

SAMA INSIDER

SEPTEMBER 2013

**SAMA
Conference 2013**
Changing the future
of healthcare



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

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Fax: +27 (21) 938 9704



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EDITOR'S NOTE SEPTEMBER 2013



Conrad Strydom
Editor: SAMA INSIDER

Conference pulls out all the stops

Universal agreement is a rare thing, but I dare say everyone thinks the recent SAMA Conference was a success. It was a conference full of politics, hopefulness, and concern – for patients, hospital workers and those left behind by the system – that presented a compelling miniature of South Africa's health system. The finger foods were nice too.

While we cover the conference in depth in this issue, we have not allowed it to overshadow matters of pressing concern to healthcare providers. To ensure that you stay informed, we examine one of the most worrying issues in the current landscape: the national rise in medical malpractice claims. Featuring inputs from doctors, lawyers and insurers, our article – 'Suing frenzy' – aims for a broad, balanced view of the issue and finds that, while the controversy around it is warranted, it is probably counter-productive.

We also feature an interview with Dr JudyAnn Bigby, former health secretary of Massachusetts and currently one of US President Barack Obama's health advisors. During her tenure in Massachusetts, Bigby was instrumental in the implementation of "Romneycare", a mirror-image precursor programme to the present administration's "Obamacare" policies, under which over 98% of the state's residents gained access to free health coverage.

We also feature all the relevant public and private practice news and check in with one of our members, Dr Kgopotso Pege, to hear about the daily struggles of a junior doctor. If there is anything at all you would like to see highlighted in upcoming *Insiders*, or if you have any suggestions about improving the magazine, feel free to contact us. In case you missed the small print at the bottom of this page, my email address is conrads@samedical.org.

Until next month, pleasant practice!

Editor: Conrad Strydom
Advertising Manager: Diane Smith
Production Editors: Melissa Rhode and Megan Sell

Editorial Enquiries: 012 481 2041
Advertising Enquiries: 012 481 2069
Email: conrads@samedical.org

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Block F, Castle Walk Corporate Park,
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HIV/AIDS – Beyond the Millennium Development Goals



Prof. Zephne van der Spuy, President, SAMA

Millennium Development Goal (MDG) 6 talks to combating HIV/AIDS, malaria and other diseases. The MDGs are interrelated and obviously combating HIV/AIDS will also reduce child mortality rates (MDG 4) and improve maternal health and achieve universal access to reproductive health (MDG 5). In addition, MDG 3 which promotes gender equality and empowers women will have a role to play in combating HIV/AIDS.

It has been reported that 80% of people who are HIV-positive in the world live in sub-Saharan Africa with 20% of them in South Africa. World-wide our country has had the most rapid increase in the infection and the biggest impact. Our approach to managing HIV/AIDS was unfortunately initially inadequate and inappropriate but there have been considerable advances in improving the management of HIV/AIDS in South Africa.

There are challenges and it has been reported that for every one infected person who starts treatment with antiretroviral (ARV) therapy, four new infections occur.

It is obviously important that we address this problem. We appreciate that the programmes to prevent mother-to-child transmission (MTCT) of HIV have improved enormously and the transmission has reduced over the last decade and so we can with confidence predict that most women who are HIV-positive will, with appropriate care, deliver a HIV-negative child.

There is also follow-up of infants and many of those who were born infected are now reaching

maturity as healthy adults thanks to the ARV therapy they have received. Managing HIV/AIDS is a priority. It is recognised as part of our quadruple burden of disease, it is prioritised in the ten-point plan issued by the Minister of Health, Dr Aaron Motsoaledi, and it is part of the recommendations of the National Committee on Confidential Enquiries into Maternal Deaths (NCEMD).

While all of these efforts are valuable and important and have done much to deal with the AIDS pandemic, it is now time that we look at long-term care of these members of our communities.

There are good systems in place for the programmes for the prevention of MTCT and the protocols which are currently utilised provide ARV roll-out for women in pregnancy.

“Published research and reviews indicated that HIV was considered universally fatal in Africa and it was recognised that it affected adults in their most productive years”

We however need to look to other needs of those infected with HIV. There are already reproductive health clinics specifically designed for young people who were born HIV-positive and this is undoubtedly a very important and valuable incentive.

What is not in place is a system addressing the needs of those men and women who are HIV-positive and desire fertility but also wish to ensure that they access the safest options for achieving a pregnancy and hopefully the best possible pregnancy outcomes. The problem is obviously different for serodiscordant and seroconcordant couples and at present within

the public sector good services meeting the needs of these patients are often not available.

Published research and reviews from just a few years ago indicated that HIV was considered universally fatal in Africa and it was recognised that it affected adults in their most productive years. It was the leading cause of death in Africa and affected individuals across the entire socio-economic spectrum.

What has not been recognised is the need for fertility in many of these patients and the lack of resources. In Africa there is little or no voluntary childlessness and we live in a pronatalist society.

There is often an early start to child-bearing and contraceptive services, especially among young women, are frequently limited. Research has indicated that the decision about fertility usually does not depend on HIV status as there is an imperative to have children within African societies. While in South Africa we are moving forward in providing better services for pregnant women who are HIV-positive, and for follow-up of infected infants and there is an accelerated roll-out of antiretroviral therapy, we also need to look to the future.

These patients can now expect to live into adulthood and it is realistic to expect them to want to have families and we need to provide the safest possible advice both for those who do not have problems with conceiving and those who possibly have fertility problems.

This service is currently not provided in the state although there are excellent private clinics which treat HIV-positive couples. Given the enormous strides we have made in dealing with HIV/AIDS, and the recognition that this is becoming a chronic disease and not a fatal illness in our society it is imperative that we make sure there are services for young adults who are sexually active and for those who wish to become pregnant. I would suggest there should be designated clinics which can offer appropriate care to HIV-positive couples with regard to reproductive health and fertility services. Those who are affected by this pandemic should not be disadvantaged all their life because of a lack of holistic care.

We can guarantee safe maternity care and we can also be confident that most of the infants will not be infected. We now need to move forward to provide more sophisticated and better long-term services for the reproductive needs for all who are infected.



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SAMA Conference: Day 1

The annual SAMA conference kicked off with a bang on 16 August. Held on the ample grounds of the Birchwood Hotel and Conference Centre, the conference managed to attract well over 400 full-time medical practitioners from South Africa, and at least one very boisterous one from Lesotho.

Policy makers, opinion formers, academics and practitioners were on site to address obstacles and figure out ways to optimise access to quality healthcare nationwide.

“SAMA concedes that the difficulties we face are formidable, but we are confident that anything broken can be fixed”

The conference was also an ideal opportunity for medical practitioners to acquire all-important continuing professional development (CPD) points. These were divided into 15 clinical and 8 ethics points.

After a brief meeting with the press, SAMA chairman Dr Mzukisi Grootboom headed

to the podium, where he opened the proceedings with a stirring address on the conference's theme, “Changing the Future of Healthcare”.

“We at SAMA must concede that the difficulties [we face] are indeed formidable,” Dr Grootboom said, “but we are confident that anything broken can be fixed.” He introduced the conference's keynote speaker, Prof. Adam Habib, the vice-chancellor of Wits University, who delivered a very interesting talk on the development accord between his institution and the Department of Health (DoH).

He emphasised that, if health practitioners hope to achieve their goals, they will have to strike while the iron is hot. “At long last, the top of the health department is dominated by people who want to fix things,” Prof. Habib said. “Let's not waste this opportunity.”

The next speaker was Dr Sam Mokgopong, the president of the Health Professions Council of South Africa (HPCSA), who provided an overview of the HPCSA's current and future role as a protector of healthcare standards. Dr Mokgopong elicited quite a heated reaction with his stances on Remunerated Work Outside the Public Service (RWOPS) and doctors' right to unionise, pointing out that, while it is possible to do so, health professionals are classified as providers of an “essential service” and therefore do not have a right to strike action. He also stated that RWOPS while engaged in public sector work is not desirable and should be discouraged.



