

SAMA INSIDER

JUNE 2019

WHO releases digital health interventions guidelines

New PMB definitions published



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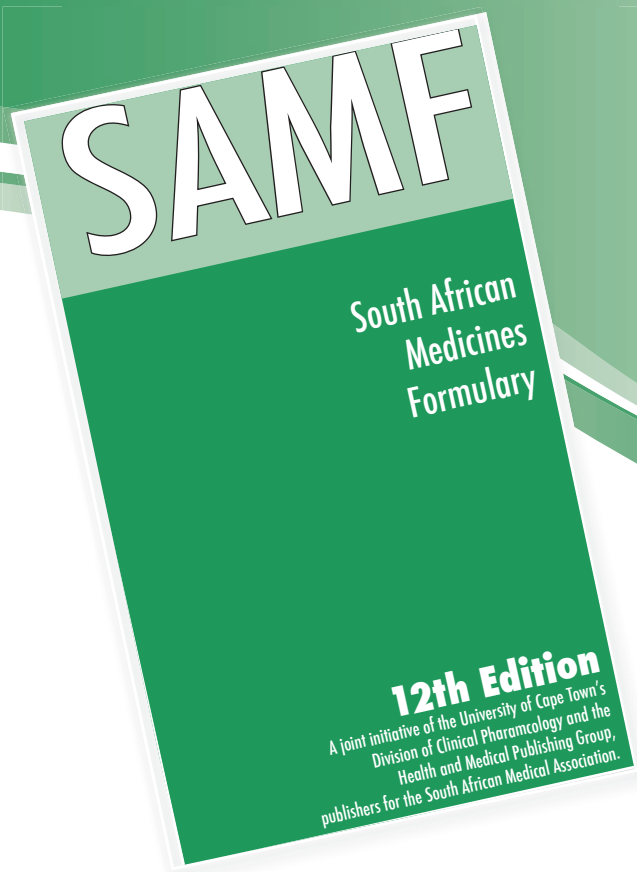
CONTENTS

JUNE 2019



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- 3 **EDITOR'S NOTE**
A national and international healthcare perspective
Diane de Kock
- 4 **WORLD HEALTH**
WHO Director-General on World Health Day 2019
Dr Tedros Adhanom Ghebreyesus
- 4 WHO releases first guidelines on digital health interventions
SAMA Communications Department
- 5 **FEATURES**
Council for Medical Schemes publishes new batch of PMB definitions
Shelley McGee
- 7 Starting working life: An intern's perspective
Dr Jacques Geldenhuys
- 8 Interpretation of rule G: Delegation of postoperative care
Dr Rosanna Naidoo
- 9 HPCSA guidelines and procedures when selling your practice
Hanneke Verwey
- 10 Raising awareness during African Vaccination Week
SAMA Communications Department
- 11 We helped, but the Iraqi doctors are the ones who made it work
Dr Sian Geraty
- 12 What's new in the management of drug-resistant TB?
Dr Norbert Ndjeka
- 13 Purchasing SAMA products
Tebogo Sanyane
- 14 Recruitment and selection processes for the employer
Phumzile Gwala
- 17 SAMA position on Caster Semenya and the IAAF
SAMA Communications Department
- 18 Your financial health
Gert Viljoen
- 19 **LETTERS TO THE EDITOR**
Re: May one charge for cancellations and no-shows?
Dr Wim Beukes
- 20 **MEDICINE AND THE LAW**
Problematic pacemaker placement
Medical Protection Society



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Diane de Kock
Editor: *SAMA INSIDER*

A national and international healthcare perspective

This month our focus is on healthcare from a national and international perspective.

On 7 April, World Health Day, the WHO Director-General, Dr Tedros, made a statement about the state of healthcare in the world (page 4): "Although we have made enormous progress in recent years against some of the world's leading causes of death and disease, we still have a lot of work to do to realise that vision ... a world in which all people enjoy the highest attainable standard of health."

Also in April, the WHO released new recommendations on 10 ways that countries can use digital health technology to improve essential services and people's health (page 4). These are challenges faced by healthcare workers all over the world, and particularly in Africa.

This international perspective provides a challenging backdrop to the day-to-day hurdles in the healthcare arena in SA. On page 5, Shelley McGee unpacks the recently published set of prescribed minimum benefits by the Council for Medical Schemes, "specifically relating to the identification, diagnosis and management of gynaecological cancers".

A new intern, Dr Jacques Geldenhuys, provides an informative personal perspective on starting working life in KwaZulu-Natal (page 7).

Some practical advice from Hanneke Verwey (page 9) on selling your practice addresses another day-to-day challenge faced by many doctors at some stage of their careers.

