is one that will have justice as its foundation, and will be upheld by the pillars of inclusion, transparency, accountability and a passion for service.

This year is proving to be one of revival for JUDASA, and of progress: the year of revolution.

Doctors should know how impairment is rated

Alta Kruger, head, FPD Occupational Health, Safety & Wellness School

The World Bank estimates that around 1 billion people – 15% of the world's population – experience some form of disability, with a higher incidence in

developing countries. The statistics show a better-than-average situation in SA, and the national disability prevalence rate was reported as around 7.5% in the 2011 census.

It is more prevalent among women than men, at 8.3% and 6.5%, respectively.

Predictably, the number of people living with disabilities increases across age groups,

with more than half (53.2%) of people aged 85 and over reporting a disability. There is a multitude of conditions that can impair normal functioning, and prevalence rates vary considerably for specific disability conditions. The census data showed that 11% of people aged 5 years and older had difficulty with seeing, 4.2% reported cognitive impairment (difficulties around remembering/concentrating), 3.6% hearing impairment, 2% difficulty in communication and 2% mobility impairment. However, according to the SA Human Rights Commission, there is still substantial stigma associated with disability, and it is therefore reasonable to assume that there is considerable underreporting of it. The Institute for Employment Studies states that the ratio of workers to retired people will rapidly increase, from 27.6 % in 2015, to 35% in 2030, thereby not only increasing the number of people living with disabilities, but also increasingly ushering in a future where economic realities will necessitate workers retiring later.

What these trends show is that there is an increasing need for doctors to focus on disability within their practice environment, and an increasing market for impairment assessment. Sluggish local economic growth and a rapidly changing world of work due to the fourth industrial revolution also increase the potential for both workers and employers to look at disability and impairment as an exit strategy for older or non-productive workers. Evaluating and assessing impairment is

therefore becoming an increasingly complex and daunting exercise, requiring in-depth knowledge of assessment rating tools. In SA, the gold standard is the 6th edition of the American Medical Association (AMA) *Guidelines for the Evaluation of Permanent Impairment*. These guidelines are designed to ensure consistency and accuracy, especially where compensation for impairment has to be calculated by bodies such as the Road Accident Fund (RAF), Workmen's Compensation Fund and insurance companies, for the assessment of claims from road accidents, injuries on duty and other disabilities.

The AMA guidelines define **impairment** as the loss of use, or derangement, of any body part, organ system or organ function, and **disability** as the alteration of an individual's capacity to meet personal, social or occupational demands because of an impairment.

A **permanent impairment** is defined as one that has reached maximum medical improvement (MMI), and is well stabilised and unlikely to change substantially in the next year, with or without medical treatment.

Impairment evaluation refers to the "acquisition, recording and reporting of medical evidence, using a standard method such as described in the Guides to determine permanent impairment associated with a physical or mental condition". The result is an impairment rating which is a "consensus-derived percentage estimate of loss of activity, which reflects severity of impairment for a

given health condition, and the degree of associated limitations in terms of activities of daily living (ADLs)".

In this context, it is important to note that the role of the doctor is to conduct a clinical determination, as objectively as possible, to rate the impairment of each patient whom they assess, and to provide the insurer with the information required to determine whether the person living with a disability is able to do his or her work.

Given the economic and educational exclusion of people living with disabilities, various strategies are proposed for SA that include a focus on rehabilitation, reintegration and return to work. The Department of Labour's strategic plan proposes amending the Compensation for Occupational Injuries and Diseases Act No. 130 of 1993 to focus on reintegrating injured workers, and provides a commitment to work with other SA entities to ensure that policies and programmes stress the importance of vocational integration.

SAMA and the FPD (www.foundation.co.za), in response to this evolving practice environment, have developed an affordable, locally accredited training programme for doctors on the evaluation of permanent medical impairment guidelines, based on the AMA 6th edition, which has already been completed by more than 430 healthcare professionals in SA.

References available on request.

Killing healthcare workers is an amoral, slippery slope

To actively target and kill a healthcare worker truly transgresses all bounds of barbarity, writes Dr Aayesha J Soni



"We have one goal – to save lives and evacuate wounded people." These were the words of 21-year-old volunteer paramedic Razan Al-Najjar, in an interview with the *New York Times* last month. Today, she lies buried, after being shot in the chest by Israeli snipers. At the time of her murder, Razan's hands were in the air as she moved towards an injured protestor, wearing her white medical coat and clear identification of her being medical personnel. This was obviously no deterrent to the Israeli sniper who murdered her, and is indicative of the culture of plain disregard for basic human rights, wanton intention to harm and kill and flagrant abuse of power and

destruction that the Israeli Defence Force has adopted.