Prof. Adam Habib

Esteemed SAMA president Prof. Zephne van der Spuy was next, delivering an impassioned speech on the way in which health will be regulated in future. Prof. van der Spuy covered a broad range of topics in her speech, including the worrying lack of attention paid to the Millenium Development Goals, the reasons for South Africa's ability to retain its graduates and her concern about the lack of compassion in healthcare. The other speakers were Prof. Christopher Szabo, who examined the roots and treatment of depression, and Dr Veruschka Ramanjam, whose talk on new developments in our understanding of ADHD offered up valuable food for thought.



SAMA conference display



SAMA conference



The HPCSA's Dr Sam Mokgopong

The day's only real disappointment was the fact that none of the winners of SAMA's annual photography competition showed up to claim their prizes. At least Dr Phophi Ramathuba's birthday song was there to

distract from that damp squib; she received a rowdy improvised version of “Happy birthday to you” from the aforementioned Lesotho delegate that had the whole venue cheering.

SAMA Conference: Day 2

Before the day's proceedings got under way, former SAMA president Prof. Mac Lukhele and renowned sports nutritionist Prof. Tim Noakes had already made an appearance on e-news' Sunrise TV programme. The two spoke about SAMA's goals with the conference and the need to increase the number of doctors in the country. After an opening talk by Bonitas Medical Fund's Dr Bobby Ramasia, the proverbial fireworks were lit by an ever-fiery Dr Phophi Ramathuba, who spoke about the public sector's role in the looming National Health Insurance (NHI) programme. She slammed the poor working conditions at public hospitals, arguing that NHI cannot be implemented before these conditions are improved. She also lamented the low number of medical graduates and concluded her talk by explaining why SAMA has decided to unionise, refuting the views expressed by Dr Sam Mokgopong during the previous day.

Dr Marmol Stoltz represented the private practice view of NHI. She argued that the proposed NHI model would blend public and private practice and noted that this would be

detrimental. She also expressed concern about GPs' roles as gatekeepers would be diluted by the programme, and recommended a process of upskilling for GPs. Next up was Prof. Marian Jacobs, who gave an enlightening talk on leadership in healthcare, focusing particularly on the difference between leadership and management. She emphasised that there was a lack of direction in this regard, and proposed that SAMA play an important role in clinical leadership and governance. She also provided several examples of promising young leaders in the South African medical community.

Dr Sean Chetty's talk concerned the management of chronic, non-malignant pain, which he described as an unrecognised epidemic in South Africa. His overview of the condition of pain included a call for greater recognition of the growing field of pain medicine and why it is necessary to treat pain, even if it is not life-threatening.

Dr Lebo Masunyane tackled the problem of type 2 diabetes. He looked intensively at approaches to its treatment and the unfortunate lack of clarity concerning the disease, before addressing practical ways

“If now, at the beginning of the twenty-first century, a hospital does not have aspirin, someone should be shot for it.” – Prof. Adam Habib

“It is incredible that, while only twenty percent of our population use private healthcare, seventy-five percent of doctors work there. The eighty percent who have to make do with public healthcare also have to make do with twenty-five percent of the doctors.” – Prof. Zephne van der Spuy

“Electro-convulsive therapy is very effective and, by and large, very safe, but it is probably best used as a last resort.” – Prof. Christopher Szabo



Prof. Tim Noakes

to manage hypoglaecemia. Matters of a philosophical and esoteric nature were discussed by Dr Shadrack Mazaza, arguably one the conference's most interesting speakers. His talk took an open-minded walk through new discoveries in quantum physics, chaos



Dr Phophi Ramathuba

“Public practitioners would not be doing RWOPS if they were paid properly.” – Dr Phophi Ramathuba

“Hospital managers need more than just an MBA, they need coaching in order to deal with the conditions in our hospitals.” – Prof. Marian Jacobs

“The brain is the only organ that can experience pain.” – Dr Sean Chetty

“In Sweden, doctors who collect forensic evidence don’t have to appear in court. They seal evidence using a government-sponsored kit and send it to police when the victim decides to lay charges.” – Dr Gustaaf Wolvaardt

“There is not only one model that explains weight gain, there are two, and it is unethical to only teach one approach at medical school.” – Prof. Tim Noakes



Dr Shadrack Mazaza

theory and systems thinking and attempted to show how all knowledge shares a holistic paradigm. Dr Mazaza indicated that the conceptual framework of Western medicine had failed to keep up with cutting-edge scientific discoveries, and urged conference-goers to remain open to the valid medical knowledge that may well be contained in so-called “alternative” therapies and African traditional medicine.

The head of the Foundation for Professional Development, Dr Gustaaf Wolvaardt, spoke about the epidemic of gender-based violence in South Africa. He showed how the official number of rapes per year was grossly underreported and could be as high as 600 000. Up to 40 percent of these were against underage girls. He urged doctors to display anti-domestic violence posters in their

practices and to encourage victims of abuse to speak out.

What followed next was perhaps the most talked-about presentation of the entire three days. Prof. Tim Noakes turned nearly everyone’s concept of weight loss on its head. Body weight can only be understood in the context of insulin resistance, he argued, before roundly dismissing both calorie counting and exercise as effective weight loss tools. “The cause of obesity is the consumption of large amounts of carbohydrates by people with varying amounts of insulin resistance,” he said. He showed how carbohydrates actually drive hunger and recommended a low-carb diet to people who wish to lose weight (50g a day – 25g for diabetics). Dr Harlem Gongxeka closed the day with a discussion on the interpretation of chest x-rays.

SAMA-BONITAS HOUSE CALL DOCTOR’S AWARDS

The OR Tambo room of Birchwood Hotel was packed with dressed-to-the-nines dignitaries during the annual SAMA-Bonitas Doctor’s Awards. After Bonitas’ principal executive officer Dr Bobby Ramasia and SAMA chairperson Dr Mzukisi Grootboom opened proceedings, the audience was addressed by Gauteng Health MEC Hope Papo. The winners were Prof. Marian Jacobs (Medal of Honour); Dr Wilma Lotter (Medal of Transformation); Associate Prof. Wendy Spearman (Gender Acclaim Award); Prof. Peter Jacobs (Fellowship in Art and Science of Medicine Award); Prof. Kenneth Huddle (Extraordinary Service to Medicine Award); Prof. AA Stulting (Lifetime Achievement Award); Dr Joseph Teeger Lifetime Achievement Award); Dr Vuyane Mhlomi (Young Leaders Award); Community Service Award (Dr Victor Fredlund) and a loyalty award to Prof. Angus Macdonald. A Special Merit Award was granted to Michael Bagraim and International Relations minister Maite Nkoana-Mashabane for their role in securing the release of Prof. Cyril Karabus.

SAMA Conference: Day 3

With the previous evening’s Awards Dinner still fresh in their memories, the delegates filed into the conference hall at 08:00 to listen to Dr Omolemo Kitchin, a respected pulmonologist, present a talk on refractory asthma. Dr Kitchin also touched on the awful medical infrastructure in certain rural areas. Next was Prof. Jerry Coovadia, who both entertained and informed the audience with his straightforward style. Prof. Coovadia spoke about the state of HIV/AIDS among children in South Africa, and pointed out that the rate of infection was declining rapidly, and expressed high hopes for the prevention and eventual eradication of the disease, citing the little-known story of the baby in Mississippi who was cured of HIV.

The next speaker was Prof. Shingai Mutambirwa who delivered a talk about male sexual dysfunction. He highlighted how the condition should be treated by medical practitioners and also came out in favour of controversial testosterone replacement therapy. He also emphasised the need to educate practitioners about how to take a patient’s sexual history.