SAMA addresses the importance of vaccinations during African Vaccination Week from 24 to 30 April (page 10), informs members about how to purchase SAMA products (page 13), gives advice to employers on recruitment and selection processes (page 14), and reacts along with many South Africans to the recent IAAF ruling on Caster Semenya (page 17).

We welcome a letter from Dr Wim Beukes (page 19) on Hanneke Verwey's April 2019 article "May one charge for cancellations and no-shows?", a query that reflects the concerns of many SAMA members.

Your concerns are important to us. We look forward to hearing from you.

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WHO Director-General on World Health Day 2019

Dr Tedros Adhanom Ghebreyesus, *WHO Director-General*



The WHO was born on 7 April 1948, with a clear and ambitious vision: a world in which all people enjoy the highest attainable standard of health.

Although we have made enormous progress in recent years against some of the world's leading causes of death and disease, we still have a lot of work to do to realise that vision.

Today, half the world's population cannot access essential health services. Millions of women give birth without help from a skilled attendant; millions of children miss out on vaccinations against killer diseases; and millions suffer and die because they cannot access treatment for HIV/AIDS, TB and malaria.

In 2019, this is simply unacceptable.

The good news is that there is a growing movement to address these inequalities.

Last October, we saw a momentous commitment to health for all, with the signing of the historic Declaration of Astana on primary healthcare, in Kazakhstan.

This was a key milestone. Strong and sustainable primary healthcare is the bedrock of universal health coverage (UHC), and the best defence against disease outbreaks and other health emergencies.

Although there will always be outbreaks, and other disasters with health consequences, investing in stronger health systems can help to prevent or mitigate them.

As one of the Sustainable Development Goals, all countries have committed to achieving UHC by 2030. To meet that target, we need to see 1 billion people benefitting from UHC in the next 5 years.

This is not an unattainable dream, nor will it require billions of dollars to implement. UHC is achievable, right here, right now, for all of us.

Health for all is possible even with health systems that are less than perfect – countries at many different income levels are making progress with the resources they have.

On Friday 5 April, WHO colleagues joined hands with staff from health and development organisations around the world to symbolise our shared commitment to ensuring health for everyone, everywhere.

This shared commitment will be fundamental as we move forward to the next milestone in the global push towards universal health coverage, at the UN high-level meeting on UHC in New York later this year.

Health for all is possible even with health systems that are less than perfect

At that meeting, world leaders will have the opportunity to demonstrate their commitment to UHC, and to ensuring that every mother can give birth safely, that every child survives past his or her fifth birthday and that no one dies simply because they are poor.

As we celebrate World Health Day, I pay tribute to health workers all over the world who are working to promote health, keep the world safe and serve the vulnerable. I especially thank the dedicated personnel from the WHO and our partners who are working around the clock in extreme circumstances, including in the Democratic Republic of the Congo, Mozambique and Yemen.

WHO releases first guidelines on digital health interventions

SAMA Communications Department

On 17 April, the WHO released new recommendations on 10 ways that countries can use digital health technology, accessible via mobile phones, tablets and computers, to improve essential services, and people's health.

"Harnessing the power of digital technologies is essential for achieving universal health coverage," says WHO Director-General Dr Tedros Adhanom Ghebreyesus. "Ultimately, digital technologies are not ends in themselves;

they are vital tools to promote health, keep the world safe and serve the vulnerable."

Over the past 2 years, the WHO systematically reviewed evidence on digital technologies and consulted with experts from around the world to produce recommendations on some key ways in which such tools may be used for maximum impact on health systems and people's health.

One digital intervention already having positive effects in some areas is the sending

of reminders to pregnant women to attend antenatal care appointments, and to parents to have children return for vaccinations. Other digital approaches reviewed include using decision-support tools to guide health workers as they provide care, and enabling individuals and health workers to communicate and consult on health issues from across different locations.

"The use of digital technologies offers new opportunities to improve people's health,"

says Dr Soumya Swaminathan, chief scientist at the WHO. "But the evidence also highlights challenges in the impact of some interventions."

She adds: "If digital technologies are to be sustained and integrated into health systems, they must be able to demonstrate long-term improvements over the traditional ways of delivering health services."

For example, the guidelines point to the potential to improve stock management. Digital technologies enable health workers to communicate more efficiently on the status of commodity stocks and gaps. However, notification alone is not enough to improve commodity management; health systems must also respond and take action in a timely manner to replenish needed commodities.

"Digital interventions depend heavily on the context, and on ensuring appropriate design," warns Dr Garrett Mehl, WHO scientist in digital innovations and research. "This includes structural issues in the settings where they are being used, available infrastructure, the health needs they are trying to address and the ease of use of the technology itself."