The (1949) Fourth Geneva Convention (to which Israel was a signatory a year after its formulation, in 1950) has two protocols that afford special protection to medical personnel and humanitarian staff; these are enshrined in articles 14 - 24. The Convention also guarantees respect for the freedom of movement of medical personnel, and ensures that they are granted all necessary material facilities for them to perform their duties, including removal of victims and attending to and transferring injured and sick civilians. One can argue that besides breaking international law, this murder violates all human instincts

of decency. As a doctor and human, I can say with confidence that indeed, Israel has crossed all limits with its latest actions.

Tens of thousands of Palestinians have been protesting in the Gaza Strip since 30 March, intending to shine a light on the Israeli-Egyptian blockade on Gaza, and also calling for the “right of return” for the 750 000 Palestinian refugees displaced during 1948. I had the privilege of visiting Gaza as a medical student in 2013. The devastation of Israel’s blockade on all supplies (especially medical) and its routine massacres and bombardment of the civilian population, and the evidence everywhere of what is obviously a debilitating system of oppression, were evident in every daily living activity. My experience in the Al-Shifa hospital was that it was just as short-supplied and struggling as every public hospital I have worked in in SA. How Al-Shifa is managing with the casualties in Gaza that have been occurring since 30 March is baffling. Any healthcare system in a First-World country would collapse if it had to treat as many gunshot wounds in a single day as there are in the Gaza Strip, yet Gaza’s medical system, which for years has been on the brink of collapse as a result of the Israeli blockade, copes amazingly well with the challenge.

Jonathan Whittall, the director of the analysis department at Doctors Without Borders SA, has also visited Gaza and the occupied Palestinian territories. He reports that Gaza ran out of 40% of essential medicines earlier this year, electricity appears for only 4 hours a day and 97% of Gaza’s water is undrinkable. If you have cancer, Whittall writes, you are unlikely to find

treatment. And if you need to be referred to a hospital outside of Gaza, it is unlikely that permission will be granted by Israel. This was affirmed on my visit to the area, as we visited patients dying from cancers that are treatable in other areas of the world, yet who were doomed to suffering and death, as they were not allowed to travel out of Gaza for treatment. To experience such helplessness and despair is emotionally shattering.

Between 30 March and 22 May, a total of 13 190 people, including 1 136 children, were injured in the demonstrations along the border with Israel, according to a WHO report. Of these, 3 360 were injured by live ammunition. On 14 May, a paramedic from the Palestinian Civil Defense was killed, shot on the way to rescuing an injured protester. For around 20 minutes, his colleagues tried to reach him, but failed, deterred by the heavy gunfire. The paramedic died. In the week of 13 - 20 May, an additional 24 medical personnel were injured – 8 by live ammunition, 6 by bullet shrapnel, 1 by a tear-gas grenade and 9 by exposure to tear gas. Twelve ambulances were damaged. Since the peaceful protests began, a total of 238 medical personnel have been injured, and 38 ambulances damaged.

While these may simply read as statistics to most, I am flabbergasted at the abolishment of the sanctity that usually accompanies being a healthcare worker. We take oaths, dedicate hours above and beyond the call of duty and sacrifice so much, in the hope of serving humanity. Razan was completely dedicated to this cause, and for that not to be respected

means that Israel has amorally crossed a line of no return.

It is imperative to step away from the politics of the region, and address the humanity of this problem.

Why Israel is no longer held to the same standards of morality as the rest of the world is a question that has long been left unanswered. In a recent report, Human Rights Watch accused Israel of perpetrating war crimes in its efforts to suppress Palestinian demands for liberation. Meanwhile, the UN General Assembly passed a resolution with an overwhelming majority condemning Israel’s use of “indiscriminate force”. Still, accountability remains an ever-elusive notion for the occupying force.

It has become apparent to me that the healthcare workers in Gaza put their lives in danger in a more serious manner than any other healthcare workers across the globe. By taking an active decision to be on duty for the civilian population of Gaza, they knowingly risk their own lives, and yet with every single doctor I met in Gaza, it was apparent that this was a sacrifice they would be willing to make over and over again. Razan will forever be immortalised as a hero; however, how many more young people must lose their lives in the line of duty as healthcare workers before the Israeli occupation is recognised for the monster that it is?

Dr Ayesha J Soni is a medical doctor and member of the Media Review Network (MRN). She was named one of the Mail and Guardian’s Top 200 Young South Africans of 2017.

Mandatory reporting of child abuse: The legislative framework

Hanneke Verwey, legal advisor, SAMA Governance and Legal Unit

In terms of section 28 of the Constitution, every child has the right to be protected from maltreatment, neglect, abuse or degradation. The Children’s Act No. 38 of 2005 aims to give effect to this right by, *inter alia*, the creation of a statutory duty to report child abuse and neglect. Given the prevalence of child abuse, the need to protect vulnerable children and the serious consequences that may follow in the case of a failure to report such abuse, it is essential that doctors

familiarise themselves with the legislative framework.

Who should report abuse?

