

SAMA INSIDER

APRIL 2019

Too few accredited intern posts in SA: A review

Think equal, build smart
and innovate
for change



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

**SOUTH AFRICAN
MEDICAL ASSOCIATION**



O&G UPDATE 2019 ORGANISERS

Londocor Event Management

Sonja du Plessis

Tel: +27 82 455 7853

Email: sonja@londocor.co.za

Carina du Plessis

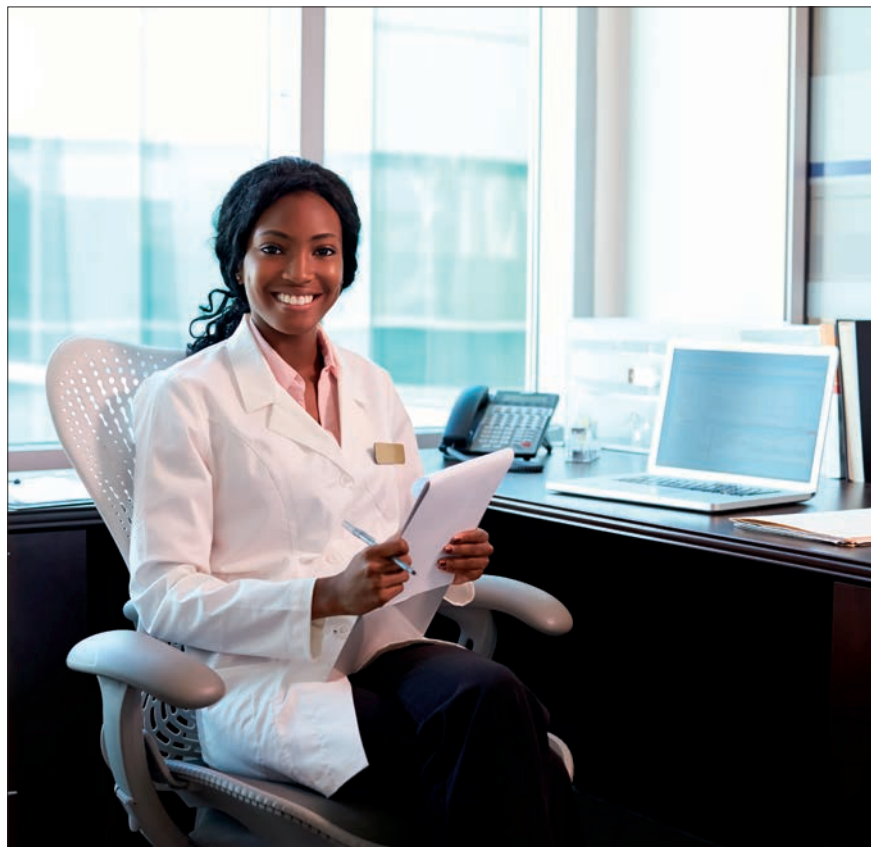
Tel: +27 82 788 6879

Email: carina@londocor.co.za



CONTENTS

APRIL 2019



Source: Shutterstock: Monkey Business Images

- 3 **EDITOR'S NOTE**
Celebrating women
Diane de Kock
- 4 **FROM THE PRESIDENT'S DESK**
Building organisations from their roots: Community-based movements for change
Prof. Hoosen Coovadia
- 5 **FEATURES**
Too few accredited posts in SA: A review of internships and community service placements
Dr Michael Cloete, Dr Sazi Z Nzama
- 7 Competition Commission health market inquiry to start up again in April 2019
Shelly McGee
- 8 Precautionary suspension – principles and the Concourt judgement
Keletso Makwe
- 9 May one charge for cancellations and no-shows?
Hanneke Verwey
- 10 Unpacking *locum tenens*
Wendy Massaingaie
- 10 SAMA supports Caster Semenya
SAMA Communications Department
- 12 Add-on codes for unscheduled and emergency visits
Anton van Schalkwyk
- 13 Better financial acumen can improve your practice
Lerisa Roberts, Dr Gustaaf Wolvaardt
- 14 WHO celebrates women leaders in science and health
World Health Organization
- 15 Think equal, build smart and innovate for change
SA Society of Obstetricians and Gynaecologists
- 15 Eating disorders: The silent killer
SAMA Communications Department
- 17 Hopes for hearing shouldn't fall on deaf ears
SAMA Communications Department
- 17 SAMAREC hold enlightening research ethics breakfast
SAMA Communications Department
- 18 **MEDICINE AND THE LAW**
A sight for sore eyes
Medical Protection Society
- 19 **BRANCH NEWS**

MEMBER BENEFITS



Alexander Forbes

Herman Steyn

012 452 7121 / 083 389 6935 | steynher@forbes.co.za

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



Automobile Association of South Africa (AA)

AA Customer Care Centre

0861 000 234 | kdeyzel@aasa.co.za

The AA offers a 12.5% discount to SAMA members on the AA Advantage and AA Advantage Plus Membership packages.



APLS

Cindy Maree

021 406 6733 | cindy.maree@uct.ac.za | www.apls.co.za

APLS offers SAMA members a 10% discount on the 2-day Advanced Paediatric Life Support Course.



Barloworld

Tender Smith : External Accounts Manager: EVC

011 052 0182 | tender.smith@bwfm.co.za

Barloworld Retail Digital Channels offers competitive pricing on New vehicles; negotiated pricing on demo and pre-owned vehicles; Trade in's; Test Drives and Vehicle Finance.



BMW

Melissa van Wyk : Corporate Sales Manager

079 523 9043 | melissa.vanwyk1@bmwdealer.co.za

SAMA members qualify for a minimum of 8% discount on selected BMW & MINI models. All Members also receive competitive pricing on Lifestyle items and accessories.



DLT Magazines

Tracey Hack : General Manager

011304 7600 | 076 020 5280 | tracey@dltmedia.co.za

DLT Magazines offers medical practices current consumer magazines for their patients, to keep them relaxed and occupied while that wait for their service. We work with premium consumer titles from all major publishers in South Africa. SAMA members qualify for a 10% discount off any of our current custom and or preselect magazine packs. We also offer magazine racks at 50% discount for SAMA Members.



Ford/Kia Centurion

Burger Genis : New Vehicle Sales Manager – Ford Centurion

012 678 0000 | burger@laz.co.za

Tyren Long : New vehicle Sales Manager – Kia Centurion

012 678 5220 | tyren.long@kiacenturion.co.za

Lazarus Ford/Kia Centurion, as part of the Lazarus Motor Company group, sells and services the full range of Ford and Kia passenger and commercial vehicles. SAMA Members qualify for agreed minimum discounts on selected Ford and Kia vehicles sourced from Lazarus Ford / Kia Centurion. SAMA members who own a Ford/Kia vehicle also qualify for preferential servicing arrangements. We will structure a transaction to suit your needs.



Hertz Rent a Car

Lorick Barlow

072 308 8516 | lorick@hertz.co.za

Hertz is proud to offer preferential car rental rates to SAMA members. A range of value-add product and service options also available. No cost to register as a Gold Plus Rewards member to enjoy a host of exclusive benefits.





Diane de Kock
Editor: *SAMA INSIDER*

Celebrating women

On 8 March we celebrated International Women's Day (IWD) 2019, a global day celebrating the social, economic, cultural and political achievements of women – while also making a call to action for accelerating gender balance.

The first IWD occurred in 1911, supported by over 1 million people. Today, IWD belongs to all groups collectively, everywhere. IWD is not country-, group- or organisation-specific. This year the theme is building a gender-balanced world (#BalanceforBetter): "Balance is not a women's issue – it's a business issue."

In this issue, we focus on SAMA's support for Caster Semenya (page 11) and concern about the proposed rule changes by the International Association of Athletics Federations (IAAF), to impose an upper hormonal limit for athletes wishing to compete in the female category in international athletics competitions – one of the many challenges faced only by women, in what is still an unbalanced environment.

The WHO celebrated all women who have had a pioneering role in advancing science and health on 8 March (page 14), while at the same time highlighting the still-marked disparities in the sector internationally. Increasing the representation of women leaders in science and health "can benefit business. But a business case cannot be the only reason for advancing women in science."

In SA, the SA Society for Obstetricians and Gynaecologists (page 15) declared their commitment to accelerating gender parity on women's day, and in the context of women's health, the theme "Think equal, build smart and innovate for change" highlights the need to reduce inequity in access to healthcare, and the need to address the unique challenges faced by women in SA.

This is a challenge which affects us all – let's strive for better balance in all aspects of our society.

As always, we would like to know what you think, and what's on your mind. Send an email to the editor at dianed@hmpg.co.za.