Digital health interventions are not sufficient on their own

The guidelines demonstrate that health systems need to respond to the increased visibility and availability of information. People

must also be assured that their own data is safe and that they are not being put at risk because they have accessed information on sensitive health topics, such as sexual and reproductive health issues.

"Digital technologies ... are vital tools to promote health, keep the world safe and serve the vulnerable"

Health workers need adequate training to boost their motivation to transition to this new way of working, and need to be able to use the technology easily. The guidelines stress the importance of providing supportive environments for training, and of dealing with unstable infrastructure, as well as policies to protect the privacy of individuals, and governance and co-ordination to ensure that these tools are not fragmented across the health system.

The guidelines encourage policy-makers and implementers to review and adapt to these conditions if they want digital tools to drive tangible changes, and they provide guidance on privacy considerations in access to patient data.

"Digital health is not a silver bullet," says Bernardo Mariano, the WHO's chief information officer. "The WHO is working to make sure it's used as effectively as possible. This means ensuring that it adds value to the health workers and individuals using these technologies, and takes into account the infrastructural limitations, and that there is proper co-ordination."

The guidelines also make recommendations about telemedicine, which allows people living in remote locations to obtain health services by using mobile phones, web portals or other digital tools. The WHO points out that this is a valuable complement to face-to-face interactions, but it cannot replace them entirely. It is also important that consultations are conducted by qualified health workers, and that the privacy of individuals' health information is maintained.

The guidelines emphasise the importance of reaching vulnerable populations, and ensuring that digital health interventions do not endanger them in any way.

Council for Medical Schemes publishes new batch of PMB definitions

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



In April 2019, the Council for Medical Schemes (CMS) published a new set of prescribed minimum benefit (PMB) definitions specifically relating to the identification, diagnosis and management of gynaecological cancers (cervical, ovarian, vulvovaginal and endometrial cancer).

The PMB definition project has been running since 2010, when the council acknowledged that as a result of inadequate clarity in the regulations regarding some diagnosis and treatment pairs (DTPs), medical scheme beneficiaries found it difficult to know in advance what their entitlements were.

The CMS has been co-ordinating a process to develop condition-specific benefit

definitions (BDs). The process has taken place in consultation and in collaboration with funders, practitioners, academic representatives, device and pharmaceutical companies and patient advocacy groups. The envisaged BDs are to be comprehensive descriptions of benefits available under PMB regulations, and include condition-specific standardised entry and verification criteria, and defined baskets of goods and services associated with this entitlement.

The consultation and development process for the BDs has been intensive, and since 2010, less than 30 BDs have been finalised. This may seem like a drop in the ocean compared with the 270 DTP-PMBs

that medical schemes are mandated to fund, but SAMA feels that the process has been worth supporting, as key principles in relation to the DTP-PMBs have also been addressed during the process.

Unfortunately, these definitions do not supersede the regulations relating to these conditions, which remain generally vague. However, the improved detail in a consultative document will certainly guide the CMS in rulings on benefit entitlements, and, SAMA hopes, will also guide medical schemes in the minimum requirements that they are expected to adhere to in their benefit designs.

Where these definitions are proving important is during the separate discussions on the PMB review. The CMS aims to review the full structure of the current PMBs, and to include substantive primary health and preventative benefits, which are lacking from the current package. Looking at the specifics of the benefits available may indicate where the gaps in the current structures are, and where health needs are not being met.

PMB definition processes

Members will have seen calls for comment and input to the BDs a number of times in the SAMA newsletter.

The CMS initially publishes an open period for comment on a specific DTP-PMB, providing a template structure for submission. At the same time, a date is announced for a clinical advisory committee (CAC) meeting, and a call for CV submission is made for experts and stakeholders to attend the CAC.

The CMS appoints its own panel of advisory experts, most of whom are clinicians working in both the public and private sectors, and who contribute substantially to the discussions at the CAC and the final development of the PMB definitions.

The CAC generally holds a one-day meeting per topic, inclusive of clinical, funding, academic and patient stakeholders. A few months later, a draft BD is published for further comment (again, members will have seen the SAMA calls for input on draft definitions in the newsletter).

The final BD is usually published a month or two after comments on the draft have been received.

Gynaecological cancer DTP-PMB definitions

Published on 14 April on the CMS website, the four final gynaecological cancer DTP-

PMB definitions address multiple aspects of screening, diagnosis, staging, treatment and supportive care for these gynaecological conditions. They also acknowledge the input received during the drafting process, and the input from stakeholders to develop and finalise the benefits.

The cervical cancer BD, unfortunately, does not address key issues around prevention and screening, including the HPV vaccines and the frequency and age from which regular pap-smear tests should be available.