Another presentation on an intimate matter followed, courtesy of Dr Ros Boa. Her presentation on female sexual pain disorders explored the roots of sexual pain in women and emphasised clinical and therapeutic ways to deal with the condition. Besides physiological causes, Dr Boa also stressed the role of personality and relationship factors in treatment.

After lunch, Prof. Petrus Steyn delivered a much-needed clarification of the term ‘personhood’, on which the legal basis of abortion procedures is predicated. According to Prof. Steyn, the issue becomes complicated when one introduces the term potential personhood into the mix, but he nevertheless

provided guidelines for performing an abortion within the scope of the law. He also urged medical professionals to phone the police whenever they encounter unlicensed abortion clinics.

Prof. Mac Lukhele took to the stage to thank the conference-goers for their attendance and provide an overview of the last three days. He praised the eagerness to participate demonstrated by the attendees and spoke highly of keynote speaker Prof. Adam Habib’s call for health industry stakeholders to “talk to each other, not over each other.”

SAMA chairman Dr Mzukisi Grootboom had the last word. After thanking the speakers, SAMA staff, the medical association of Lesotho, the delegates and the Birchwood Hotel, Dr Grootboom reminded the conference that actions would have to speak louder than words if the South African health system is to improve. He emphasised the lack of medical professionals in South Africa, pointing out that a staggering 34 000 doctors are needed to satisfy

the current demand. He also announced that SAMA, in conjunction with the national dental associations, would soon engage in a meeting on a campaign to re-establish an independent medical and dental council for South Africa, an announcement which was met with applause.

“I can guarantee we will have a lack of doctors for the next twenty years at least. What we can do in the meantime is increase the number of mid-level health workers.” – Prof. Jerry Coovadia

“From the age of 30, our testosterone goes down – in effect, a male menopause.” – Dr Shingai Mutambirwa

“Always acknowledge to women that their sexual pains are real as a first step to their recovery.” – Dr Ros Boa

“34% of local medical graduates go overseas, many of them to escape the NHI. Ironically, they often go to areas where a form of NHI is already in place: the National Health Service in the UK or the systems of Canada and New Zealand.” – Dr Mzukisi Grootboom



Dr Ros Boa

SAMA CONFERENCE 2013 IN A NUTSHELL:

Despite the issues raised, most doctors were positive about the future of healthcare. The different parts of the health industry should stop fighting and try to work together.

The severe shortage of doctors will likely continue for decades to come.

NHI can only be effective if the health infrastructure gets fixed.

Carbohydrates are not your friends.

We are winning the fight against HIV/AIDS, but other epidemics (obesity, gender violence) demand our attention.

The HPCSA is not in favour of unionisation.

One of the cornerstones of practice must be compassionate care.

Suing frenzy: The truth about malpractice claims

Many medical practitioners working today can remember a time when the threat of medical malpractice was an occasional, not an ever-present danger. However, recent developments in the South African legal landscape have changed this perception.

Medical malpractice claims have become a veritable growth market in this country, with recent statistics indicating that malpractice claims have not only increased in number (there was a 30% increase between 2007 and 2011 alone), but also in cost.

According to Dr Graham Howarth, the Medical Protection Society's (MPS) head of medical services for Africa, the cost of an average claim has, on average, doubled every five years. "A claim which would have settled for R1 million in 2002 would settle for R4 million in 2012," Dr Howarth was quoted as saying. Another incredibly alarming piece of information, recently reported in the *South African Medical Journal*, is that the number of claims valued at over R5 million has increased by 900% in the last five years alone. How did this state of affairs come about?

Causes

The simplest and possibly least accurate answer is that patients have become more aware of their capacity to litigate. Public awareness campaigns such as the one launched by the Health Professions Council of South Africa (HPCSA) in March last year have undoubtedly raised the profile of medical litigation. While these campaigns are no doubt necessary, it is also possible that they have fostered a culture of mistrust between doctors and patients.

Another view is that professional standards among medical professionals have dropped, resulting in a greater number of litigation-worthy offences. The origin of this view appears to be a comment made by the former CEO of the HPCSA prior to the launch of their awareness campaign. In fairness, the view does not seem to be universal among the HPCSA's ranks; when questioned about it recently, the HPCSA's Bertha Peters-Scheepers responded in a decidedly different manner, praising local medical doctors as "among the best in the world." Assuming that the increase in malpractice claims correlates to a decline in professional standards ignores the fact that South Africa is not the only country which has



experienced such an increase. Both cost and frequency of claims are on the rise globally. According to the MPS, there has been an equally marked increase in their overseas markets, while international surveys have revealed a blanket rise in all types of litigation, proving that this is not a localised problem. The rise may also be due to the advance of medical technology; improved machinery often costs more to maintain, raising the cost of care and pushing up the amounts awarded in negligence cases.

Here be lawyers

Probably the most shocking claim about the root of the litigatory avalanche is that it is being deliberately engineered by the South African legal fraternity. Prior to 2008, many South African lawyers had built their careers on pursuing litigation against the Road Accident Fund (RAF). When an Amendment Act to the RAF capped the amount the fund could pay out, these lawyers were left without a stable source of income and many have turned to medical litigation as the next best option.

"Lots of attorneys are jumping on the bandwagon, but they are bumping their

heads very quickly," says Gary Austin of Austin Attorneys, known as one of the country's most successful malpractice attorneys. "Medical claims are much, much different from the sorts of claims these guys were used to with the RAF," Austin said, "and quite a few are struggling to get a foot in the door."

Austin also stated that doctors should not panic about the size of claims because of the nature of South African law: "This is not the United States, where vast amounts are paid out regularly.

In South Africa, you firstly have to determine exactly how much you have lost due to malpractice and then determine a fixed amount you can sue for, based on previously-awarded amounts. It is a scientific guess, not a thumb suck."

Austin was also keen to point out that, since many losses can't be proven, the amounts awarded in these cases are often less than the actual damages suffered.

Conversely, in certain highly publicised cases, the large amounts paid out often serve to obscure the reason for those amounts. "Take the R25 million that was

recently awarded. It received a lot of media exposure, but everyone forgot to mention that, although the offence took place in South Africa, the family involved live in Ireland – they had to be paid in pounds!"

The legal basis of medical negligence claims is relatively straightforward. In order to secure a claim, a patient's legal team has to prove that a practitioner "failed to foresee the possibility of harm occurring to his/her patient in circumstances where a reasonable practitioner [would have done so] and would have taken steps to avoid it," according to *law24.com*. Furthermore, the medical practitioner has what is called a "duty of care" to a patient, under which a practitioner must proceed with all the care that can reasonably be expected of them given the circumstances they find themselves in.

"If you go overboard trying to protect yourself, the medical aids will increase their premiums because of all the extra measures you take. In the end, it is the patient who will suffer"

There is also the matter of "vicarious liability", which holds hospitals and health departments responsible for the actions of their medical practitioners. Simply put, the hospital as a whole is held liable in the case of private institutions, while the provincial state representative (the Premier of Gauteng, for example) will be held liable when public institutions are involved. Hospitals have tried to reclaim some ground by obliging patients to sign indemnity forms, but the use of these is a controversial grey area in South African law and does not by any means guarantee indemnity to the hospital involved.

Laager mentality

The fact that patients should be protected is non-negotiable. However, as SAMA's Dr Phophi Ramathuba knows, everyday practice is often more complicated than the law.

According to her, the threat of litigation is forcing doctors to take defensive measures that cause them to remove their focus from their patients, in turn laying the groundwork for further litigation. "If you go overboard trying to protect yourself," Dr Ramathuba said, "then the medical aids are going to increase their premiums because of all the extra measures you will have to take. In the end, it is the patients who will suffer."

Dr Ramathuba also lamented the exodus of specialists (who are hit hardest by malpractice claims) from the profession.