In terms of section 110(1) of the Children’s Act, there is a duty on certain professionals, including dentists, homeopaths, medical practitioners, midwives, occupational therapists, physiotherapists, psychologists, speech therapists and traditional health practitioners, who on reasonable grounds conclude that a

child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, to report that conclusion, using the prescribed form, to a designated child-protection organisation, the provincial department of social development or a police official.

Definitions of abuse, sexual abuse and neglect

The Act defines abuse as any form of harm or ill-treatment deliberately inflicted on a child,

which includes: (i) assaulting or inflicting any other form of deliberate injury; (ii) sexually abusing or allowing a child to be sexually abused; (iii) bullying by another child; (iv) a labour practice that exploits a child; and (v) exposing or subjecting a child to behaviour that may harm the child psychologically or emotionally.

Sexual abuse means: (i) sexually molesting or assaulting a child, or allowing a child to be sexually molested or assaulted; (ii) encouraging, inducing or forcing a child to be used for the sexual gratification of another person; (iii) using a child in, or deliberately exposing a child to, sexual activities or pornography; or (iv) procuring or allowing a child to be procured for commercial sexual exploitation, or participating or assisting in the commercial sexual exploitation of a child.

Neglect, in relation to a child, means a failure in the exercise of parental responsibilities to provide for the basic physical, intellectual, emotional or social needs of the child.

A conclusion based on reasonable grounds

The reporting duty is triggered by a conclusion (of abuse, sexual abuse or neglect) that is based on reasonable grounds. Although courts have not yet had the opportunity to interpret the meaning of "reasonable grounds" in the context of the Children's Act, the phrase has been interpreted in several judgments relating to the Criminal Procedure Act No. 51 of 1977 and the Prevention of Organised Crime Act No. 121 of 1998. In this regard, "reasonable grounds" is interpreted objectively, and the grounds must be those that would induce a reasonable person to draw the same conclusion. The conclusion should be objectively justifiable, meaning that it should be based on reason, in which a factual base for the reason exists. Proof is not required, but the belief has to be founded upon evidence that might reasonably support the conclusion contended for.

Regulation 35(2), published in terms of the Children's Act, also provides some guidance as to the factors that may support a conclusion based on reasonable grounds. Although a mere suspicion is insufficient to trigger the reporting duty, it does not follow that one's suspicions must simply be ignored. Instead, when doctors suspect abuse or neglect, they should consult regulation 35(2) in order to determine whether there are specific indicators or

factors that could justify a conclusion of abuse or neglect.

The possible indicators listed in regulation 35(2) are extensive, but do not constitute a closed list. The broad risk-assessment framework includes the following:

- the presence of indicators of physical abuse, including: bruises on the body; grasp marks on the arms, chest or face; variations in bruising colour; black eyes; belt marks; tears around or behind the ears; cigarette or other burn marks; cuts; welts; fractures; head injuries; convulsions that are not due to epilepsy or high temperature; drowsiness; irregular breathing; vomiting; pain; fever or restlessness
- the presence of developmental indicators of physical, psychological or sexual abuse, including: failure to thrive; failure to meet physical and psychological developmental norms; withdrawal; stuttering; unwillingness to partake in group activities; clumsiness; lack of co-ordination or orientation, or observable thriving of children away from their home environment
- the presence of indicators of deliberate neglect, including: underweight; reddish scanty hair; sores around the mouth; slight water retention on the palms or in the legs; extended or slightly hardened abdomen; thin and dry skin; dark pigmentation of skin, especially on extremities; abnormally thin muscles; developmental delay; lack of fatty tissue; disorientation; intellectual disability; irritability; lethargy, withdrawal, bedsores and contractures
- a disclosure of abuse or deliberate neglect by the child
- a statement from a witness relating to a pattern or history of abuse or deliberate neglect.
- many indicators may be nonspecific to abuse or neglect
- a cluster or pattern of indicators, as opposed to a single isolated indicator, will provide support for a conclusion of abuse or neglect
- information about specific times of any incidents, places where incidents have taken place and the context within which incidents have taken place, which must be noted in writing, may provide support for a conclusion of abuse or neglect
- abuse may be unintentional, but failure on the part of the parent or caregiver to prevent abuse of the child may amount to neglect
- abuse may be physical, psychological or sexual without any visible indicators, and is likely to exist if the child continually reports threats of harm or punishment
- a series of minor incidents, which may not amount to abuse or neglect when considered in isolation, may constitute abuse or neglect when considered together
- the child's age, personality and temperament should be taken into account
- discrepancies in the rendition of incidents by the child and parent or caregiver may either provide or diminish support for a conclusion of abuse or neglect
- any unexplained delay in seeking medical treatment for a child who is seriously injured should be considered as a possible indicator of abuse or neglect.