Editor: Diane de Kock
Head of Publishing: Diane Smith
Copyeditor: Kirsten Morreira

Editorial Enquiries: 083 301 8822 | dianed@hmpg.co.za
Advertising Enquiries: 012 481 2069
Email: dianes@hmpg.co.za

Senior Designer: Clinton Griffin

Published by the South African Medical Association
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 Tandy Print (Pty) Ltd

Opinions and statements, of whatever nature, are published in *SAMA Insider* under the authority of the submitting author, and should not be taken to present the official policy of the South African Medical Association (SAMA) unless an express statement accompanies the item in question. The publication of advertisements promoting materials or services does not imply an endorsement by SAMA, unless such endorsement has been granted. SAMA does not guarantee any claims made for products by their manufacturers. SAMA accepts no responsibility for any advertisement or inserts that are published and inserted into *SAMA Insider*. All advertisements and inserts are published on behalf of and paid for by advertisers.

LEGAL ADVICE

The information contained in *SAMA Insider* is for informational purposes and does not constitute legal advice or give rise to any legal relationship between SAMA and the receiver of the information, and should not be acted upon until confirmed by a legal specialist.

Building organisations from their roots: Community-based movements for change



Prof. Hoosen Coovadia, SAMA president

Every individual has a unique make-up, comprised of personal experiences related to social factors, genetic composition and other critical biological features. Every individual also has a right to have, and to express, his or her views, opinions and beliefs; this right is the foundation for building a consensus, or a policy, based on an individual expression of the subject under discussion. These aggregated and collaborative views are the basis of democracy. In my own case, many different individuals have contributed to the philosophical underpinnings that I now hold dear and which are central to my current beliefs. And the same applies to many, if not all people. In theory, we have the possibility of aggregating many millions of different viewpoints, from many millions of individuals, on how our society should be constructed; our population size, including children, is

about 57.7 million. Therefore we could end up with many millions of viewpoints on society and the nature of its institutions. However, any representative view is by its nature one remove from the individual. And while it may be absolutely authentic, on the other hand, it may not. The point is surely that every person has the right to express his or her opinion and participate in any election aimed at reflecting this view, no matter how extreme, and maybe even bizarre, it may be. It is the task of elected leaders and democratic organisations of the people to achieve coherence from this mass of ideas and beliefs.

The ideas in this article, on this subject, derive from personal engagement in a number of situations and experiences during my adult life. I have learned about democracy from joint down-to-earth opposition to apartheid with many colleagues, and from important published works on the subject. Let me enumerate some of these influences: a reasonable education, especially those parts that inculcated a love of English literature, which did not exclude a fascination for Indian (Urdu/Hindi) music and ghazals; studying medicine in Bombay during the period of Nehru and the Indian Congress; building an SA Students Association in India, which expanded our appreciation of the anti-apartheid struggle at that time; opportunities for full participation in university life, often linked to the political developments in India and SA. And above all, close involvement in the daily struggles of the poor in KwaZulu-Natal around rents, social services, education, safety and security and other similar ostensibly mundane matters.

My participation in the National Development Plan 2030 exposed me to a marvellous breadth and depth of community views through out the nation. The approach of the plan revolved around citizens being active in development, and creating a capable and developmental state, able to intervene to correct our historical inequities, and building strong leadership throughout society, working together to solve our problems. The plan was the product of hundreds of interactions with South Africans, input from tens of thousands, extensive research and robust debate through out the country. It addressed the need to enhance the capabilities of our people so that they could live the lives they desired. The issues we dealt with are given as chapters in the *National Development Plan 2030: Our Future – make it work*. The key chapter arguing for community engagement and mobilisation is “Conversations with South Africans”, on strategies for public participation. There is an enormous amount of detail about the scope, extent and depth of the consultations we undertook using both traditional and electronic media, together with contact with the leadership of the major institutions in the country: government, provincial executive, civil society, trade unions, institutions of learning, etc. A detailed account is available in the published volume on the subject: *National Development Plan 2030: Our Future – make it work*. ISBN: 978-0-621-41180-5. Shereno printers, 2012. <https://www.gov.za/documents/national-development-plan-2030-our-future-make-it-work>.

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 note that letters:

- should be no longer than 500 words
- can be published anonymously, but writer details must be submitted to the editor in confidence
- must be on subjects pertinent to healthcare delivery
- should be submitted before the 6th of the month in order to be published in the next issue of *SAMA Insider*.

Please email contributions to: Diane de Kock, dianed@hmpg.co.za.



Too few accredited posts in SA: A review of internships and community service placements

Dr Michael Cloete, *student liaison officer, JUDASA NEC*, Dr Sazi Z Nzama, *deputy chairperson, JUDASA NEC*

For decades, the guarantee of employment upon completion was a reward for the countless hours and inordinately long years of undergraduate medical training. However, this has not been the case in SA for at least the last 5 years – there has been a rapid rise in reports of doctors being unemployed upon graduation.

These reports were brought to the attention of SAMA through its special interest group, the Junior Doctors Association of South Africa (JUDASA), following the introduction of the National Department of Health (NDoH)'s online application system for internship and community service placements (the ICSP) in 2016. This new system, which combines the allocations of all healthcare professionals on one online platform, as opposed to the previous paper-based system, was welcomed as a positive step towards a more efficient application process. Instead, the converse proved to be the case – the extent of the problems faced during the annual placement process multiplied. Inability to access the system, incorrect data capturing of qualifications or placement, inability to update applications and a delayed response time from the ICSP's technical support team were among the many problems that were noted with this system soon after its launch. The combination of these issues and more warranted that JUDASA and SAMA should play a more active role in the ICSP process as the years unfolded.

As a result, the national executive committee (NEC) of JUDASA commissioned a selection of its committee members to monitor and address issues arising from the ICSP online application process in 2018, giving birth to the JUDASA ICSP Team. Its purpose was to keep its finger on the pulse of the matter on behalf of junior doctors across the country, and to serve as an official communicator between applicants and the NDoH. A major concern noted by this team, over the years, has been the lack of familiarity with the applications process in medical professionals, the majority of

Considerations that WILL be considered	Considerations that WILL NOT be considered
Pregnancy	Engagements or marriages
Child established in school	Religion
Own health needs	Student and other loans
	Own health needs that do not require active management by a specialist
	Health needs of parents
	Property ownership
	Legal matters

Page 7, ICSP handbook 2018/2019

whom have completed the obligatory 2 years of internship, as mandated by the HPCSA. Following the full implementation of the online application system, based on ever-changing and reservedly published guidelines from the NDoH, the entire process exploded into the public's attention when the system struggled to place a high number of graduates and community service officers going into the 2018 annual employment cycle.

There has been a rapid rise in reports of doctors being unemployed upon graduation

For the 2018/2019 cycle, a new "tiering" system was introduced, prioritising overloaded and understaffed areas throughout the country. This meant that applicants had to choose a total of five facilities, which had to be spread across three provinces, and include no more than two metropolitan areas, among other criteria. The NDoH ICSP released guidelines that stated the rules for applicants, as pictured.

Furthermore, the NDoH announced that only one round of applications and

allocations would take place, adding to the tension already surrounding the entire process, as this was a further departure from previous years, where there had been up to four rounds of applications and allocations. Other changes to the system included the addition of "special considerations", such as marriage, family responsibilities and even medical conditions specific to an individual, to support placements in specific regions. These amendments were presented at the JUDASA AGM in 2018 by the then chief director for human resources for health at the NDoH, Mr Gavin Steele. These sparked much debate from JUDASA during that engagement. Among the most striking amendments made in the 2018 cycle was the new rule that provincial bursary holders would only be allowed to apply for placement within their bursary-providing province for community service.

Reasons for the amendments can be seen in the photograph of page 11 of the ICSP handbook 2018/2019.

The NDoH, in keeping with their policy on the practice of medical professionals in SA, which was released on 25 June 2018, prioritised the placement of SA-born and trained individuals before those trained abroad, whether SA citizens or not.

On 24 July 2018 the application cycle for 2019 opened, with the end of August set as the deadline for the finalisation of all

Rules for choosing posts to apply for:

- You can select a maximum of 5 facilities
- You must select a minimum of 3 provinces
- You must select a minimum of 4 districts
- You may only select up to 3 districts within a particular province
- You may only select 1 metro

Examples of two options based on the application rules above:

Option 1	Option 2
Choose 3 posts in 1st choice province – BUT they must be in at least 2 districts	Choose 2 posts in your 1 st choice province (they can be in the same or different districts)
Choose 1 post in your 2 nd choice province	Choose 2 posts in your 2 nd choice province – BUT they must be in 2 different districts
Choose 1 post in your 3 rd choice province	Choose 1 post in your 3 rd choice province

Note: Community service applicants must choose facilities based on the priority rankings below:

Facility ranking	Description	# Choices allowed
Priority 1	Rural facilities that are grossly under staffed.	Minimum of 3
Priority 2	Rural or peri-urban facilities with some need for staff.	Maximum of 2
Priority 3	Urban facilities that are generally adequately staffed.	Maximum of 1

Bursary holders - see additional information below.