While cervical cancers fall under two DTP-PMB codes (954M and 266M, "cancer of cervix – treatable" and "dysplasia of cervix and cervical carcinoma-in-situ; cervical condylomata", respectively), screening for cervical cancer falls under a separate code, 960M, "cervical and breast cancer screening". A definition for screening services has yet to be completed, although the published final cervical cancer definition promises that the CMS will do so.

The definition tries to make recommendations for the minimum level of care, from the first GP or physician visit leading to a suspicion of diagnosis, through to palliation and best supportive care for more advanced disease management.

This includes recommendations for levels of care, and the diagnostic, radiological, surgical and pharmacological modalities that should be paid for as PMB level of care. Certain exclusions have also been named in the document as specifically not PMB level of care.

In the ovarian cancer PMB definition, the CMS recognises that genetically high-risk patients (e.g. BRCA gene 1 or 2 mutations) are not catered for in the current PMB regulations, and permits schemes to make their own arrangements for risk reduction interventions in these patients.

A number of chemotherapy agents have also been clearly excluded as PMB level of care, as has intraperitoneal chemotherapy.

Vulvovaginal and endometrial cancer definitions provide similar guidance for multiple aspects of management of the disease, and a guide to what medical schemes are supposed to cover as PMB level of care.

Unfortunately, the fragmented current structure of the DTP-PMBs means that screening benefits often fall under one DTP, the management of the condition under another and finally, the palliative or long-term aspects under yet another, or even a chronic disease PMB.

As it is well accepted that palliation begins early in disease processes, not only in the terminal phases, and given that screening and early detection are integral parts of disease prevention and management, it is easy to see how this fragmented regulatory arrangement contributes to fragmented patient management.

SAMA encourages active participation by members with skills and experience in the areas to be addressed

SAMA encourages all clinicians potentially affected to consult the BDs on the CMS website (www.medicalschemes.com; click on the "publications" tab at the top, and then find the "PMB Definition Project" tab down the side of the page). We also published the links to the PMB definitions in the SAMA newsletter in April and May 2019.

Upcoming PMB definitions

During 2019 so far, SAMA has also submitted to and participated in BD committees on mental health emergencies, schizophrenia and bipolar disorder, and breast cancers. We anticipate that these will be published as final definitions in the near future.

As these BDs continue to inform member benefits both directly in the present and into the future, SAMA encourages active participation by members with skills and experience in the areas to be addressed, while the PMBs are under review.

We are very grateful for the membership inputs we have received on the gynaecological cancers definitions, as well as the assistance in review provided by the SA Society of Obstetrics and Gynaecology (SASOG).

The importance and influence of clinicians in this definition process cannot be overstated.

For queries or more information, contact the KMRD: 012 481 2043.

Starting working life: An intern's perspective

Dr Jacques Geldenhuys

After acquiring my MB ChB at Stellenbosch University in Cape Town, my passion for rural medicine brought me to do my internship in KwaZulu-Natal. I have just completed my first 4-month rotation as an intern in the department of Obstetrics and Gynaecology at Queen Nandi Regional Hospital (QNRH), located in Empangeni.

Learning when to say "yes" and when to say "no" is crucial

The first challenge was budgeting for food, accommodation and transport for the month before the first paycheck arrived. After an orientation session and sorting out administration with the HR department at the hospital, we started working full time. This was daunting, but as interns we always work under supervision/consultation, easing the anxiety of our newly acquired responsibilities. Working days consist of seeing and managing patients (either in the ward or in a clinic) and performing procedures. Over the 4 months at QNRH, I performed about 40 caesarean sections and 20 manual vacuum aspirations, and removed 5 ectopic pregnancies, among other, smaller, procedures.

We worked at least one call shift a week on which we were the first responder to the gynaecology emergency arrivals, assisted in all operations and oversaw patients in the latent phase of labour. This was usually enough to keep us up all night long, but if you were lucky, you would get an hour or two's worth of light sleep between the phone-calls that always seemed to come just as you were falling asleep. Anyone who has experienced jet-lag or sleep deprivation knows what the feeling of brain fog and body aches for the next 2 days is like. Repeat this on a weekly basis and it's no surprise that so many doctors struggle with mental wellness and interpersonal relations.