The best interests of the child are always of paramount importance

When assessing whether a child has likely been abused or neglected, the focus should not fall on only one factor or indicator. The aforementioned indicators should instead be considered in the total context of the child's situation, in accordance with the following further guidelines contained in regulation 35(3):

Liability

Failure to report neglect or abuse constitutes an offence in terms of the Act, which is liable to a fine or to imprisonment for a period not exceeding 10 years, or both. Failure to report abuse or neglect may also result in civil liability for damages if the child suffers further harm as a result of the failure. Similarly, a failure to report child abuse or neglect would constitute unprofessional conduct in terms of the ethical rules of the HPCSA.

Although the conclusion or belief must be substantiated, doctors should not hesitate to report abuse or neglect for fear of being mistaken and thus exposing themselves to civil action or complaints by the aggrieved falsely accused party. The Act provides that someone who makes a report in good faith will not be liable to civil action on the basis of the report, even if it is subsequently determined that there is no abuse or neglect. Similarly, a report made in good faith and based on reasonable grounds will not constitute

unprofessional conduct. It is therefore important to make detailed clinical notes regarding any suspicions, in order to indicate that the conclusion was based on reasonable grounds. In case of doubt, doctors should seek the opinion of a senior colleague, attorney, professional association or indemnity provider before proceeding with the report.

Confidentiality

The child's right to privacy is not absolute, and the reporting of abuse is a justifiable, and in fact mandatory, limitation of such

right. In terms of section 13 of the Children's Act, every child has a right to confidentiality regarding his or her health status, except when maintaining such confidentiality is not in the best interests of the child. Failing to report abuse or neglect in order to maintain the child's confidentiality is not in the child's best interests. Doctors should therefore report abuse or neglect even if the child does not want to alert the authorities. The Act does not stipulate whether one needs to inform the child of one's intention to report the matter. Doctors should therefore use their discretion

in this regard, by taking the context and the child's individual circumstances into account. Where the child may be placed at greater risk upon being notified of such intention, the report should be made without the child's knowledge.

Conclusion

The best interests of the child are always of paramount importance. If a conclusion of abuse or neglect is made, doctors do not have a discretion, and it has to be reported to the relevant authorities for further investigation.

Unilateral changes to terms and conditions of service

Modisane Lelaka, *industrial relations advisor, SAMA Industrial Relations Department*

A unilateral change to terms and conditions of service occurs when the employer alters the employment contract and changes its terms and conditions, and substituted them with those convenient to the employer, without first consulting the employee. However, the employer can unilaterally change policies without consultation, and the unilateral change of these policies would not constitute a unilateral change to terms and conditions, even when the changes affect those in the contract. However, when the unilateral alteration of work practices would most likely cause any form of unhappiness within the workplace, the employer is obligated to negotiate with the unions.

Employers often exercise their powers by unilaterally changing an employee's terms and conditions of employment. In some cases, managers advance their managerial prerogative to vary the conditions in order to complement service delivery. However, varying from contracts can be done to frustrate the employee. Employers seem to believe that they have the power to vary conditions of services without consulting employees. At times, it is only after the implementation of the changes that the employer returns to persuade the employees to agree to them. The question remains as to whether the employer has the right to change the terms and conditions of the employment contract unilaterally. In some instances, employers argue that the changes do not need the employee's consent. It should be noted, however, that a unilateral change to

terms and conditions of employment amounts to breach of contract.

An employee has the right to be consulted when the changes are to be made

Some examples of unilateral changes are:

- non-payment, or reduction, of salary
- changes to hours of work
- changes to duration of annual leave
- changes in lunch or tea times
- introduction of new shifts system or changes in shifts
- transfer from one workplace to another
- increase in work load
- increase in hours of work
- changes to any issue that are subject to review by a collective agreement.

An employee has the right to be consulted when the changes are to be made. Employees can be consulted directly or through their unions.

An employer's possible recourses in a situation in which employees refuse to accept the proposed changes are to:

- dismiss employees due to operational requirements 187(1)(c)
- declare a dispute and lock out the employees

- (if the service rendered is not essential), to force them to agree to the changes
- unilaterally implement the changes.

In the case of employees in such a situation, the union or the employees can refuse to accept the changes. If the employer continues to implement them unilaterally, the employees can declare a dispute to the Bargaining Council.

In response to a lockout by the employer, employees can strike. However, since doctors are regarded as providing essential services, the right to strike cannot be exercised. SAMA, on behalf of an employee(s), would declare a dispute in terms of section 74 of the Labour Relations Act No. 66 of 1995. If, after conciliation, the matter remains unresolved, an application for arbitration must be made, and the matter arbitrated.

Section 64, subsection 4, of the Labour Relations Act stipulates that:

"Any employee or any trade union that refers a dispute about a unilateral change to terms and conditions of employment to the council or Commission in terms of subsection 1(a) may, in the referral, and for the period referred to in subsection (a) –

(a) require the employer not to implement unilaterally the change to the terms and conditions of employment; or

(b) if the employer has already implemented the change unilaterally, require the employer to restore the terms and conditions that applied before the change."

Climate change and health CPD enlightens

SAMA Communications Department

As climate change dialogue and action continue to gain momentum globally, SAMA has stepped up its efforts to contribute to global and national activities, and to enlighten the medical profession on the key issues surrounding the topic.