Page 11, ICSP handbook 2018/2019

placements and appointments for the 2019 annual cycle. Unfortunately, a multitude of challenges were encountered that led to the NDoH failing to meet the deadlines it had set, warranting numerous extensions.

According to the NDoH, an excess of over 1 800 final-year medical students had applied for internship placement for the 2018/2019 annual cycle – far above the 1 413 applications they had received the previous year. The reason stated for this was the submission of inaccurate figures by the country’s medical schools. This excess of over 400 applicants meant that although the posts were available and accredited by the HPCSA, the state did not have the resources to fund them – a situation that the NDoH was compelled to remedy before the process was concluded.

The result of the remedial action was that, as it stands, the majority of yet-unplaced applicants in the 2018/2019 cycle are in the categories of SA citizens who studied abroad, and foreign nationals who studied locally (without permanent resident status) or abroad, now seeking employment within the state system. In this regard, following the events of recent years, some SADC countries have begun to engage with SA about employing their newly qualified medical professionals for the mandatory HPCSA-prescribed periods before returning home to serve their citizens; however, much discussion is still required.

Over the past 3 years, with JUDASA and SAMA advocating for junior doctors across the country, progress has been noted in the NDoH’s recent attempts to streamline and

accelerate their action and reaction times in the placement process. Laudably, the year 2018 saw the NDoH reacting more swiftly to queries and challenges than in previous years.

The rising number of graduates that require placement for internship training and the lack of funded posts for these individuals remain a concern for JUDASA, however, particularly given the approximately 2 000 candidates expected to be joining the workforce in 2020 following the closure of the Nelson Mandela-Fidel Castro Collaboration. As these challenges persist, we cannot help but wonder if the NDoH will be able to continue making the necessary provisions to accommodate the much-needed but rapidly increasing numbers of medical graduates in SA.

We would like to work more closely with the NDoH to facilitate a smoother process in future

JUDASA and SAMA are continuously trying to solve the future problems faced by junior doctors today. Questions that remain unanswered include: What strategies are proposed for the country to retain doctors and other healthcare professionals in the heavily strained public sector? How can JUDASA, together with SAMA, assist the NDoH to rectify past and current mistakes in the placement process, to avoid repeating them in future? Have we reached a point where there are now too many doctors in SA, and if so, where are they hiding?

As the JUDASA ICSP team, we would like to work more closely with the NDoH and other relevant stakeholders to facilitate a smoother process in future. JUDASA will continue to champion issues in the interests of its members and junior doctors across the country as a whole regarding the ICSP process. Anyone who has queries or would like to comment/enquire about the organisation of the ICSP process are welcome to contact our NEC on judasanec@gmail.com.

Competition Commission health market inquiry to start up again in April 2019

Shelley McGee, health policy researcher, SAMA Knowledge Management and Research Department



The Competition Commission's market inquiry into private healthcare (health market inquiry (HMI)) in SA is taking much longer than expected to reach its conclusion. The HMI began in January 2014, with the overall objective of establishing whether there were barriers to competition in the private healthcare sector. Originally, a final report was anticipated in November 2016. However, the complexity of engaging with the private sector, and the multiple issues the inquiry has faced, have resulted in several delays. The latest delay occurred when the inquiry ran out of funds towards the end of the last financial year, and activities planned for early 2019 had to be delayed. The Competition Commission announced in February that the inquiry is set to start up again in the 2019/2020 financial year, and will be completed by November 2019.

The HMI's provisional report was published last July, inviting comments by the end of October. This was at more or less the same time as the revised National Health Insurance (NHI) white paper and the Medical Schemes Amendment Bill were published for comment. Many readers might have attended one of the workshops that SAMA organised in August in order for membership to interrogate and contribute comments to all of these important policy documents.

SAMA's comments on the HMI report were submitted in September 2018, and we are continuing to engage with the HMI processes to make sure that interpretation and concerns about the provisional report are adequately considered.

HMI findings relevant to practitioners

The HMI panel, composed in the main of health economists and public health specialists, identified many issues in private healthcare that they believe are distorting pricing to the users and negatively affecting the services provided and the clinical outcomes achieved.

The provisional report has criticisms to level at all participants in private healthcare, from patients to practitioners to medical schemes, and the regulatory bodies themselves. Of most concern from SAMA's point of view are the findings about practitioners, and the recommendations to potentially address these.

Of most concern [to SAMA] are the findings about practitioners

The HMI found that medical practitioners drive much of the healthcare expenditure in the private sector, and that societies and associations aim to ensure that practitioners are well remunerated, in addition to other activities. The main problem identified by the HMI in this regard is "supply-induced demand", a phenomenon whereby the supply of services creates demand for these services. These findings were supported by a number of analyses of claims data that showed unexplained increases in claims and claims expenditure between 2010 and 2014.

The HMI also found that specialists "sometimes operate collectively to resist joining provider networks, and introduce

or adapt codes that push up prices without commensurate improvement in quality of care or value."

The HMI panel determined that fee-for-service models of remuneration stimulate oversupply of services, which results in wasteful expenditure and incentivises practitioners to provide more services than needed. The panel also found that a weakness in the private sector is lack of accountability on the part of practitioners, with little emphasis on interventions such as case review, peer review and morbidity and mortality meetings. In addition, they declared that academia has also shown little leadership in driving evidence-based practice in the private sector.

Increased admission to hospital, increased length of patient stay, higher levels of care and greater intensity of care have all manifested, and seemingly cannot be explained by the disease burden in the population.

The HPCSA also came under scrutiny, and the HMI found that the regulator is cited as the reason that innovative models of care and alternative reimbursement models have been difficult to implement in the private sector. The HMI concluded that the HPCSA is not sensitive to the benefits of competition in creating incentives for affordable and quality care.

SAMA's submission to the HMI

SAMA has been a committed participant in the Competition Commission processes from the start of the inquiry, and we have responded to multiple calls for comment and participated in a number of seminars and stakeholder sessions called by the HMI to address specific aspects of competition in the private health sector.

SAMA believes that the findings of the inquiry, the first to truly try to interrogate the situation in private healthcare, will be key to the future of the whole health system in the country, including considerations around the implementation of NHI and the proposed single-payer monopoly which has been proposed for this purpose.

Actually demonstrating market distortion within patterns provided by claims data has proven difficult.

In response to the provisional report, SAMA was concerned that the HMI had used the technical services of data analytics firms who serve the medical schemes environment, and whose client base is predominantly medical schemes and medical scheme administrators. We believe that this may unfortunately have introduced an element of bias into the analyses produced by the HMI.

SAMA was also able to identify a number of faults in the way the data was analysed and interpreted. The models used fail to adequately consider changes in disease

burden and developments in technology, and models for specific disciplines generally lack an understanding of the environment, epidemiology, dynamics and developments in the fields assessed.

Where comparisons were made indicating patterns of higher hospital admission rates in the SA private sector than in other countries, we feel these were conducted without consideration of such key factors as local disease burden, patient waiting times, facility availability and balance of funding (public and private) in other jurisdictions.

SAMA is concerned that the analyses that have supposedly proven the existence of overservicing, supply-induced demand and unsubstantiated increases in care intensity

have not been conducted with due attention to detail on the local issues, new technology available and burden of disease.

Full stakeholder comments submitted in response to the HMI report were made public in December 2018, and after some significant reading, we have found several areas where our concerns regarding the HMI analyses are shared by specialist societies and several actuarial analyses.

When the HMI commences again this month, SAMA hopes that attention will fall on some of the challenges in the provisional report, and that some review may be triggered so that the findings and recommendations are based on a solid set of data analyses.

Precautionary suspension, principles and the Concourt judgement

Keletso Makwe, *advisor, SAMA Industrial Relations Department*

To assist SAMA members, we look at precautionary suspension and the principles behind the recent Constitutional Court (Concourt) judgement (<http://www.saflii.org/za/cases/ZACC/2019/7.html>). Here is an extract from the judgement:

"This case concerns fair labour practices in terms of section 23 of the Constitution, and specifically whether there is a requirement for a pre-suspension hearing in the case of a precautionary suspension."

The employer may place an employee on precautionary suspension or transfer to enable them to investigate an alleged misconduct deemed to be of a serious nature. The Public Service Co-ordinating Bargaining Council Resolution 1 of 2003 (Disciplinary Code in the Public Sector) states that:

- "the employer may suspend an employee on full pay or transfer the employee if:
 - (i) the employee is alleged to have committed a serious offence; and
 - (ii) the employer believes that the presence of an employee at the workplace might jeopardise any investigation into the alleged misconduct, or endanger the wellbeing or safety of any person or state property.
- A suspension of this kind is a precautionary measure that does not constitute a judgement, and must be on full pay.