"It is already expensive to undergo training as a specialist, then on top of that you have to spend half a million on insurance every year the way some obstetricians do? It is simply not viable. People have said to me that it is not worth it to practice," Dr Ramathuba said. In the private sector, where the principle of vicarious liability holds sway, malpractice claims are a serious concern, especially since the state of South African public care leaves much to be desired.

"Some hospitals are so underfunded they are forced to improvise equipment during major surgeries," Dr Ramathuba said. "I know of a specific hospital that had to make do without an MRI machine for six months, while rural doctors often have to operate alone. If a midwife has to deliver 20 babies at once, how can she cope?" The plethora of lawyers advertising themselves as medical litigators is also particularly galling to Dr Ramathuba. "Patients must be wary of these guys. As doctors, we would love to claim an 100% efficiency rate," she said, "but we can't, and patients must understand that when they release themselves into our care."

Keep calm and carry on

The defensive system of healthcare which so many physicians are concerned about has led to an atmosphere of paranoia in some practices. According to a 2012 study by the MPS, 58% of private GPs said that they had changed their method of practice as a result of negligence claims. While this is certainly cause for concern, practitioners are urged not to go overboard in protecting themselves – slip-ups will occur, and a set of basic, practical measures are the best response to the current climate.

According to the MPS, self-defence starts with improving communication between you and your patients – doctors should at all times explain their procedures to their patients as clearly as they are able to. Doctors should not attempt to hide the risks involved in procedures and should only order tests and examinations when they are strictly necessary. It is also recommended that doctors keep extremely detailed records of their interactions with patients and keep abreast of developments in their field.

"As doctors, we would love to claim an 100% efficiency rate, but we can't, and patients must understand that when they release themselves into our care"

It is also encouraging to remember that, although the frequency of claims has risen, they are still rare enough to be remarked upon. As the HPCSA puts it: "Considering the number of practitioner-patient interactions on a daily basis, the average of 2500 to 3000 complaints annually lodged with the Council is negligible."

The HPCSA has held a number of roadshows over the past year on best practice methods to avoid litigation, it urges practitioners to attend.

In the absence of legislation regulating negligence claims, there is not much more that doctors can do other than ride out the storm. It is however heartening to note that the abuse of the Road Accident Fund claims system was rectified within a reasonable period of time. Perhaps similar amendments to the current medical laws are not far off? The medical community can only hope that, by the year 2023, South African lawyers will have found a new growth market in an area that could use it, such as police corruption and pension-fund embezzlement.

Wound coverage: Dr Bigby fixes the system



Dr JudyAnn Bigby

At the beginning of 2006 the US state of Massachusetts began enacting an ambitious set of laws aimed at providing universal health coverage to every resident of Massachusetts and guaranteeing health coverage to the poorest of the poor.

The legislation predates current US president Barack Obama's universal healthcare programme and has also been seen to be controversial in some sectors.

There can be no doubt however that it has achieved its goals. No less than 97% of adults and 99.8% of children in Massachusetts have health cover, while 76% of businesses offer health cover to their employees.

These figures are up from 68% before the bill's introduction.

As secretary of health and human services for Massachusetts from 2007 to 2013, Dr JudyAnn Bigby played a very instrumental role in successfully implementing this programme.

Dr Bigby was in South Africa recently as a guest of the Albertina Sisulu Executive Leadership Programme that took place in Cape Town in May of this year.

We had the pleasure of her company as she stopped by SAMA headquarters in Pretoria for a very enlightening discussion.

Why was a new system of healthcare necessary?

In 1965 Congress created Medicare, a programme that initially only covered people 65 years and older. Unfortunately, it only covered 80% of costs at most. Medicare was accompanied by Medicaid, which was aimed at providing coverage for financially disadvantaged citizens, but because these programmes only covered children, the elderly, the disabled and the unemployed, the working poor were excluded. They were also unnecessarily expensive. The system we ended up implementing in Massachusetts was aimed at addressing those imbalances, and I believe the results speak for themselves.

Why has this programme been so successful?

I think one of the main reasons for its success was that we created a forum for practicing physicians to share their views on the programme before we implemented it.

If there were parts they didn't like, we heeded their advice and left those parts out. They didn't want price regulation, for example, or a cap imposed on the number of specialists. By the way, you should always consult practicing physicians in these matters before you consult academics. Also, keep in mind that not all fears are well-founded. Medical schemes, for example, were worried that patients would abandon them if government care dramatically improved. This did not happen.

Does this healthcare system protect patients from profit-driven medicine?

Look, we are not at all against people making a profit. At the same time, market forces don't always apply in the health sector – it is not a regular market, and it has its own rules. If you pay physicians to generate more volume, like Medicare did, then they will do that explicitly, but what you want is to reward value of service, not volume of service. In the US, people who are anti-government, who feel that the market should not be regulated, forget that the government has a responsibility to its citizens. In our view, that responsibility is simple: everyone should have access to healthcare. At the same time, we are

not going to prescribe how people should make money. If people want to profit from healthcare, that's their prerogative.

Do people abuse this system?

Actually, the level of abuse is very negligible. Obviously, hypochondriac patients do pose a problem, but most of the abuse is on the side of doctors who take unnecessary measures because they know they will get paid for them. Specialists especially will agree to see patients that they know they do not need to see, and this clogs up the system quite a lot. Someone with a pain in their knee doesn't always need to see an orthopaedic surgeon. We have tried to curb this by capping specialists' fees. It's not a huge problem, but it does exist.

What about paperwork?

One of the great things about the system we implemented is that it simplifies the paper trail. Health information systems are a vital part of the practice environment, but in the past we found that records were kept but not utilised properly. Different schemes have different stipulations, so patient administration becomes a nightmare when you have to tailor a separate form for the hundreds of medical schemes out there. Now that the process has been centralised, it is much simpler.

What concerns you most about the state of US healthcare?

I'm worried about the way we train our doctors. Firstly, they train for too long – up to 11 years. As a result, US doctors often graduate with an average of \$200 000 in study debt, so many feel they have to specialise in order to pay this off. At the moment, 80% of US physicians are specialists – a huge problem. We also emphasise the wrong things in medical training, favouring IQ over EQ. Studies have shown that people with high levels of emotional intelligence make better doctors. If you have no compassion for your patients, medicine is probably not for you. In Israel they factor this into their training programme. Their students have to spend time working as nurses before they are allowed to commence training.

Social media and medicine



Bernard Mutsago, SAMA Health Policy Researcher

Social media in healthcare is a growing field of research and ethical debate. It has become a sensation in South Africa as well as on a global scale.

Social media takes the form of Facebook, Twitter, Mxit, YouTube, Wikipedia, WhatsApp, Pinterest, blogs, chatrooms and sites for rating physicians (eg 'RateMDs' in the USA) to name a few. In August 2012, over 5.33 million South Africans were using Facebook, 2.43 million were on Twitter and 9.35 million on Mxit. LinkedIn has a user base of 1.93 million and WhatsApp 4.6 million. And the numbers are rising considerably.

Social media, which has become a staple among patients and health professionals alike, is being used as an adjunct to traditional media sources like radio, TV and print media. This revolution has both threats and opportunities which this short narrative aims to describe.

At a time when we have a commensurate rise in use of social media among physicians, junior doctors, medical students and patients worldwide, the World Medical Association (WMA) in 2011 passed an official Statement on the professional and ethical use of social media. A related discussion document (White Paper) by the WMA's Junior Doctor Network takes a balanced view and gives deeper insights and specificities into the obscure

world of cyberspace and healthcare. These two important documents merit your reading and digesting.

The downside of technological inventions is that health content shared through social sites is not always credible and thus can have significant negative implications for doctor-patient relationships and professionalism: Unscrupulous agents often alter online health content and patients succumb to wrong information; and patients self-diagnose and demand specific (and sometimes unreasonable) care from doctors.