Since 2017, SAMA has been running a series of CPD talks targeting doctors, which are delivered at public healthcare institutions. The CPD sessions have been well received and well attended. Each session is 1 hour long, and worth 2 CPD ethics points. The latest CPD presentation was delivered at Dr George Mukhari Academic Hospital in Ga-Rankuwa on 14 June 2018, by the SAMA senior researcher, Mr Bernard Mutsago. It was entitled "Climate change and health: A medical professionals' perspective". More such presentations are planned for the rest of the year, and the years ahead.

SAMA is a member of the WMA, which is globally spearheading climate-responsive action by medical doctors, such as building resilient health systems and encouraging eco-friendliness in medical practice and in doctors' daily lives. As such, SAMA aligns itself with the 2012 WMA *Declaration of Delhi on Health and Climate Change*, which also informs the SAMA draft policy on climate change.

Bernard Mutsago highlighted the anthropogenicity (human influence) of climate change, and noted that the recent emissions levels of greenhouse gases are the highest in history. Such changes have had, and will continue to have, widespread impacts on human health. The presentation also acknowledged the existence of good scientific evidence linking climate change with the growing burden of disease. The impacts of climate change are both direct and indirect. **Direct impacts** are changing weather patterns, e.g. rising temperatures, heavy or diminished rainfall, sea-level increases and extreme weather events. The Western Cape drought is an illustrious example of a direct impact on climate. **Indirect impacts** affect vector ecology and ecosystems, changing water, air and food quantity and quality, and leading to changes in agriculture, industry, settlements and the economy.

Such climate influences might lead to changes in the burden of disease, such as more people dying or suffering from disease and injury from heatwaves, floods, storms, fires and droughts; changes in the distribution of infectious disease vectors such as dengue fever and yellow fever; and changes in the geographical range and distribution of malaria, which could, for example, see malaria

migrating from the three malaria-endemic provinces in SA (Limpopo, Mpumalanga and KwaZulu-Natal) to other provinces.

According to the latest (the fifth) scientific report of the Intergovernmental Panel on Climate Change, climate change threatens all countries; however, adverse health impacts will be greatest in lower-income countries or populations.

What can doctors and health professionals do? Climate-responsive action can be executed at three levels: organisational, collective and individual. Health establishments such as hospitals are urged to be eco-friendly in their processes and policies, such as in building design, resource procurement, "green fleet" use, renewable energy use and waste management. As a collective, the medical profession has a duty to lobby government to regard health as a priority in national policies, and to commit to international climate change treaties such as the Paris Agreement. At an individual level, doctors can keep pace with climate change developments, advocate for, or personally practise, low-carbon practices in healthcare, actively participate in active surveillance, contribute research and take part in environmentally sustainable activities, such as cycling to work instead of using heavy-engine vehicles.

Consolidation of medical schemes and benefit options: Are there opportunities?

Charlton Murove, BHF Global

There is growing consensus that the private health sector is neither sufficiently focused nor optimally structured to deliver value to the ordinary healthcare consumer. The need for greater alignment between private healthcare funding, healthcare provision and broader policy reform cannot be overstated.

With this in view, medical scheme and benefit option consolidation is undoubtedly necessary to provide adequate care when

needed by a medical scheme member. However, this move has been criticised by some experts in the industry. The just-ended 19th Board of Healthcare Funders (BHF) conference featured discussions on scheme and benefit option consolidation. Technical evidence shows that consolidation provides larger risk pools and simpler benefit option design, and potentially lowers non-healthcare costs. The efficiencies that come with consolidation enable schemes to cover

rare expensive conditions, and lower the reserve requirements on a risk-based capital approach.

The current system is highly fragmented, with the number of medical schemes gradually declining over the past 10 years. Currently, there are 82 medical schemes, with more than 360 benefit options, across the funding sector, which makes it difficult for the consumer to choose between medical schemes. Due to the fragmentation of the risk

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pools, consumers are risk-rated, which goes against the Medical Schemes Act No. 131 of 1998 objective of providing beneficiaries protection through community rating (charging the same premium despite the risk profile of the beneficiary).

Since last year, the Council for Medical Schemes (CMS) has been engaging the industry and experts on a proposed framework that highlights the benefits of consolidation. Initially, consolidation was planned for schemes with fewer than 6 000 principal members, and loss-making benefit options. This was met with some resistance – some of it justifiable. There has, however, been significant progress in this debate.

The majority of the medical schemes with fewer than 6 000 principal members are restricted schemes with significant employer-group support. Most of these restricted schemes have only one benefit option, and income-based contribution tables. Of the 28 small restricted schemes, 18 have a single option, 6 have 2 options and 4 have 3. These schemes have not fragmented their risk pool as much as the rest of the funding industry.