- If an employee is suspended or transferred as a precautionary measure, the employer must hold a disciplinary hearing within a month or 60 days, depending on the complexity of the matter and the length of the investigation. The chair of the hearing must then decide on any further postponement."

"A precautionary suspension is not a disciplinary..."

The general practice in the public sector has been that the employer gives the employee the opportunity to make representations as to why they should not be suspended. In almost all cases, however, the employer has already decided that the employee will be suspended, regardless of their representation.

We have had members approach us asking us to intervene and compel the employer to give them the opportunity to make representations, and we have always tried to explain that it is not a requirement by legislation for any representations to be made.

SAMA, as the employee representative, also gets requests from members to advise and/or assist in making the representations. We note, however that neither the Labour Relations Act No. 66 of 1995 (LRA) nor the Disciplinary Code states that an employee should respond to an intention to suspend an employee.

In *Long v South African Breweries (Pty) Ltd and Others* (CCT61/18)[2019] ZACC 7 (19 February 2019), the Concourt judges found in principle that "an employer is not required to give an employee an opportunity to make representations prior to a precautionary suspension. A precautionary suspension is not a disciplinary and consequently, the requirements relating to fair disciplinary action under the LRA do not apply."

The judgement further states that "where the suspension is precautionary and not punitive, there is no requirement to afford the employee an opportunity to make presentations."

Employers should also take note of the judgement, as in many instances they compel or instruct employees to make representations, and when employees fail to do so, this may be construed as an admission of guilt or failing to co-operate in the process.

Employees who are members of SAMA should contact us for assistance if they are compelled to make such representations.

May one charge for cancellations and no-shows?

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

SAMA has received a number of queries in recent months regarding whether or not healthcare practitioners may legally charge patients for missed appointments, that is, the late cancellation of or the failure to attend a scheduled appointment. This concern is understandable. Staff time and resources are required to reschedule appointments. Furthermore, the time allotted to that patient is lost, consequently resulting in a loss of revenue. The fact that the existing ethical guidelines of the HPCSA appear to contradict the legal position has also led to confusion.

The legal position is set out in section 17 of the Consumer Protection Act No. 68 of 2008. A patient qualifies as a consumer in terms of the Act, while a healthcare practitioner is a supplier of services. The Act provides that a consumer has the right to cancel any advance booking or reservation, which would include a medical appointment. The Act also provides that a supplier, such as a healthcare practitioner, who makes a commitment or accepts a reservation to supply services on a later date may impose a reasonable charge for cancellation of the reservation.

It is critical that practice staff inform patients of policy at the time of scheduling the appointment

In terms of the Act, a charge is unreasonable if it exceeds a fair amount in the circumstances, having regard to (i) the nature of the services that were reserved or booked; (ii) the length of notice of cancellation provided by the consumer; (iii) the reasonable potential for the service provider, acting diligently, to find an alternative consumer between the time of receiving the cancellation notice and the time of the cancelled reservation; and (iv) the general practice of the relevant industry. A supplier may not impose any cancellation fee in respect of a booking or reservation if the consumer is unable to honour the booking



or reservation because of the death or hospitalisation of the person for whom, or for whose benefit, the booking or reservation was made. The Act does not specifically address the issue of a so-called “no-show” patient; however, it would be logically inconsistent to exclude this from the ambit of section 17.

The provisions of booklet 11 of the HPCSA Guidelines for Good Practice in the Healthcare Professions (Guidelines on over-servicing, perverse incentives and related matters) appear to contradict section 17 of the Consumer Protection Act. Ethical rule 7(5), published under the Health Professions Act No. 56 of 1974, provides that a practitioner may not charge or receive fees for services not personally rendered. The council’s interpretation of rule 7(5) is set out in section 3.10.4 of booklet 11. In this regard, section 3.10.4 provides that “a practitioner shall not charge or receive fees for services not rendered. An appointment that was not honoured by the patient is equivalent to services not rendered, and for that [reason], a practitioner may not charge or receive fees.” This position was also confirmed in an undated statement, which is still available, on the council’s website. Booklet 11, dated September 2016, ostensibly overturned an earlier ruling of the council, according to which practitioners could charge a consultation fee if timely steps were not taken to cancel an appointment.

SAMA has engaged the HPCSA in respect of this matter. As a result, the HPCSA has issued a new statement advising that it has reviewed its ethical ruling of 2016 and has ruled on the matter as follows:

“A patient reserves the right to cancel a medical or dental appointment, and a medical or dental practitioner may not charge a consultation fee or a procedure fee for such a cancelled appointment unless:

- the cancellation was made less than 24 hours for a specialist appointment, and 2 hours for a general practitioner appointment, before the appointment time.
- a practitioner can provide evidence of failure to find an alternative patient between the time of receiving the cancellation notice and the time of the cancelled appointment
- the practitioner can provide sufficient proof that the patient was informed of the cancellation of appointments policy
- the practitioner has first established the reasons for the patient’s failure to cancel or honour the appointment.

The HPCSA advises practitioners who have a cancellation or no-show policy to inform their patients at the time of booking that there will be charges incurred for failing to arrive for an appointment.”

By virtue of this statement, the HPCSA’s stance is now aligned with that of the Consumer Protection Act. At the date of this publication, however, booklet 11 has not been amended or removed from the council’s website. Practitioners should nevertheless consider the provisions of the Act as the binding authority. As recommended by the HPCSA, it is critical that practice staff inform patients of this policy at the time of scheduling the appointment.

Unpacking *locum tenens*

Wendy Massaingaie, legal advisor, SAMA Governance and Legal Department

In terms of the law as well as practice, whenever a doctor “fills in” for another doctor, this constitutes a *locum tenens*. However, there needs to be a contract between the instructing doctor and the locum. There have been numerous cases reported to the HPCSA regarding doctors employing non-registered doctors as locums, and so special attention needs to be given to this occurrence.

Legal requirements

Essentially, it has to be determined whether the locum is instructed as an employee or as an independent contractor. If instructed as an employee, the Labour Relations Act No. 66 of 1995 and the Basic Conditions of Employment Act No. 75 of 1997 come into effect. Vicarious liability passes to the doctor who appointed the locum. If the locum is instructed as an independent contractor, vicarious liability would only pass to the doctor if they had instructed an incompetent locum. The onus to ensure that the locum is registered and fit to practise rests with the doctor who instructed him or her. It is therefore imperative that the doctor exercises due diligence in such an appointment.

The Health Professions Act No. 56 of 1974 addresses the issue of the appointment of a locum under Rule 9 of the Ethical Rules of Conduct for Practitioners as follows:

“9. Covering

(1) A practitioner shall employ as a professional assistant or *locum tenens*, or in any other contractual capacity and, in the case

of *locum tenens* for a period not exceeding 6 months, only a person –

- (a) who is registered under the Act to practise in independent practice;
- (b) whose name currently appears on the register kept by the registrar in terms of section 18 of the Act; and
- (c) who is not suspended from practising his or her profession.”

There needs to be a contract between the instructing doctor and the locum

In addition to the above, rule 18(1) reads:

“(1) A practitioner shall accept a professional appointment or employment from employers approved by council only in accordance with a written contract of appointment or employment which is drawn up on a basis which is in the interest of the public and the profession.”

In certain instances, there may be doubt as to the capacity under which the locum has been “employed”, and so the Labour Relations Act creates a series of rebuttable presumptions as to who qualifies as an employee. Section 200A of the Act provides as follows:

“(1) Unless the contrary is proved ... a person who works for or renders services to any other person is presumed, regardless of the form of

the contract, to be an employee if any one or more of the following factors are present:

- (a) the manner in which the person works is subject to the control or direction of another person;
- (b) the person's hours of work are subject to the control or direction of another person;
- (c) in the case of a person who works for an organisation, the person forms part of that organisation;
- (d) the person has worked for that other person for an average of at least 40 hours per month over the last 3 months;
- (e) the person is economically dependent on the other person for whom he or she works or renders services;
- (f) the person is provided with tools of the trade or work equipment by the other person; or
- (g) the person only works for or renders services to one person.”

Where there is a dispute as to whether one is an employee or independent contractor, the Commission for Conciliation, Mediation and Arbitration should be approached for an advisory arbitration award.

Conclusion

In light of the above, doctors employing a locum should be vigilant and avoid employing persons who are not fit to practise and/or are unregistered, as this would be in violation of the Ethical Rules, which could lead to the employing doctor facing sanctions from the HPCSA.

SAMA supports Caster Semenya

SAMA Communications Department

SAMA is deeply concerned about the proposed rule changes by the International Association of Athletics Federations (IAAF) to impose an upper hormonal limit for athletes wishing to compete in the female category in international athletics competitions.