As new working professionals, we are hunted down by service providers offering everything from insurance to loans, investment opportunities and subscriptions



Interns in the department of Obstetrics and Gynaecology at Queen Nandi Regional Hospital: back, left to right, Dr Geldenhuys, Dr Malende (intern curator), Dr Muanza, Dr Grant, Dr Dube; front, left to right, Dr Chipulu, Dr Patchitt, Dr Ncane, Dr Dingle, Dr Masinga

for a variety of services. It's often tough to decide which products are necessary, and self-education is the only way to find out. Managing your free time also becomes an art of knowing what's best for you – unwind in front of the TV, sleep, eat, exercise, go out for dinner and drinks, read or study? Eating healthy consistently is important, but tough when you are self-reliant. I managed to have healthy meals by cooking for the week in advance, but when I didn't do this, I found myself eating fast food, and often skipping meals altogether.

It's important for us to recognise our limits

Ethical issues were encountered daily, ranging from the doctor-patient relationship to complex management decisions that needed to be made. One example is when we had to decide whether to actively resuscitate a newborn of 22 weeks' gestational age (non-viable according to SA standards) that had incorrectly been steroid matured (improving its chances of survival). Another common issue we faced was whether or not to abort a pregnancy.

Teamwork comes with its own challenges, and it is easy to get caught up in the politics

of, among other things, hierarchy and exploitation, the amount of time/effort contributed per person, interpersonal relations and patient satisfaction. As a junior doctor, I try to keep things uncomplicated by focusing on doing my part as best I can – and recognising my limits, at which stage I ask for assistance. This approach has made the process easy and without conflict.

Despite its challenges, the sense of responsibility and purpose makes working life much more satisfying than being a student. The fast pace of learning and commitment to one's patients provides a feeling of accomplishment, and managing one's personal life gives one a sense of freedom and pride. Having spoken to fellow interns, I know we're all on the same rollercoaster. Often we feel defeated, unsure of why we are still choosing this path and not knowing whether we're making the right decision. At other times, the learning experience and prospects of the future are exciting. It's easy to feel defeated by work exhaustion and pressure to perform, but beyond the challenges, the privilege of being employed in SA and the innumerable possibilities that lie ahead keep me motivated. It's important for us to recognise our limits. Learning when to say "yes" and when to say "no" is crucial if we want to make the most of our internship years, in order to grow holistically as people as well as professionally as doctors.

Interpretation of rule G: Delegation of postoperative care

Dr Rosanna Naidoo, principal business officer, SAMA Private Practice Department

Standard, uncomplicated postoperative aftercare is incorporated for 4 weeks in the global fee for any surgery, unless otherwise specified (preoperative care, the operation/procedure and postoperative care form part of the global surgical package).

If the standard aftercare is delegated to another registered health professional, and not concluded by the surgeon, it is the surgeon's responsibility to arrange for the service to be rendered without extra charge.

The exception to the rule is a complication of an underlying comorbidity, or other diseases present.

If a specialist of another discipline, such as a physician or cardiologist, codes for aftercare for specific exacerbations or complications of a condition (e.g. cardiac disease) during the global period after surgery, these services are not to be considered part of normal aftercare, and are therefore exceptions to the global period, as stated by rule G of the SAMA Medical Doctors' Coding Manual (MDCM). The medical scheme, and not the referring doctor, is then responsible for receipt of the claim.

It is important to add the appropriate ICD-10 codes to the claim, to indicate the reason that the patient was seen by a specialist of another discipline.

Rule G in the MDCM states:

"Postoperative care:

- (a) Unless otherwise stated, the units in respect of an operation shall include normal aftercare for a period not exceeding 4 weeks (aftercare is excluded from pure diagnostic procedures during which no therapeutic procedures were performed).
- (b) If the normal aftercare is delegated to another registered healthcare professional, and not completed by the surgeon, it shall be his/her own responsibility to arrange for services to be rendered without extra codes.
- (c) When postoperative care of a prolonged or specialised nature is required, the benefit, as may be agreed upon between the surgeon and the scheme or the patient, may be used.
- (d) Normal aftercare refers to an uncomplicated postoperative period not requiring any further incisions.

(e) A complication or exacerbation of an underlying comorbidity that requires care other than normal aftercare for the particular operation will qualify for a follow-up consultation item. Treatment of conditions such as postoperative pneumonia, pyrexia, wound complications, etc., is not considered part of normal aftercare."

Modifier 0006 (regarding visiting specialists performing procedures) is the exception to this rule, in the case of a procedure being done by a specialist in a smaller centre, and the aftercare by the referring doctor, where the specialist has travelled to the smaller centre and performed the procedure, and the patient's GP looks after the patient during the postoperative care period.

Rule G is in place so that the same service is not charged for twice. A surgeon is remunerated for the time needed to care for patients postoperatively, and into their recovery period post discharge. In the event of such care being delegated to a colleague, this would then levy an additional charge. In effect, the patient or medical scheme will be paying twice for the same service.