Also, some rating site that rate a doctor's/facility services or personality may damage a doctor's or facility's reputation. When used by doctors themselves, professional boundaries are often blurred and there is a threat to protection of patient privacy and confidentiality.

This raises liability concerns for the care providers and facilities. Risks are also attendant through the idea of permanence (digital footprint) of information in cyberspace; once posted out there, negative information might not be taken back.

The comforting news is that the simplicity and ease of the Internet has made it a tremendous tool for social and professional interaction and a tremendous source of health information. Social media has become a staple among patients and organisations, and has been demonstrated to improve disease outcomes and knowledge.

Patients can increase their health literacy and can interact easily with their doctor or members of a peer support group. Many USA hospitals and international health entities are also increasingly using social media. For example the Mayo Clinic, the US Centre for Disease Control, and the World Health Organization all have successful social media programmes.

The aforementioned White Paper and WMA statement take seriously the question doctors not being exempt from their professional and ethical obligations even in a cyber environment. Not many physicians are aware that they should not be using public, open social networks like Facebook, Twitter, or LinkedIn to discuss sensitive patient information. The above White Paper says "It

remains the physicians' responsibility to ensure that the patient receives the best possible care, avoiding unnecessary or frivolous testing and protecting patients from the potential mental and personal harm related to self-diagnosis resulting from misinformation from the internet".

It is supposed that social media can make telemedicine more effective. While other countries have successful telemedicine programmes, the story of telemedicine in South Africa has its own complexion and was tainted by controversy in 2011 after the launch of the *Hello Doctor* service, which was denounced by the HPCSA and SAMA and was subsequently suspended.

“The comforting news is that the simplicity and ease of the Internet has made it a tremendous tool for social and professional interaction and a tremendous source of health information”

The huge potential presented by social media must be carefully weighed against the risks. The WMA's Statement urges National Medical Associations, including SAMA, to establish guidelines for their physicians, addressing a number of issues. Given that a number of medical associations, specifically the American, Australian, and British medical associations, now have guidelines/policy on social media, it is exceedingly necessary for SAMA to consider going the same route.

Emotions run high at GP Indaba 2013

The South African Medical Association's annual GP Indaba took place on the 26th and 27th of July at the Birchwood Hotel and Conference Centre in Boksburg.

The indaba's theme was "Can general practitioners reclaim their rightful place as the co-ordinators of care?", which proved to be a matter close to the hearts of many of the attendees.

The conference was kicked off by SAMA's head of private practice, Dr Jacques Botha, who presented a talk on the position of GPs in the private healthcare market. He decried the lack of funding available for GPs and highlighted

that GPs have lost 39% of private market share in recent years. Next was Dr Marmol Stoltz, whose impassioned presentation urging medical schemes to switch their focus from hospicentric to primary care included an underlying theme of promoting unity among the country's GPs.

Other presentations covered the benefit design process of a medical scheme (presented by Dr Stan Moloabi, head of GEMS) and a talk about prescribed minimum benefits by Agility's Prof. Jacques Snyman. Discovery Health's Emile Stipp elicited the biggest reaction. The attending GPs were clearly universally upset with the lack of status awarded them by Discovery and other

medical aid schemes, and vented their frustrations at these companies' representatives, which included Dr Maurice Goodman, Discovery's head of health profession strategy.

Some concerns raised by GPs included the perceived bullying they receive from medical aids, the issue of medical aid contracts (particularly network contracts), the lack of a unified structure to provide a voice for GPs, and the decreasing number of medical students who choose to become GPs. Despite the strong emotions that were expressed, there was a consensus that both sides understood each other's viewpoints by the end of the conference.

SAMA holds Doctors' Billing Manual training workshops

The South African Medical Association (SAMA) has identified a need for procedural training in the private sector and medical scheme industry. Doctors' Billing Manual training workshops will be held at SAMA Head Office in Pretoria.

It is vital to understand coding when rendering accounts to third party payers as well as during the assessment of claims, as incorrect coding has great financial implications for doctors in the private sector.

The workshops will start off with 'Coding 101' which provides basic training

in the use and interpretations of the Rules and Modifiers applicable to the coding structure. Time will also be allocated to informal discussions of general problems experienced by coders.

Training will take place over at the SAMA head office in Pretoria. Requests for training in other centres will also be considered. Attendees will receive a printed copy of the 2013 Doctor's Billing manual, training material and a light lunch.

The target audience for these workshops are receptionists, practice managers, doctors,

medical schemes and statutory bodies such as the Compensation Fund and Road Accident Fund. 'Coding 101' is a must for people who have to compile accounts for the first time as well as established coders who would like refresh their knowledge on coding.

A working knowledge of anatomy, physiology and medical terminology is recommended for those who wish to attend these workshops. Please contact the SAMA Coding Unit on coding@samedical.org or 012 4812073.

MPC introduces Practice Cost Calculator

SAMA, in conjunction with Medical Practice Consulting (MPC), is proud to announce the introduction of the Practice Cost Calculator (PCC). The PCC is designed to assist private practice healthcare professionals in ascertaining the cost of delivering healthcare services.

It uses a financial model based on the principles of activity-based costing for the allocation of overheads and uses clinical qualitative research performed by Harvard University – under license from SAMA – as its cost driver.

The PCC displays the calculated minimum price that medical practitioners can

charge for procedures without making a loss, based on financial information supplied during the input phase.

Once a practitioner has calculated the cost at which their practice will break even, they can use the PCC to forecast their profit for the next financial year. The PCC is meant to assist private healthcare practitioners in:

- Determining how much it costs to deliver a service
- Calculating their revenue per procedure or service
- Comparing their practice-specific overhead costs to the payment received from patients and funders

- Equipping a private healthcare practitioner with the financial data to empower him/her to negotiate tariffs with funders or patients from a position of knowledge.

By employing this unique online tool and completing the four easy steps, private practice healthcare professionals can accurately plan and manage their finances.

In order to make use of the PCC, please sign up for a free profile on the MPC website: www.mpconsulting.co.za.

SAMA members receive a 20% discount on the annual fee of the PCC.

SAMA Trade Union joins government's RWOPS team



Dr Phopi Ramathuba, chairperson of the SAMA Trade Union

The SAMA Trade Union leadership, in partnership with the South African Committee of Health Sciences Deans (SACOHSD), got an opportunity on Tuesday, 30 July 2013 to present their positions on the issue of Remuneration of Work Outside Public Service (RWOPS) and its management.

The SAMA Trade union presentation was based on the work done by the trade union

task team and took into account general membership inputs obtained over the previous months. These presentations were made to the National Health Council, which is a body comprising the Health Minister, the Deputy Minister, the Director General and all 9 provincial MEC's and their Provincial Heads of Department. This was a follow up on the bilateral engagement between the trade union leadership and the national minister of health Dr Aaron Motsoaledi that was held on 22 July 2013.

SAMA is proud to announce that, while we cannot divulge full details of the meeting at this stage, we emerged with a general consensus on the management of RWOPS. Furthermore, two of our own leaders have been invited to serve in the ministerial RWOPS task team, namely Dr Phopi Ramathuba, our trade union chairperson and Dr Menge who is the current SAMA RWOPS task team co-ordinator. SAMA would like to reassure all its members of the association's commitment towards fighting for the protection of RWOPS, while also assisting in the management of RWOPS to avoid and eliminate any form of

abuse which may result in negative publicity that can tarnish the image of our profession.

We thank the leadership of SAMA who, on a voluntary basis, are working hard towards defending our position on RWOPS.

We further wish to express our sincere gratitude to all members on the ground that took time to apply their minds on this matter and provided us with comments on the RWOPS position document.