“We deem the requirement for hormonal manipulation in these athletes unethical and invasive. It runs in stark contrast to the

entrenched principle of athletes competing in their natural state. Such rules are – in our view – excessive and would constitute a systematic affront to the dignity of all female athletes,” says Dr Angelique Coetzee, chairperson of SAMA.

Dr Coetzee says that in the interests of medical ethics, the medical profession is compelled to denounce any policies in sport, or any other field that are not compatible with

the basic human rights principles of individual choice, confidentiality, consent, dignity, non-discrimination and equity. The IAAF and other international sporting bodies should not be allowed to violate these core principles. Any medical decisions and interventions should be based on evidence from well-designed and well-conducted research.

“We are concerned that the arguments by the IAAF for regulating testosterone levels in



such athletes are most likely based on a single, flawed study in which reporters were highly conflicted. SAMA urges medical scientists and doctors involved in the IAAF's medical procedures and tests to pay due regard to scientific rigour, evidence-based practice and medical ethics. Until sound scientific evidence is generated, SAMA dismisses such flawed arguments," notes Dr Coetzee.

She says the WMA's Declaration of Geneva and its International Code of Medical Ethics require doctors to maintain the highest standards of professional conduct, not to allow their judgement to be influenced by unfair discrimination, to act in the patient's best interest and to do no harm. Furthermore, the WMA Statement on Principles of Health Care for Sports Medicine requires that physicians oppose or refuse to administer any such means or method that is not in accordance with medical ethics, and/or might be harmful to the athlete using it, especially procedures which artificially modify blood constituents or biochemistry, among others.

"Therefore," Dr Coetzee adds, "artificially lowering endogenous testosterone in athletes has to be considered unethical. In addition, doctors prescribing treatment of this nature for a condition that is not recognised as a pathology will be in violation of medical ethics."

Apart from this, Dr Coetzee says it is of concern that medical manipulation in sport is being implemented disproportionately.

Any medical decisions and interventions should be based on evidence from well-designed and well-conducted research

"It is baffling that natural advantages in sport are being critiqued for athletics, but not for other sports. Basketball, high jump and goal-keeping in soccer are examples where acromegaly – a condition responsible for excessive tallness – would confer a clear advantage."

According to Dr Coetzee this problem also sharply brings to the fore the issue of economic and social injustice.

She says it would appear that better-resourced people or societies have more

opportunities, or exposure to environments that enhance sporting prowess, such as professional training programmes. When individuals from such environments compete with those from disadvantaged societies, such as in the case of Ms Caster Semenya, the playing field is obviously not level. It is also concerning that debates on natural attributes such as body shape and genetic composition seem to arise disproportionately more often with successful athletes from low- and middle-income countries.

"It should be an essential principle of sport that athletes must perform in their natural state, unmodified by medical interventions," notes Dr Coetzee.

SAMA has carefully followed Ms Semenya's involvement with sex verification policies for the past few years, including her recent high-profile appeal case against the IAAF's new rules, which were scheduled to come into effect in November 2018. Due to her appeal, these are now expected on 26 March 2019.

"We support Ms Semenya in this legal battle and look forward to a successful outcome for her. We urge the IAAF to reconsider their stance on this issue and to rely on better and more extensive research emanating from the world's greater medical community," concludes Dr Coetzee.

Add-on codes for unscheduled and emergency visits

Anton van Schalkwyk, *medical coding specialist, SAMA Private Practice Department*

There is a lot of confusion on when the use of add-on codes for consultative services is permitted with doctors' visits. Correct coding is of utmost importance to help ensure the sustainability of private healthcare in SA. These add-on codes are increasingly being investigated by the medical schemes for abuse, and it therefore becomes all the more important that medical doctors as well as funders ensure that they understand the rules that govern these codes.

The most important thing to remember about items 0145, 0146, 0126 and 0147 is that one may use only one at a time, and not combinations thereof.

Add-on item 0145

For consultation/visit **away** from the medical doctor's home or rooms (non-emergency).

- Add only to the consultation/visit items 0190 - 0193, items 0173 - 0175, items 0161 - 0164, items 0166 - 0169, items 0151 - 0153 or item 0109, as appropriate.
- It is important to note that for item 0109 (subsequent hospital visits), item 0145 is excluded from medical scheme benefits.

Example: the doctor visits patients in a retirement home for non-emergencies. Also to be used for a non-emergency first visit in the hospital when it is a non-emergency admission.

Add-on item 0146

For an emergency consultation/visit at the medical doctor's home or rooms.

- Add to the consultation/visit items 0190 - 0196, items 0161 - 0164 or items 0151 - 0153.
- Refer to item 0126 for unscheduled consultation/visit at doctor's rooms or home.
- Add to items 0190 - 0193 (as appropriate) for consultations/visits in the doctor's rooms.
- It is appropriate for doctors working at 24-hour emergency facilities to use this code when appropriate.

The Medical Schemes Act No. 131 of 1998 defines an emergency medical condition as "the sudden and, at the time, unexpected onset of a health condition that requires

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

Correct coding is of utmost importance to help ensure the sustainability of private healthcare

In cases of bona fide emergency, ensure that the ICD-10 coding reflects the condition that would define the case as an emergency.

The diagnosis after the visit is not enough to classify the case as an emergency visit. If the patient presents with symptoms severe enough to indicate that it might be perceived as a medical emergency it would be enough to code item 0146.

Example: the patient presents with symptoms that are perceived as a possible myocardial infarction. Lack of immediate attention could possibly lead to imminent death. Even if the diagnosis is not myocardial infarction, at the time it was perceived and handled as an emergency and may be coded with item 0146.

Example: the patient comes into the consulting rooms without an appointment, with severe symptoms that require immediate attention. The diagnosis is that of hypoglycaemia. The visit is coded with add-on item 0146 to items 0190 - 0193 as appropriate, with ICD-10 code E16.2 in order to confirm diagnosis of the emergency.

Add-on item 0126

For an unscheduled consultation/visit at the doctor's home or rooms.

- Add only to the consultation/visit items 0190 - 0193, 0161 - 0164 or 0151 - 0153.
- It is not appropriate to add to items in the case of confinements in after-hours periods, where global obstetric units are coded.
- This may not be added to items 1204 - 1210.

This item may not be used by practices where patients are seen on a first-come-first-serve basis without scheduled appointments.

Example: the practice has to fit a patient in between scheduled appointments. The patient did not contact the practice before coming in for a consultation. It does not qualify as an emergency, but the patient cannot wait until the next day for a scheduled appointment.

Add-on item 0147

For an emergency **or** unscheduled consultation/visit away from the medical doctor's home or rooms, at any hour.

- Add only to the consultation/visit items 0190 - 0193, 0173 - 0175, 0161 - 0164, 0166 - 0169 or 151 - 0153, as appropriate.
- Item 0147 may be added to items 0151 - 0153 (as appropriate) when an elective worklist was not submitted to the anaesthesiologist/anaesthetist by 16h00 on the day prior to the procedure(s).
- This is not to be added to items 0190 - 0193 for consultations by doctors normally using 24-hour emergency facilities.
- It is not to be added to items 1205 - 1210.
- It is not appropriate to add to items in the case of confinements in after-hour periods, where global obstetric units are coded.

Item 0147 should not be used when the patient is being admitted for planned surgery, and should therefore not be used as a standard add-on for all first consultations in the hospital.

Example: the doctor is called by the emergency rooms to attend to a patient. The patient arrived with a series of stab wounds to the abdomen and needs emergency surgery.

Example: the doctor is called out to see a patient at a retirement home to treat a case of the flu. The patient is bedridden and is difficult to move. It is not an emergency, but it is an unscheduled appointment.

Conclusion

It must be stressed that when a medical scheme rejects the occurrence of one of these add-on codes on the claim, the patient may be held liable for that part of the claim.

Better financial acumen can improve your practice

Lerisa Roberts, Dr Gustaaf Wolvaardt, FPD Business School

In SA, the major reason for business failure is poor financial management (Fin24, 2010).

Medical practitioners, like many other business owners, often leave key business processes that fall outside their own areas of expertise, such as financial management, in the hands of their accountants. The most common reason given for this decision is that accounting is difficult to understand and is best left to those who have expertise in the field. This is a risky strategy, and you only have to look at the news to realise the potential dire consequences of managers not focusing on the financial aspects of their businesses. There is an old management saying that "if you cannot measure it, you cannot manage it". Unfortunately, when it comes to financial management the accounting system is how we measure financial performance, so like it or not, as the practice owner, you need to become comfortable with the basics of accounting and financial management.

Fortunately, there is nothing mysterious about accounting; it simply involves the routine recording of business transactions, where transactions are defined as the exchange of and the payment for both goods and services in money values. Financial management, on the other hand, is the process of allocating resources across time, and includes the responsibility of making sure that the business makes the most of its financial resources.