The SA Society of Anaesthesiologists recommends:

- In the case of an uncomplicated surgical procedure and patient, the surgeon is (in terms of coding rules) remunerated for the care of the patient. Any funder would be within their right not to pay additional fees to other practitioners for this expected standard care.
- In the case of a complicated patient or procedure, additional ICD-10 codes would be appropriate to the patient. This must be reported by any professional delivering care additional to the surgeon's postoperative care. The failure to report these codes gives no insight to a funder as to why a patient required more than expected postoperative care. The primary surgical code should still appear on the colleague's invoice, as well as applicable additional codes. The concerns are that:
 - many schemes expect coding of all parties to match and remain consistent, and will not reimburse outside of this
 - many schemes require the hospital case manager to submit additional ICD-10

codes, but their coding may be incorrect or incomplete, resulting in invoices from the practitioners being rejected

- Certain procedures are inherently more complex due to more intensive postoperative care requirements outside the surgeon's domain of care. Such instances may be poorly catered for with respect to specific ICD-10 coding.
- Cases that require anaesthetic consultations and anaesthesia-related care, such as pain management (outside the domain of the surgeon, e.g. epidural care) in the postoperative patient, are specifically excluded from rule G, and may be reported using the same ICD-10 codes as for surgical procedure.
- Rule G applies also to patients admitted to high care or ICU post procedure. Clearly these patients are more likely to have comorbidities, and may require multidisciplinary care within the prescripts of rule G.

In terms of ICU coding:

- The doctors involved must decide who the primary doctor is. This should be indicated on the ICU chart so that all doctors involved can communicate with him or her.
- A decision needs to be made on the category of the patient, and all involved doctors should use the appropriate codes. The category of the patient should be clearly indicated on the chart by the primary doctor.
- The correct, appropriate, ICD-10 codes should be used by all treating doctors, uniquely identifying their roles in the care of the patient, in addition to the ICD-10 code(s) that affirm the condition for which the procedure was done. ICD-10 coding may need amendment after admission, and hospital administration staff must be encouraged to update these codes daily.

When billing:

- Only one doctor can use item 1204, and the rest use item 0109. Item 1204 should only be used for category 1 patients.
- For category 2 patients, where the primary doctor uses items 1205, 1206 or 1207, all other doctors can only use item 0109.

- For a category 3 or category 2 patient with multi-organ failure, on the first day, the primary doctor uses item 1208, and supporting doctors use item 1209. Item 1210 may be used by the primary doctor as well as the supporting doctors on subsequent days (in other words, one can use item 1210 if the primary doctor is also using item 1210).

Please note that a specialist of another discipline must obtain specific authorisation for the hospital service, and cannot simply ride on the primary specialist for e.g. orthopaedic procedural authorisation.

Many schemes now insist on separate authorisation per clinical and medical necessity for the co-attending multidisciplinary team. Physiotherapist, dietician, occupational

therapist and specialised radiology all require separate pre-authorisation reports.

It is incumbent upon providers to ensure that unique individual services are encoded by accurate descriptive ICD-10 code(s) in the primary position on the account, to enlighten the funder as to multidisciplinary services where more than one doctor is treating the patient for the same condition.

HPCSA guidelines and procedures when selling your practice

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

When selling your practice, certain arrangements need to be made in respect of avoiding patient abandonment and ensuring continuity of care, by notifying patients of the change in ownership and managing the handover of medical records. These arrangements are prescribed by the ethical rules of the HPCSA and good industry practice.

The medical record of a patient is an umbrella term for any documentation or other media that relates to the diagnosis, treatment and care of the patient. It therefore includes clinical notes (handwritten or electronic), reports from laboratories, radiological images and reports, sonograms, audiovisual material (e.g. photographs and video or voice recordings) and printed readings from medical devices.

Notifying patients

In terms of paragraph 10.5 of the HPCSA Guidelines on the Keeping of Patient Records (booklet 9), healthcare practitioners in private practice who are closing their practice (for whatever reason) shall, 3 months prior to closure, inform all their patients in writing that: (i) the practice is being closed as of a specific date; (ii) requests may be made for patient records to be transferred to other healthcare practitioners of their choice; and (iii) after the date concerned, the records will be kept in safe-keeping for a period of at least 12 months by an identified healthcare practitioner or health institution with full authority to deal with the files as he or she may deem appropriate, provided the provisions of the rules on professional confidentiality are observed.

Paragraph 4 of the same set of guidelines states that should a healthcare practitioner in private practice (either a single practice or a partnership) pass away, his or her estate, which includes patient records, will be administered by the executor of the estate. Should the practice be taken over by another healthcare practitioner, the executor shall carry over the records to the new healthcare practitioner. This practitioner is obliged to take reasonable steps to inform all patients of the change in ownership, and explain that they may either remain with the new healthcare practitioner, or request that their records be transferred to another of their choice.