SAMA's position on RWOPS

In a statement released earlier this year, SAMA outlined its position on RWOPS in the following way: "SAMA supports the principles of RWOPS [but] condemns [its] abuse at the expense of poor patients. SAMA supports its members who perform RWOPS within the prescripts of the law and objects to the withdrawal of RWOPS, which would be a denial of our rights as workers and will result in a massive exodus of specialists into full-time private practice. This would be disastrous for teaching, research and patient care in our public facilities, which are already in crisis."



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Member profile: Dr Kgopotso Pege



Dr Kgopotso Pege, JUDASA President

As the current president of the Junior Doctors Association of South Africa (JUDASA) and a practicing junior doctor at Job Shimankana Tabane hospital in Rustenburg, Dr Kgopotso Pege has a serious lack of spare time.

We caught up with her for some insights into the life of a junior practitioner and to find out some more about JUDASA's often unpublicised activities.

Describe a day in the life of Kgopotso Pege

I wake up early and head off to Job Shimankana Tabane, where I am currently doing my community service. I did my internship there too. My work is paediatrics, so as soon as I get to the hospital I do a round of the wards and check up on the babies.

Sometimes I consult with others on how to treat a new patient. It's a standard day in a doctor's life – sometimes there is drama and usually there is a lot of paperwork. In between my hospital work, I have to attend to JUDASA matters. The spare time I have I divide between my family, friends and the gym.

What has JUDASA been focusing on lately?

We constantly work on issues, such as the recent Cuban student crisis. We are always trying to improve conditions. An area that is of concern is the Department of Health's (DoHs) failure to employ all the doctors that graduate from South African medical schools. It is ridiculous that qualified medical practitioners are sitting at home while the country suffers from a severe medical skills shortage. How can the DoH spend time and money sending students to Cuba when it cannot find employment for the few qualified ones who are sitting at home?

Our successes don't often make the news, but they are significant. For example, we recently managed to resolve a dispute between the Department of Defence (DoD) and military doctors who were working a ridiculous amount of overtime without compensation. At first, the DoD did not take us seriously, but as soon as we took the legal route they were keen to meet us.

They settled out of court with the doctors involved and have promised to pay overtime in the future.

What bothers you most in your daily practice?

The thing that bothers junior doctors more than anything, is the sub-par management of our public health institutions. Hospitals and clinics should be run by people who understand the health profession and understand what doctors and patients have to deal with.

Management does not provide adequate training to junior doctors, either they do not have sufficient staff to provide the training or the staff they have are overworked and cannot provide it.

Junior doctors are being cheated in this regard. Also, I am bothered by how the harsh reality of public service takes career hopes and ideals away from medical students.

Medical Snippets

Medical jokes

An old woman walks into a doctor's office and says, "Doctor, you must help – I am always farting! It's not a social problem, since you can't smell it or hear it, but since talking to you I have farted twenty times!" The doctor examined her for a while, then said, "Take this bottle of pills and drink them all. When they are done, come back to see me." Sure enough, the old lady showed up at the doctor's office after two weeks, shaking her fist in anger. "What good were those pills? I fart just as much as ever. You still can't hear them, but now they smell horrible!"

The doctor nodded sagely and said, "Great, that takes care of your sinus problem, madam. Now let's work on your hearing."

History of medicine

1716: Onesimus, an African slave in Boston, Massachusetts, teaches Cotton Mather, a landowner, the practice of smallpox variolation. Thanks to this, Mather is able to save many of his fellow Bostonians during a smallpox epidemic in 1721. Onesimus had learned variolation in his country of origin. It remained the most effective way to treat smallpox until a vaccine was invented in 1796.

Numbers

5 600 000: The number of South Africans currently estimated to be living with HIV/Aids. The rate is based on a 2007 study, meaning that the current number is possibly higher. It is the highest number of infected people of any country on earth.

Global healing

Incredibly, the government of Andhra Pradesh, India's fourth largest state, has managed to institute a healthcare programme. The programme provides free hospital care to all people who live below the poverty line, a free ambulance service and a tele-consultation and electronic prescription system. The programme will cost the average family no more than R120 a year.

Fast fact

78.3% of SA men identify as perpetrators of some form of violence against women. Whether it be physical, emotional or sexual violence.

Interestingly, only 51% of women identify as victims of abuse.

Risk management: Policies, protocols and guidelines

Julian Botha, Senior legal advisor

Doctors have a professional duty to care for the safety and wellbeing of their patients. Although good diagnostic and therapeutic skills are important in this regard, they can be let down by a poorly designed office environment, incompetent or uncaring staff, or an absence of clear and workable policies, protocols or guidelines to support your clinical work. If you arrange lab tests for a patient, for example, you need to feel confident that you will immediately be aware of any significant results.

Years of research and development in clinical risk management have demonstrated how protocols and recognised guidelines can help to control some of the most risky areas of practice (such as repeat prescribing and following up test results). We would advise you not to introduce so many protocols that they become confusing or hard to remember, or prohibit the exercise of judgment where this may be necessary.

It is best to introduce a judicious mixture of policies (which set out the guiding principles for staff to apply when exercising their judgment), protocols (which are a series of steps that must be followed without deviation) and guidelines (a description of the practice's preferred method of performing a task, or series of tasks).

Policies

Policies are broad statements about principles, coupled with guidance for staff on how they're expected to comply with those principles.

A confidentiality policy, for example, might start with a statement that the practice respects and upholds the principle of patient confidentiality, and why.

It might then go on to describe in broad terms what this means in practice – that all staff must sign a confidentiality agreement and that breaches of confidentiality are treated as serious offences; that patient information is not to be shared with third parties without the patient's consent; that information is only to be shared within the healthcare team on a need-to-know basis; that records are to be kept securely, etc.

Try to make the policy as succinct as possible; save the finer details of implementation for your protocol and guideline documents. Some of the areas for which you will need policies are listed below:

Policy areas

Confidentiality, chaperones, aggressive or violent patients, child protection, delegation and supervision, employing locums, advertising, relationships with service suppliers, complaints from patients and carers.

Protocols and guidelines

Protocols provide staff with step-by-step rules that they must follow without deviation. The difference between a protocol and a guideline is not always clear, the two words often being used interchangeably. For the purposes of this booklet, however, we make the following distinction:

Protocols provide staff with step-by-step rules that they must follow without deviation. They lend themselves to administrative systems that (a) can easily be standardised, and (b) represent an area of high risk for patients. The most obvious of these is test results, which are often implicated in incidents of avoidable harm to patients (see the case report "A missed opportunity" as an example).

Guidelines are less prescriptive descriptions of the general approach to take when dealing with situations where more variables are likely to be encountered. They allow more room for personal and professional judgment. A guideline for obtaining consent to treatment is a good illustration of this: as each patient's circumstances is different, a step-by-step rigid protocol would not be flexible enough to accommodate those differences. A guideline, on the other hand, would make sure that you covered essentials like satisfying yourself that the patient has decisional capacity and ensuring that all the material risks and benefits have been discussed and noted in the patient's records, without dictating exactly how you should go about it.

Case report: A missed opportunity:

Mrs A, a 34-year-old school secretary, attended a new GP practice when she moved

house. As part of her routine new patient health check, she had her urine analysed by the practice nurse and proteinuria +++ was detected. Dr D saw Mrs A immediately after this and issued a repeat prescription for her long-term antidepressant medication. No comment upon the proteinuria or a plan of investigation was recorded in the notes. Dr D saw Mrs A one month later when she was having difficulty coping in her job due to depression and a family crisis. Again, no comment was passed upon the proteinuria. Seven months after this, Mrs A came to see Dr E as she had suffered a few days of urinary frequency and urgency with dysuria. Dr E prescribed a course of trimethoprim, but did not ask for a urine sample. Dr E's record made no reference to the proteinuria detected at registration, so presumably he had not noticed. Mrs A saw Drs D and E for a range of unrelated minor complaints over the next three years. After an acute illness she was admitted to hospital and found to be suffering from acute-on-chronic renal failure of uncertain aetiology. Her condition progressed over the next few years to end-stage renal failure requiring dialysis, and ultimately she had a successful renal transplant. Mrs A started a legal claim against both doctors, alleging negligence in failing to take notice of, or act upon, her significant proteinuria when she first registered with the practice.