Approximately 60% of the 42 benefit options of these small restricted schemes have income-based contribution tables. Income-based contribution tables are important, as they allow for income cross-subsidisation, providing all beneficiaries with the same amount of benefits, with high-income earners subsidising low-income earners.

A benefit richness model by Insight Consultants and Actuaries compared the health benefits to contributions ratio of one such small restricted scheme with several others. The results showed a marked difference between the benefits and costs of

the small restricted scheme and the rest of the schemes. The benefits offered by this scheme were very rich, yet the cost comparatively low. If this scheme were to be closed, and members wished to join a scheme with similar benefits, then the members of this scheme would face increases in contributions ranging from 50% to 100%.

The restricted schemes have the important feature of being tied to an employer group, which generally has an interest in ensuring that employees are healthy, and as productive as possible. To this end, these schemes often have support from the employer groups – either financial or structural. An added feature of these schemes is the personalised relationship between the scheme and the beneficiaries. These schemes are often used as a recruitment tool by these employer groups – they help to ensure that the scheme offers attractive benefits, and this is used to attract talent. Therefore, the employer groups are a key stakeholder in these schemes, and their concerns and interests need to be considered in the matter of consolidation reforms.

The other scheme types (open schemes, and restricted schemes with more than 6 000 beneficiaries) are markedly different. They have a lower average member age and lower pensioner ratio, a lower claims ratio (a smaller proportion of their revenue is spent on healthcare expenditure) and potentially lower benefit richness. These schemes spent almost 25% more than the small restricted schemes on non-healthcare expenditure per beneficiary in the year 2016.

These schemes have more fragmented risk pools, with a significant number having more than 8 benefit options, and some as high as 20 benefit options. Closer inspection of the

benefit options also highlights how benefit design has been used to fragment risk pools by risk profile. There is also limited income cross-subsidisation across most of the options. This environment does not encourage social solidarity.

It is clear that forcing the small restricted schemes to consolidate and simply join the larger schemes is not in the best interests of their beneficiaries. They would lose their rich benefits, and pay more in contributions than they currently do. The support from the employer groups would be lost, and income cross-subsidisation reduced. If this consolidation is not structured well, the fragmentation may not decrease, as the receiving schemes may end up increasing the number of benefit options.

A proposal from some of the small schemes was that consolidation should take place among themselves. The small restricted schemes interviewed ahead of the BHF conference were open to this idea. They noted that this would require rationalisation of benefits among themselves, as well as contribution tables. This view was further supported by a presentation from Shivani Ranchod, who put forward a proposal for an umbrella fund.

For schemes other than these small, restricted ones, what are some of the options? Shivani also proposed that schemes prepare to be receptor schemes – those that will absorb other schemes through consolidation. She did not elaborate on how such a receptor scheme might work, but one might expect that it would have to have significant income cross-subsidisation, simpler benefit-option design, strong governance and other desirable features.

SAMA hosts successful 5 and 10 km run/walk

SAMA Communications Department

SAMA, in partnership with the Phoenix Villagers Athletic Club, recently hosted a successful 5 and 10 km run and walk. The weather, although slightly cold for Durban, was excellent for the race.

The more than 500 runners and walkers who participated in the event were treated to excellent support and encouragement along the way.

The race started outside the Kings Park Stadium and headed north towards the

banks of the Umgeni River at Blue Lagoon. The participants then continued along the breath-taking promenade of the Durban beachfront.

The 5 km participants turned back adjacent to the Moses Mabhida Stadium, while the 10 km participants continued along the beachfront, and turned at the 7.5 km mark, before returning to the stadium. The event was supported by the eThekweni Municipality, and all roads were closed for

the event so that the competitors had could walk in safety.

The winners of the various events were:

- 10 km male runner: Bonginkosi Zwane (30 min 24 sec)
- 10 km female runner: Zama Mokoena (39 min 30 sec)
- 10 km male walker: Aaron Mahlangu (48 min 52 sec)
- 10 km female walker: Natalie le Roux (56 min 00 sec).



Prof. M Naidoo (far left), Mr S Govender (chair of the Phoenix Villagers Athletic Club), Dr M Mzukwa (far right – chair of KZNCA) and Dr A Chetty (seated), with the winners in the various categories

Feedback from the participants was extremely positive, with many indicating they will be back next year. SAMA anticipates that the run and walk will grow to become an important event on the KwaZulu-Natal athletics calendar.

Participants used the SAMA tent, staffed by Dr Anand Chetty, Dr Manny Thandrayen, Dr Natasha Sewnarain and Prof. Mergan Naidoo, to check their height, weight, body mass indexes (BMIs), blood sugar levels and



Medical screening at the SAMA tent

blood pressure. These doctors also provided health advice to those runners and walkers who wanted it.

In addition to this medical advice, members of the Chiropractic Department of the Durban University of Technology offered advice on musculoskeletal ailments, and provided free massages. This service was very popular with participants.