In circumstances other than the practitioner's death, the guidelines do not specifically prescribe how a healthcare practitioner in private practice should go about notifying patients when there is a change in ownership of the practice. However, based on a purposive interpretation of the guidelines, one can infer that the healthcare practitioner selling the practice should inform his or her patients that there will be a change in ownership, and notify them of the date when the practitioner will be leaving

the practice. It is furthermore required that patients be notified that they may remain with the practice, or alternatively, request the transfer of their clinical records to another healthcare practitioner of their choice.

In most practices, it will not be possible to notify individual patients of the change in ownership. In those circumstances, a notice could be placed on the practice website or posted in the waiting room. Only reasonable steps need be taken to notify patients of the change in ownership. It is, however, advisable that patients who are actively consulting the practitioner and still receiving a course of ongoing treatment be informed individually. If a patient in active treatment chooses to change providers, a mechanism should be in place to ensure that the new provider is aware of any outstanding investigations, and that lab or X-ray facilities are aware that those reports should be sent to the new provider. By taking this step, the practitioner should be able to avoid accusations of patient abandonment. Abandonment refers to a situation where a practitioner ceases a course of necessary treatment before the patient has recovered, or terminated the contract with the practitioner,



and where no offer has been made to make arrangements to transfer care to an alternative provider. In this regard, an implied term of the contract between practitioners and patients is that the practitioner will not abandon patients before they are cured or other arrangements for treatment have been made.

Transferring patient records

When it comes to the transfer of patient records, ownership of these vests in the existing owner of the practice. Patients are, however, entitled to copies of their records, and the practitioner may ask a reasonable fee in respect of photocopying charges. However, practitioners should take each individual patient's ability to pay into account in this regard. Levying photocopying charges should not hamper the orderly and timeous transfer of the records. The HPCSA guidelines provide that in cases where patients are required to pay for records (e.g. X-rays or CT scans), such patients must be allowed to retain such records, unless the healthcare practitioner deems it necessary to retain the records for the purpose of monitoring treatment for a given period. As the patient has paid for these particular records, he or she would enjoy ownership of

them. However, should the patient require the records and/or images to further or protect an interest (e.g. consulting with another practitioner) he or she must be allowed to access the originals for these purposes.

In general, a new owner of a practice must keep patient records for at least 6 years after the date that the file became dormant, that is, the date of the last consultation. In the case of minors, or of patients who are mentally incompetent, healthcare practitioners should keep the records for a longer period. For minors under the age of 18 years, health records should be kept until their 21st birthday. This applies equally for obstetric records. For mentally incompetent patients, the records should be kept for the duration of the patient's lifetime. For patients treated in terms of the Occupational Health and Safety Act No. 85 of 1993, health records must be kept for a period of 20 years after treatment.

In addition to the time periods mentioned above, there are a number of other factors that may require health records to be kept for longer periods, but no clear-cut rules exist in this regard. For instance, certain health conditions take a long period to manifest themselves (e.g. asbestosis), and records of

patients who may have been exposed to such conditions should be kept for a sufficient period of time. The HPCSA recommends that this should not be less than 25 years. A balance must be reached between the costs of (indefinite) retention of records (in terms of space, equipment, etc.) and the occasional case where the practitioner's defence of a case of negligence may be handicapped by the absence of records. In cases where significant adverse incidents have occurred and a risk of litigation exists, it is highly advisable that these records be kept for a longer period. For the sake of prudence, arrangements should be made to ensure that these records are not disposed of prematurely, and that a complete set of records is safeguarded.

When selling their practice, practitioners should ensure that patient care is not compromised. Continuity of care ultimately underlies all of the aforementioned recommendations. Practitioners should also implement these procedures in order to protect their own interests, including avoiding a complaint with the HPCSA relating to a failure to comply with the guidelines, and ensuring that a complete set of records will always be available in case of a civil claim or complaint.

Raising awareness during African Vaccination Week

SAMA Communications Department

During African vaccination week (24 - 30 April), SAMA urged all South Africans to find out more about vaccinations available in their area, and to ensure that they and their children are vaccinated.

African Vaccination Week coincides with World Immunisation Week, which this year will be commemorated under the theme #VaccinesWork. This theme is aimed at raising awareness of the importance of full immunisation throughout life.

"Statistics show that vaccines do work, and it is imperative that adults and children are properly immunised. SAMA stands firmly behind these celebrations, which aim to raise awareness and increase the number of vaccinations throughout the country," says Dr Angelique Coetzee, chairperson of SAMA.