Financial management

Why, then, should practice owners set out to understand basic financial management principles? Simply put, because they need to assess the financial performance of their business and strategically manage their financial resources. More than 85% of new businesses in SA fail within the first 3 years, usually as a result of not managing their cash flow. In essence, financial management skills are as important as clinical skills in ensuring a thriving private practice.

Doctors understand the importance of converting data into strategic information that guides clinical decisions. The same principle applies to managing the finances of

a medical practice. The accounting system will generate the data that need to be converted to the strategic information required by the doctor to make informed financial decisions.



Every business must have a budget, and your practice is no exception

Developing the skills for such an analysis will help the practitioner to clearly define their goals, and plan accordingly. Looking back, in this instance, helps to mitigate risk in the future, because if a business knows exactly what its expenses are, then the required income can be calculated, and relevant targets set, to ensure that the business is profitable.

Additionally, it is important for practitioners to monitor expenses on a monthly basis, in order to compare actual against planned expenses. It is therefore imperative for practitioners to understand financial management. At a minimum, the business (practice) owner should be comfortable with navigating the budgeting process, understanding income statements and interrogating their balance sheet.

Budgeting

Every business must have a budget, and your practice is no exception. The budgeting process begins with the projection of expected sales within the period for which planning is being done (Weetman, 2016). Most businesses have an annual budget, but it is a good idea to revisit the budget on a quarterly basis to measure projections against actual targets achieved. In this way, the relevant adjustments can be made, and there are no surprises at the

end of the financial year. There are, however, macroeconomic factors to be cognisant of when budgeting. For example, expectations about the growth in gross domestic product (GDP), and the extent to which the medical industry contributes to the GDP, will influence your practice's sales forecasts.

The income statement

Income statements are prepared on a monthly basis. These provide a summary of the revenue earned and expenses incurred by the business across a specific period. The difference between these two values will indicate whether or not the business has been running at a profit or a loss for that period.

Statement of financial position (balance sheet)

The statement of financial position provides an overview of a business at a particular date. Also known as the balance sheet, this statement records the total assets (what you own) and total liabilities (what you owe), thus giving business owners an overview of how much is invested in the business.

Time value of money

The idea of time value of money is that a particular sum of money in hand today is worth more than the same amount of money in the future. This is important to understand when making capital investment decisions. For example, if you choose to invest in a new piece of equipment, it may be years before a return on your investment is actually realised, but rapid technological advances dictate the need for medical equipment to be updated every 2 - 4 years; thus choosing to invest in a new piece of equipment requires strategic thinking that cannot be left to the "bean counter". For this reason, financial management becomes imperative for you as a practitioner, whether you are running an existing practice, setting up a new practice or expanding. Understanding financial management will give you the confidence to run your practice effectively.

References available on request.

Short Course in Practice Finance for Private Practitioners

WHO SHOULD ENROL?

Professionally skilled people who want to increase the financial discipline in the management of their practice

MODE: Contact Tuition
Interactive sessions on practice finance

CEUs: 30 Ethical CEUs

PRICE: R 3 695.00 (incl VAT)



WHO celebrates women leaders in science and health

World Health Organization

On International Women's Day, we celebrate all the women who have had a pioneering role in advancing science and health. One of the best known is Florence Nightingale, a 19th-century statistician and the founder of modern nursing, who understood the benefits of hygiene and sanitation in preventing disease.

Fe del Mundo, a paediatrician from the Philippines who went on to do pioneering work on infectious diseases including dengue, was the first female student at Harvard Medical School.

Anandi Gopal Joshi was one of the first Indian female doctors, and appointed physician-in-charge at a hospital in central India, before she died of TB aged just 22.

Elizabeth Garrett Anderson, born shortly after Florence Nightingale, taught herself French so that she could obtain a medical degree at Sorbonne University in Paris. She became Britain's first female doctor.

In the 20th century, Anne Szarewski discovered the cause of cervical cancer, leading to the first-ever HPV vaccine, and Françoise Barré-Sinoussi's work on HIV was fundamental to the identification of the virus as the cause of AIDS.

In 2019, however, women still only make up a third of researchers worldwide, on average. Some regions, such as Central Asia, Latin America and the Caribbean, have a nearly equal gender balance, but in Europe and North America, the proportion of women remains at around 30 - 35%.

Women also struggle to rise up the ranks in both health and science. Women make up just 12% of the membership of national science academies around the world. Female health workers comprise 70% of the health workforce worldwide, yet women occupy only 25% of leadership positions in health.

And the pay differential is high: the gender pay gap in the health and social sectors is around 26% in high-income countries, and



Fe del Mundo, Anandi Gopal Joshi, Elizabeth Garrett Anderson



Anne Szarewski, Françoise Barré-Sinoussi, Florence Nightingale

29% in upper-middle-income countries. Gender discrimination, implicit bias and sexual harassment and assault have been found to be systemic barriers to women's advancement in global health careers. These are compounded by an absence of policies to accommodate women with children (including flexible working arrangements and increased paternity leave).

There are positive signs that change is coming. In the WHO for example, women hold 60% of senior leadership positions. The WHO also has an active gender equity hub to ensure that a gender lens is applied to health workforce policies worldwide. Things are changing in academia as well: last year, nearly 40% of new members in the US National Academy of Medicine were women.

Evidence is already emerging that implementing flexible working arrangements, providing mentorship programmes and instituting formal policies on gender discrimination and harassment, and gender-

specific leadership training, can break down the barriers for women to lead in global health. However, it is important to transform the very systems that women work in. This may require re-examining traditional career trajectories and methods of promotion. Too often, women are encouraged to mould themselves to a system that has been designed for men. Nevertheless, new waves of women leaders are succeeding in ways that reflect tolerance, co-operation and resolve. These women may lead in different ways, sharing power and information while enhancing other people's self-worth.

The argument for increasing the representation of women leaders in science and health is often economic, on the basis that diverse perspectives in leadership can benefit business. But a business case cannot be the only reason for advancing women in science. To this end, 8 March 2019 was a moment to recall that principles of human rights and social equity require that women play just as significant a role in science and health as men.

Think equal, build smart and innovate for change

The SA Society of Obstetricians and Gynaecologists

International Women's Day is celebrated globally on 8 March every year. It is a celebration of the social, economic, cultural

and political achievements of women. The day also marks a call to action for accelerating gender parity. In the context of women's

health, the theme "Think equal, build smart and innovate for change" for 2019 refers to reducing inequity in access to healthcare by

using novel ideas and affordable technology to meet the healthcare needs of all women. SA women face a number of unique challenges.

The SA Society of Obstetricians and Gynaecologists is committed to promoting excellence and equity in women's health. They believe that some of the major issues that require innovative solutions include:

- equal access to free education for the girl-child
- access to effective contraceptive services in a private, non-judgemental setting, which would afford women equal opportunities in society
- innovative programmes to extend coverage of existing prevention services

- to control the cervical cancer epidemic
- labour wards and maternity care, which need be modified and technologically modernised, e.g. to accommodate of companions in labour
- groundbreaking research to identify and treat women with hypertensive disease in pregnancy.

Eating disorders: The silent killer

SAMA Communications Department

Eating disorders are real illnesses that do not discriminate according to race or class, have little or nothing to do with vanity and can have lifelong after-effects.

Anorexia nervosa, bulimia nervosa and binge-eating disorder are "silent diseases" that affect sufferers' physical health and quality of life, their ability to function in daily life and their relationships with family and friends. Anorexia nervosa has the highest death rate of all mental health conditions.

The spotlight has recently been turned onto the role of social media, such as the photosharing platform Instagram, with calls from eating-disorder experts and support organisations to clamp down on images and posts "glamourising" eating disorders, following the company's agreement in February 2019 to remove images of self-harm.

The SA Society of Psychiatrists (SASOP) said media stereotypes of beauty and "ideal" body types had long been implicated in contributing to eating disorders, especially for those already vulnerable or at risk.

SASOP member Prof. Christopher Paul Szabo, a leading expert on eating disorders, said there was a "real v. ideal" disconnect between average body sizes and types in real life, and the often-unattainable ideals portrayed in traditional and social media.

"This potentially creates incorrect perceptions that being underweight, meaning below healthy norms, is desirable, and contributes to the unhealthy attitudes and behaviours around weight, food, dieting and body image that are central to eating disorders," he said.

Prof. Szabo said the causes of eating disorders were complex, and treatment specific to each individual. While body image concerns were central, eating disorders were also "powerful indicators of distress that goes beyond food and body issues alone. Every sufferer has an individual story."

He warned that dieting, especially if for no clear health reason, should be added to the list of risky behaviours for teenagers, along with the usual concerns about unprotected sex and drug and alcohol abuse.