Expert opinion: A GP expert thought the practice's system for reporting new patients' abnormal urinalysis results was extremely flawed. Dr E was criticised for not looking back to check the recent urinalysis that he knew would have been conducted at the registration visit. Often the nurse wrote up her notes while the patient saw the doctor, and this information was placed in the file later. Even if he had not done this, it was felt that repeat urinalysis and urinary culture should have been performed, given Mrs A's symptoms. The case was settled for a moderate sum.

Learning points: Failure to act upon an abnormality can lead to missed opportunities to treat or prevent serious disease. Urinalysis is an extremely useful and inexpensive screening tool in both primary

care and hospital outpatient/emergency settings for detecting occult diabetes or urinary-tract pathology. Unfortunately, its widespread use often leads to it being overlooked, being seen as something “that is just done”. It should be considered as an investigation result like any other, and failure to act upon an abnormality can lead to missed opportunities to treat or prevent serious disease. It is important to have systems in place that allow all the relevant information from a patient’s previous consultations, diagnoses, medication and recent investigations to be taken into account during a consultation. This is particularly important when patients first attend a practice, as information lost at this stage may cause and compound error in future visits.

Further information: A study of 400 clinical risk self-assessments carried out by MPS Risk Consulting in the UK in 2006 found that 84% of practices had risks associated with test results. These risks included:

- Not having a tracker system in place to ensure that patients are followed up.
- Not having a system in place to show when all of a patient’s test results have been returned.
- Not recording test results onto a computer.
- Allowing non-clinical staff to inform patients of their results and the treatment required. This case report first appeared in MPS Casebook, 15(3) September 2007

Examples of protocols and/or guideline-driven functions

Protocols:

- Prescribing
- Elements of infection control such as hand-washing, cleansing and sterilising instruments, etc.
- Getting test results and informing patients
- Security of clinical records
- Access to records
- Taking and passing on messages
- Telephone consultations
- Handling pathology specimens
- Referrals and arranging investigations
- Disposal of medical waste
- Storage of dangerous drugs.

Guidelines:

- Obtaining consent to treatment
- Referrals guidelines
- Dealing with difficult patients
- Certificates

- Root cause analysis
- Dispensing
- Accommodating cultural differences
- Offering and using chaperones
- Infection control
- Dealing with complaints
- Confidentiality

Incident reporting system

Incident reporting has proved to be a useful tool in preventing error in high-risk industries, such as aviation, nuclear and petro-chemical industries. If an aviation incident occurs it is reported, investigated and lessons are learnt. Reporting when things go wrong is essential, as it explores the underlying causes of patient safety incidents. Your practice should have a systematic approach where staff knows what type of incidents to report, what information is required and how to learn from it. Staff should feel they can report incidents without the fear of personal reprimand. A positive patient safety culture is one that has open communication, mutual trust, shared perceptions of the importance of safety and confidence in the efficacy of preventative measures.

Health and safety

As a workplace, your practice comes under occupational health and safety legislation, which imposes certain obligations on you (even if you work alone). These are briefly set out in below. While health and safety issues lie outside the benefits of MPS membership and have more to do with public liability and work compensation than with clinical negligence claims, we can give the following generic advice.

Health and safety in the workplace

Employers and the self-employed must make every effort to ensure health and safety in the workplace. Health and safety incidents must be reported to health and safety representatives and inspectors.

Employer’s duties:

- Provide and maintain a safe, healthy working environment
- Ensure workers’ health and safety by providing information, instructions, training, and supervision Inform health and safety representatives of – incidents, inspections, investigations, and inquiries.
- Self-employed people must ensure that they, their workers, or others are not exposed to health or safety risks.

- A lack of attention to health and safety often contributes to adverse incidents involving patients, so the separation between this aspect of practice and clinical care is not always clear-cut. If you do not have suitable hand-washing facilities in your consulting and treatment rooms, for example, there will be a high likelihood of cross-infection between patients. Similarly, poorly maintained equipment may cause harm to patients if it malfunctions during a procedure. It is therefore important that you make sure your physical work environment is a safe place not only for you and your staff and visitors, but also for patients. If you wish to carry out a risk assessment of your premises, you might find the NHS guide useful.

Although it was written in the context of UK legal requirements, its focus is on assessing common hazards in general practices, so much of its content would be applicable in any country. The five steps to risk assessment are set out in below, (these apply equally well to a clinical risk assessment).

Five steps to risk assessment

Step 1 – Look for the hazards

A walk around the premises is useful here, also be informed by records of injuries or threats of violence, etc.

Step 2 – Decide who might be harmed and how. Undertake periodic reviews and investigate untoward incidents, near misses and complaints from staff, patients, children, contractors and other visitors. Be aware of risks to children eg. corrosive substances or sharps left within their reach, the condition of toys provided.

Step 3 – Evaluate the risks arising from the hazard. Are existing precautions adequate? Is it possible to eliminate the hazard altogether? Is staff training required?

Step 4 – Record your findings. Make a record of each hazard identified. Who is at risk? What precautions are in place?

Step 5 – Assess the effectiveness of the precautions.

NHS Health Education Authority, Health and Safety in General Practice: A Guide to Risk Assessment for GPs and Practice Managers, 1998)

Acknowledgement: This article forms part of the MPS risk management booklets and has been published with consent from the MPS.

A failure to monitor

Retired engineer Mr S, 77, went to see his GP, Dr J, with symptoms of dizziness. He had returned from a pacemaker check at the hospital that morning and while travelling home on the train he had started to feel off-balance. He managed to get an emergency appointment to see Dr J, by which time the symptoms were resolving.

Dr J noted that the pacemaker had been fitted for complete heart block six years ago, and had remained in situ without any problems since then. Mr S reported no chest pain or palpitations and Dr J, feeling reassured by the recent pacemaker check and a normal examination, attributed the symptoms to motion sickness and prescribed cinnarizine.

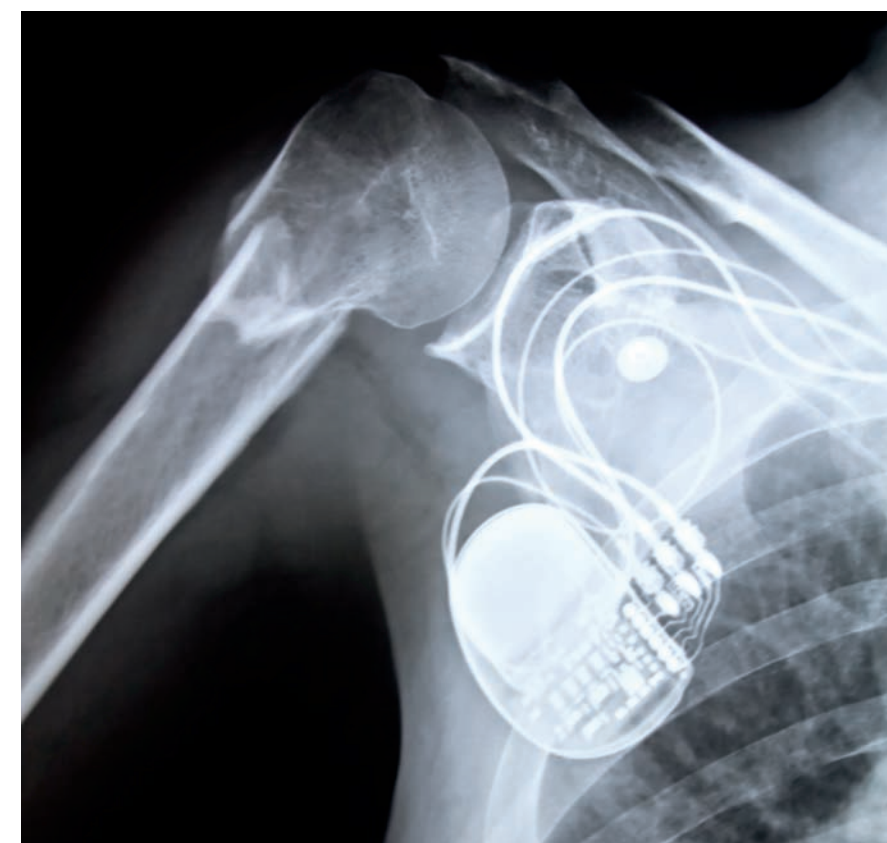
Despite taking the medication regularly, Mr S’s dizziness continued, so he returned to the practice two days later to see Dr A, his usual GP. Dr A recorded his BP as 140/50 mmHg and attributed the symptoms to benign paroxysmal positional vertigo. No record was made of Mr S’s pulse. Dr A advised Mr S to continue the medication prescribed by Dr J.