The SAMA KZN Coastal branch (KZNCA) has chosen this year to focus on the health of doctors, and also hosted a “Caring for the carers” symposium the week before the race. It is hoped that this run and walk will help more doctors to embark on a healthy lifestyle. We hope to see many more SAMA members at the next event.

Antibiotic allegations: Patient alleges GP negligent

The Medical Protection Society shares a case report from their files

Miss G, 23, presented to GP Dr Q with a 4-day history of fever, cough and green/brown sputum. On examination, she was afebrile, with no chest signs except expiratory wheeze.

Dr Q’s clinical impression was of a viral infection. The clinical findings were supported by the fact that Miss G was on day 4 of a 5-day course of amoxicillin (prescribed by her dentist) that had not produced an improvement in her symptoms.

Given the history and examination findings, Dr Q did not feel Miss G required a further course of antibiotics; in any event, Miss G was already receiving the correct antibiotic and course duration, as set out in the guidelines for empirical cover of low-risk community-acquired pneumonia.

Dr Q advised Miss G about viral infection, and performed appropriate safety-netting with instructions on what to do in the event of the symptoms worsening, new symptoms developing or a failure to improve.

Miss G did not re-present to Dr Q, but did see other doctors when her cough failed to

improve, and she received further courses of antibiotics at this point. She later fractured a rib during a bout of coughing, but made a full recovery.

Miss G made a claim against Dr Q, alleging a failure to prescribe any or an adequate dosage of antibiotics to treat the symptoms of

Learning points

- On receiving a letter of claim, many members may be shocked and aggrieved to see allegations that are factually incorrect, and may in addition be medically misconceived. In this case, we see contradictory allegations, where Dr Q is simultaneously being criticised for failing to stop an antibiotic and for failure to prescribe an antibiotic.
- MPS is accustomed to allegations of this nature and takes care to address them fully, with a comprehensive rebuttal of all factual and clinical inaccuracies. In this we are greatly assisted by thorough accounts of incidents from our members, and especially quality documentation in the form of contemporaneous medical records.

fever and productive cough. She also alleged that there was a failure to advise against continuing amoxicillin, which allegedly had not been prescribed for Miss G's symptoms and which had only one more day left of the course, and finally alleged that her chronic cough led to her rib fracture.

Expert opinion

In this case, the Medical Protection Society (MPS) was able to serve a robust defence

denying liability, based on our legal team's assessment and the quality of Dr Q's medical records, supplemented by a helpful, detailed account provided by Dr Q.

This approach by MPS enabled the claim to be dealt with rapidly, without the need to instruct an independent expert witness or generate expenditure on an expert report.

The response served by MPS highlighted the appropriate history and examination performed by Dr Q and the lack of clinical

indication for antibiotics. It also explained that Miss G was already on first-line empirical antibiotic treatment, started by another clinician for a different problem, and that advice to stop the course a day early would not have been appropriate because incomplete antibiotic courses promote the growing problem of antibiotic resistance.

Miss G's lawyers discontinued the claim after receiving a firm letter of response from MPS.

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 Katarina Milos for her contribution below.

Re: Disclosure of HIV status to a sexual partner without patient consent: Ethical implications

After reading the above-named article in the *SAMA Insider*, as a doctor, I am puzzled. The statement in the first sentence, "HIV is a disease like any other," is incorrect.

Infective diseases are different in that they are easily transmitted without the other party necessarily being aware of it.

As doctors, we have the obligation to protect the public or a third party from infective diseases, and this should outweigh the patient's right of confidentiality if, after reasonable effort, the patient does not agree to disclosure.

Should the same approach about disclosure be applied to all other infective conditions, or does it apply only to HIV?

I would like clear guidance for the future.

If legal, financial, cultural or confidentiality interests prevail over medical or general public interest, this can potentially be dangerous and uncontrollable.

Hope to hear back from you.

Dr Katarina Milos

See response from Hanneke Verwey below. Ed

Principles that might apply to cases of disclosure

Hanneke Verwey, *legal advisor, SAMA Governance and Legal Unit*

In response to the article "Disclosure of HIV status to a sexual partner without patient consent: Ethical implications" that appeared in the June 2018 issue of *SAMA Insider*, a reader query was received regarding the principles that might apply to cases of disclosure of other types of infective diseases to third parties.

Although legislation mandates that certain notifiable diseases must be reported to government authorities, there are no specific ethical guidelines regarding the disclosure of other types of infective conditions (apart from HIV) to sexual partners. The same overarching principles relating to public-interest considerations and the need to protect third parties from harm would, however, apply to other types of infective conditions as well. In this regard, the ethical guidelines of the HPCSA

regarding confidentiality (Booklet 5) provide that disclosures may be made in the public interest. The guidelines provide that in cases where healthcare practitioners have considered all available means of obtaining consent, but are satisfied that it is not practicable to do so, or that patients are not competent to give consent, or, exceptionally, in cases where patients withhold consent, personal information may be disclosed in the public interest, where the benefits of the disclosure to an individual or to society outweigh the public and the patient's interest in keeping the information confidential.