Eating disorders are most prevalent in teenage and young adult women, and there is increasing concern for pre-teens – the physical changes of puberty, along with girls maturing at younger ages, interact with social pressures for "thinness" and dieting, creating a risk for the development of eating disorders.

Prof. Szabo said that his research, from the early 1990s, has found that eating disorders affect young women of all ethnicities, resulting in similar behaviours and attitudes, and are not limited to urban or Western settings. This mirrors findings in other African countries and societies undergoing social and political changes.

He said that it was important for families, schools and medical professionals to be aware that eating disorders are possible in all cultures, socioeconomic groups and races, so that symptoms are not dismissed or misdiagnosed.

Prof. Szabo said the stereotype of eating disorders as limited to females was also changing – teenage boys and young men are increasingly at risk, due to pressures to achieve perceived ideal male body types, usually via exercise to lose weight and build muscle.

The root causes of eating disorders are often linked to the pressures of contemporary life and culture, "with the body as the vehicle for expression of conflicts of identity", Szabo said, adding that "the causes are best understood as an interaction between the individual and environment."

Perfectionism is a personality trait associated with eating disorders, he said, and combined with a preoccupation with diet and exercise regimens, should be an early warning signal.

Further possible precipitants of eating disorders can be stresses such as changes

in family circumstances, abusive situations (directly or by witnessing abuse) or pressure to perform in school or sport, leading to feelings of a lack of control, or disrupting the sufferer's sense of self-esteem and self-worth. Eating becomes the one place where the sufferer feels in control over their emotions and circumstances.

Prof. Szabo said concerns around weight – especially when a person's perception does not match their actual weight – and a history of or preoccupation with dieting, with weight and eating habits dominating conversation, are warning signals of an eating disorder.

Prof. Szabo said that treating eating disorders generally requires a specialist, as sufferers tend to deny that anything is wrong, and resist treatment. However, the family physician is often the starting point. Unlike many psychiatric conditions, where medication is the primary method of treatment, eating disorders are treated with a combination of psychotherapy, usually also involving therapy sessions for parents or family, and nutrition or dietary counselling. Treatment for anorexia may include hospitalisation, with a focus on nutrition counselling and weight restoration, which has been proven to aid also in improvement in overall psychological and emotional health. Hospitalisation may also be a requirement in certain instances for bulimia nervosa.

Prof. Christopher Paul Szabo

Prof. Szabo is currently the head of the psychiatry department at Wits, and Head of Clinical Department at Charlotte Maxeke Johannesburg Academic Hospital. He also works in private practice. His work in the field of eating disorders covers more than 20 years, and he has published widely on the topic.

MEMBER BENEFITS



Inter Africa Bureau De Change



Jaco Brits

072 626 1687 | jaco@interafribdc.co.za

Inter Africa Bureau De Change is a leading provider of foreign exchange. We are licensed by the South African Reserve Bank to operate as an Authorised Dealer in Foreign Currency.

Inter Africa offers a VIP Rate to all SAMA members

Inter Africa Bureau De Change offers a wide variety of products and services, those being: • Cash Passport (a prepaid currency card) • Transport Forex • Travel Forex • Xpress Money • Moneytrans (send and receive money around the world)

Legacy Lifestyle

Allan Mclellan

0861 925 538 / 011 806 6800 | info@legacylifestyle.co.za

SAMA members qualify for complimentary GOLD Legacy Lifestyle membership. Gold membership entitles you to earn rewards at over 250 retail stores as well as preferred rates and privileges at all Legacy Lifestyle partnered hotels and further rewards back on accommodation and extras.



Medical Practice Consulting



Inge Erasmus

012 111 7001 | 074 031 5295 | inge@mpconsulting.co.za

MPC offers SAMA members FREE access to the MPC Online Medical Education platform. SAMA members further have access to Medical Scholarships through MPC for online CPD, CME and Short Courses as well as the attendance of international conferences. For more information, please visit www.mpconsulting.co.za

Mercedes-Benz South Africa (MBSA)



Refilwe Makete

012 673-6608 | refilwe.makete@daimler.com

Mercedes-Benz offers SAMA members a special benefit through their participating dealer network in South Africa. The offer includes a guaranteed discount on brand new Mercedes-Benz vehicles. In addition SAMA members qualify for preferential service bookings and other after market benefits.

SAMA eMDCM | SAMA CCSA



Zandile Dube

012 481 2057 | coding@samedical.org

The first licence of the eMDCM is FREE to SAMA members in private practice (including limited private practice). As a SAMA member you must please log on using your username and password to qualify for this **FREE** Licence. Only the first licence is free, additional licences will be charged.



SAMA eMDCM™

CCSA: 50% discount of the first copy of the Complete CPT® for South Africa book.

Tempest Car Hire



Corinne Grobler

083 463 0882 | cgrobler@tempestcarhire.co.za

SAMA members can enjoy discounted car hire rates with Tempest Car Hire.

Thusano Group



Thabiso Makhoana

083 873 1343 | thabiso@thusanogroup.co.za

SAMA members qualify for 30 – 40% discount on all Telkom costs.

Thusano Group offers all doctors NEC Telecommunication products with a 5year warranty at discounted prices. These offers are available for SAMA members with small, medium and large practices. We will structure a solution to suit your business needs.

V Professional Services



Gert Viljoen

012 348 3567 | gert@vprof.co.za

10% discount on medical practice bureau service through V Professional Services.

PROFESSIONAL SERVICES
Medical • Accounting • Taxation • Legal

Hopes for hearing shouldn't fall on deaf ears

SAMA Communications Department

As part of the Tshemba Foundation's drive to help alleviate the strain on under-resourced healthcare facilities in Mpumalanga and Limpopo, they have set up an audiology outreach programme at local schools.

The programme aims to assist in the reduction of hearing loss or hearing impairments suffered by children in the greater Acornhoek area. However, the only way this project can become successful is to have dedicated medical professionals on the ground.

The Foundation is in need of audiologists who are eager to devote their time and expertise to the cause. By volunteering, not only will you be having a tremendous impact on the lives of children living with hearing impairments, but you'll have the privilege of leaving a lasting legacy of giving back to the communities in need.

Also, you get to spend your down time at the luxurious self-catering lodge at zero cost to you. The five-star, fully equipped lodge is nestled in the heart of a nature reserve, giving you scenic vistas of the Lowveld bush from your doorstep. This bush breakaway is the



ultimate doctor's refuge – it's safe, secluded, and you get to share your newfound sanctuary with your partner!

The lack of adequate medical supplies and equipment at their disposal exacerbates the challenging circumstances in which the Foundation operates. They are desperately seeking audiology instruments and welcome the donations of diagnostic audiometers,

tympanometers, screening audiometers and otoscopes. Donations of audiology equipment will ease the burden and go a long way in their efforts to help those in dire need of medical attention.

Should you wish to volunteer or donate, or need additional information, please visit: www.tshembafoundation.org or email Lexi Cohen at Lexi@tshembafoundation.org.

SAMAREC hold enlightening research ethics breakfast

SAMA Communications Department

Over 30 delegates joined the SAMA Research Ethics Committee (SAMAREC) for breakfast at SAMA head office on 8 March 2019. The programme included doctors and clinical research associates, who discussed recent updates in the industry:

- Prof. J Snyman: Pragmatic studies – SA needs MAPP
- Dr M Botes: Gene editing
- R Brits: Standard operating procedures
- N Stott: SA Clinical Research Association – industry update.

A sound knowledge of the ethical principles that guide informed consent and research is essential for any researcher, and the agenda of the morning provided the relevant information.



Dr M Botes looked at gene editing



Prof. Snyman discussed pragmatic studies

A sight for sore eyes

The Medical Protection Society shares a case report from their files

Dr P, an ophthalmologist with expertise in laser refractive surgery, performed bilateral Lasik procedures to correct myopic astigmatism on Mrs A, a 33-year-old recruitment consultant. Prior to the procedure Mrs A had best corrected visual acuities of 6/5 in both eyes. She had a history of dry eyes, treated with topical lubricants twice a day.

The refractive surgery was uneventful, but 5 days postoperatively Mrs A started to develop eye pain and worsening vision. She contacted Dr P 2 days later, and was seen within 4 hours. Her visual acuity had deteriorated to 6/36 in each eye. Dr P diagnosed severe bilateral infectious keratitis, took microbiological culture samples and started her on broad-spectrum topical antibiotics. Culture identified *Streptococcus pneumoniae*, sensitive to the prescribed antibiotics, and the infection settled after a prolonged course of treatment. However, Mrs A was left with residual corneal scarring and exacerbation of her pre-existing dry eyes that were difficult to manage and took more than 5 years to stabilise.