During the next six weeks, Mr S consulted with Dr A on three further occasions with ongoing symptoms of intermittent dizziness. Note-keeping from all three consultations was sparse, with no defined cause of the symptoms documented, and no further cardiovascular examination or ECG performed. Mr S was given a trial of betahistine for presumed Meniere’s disease.

Two months after his initial presentation, Mr S was taken into the Emergency Department after collapsing on the street when out shopping. He was found to be in complete heart block, with a pulse rate of 32 beats per minute. The admission ECG showed atrial pacing but no ventricular spikes, and his symptoms were attributed to a malfunctioning pacemaker.

He was admitted to hospital, and while being monitored on telemetry, the pacemaker activity resumed without intervention. Mr S became acutely confused after admission to the ward. He was treated for a urinary tract infection, and underwent a full confusion screen, which was unremarkable.

A CT scan of his brain showed small vessel disease. The patient continued to deteriorate, leading to him becoming fully dependent. He was discharged into a care home following a prolonged admission.



Experts agreed that a competent GP would rethink the diagnosis of vertigo and carry out a cardiovascular examination

Mr S’s family made a claim against Dr A, stating that the confusion and memory loss developed as a result of hypoxia, linked to the malfunctioning pacemaker. Experts agreed that a competent GP would rethink the diagnosis of vertigo and carry out a cardiovascular examination, including an ECG.

Dr A defended his actions by stating that by taking a manual blood pressure reading, he would have listened to the pulse and been aware of any significant irregularity or abnormal rate. However, opinion was divided on the causation of Mr S’s decline.

Experts found no evidence to support an episode of circulatory failure significant enough to cause prolonged hypoxic damage. The general deterioration was considered to be due to a pre-existing cognitive impairment, which was exacerbated by the hospital environment and the bradycardia – which experts agreed, would have occurred in any event with an earlier hospital admission.

The case was settled for a low sum to reflect the partial causation defence.

Learning points

- Lack of clear documentation makes a case difficult to defend. There was no record in the notes that the patient’s pulse had been taken. If an investigation is not written down, it is hard to prove that it took place.
- The allegation in this instance was of memory loss as a result of hypoxia. Ultimately, the deterioration of the patient was attributed to pre-existing cognitive impairment, hence the low settlement. From a medicolegal standpoint, this highlights the importance of fully investigating claims, since taking the claim at face value may have resulted in payment of long-term care costs.
- Be wary of repeat consultations. Dizziness is common, but revisiting a diagnosis and carrying out a basic examination, especially in a patient with a cardiac history, is essential to ensure that good quality care is provided.

The original case report can be found in MPS’s edition of Casebook Vol. 21 no. 2 - May 2013 at www.medicalprotection.org/southafrica/case-reports-may-2013/a-failure-to-monitor

Cape Western gets a new president

The Western Cape branch of SAMA celebrated their Presidential Evening on 6th July 2013. The staff spent the evening at the picturesque and historic Castle of Good Hope in Cape Town. During the course of the evening, outgoing president Dr Truda

Smit (2012 - 2013) officially handed over the leadership reigns to Prof. Janet Seggie. Prof. Seggie was a distinguished member of staff at UCT's Faculty of Health Sciences. Following her retirement in 2012, she assumed the editorship of the *South African Medical Journal*.

Dr Marmol Stoltz was the master of ceremony for the evening, while the guest of honour was Prof. Cyril Karabus, back from his ordeal in the United Arab Emirates. Prof. Karabus also contributed a notable and well-received speech to the occasion.

Free State bids farewell to Prof Stulting

It is with great sadness that the Free State branch of SAMA bids farewell to Prof. AA Stulting, one of its most eminent members. Prof. Stulting, a renowned ophthalmologist who served as the acting head of the school of medicine at the University of the Free State (UFS), has decided to step down after a long and illustrious career which included a stint as the chairman of the Foundation for Professional Development (FPD).

Prof. Stulting was also a consultant in the creation of the "Essential Drugs List" adopted by South African hospitals. The members of the Free State branch are joined by their colleagues countrywide in wishing Prof. Stulting all the best in his future endeavours.



The University of the Free State's Prof. AA Stulting with students

Border Coastal attends Public Protector roadshow

SAMA's Border Coastal branch recently attended a roadshow organised by the Office of the Public Protector at Frere Hospital in East London. The event was followed by a dialogue with stakeholders at the Quigney Hotel in East London. The Office of the Public Protector shared findings from a number of

surprise hospital visits they conducted over the course of the past few months. They found that too many nurses are engaged in clerical work rather than attending to patients, that many consulting rooms did not have the necessary medical equipment and that there is a lack of clarity about how to integrate volunteer auxiliary nurses into

the regular nursing staff. They also noted that Frere had an impressive new ICU and were saving up to R139 000 a month by digitising x-rays rather than photocopying them, but that their ambulance response times needed attention. Additionally, they issued a call for more GPs to take up work in clinics.

Gauteng North hosts Men's Health Forum

Prickly matters were addressed at the Gauteng North branch's Men's Health Forum on the 20th of July. The forum, which took place at Irene Country Lodge on the outskirts of Pretoria and was hosted in collaboration with Bayer Pharmaceuticals, included presentations by branch members such as Dr Etienne Kok, who elaborated at length and in detail on the performance of prostate examinations. The interior workings of the male rectum was thankfully not the only topic discussed.

The additional topics included an analysis of erectile dysfunction by Dr Corne van Graan and the link between testosterone treatments and hypogonadism courtesy of Dr Sindeep Bhana. In fact, the ineffectuality and plain hazardousness of testosterone treatments were a recurring theme at the forum and were discussed at length. The physicians present agreed that the only way to maintain healthy testosterone levels was the hard way: exercise and diet.



Members of SAMA's Gauteng North branch attend the Men's Health Forum on 20 July



SAMAREC/CPD SERVICES AVAILABLE:

- South Africa Medical Association Research and Ethics Committee - SAMAREC
- South African Medical Association Continued Professional Development Accreditation
- Our Mission:
 - Empowering Doctors to bring health to the nation
 - Excellent Service
 - Quick Turnaround
 - Efficiency

WHAT WE ARE ABOUT

SAMAREC:	CPD:
Evaluating the ethics of research protocols developed for clinical trials conducted in the private healthcare sector. Ensuring the protection and respect of rights, safety and well-being of participants involved in clinical trials and to provide public assurance of the protection by reviewing, approving and providing comment on clinical trial protocols, the suitability of investigators, facilities, methods and procedures used to obtain informed consent	Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association is one of the institutions that have been appointed by the Medical and Dental Professions Board of the Health Professions Council of SA to review and approve CPD applications.

For further information please contact the SAMAREC/CPD Secretariat on 012 481 2000 or email us on samarec@samedical.org , cpd@samedical.org

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