As is the case with HIV disclosures, the healthcare practitioner would have to weigh the possible harm (both to the patient, and to the overall trust between practitioners and patients) against the benefits that are likely

to arise from the disclosure of information. The guidelines provide examples of circumstances where disclosures would be justified in order to protect third parties from death or serious harm, including disclosures to facilitate access to prophylactic treatment for a person who has had contact with an infectious disease. Disclosures are more likely to be justified where there is a significant and real risk to an identifiable other. As with the case of HIV disclosures, it is highly recommended that doctors first seek advice from senior colleagues, their indemnity provider or SAMA before proceeding. The reasons for breaching patient confidentiality should also be clearly documented. In all cases, attempts should first be made to convince the patient to make the disclosure him- or herself.

Griqualand West host symposium on TB

Sultana Hartzenberg, *Griqualand West branch*

The Griqualand West branch hosted a CPD symposium on multidrug-resistant TB on Saturday 26 May 2018 at the Garden Court, Kimberley. The topics discussed at the symposium, which were presented, respectively, by Dr M J Ngundu, Dr N Ndjeka and Dr G Lemke, were "Latest developments", "Ethical issues in the management of MDR-TB" and "Hydrofluoric acid exposure".

Dr M J Ngundu qualified as a medical doctor (MD) at the University of Kinshasa in the Democratic Republic of Congo, and went on to qualify as a specialist in family medicine at the University of Pretoria. He is the current SAMA Griqualand West branch chairperson, and the Head of Clinical Unit, Family Medicine, of the Frances Baard Health District. He is also a member of the SA Academy of Family Physicians. His clinical interests include diabetes mellitus and TB.

Dr N Ndjeka is a specialist family physician with interests in TB and HIV. He has served as the Director, Drug-Resistant TB and HIV, Department of Health, since 4 May 2009. He is also the chair of the Regional Green Light Committee – Afro, and a member of the WHO



SAMA Griqualand West branch council, with sponsors, Absa, at the symposium

task force on the introduction of new and repurposed medicines for TB.

Dr G Lemke qualified as a doctor at the University of the Free State, and went on to qualify as an emergency physician. He currently works full-time in the public health sector in Kimberley. He is the HOD of the Kimberley

Hospital Department of Emergency Medicine. His clinical interests include ECGs, point-of-care ultrasound and travel medicine.

The symposium was well attended, the presentations were excellent and case studies were discussed – a very informative session.

Informed consent and medical confidentiality discussed

SAMA Communications Department

The SAMA Vaal River branch hosted a successful "Informed consent and medical confidentiality" CPD on 12 June 2018. The event was well attended and very interactive.

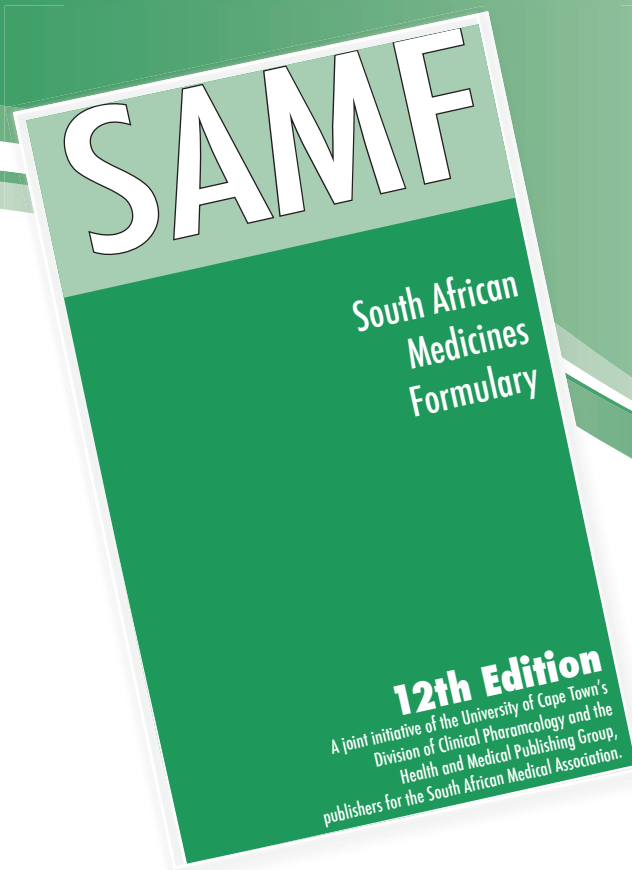
"CPD events of this nature not only ensure that our colleagues are well informed, but also give them the opportunity to positively interact on a personal level with the branch council, and with each other," said Dr Aina, the branch council chair.



Some attendees at the SAMA Vaal River branch CPD function



Dr T Rademan (branch GP representative), Dr A Aina (branch chair) and Mr V Singh (presenter)



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