At the last follow-up she required frequent topical lubricants to control her symptoms of dry eyes. She was intolerant of contact lenses and required spectacles to achieve her best visual acuity. Her uncorrected visual acuities were 6/9 in both eyes, which improved to 6/6 with spectacles.

Mrs A brought a claim against Dr P, alleging problems with extended close reading, computer work and night driving due to glare, blurring and sensitivity. She also claimed that she suffered post-traumatic stress disorder (PTSD), requiring psychiatric consultation and intervention as a result of her experience.

Mrs A further alleged that the surgery should not have been performed due to her pre-existing dry-eye disease, and that she had not given informed consent for the procedure. She also alleged that Dr P had failed to ensure that the surgical pack was sterile before the procedure. She claimed that Dr P had provided substandard postoperative care, failed to explain the nature of the complications and given her no indication of the prognosis.

Mrs A said she lived in fear of becoming permanently blind, and had no support from Dr P or his team while she was recovering, adding that he ignored the impact the

symptoms were having on her life and did not show any concern for her deterioration. She was unable to plan her future, and lost her confidence and ability to function both at work and at home.

It was alleged that Mrs A would have rapidly progressed in her career if not for her visual problems, which prevented her from returning to work on a fulltime basis and taking on responsibilities that involved night driving.

Expert opinion

Dr P contacted the Medical Protection Society (MPS), who requested his clinical records from his preoperative discussions with Mrs A. These showed that Mrs A was informed of the risks of infection and worsening of the dry-eye condition, and that she was consented appropriately. Surgical records showed that the surgical pack was checked and documented as sterile by theatre staff pre-operatively, as routine.

Expert ophthalmology opinion was supportive of this part of the care provided

by Dr P. However, the expert was critical of some aspects of Dr P's postoperative care, concluding that he should have invested more time in the doctor-patient relationship once a serious complication developed, and that this aspect of Dr P's care had been below the standard expected of a doctor. Mrs A was severely traumatised by the surgical complications and suffered PTSD. An expert in psychiatry took the view that the PTSD may have been lessened had Dr P communicated sensitively and addressed her concerns adequately and in a timely manner.

Outcome

A member of the MPS legal team accompanied Dr P to a mediation meeting, where a compromise was reached and a moderate sum accepted by Mrs A, which covered losses to past earnings, expenses incurred during her recovery period and future losses resulting from the delay to career progression.

Learning points

Poor outcomes are often a precipitating factor for litigation. However, only a small fraction of such cases end up in litigation, and not all cases of successful litigation are a result of medical negligence.

Good record-keeping is key to a successful defence when responding to complaints about care. This applies to both clinical and non-clinical concerns, and how they were addressed.

Doctors who have had a negligence claim made against them are more likely to face litigation again, even if the medical care they provide is no different from their peers. Complaints against these doctors are usually related to the quality of their communication. Key elements of effective communication include the following:

- Consultations should be directed towards meeting patient expectations. Use the consultation to build rapport, confirm patient understanding, address misconceptions and make joint decisions about care.
- The consenting process should give clear, accurate information about risks and outcomes that are personalised to the patient's needs, requests and expectations, and it should be recorded as such. Making assumptions about what the patient wants may lead to misunderstandings. When discussions are complex, consider summarising the discussion with a written letter to the patient, and including the family in discussions, if the patient agrees. Give the patient time and space before making a decision, when possible.
- Open and honest discussions when complications arise may reduce the risk of litigation. Showing empathy, being available to address concerns, acknowledging the patient's experience, taking responsibility by offering an apology if appropriate, and feeding back to the patient the lessons that have been learned and the steps taken to reduce the risk of further similar errors may reduce the psychological impact of an adverse event on a patient.

MPS offers workshops and e-learning modules on record-keeping, communication skills and consent – visit www.medicalprotection.org to find out more.

Successful pharmacology CPD at Gauteng North branch

Gauteng North branch held a very successful and well-attended pharmacology CPD on 23 February 2019.

Topics covered were:

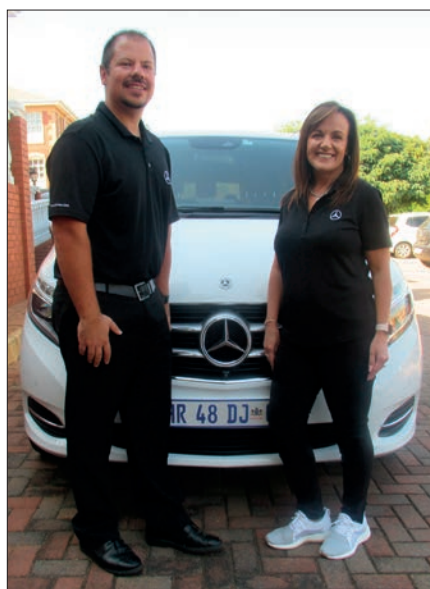
- Tricks used by patients to obtain scheduled medicine, and prevention thereof, by Dr Kim Outhoff
- Off-label drug use in children, by Dr Memela Makiwane
- Section 21 drugs: Procedures and relationship with MCC/SAHPRA, by Machel Leuschner
- Counterfeit drugs, by Prof. Duncan Cromarty
- Fatal/potentially fatal drug interactions, by Dr Andre Marais.

A big thank you to Dr Marais, who holds the CPD events portfolio on the Gauteng North branch council, for a well-organised event.



From left to right: Dr Memela Makiwane, Dr Andre Marais, Dr Kim Outhoff, Machel Leuschner and Prof. Duncan Cromarty

Driving in style



George Barnard and Annelise Crocker from Mercedes-Benz in front of a new V-Class, now available at a discount to SAMA members. Mercedes-Benz transported our branch secretaries to and from the hotel to attend their annual workshop at SAMA head office.

Intern orientation at Helderberg Hospital

Cape Town branch visited Helderberg Hospital in Somerset West on 15 February this year. Twenty interns were present to listen to the presentation, and received SAMA scrubs from visiting branch staff.



Interns at Helderberg Hospital listen to the Cape Town branch presentation

Branch secretaries attend basic coding training

Sarah Molefe, junior marketing officer, SAMA Marketing Department

SAMA branch secretaries Nosipho Jack, Sultana Hartzenberg, Emily Nel and Chenienne Gericke attended basic coding training on Wednesday 13 March 2019 at SAMA head office. The main focus of this training was to give them an overview of how the Private Practice Department (PPD) works. Ms Rendani Tendane focused on the basics of ICD-10 codes, and gave an introduction to prescribed minimum benefits. Mrs Zandile Dube introduced the following manuals that the PPD uses, and explained how they are produced:

- ICD-10 International Statistical Classification of the Diseases and Related Health Problems
- Medical Doctors Coding Manual 2019
- Complete CPT for South Africa 2018.



From left: Rendani Tendane, Private Practice Department; Nosipho Jack, Transkei branch; Sultana Hartzenberg, Griqualand West branch; Emily Nel, Cape Western branch; Zandile Dube, Private Practice Department; and Chenienne Gericke, Cape Western branch

Branch administrators' workshop

Bokang Motlhaga, junior marketing officer, SAMA Marketing Department

SAMA hosted the branch administrators' workshop at head office from 13 to 15 March 2019. The objective of this event is to ensure that branch administrators, as ambassadors of the SAMA brand in their specific regions, are well equipped with the skills that are necessary to grow SAMA and deliver an impeccable service to members.

During this event, the various SAMA departments had the opportunity to inform the administrators about the respective departments' roles in serving SAMA members, the strategies that they have in place to meet the SAMA objectives and the various activities that they are planning.

These 3 days of intense and interactive training are important to SAMA as an organisation, as it is a way of ensuring that all SAMA branches are aligned, and the values and culture of SAMA are upheld in all branches. Branch administrators, as the first point of contact with members of SAMA, understand that by providing a great service to members they are bettering the whole SA health system, as well as indirectly contributing to the delivery of health services to the citizens of SA.



From left: George Bernard (Mercedes-Benz), Nosipho Jack (Transkei Branch), Sultana Hartzenberg (Griqualand West Branch), Karen Potgieter (Lowveld Branch), Emma Netshiongolwe (Limpopo Branch) and Annelise Crocker (Mercedes-Benz)



Dr Vusi Nhlapho, head of the Private Practice Department, explaining the department's activities to attendees



Dr Manny Thandrayen, general manager of SAMA, presenting to the branch administrators

SAVE THE DATE



SAMA CONFERENCE 2019

Leadership & Quality in Healthcare
Let's close the gap



SOUTHERN SUN ELANGENI
& MAHARANI HOTEL
DURBAN



8 - 10 AUGUST
2019



SAMAREC/CPD SERVICES AVAILABLE:

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



WHAT WE ARE ABOUT

SAMAREC:

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.

CPD:

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 or cpd@samedical.org