Since 2000, the Vaccine Alliance (previously known as the Global Alliance for Vaccines and Immunisation; Gavi) has been working in public-private partnerships with organisations

such as the WHO, UNICEF and the World Bank to increase access to immunisation in 73 poor countries.

One result of these partnerships is that average child mortality in Gavi-supported countries fell from 76 deaths/1 000 live births in 2010 to 63 deaths/11 000 live births in 2015. Gavi supported the vaccination by the end of 2015 of 277 million children.

African leaders have recognised the importance of immunisation and pledged their support through the Immunise Africa 2020 Declaration. The declaration, launched on 8 May 2014, supports the joining of Africa's leaders to invest in the health of Africa's next generation. This joint action is in line with the Sustainable Development Goals, which call for "access to safe, effective, quality and affordable medicines and vaccines for all" by 2030.

In 2017 the number of children immunised – 116.2 million – was the highest ever reported.

New vaccines have been introduced to a total of 113 countries since 2010, with more than 20 million additional children vaccinated. However, vaccines such as measles, rubella and maternal and neonatal tetanus are behind schedule, and over the last 2 years, the world has seen multiple outbreaks of measles, diphtheria and various other vaccine-preventable diseases. Most of the children missing out are those living in the poorest, most marginalised and conflict-affected communities.

"We commend SA programmes such as the AIDS Vaccine Initiative, the TB Vaccine Initiative, the HPV School Vaccination Programme and the Vaccines for Africa Initiative launched by UCT to help reach the goals set for the vaccination of all, in SA and other African countries. In 2016, nearly 17 million vaccines were issued in 24 African countries, which is truly remarkable," notes Dr Coetzee.

We helped, but the Iraqi doctors are the ones who made it work

Dr Sian Geraty, *Doctors Without Borders*



When people think of Doctors Without Borders (Médecins Sans Frontières; MSF), they often picture a group of foreign doctors dealing with extreme emergencies and building hospitals at very short notice to treat people whose lives are under threat. Too little is known about the work behind the headlines – dealing with everyday emergencies. When I first set foot in Sadr City in mid-2018, I understood immediately how that dimension of our work is just as important as the rest of the things we do.

Sadr City is an overcrowded Baghdad neighborhood that is home to some 3.5

million Iraqis. There are just four hospitals to serve this population. MSF supports one of these, a 240-bed facility called the Imam Ali Hospital.

Last year, the emergency room (ER) of Imam Ali Hospital received an average of 20 000 patients per month. This means that the doctors treat up to 700 people per day. This is a massive load for a regular-sized hospital. The high number of patients is caused by various factors including the limited availability of services and high rates of accidents and disease.

The ER is staffed by Iraqi doctors in their first year of practice, under the supervision of a single emergency specialist. In an environment in which threats to doctors are relatively frequent, and where things can quickly become chaotic, these doctors struggle to work to the best of their abilities, and prioritising cases can quickly become a challenge.

An MSF team visited the Imam Ali Hospital in 2017, and immediately proposed improvements to the way the ER worked. We started by providing donations of equipment to the hospital, and went on to renovate the whole ER. We suggested implementing a triage system, which meant adapting the layout of the department.

Triage – the prioritisation of patients' treatment based on the severity of their condition – is not yet implemented in most

medical facilities in Iraq. We were confident that a triage system (MSF uses an adapted version of the South African Triage Score (SATS) in several countries, where it has proved to be very effective) would help everybody in the hospital, both doctors and patients, considerably.

We trained over 80 ER doctors and nurses in how to classify patients correctly using a simple color code: green for patients with non-serious injuries or medical conditions; yellow for patients who are seriously injured or sick, but in a condition that is not immediately life-threatening; and red for patients in need of immediate medical attention.

By the time Imam Ali Hospital's new ER opened in December 2018, doctors and nurses were ready to work with the new system. Since then, the chaos that was a daily challenge has become much more manageable. Doctors and nurses have really adopted this new system and taken ownership of it.

Our team – composed of an emergency doctor, a nursing activity manager, a translator and a community mobiliser – is still in Sadr City. While some members of the MSF team explain how triage works to the people coming in, others provide technical support to the Iraqi doctors. They often thank us for the changes we've made, but I always tell them that while we helped, they are the ones who made it work.

Find out more: www.msf.org.za/medical or Facebook: Doctors Without Borders/ Southern Africa.



Dr Sian Geraty is an SA emergency medicine specialist. She studied at the University of Pretoria and specialised at UCT. Her experience includes working at hospitals in northern KwaZulu-Natal, the Northern Cape and Western Cape. In 2018 and 2019, she spent more than 6 months working with Doctors Without Borders in Sadr City, a crowded neighborhood of the Iraqi capital, Baghdad, where she helped introduce a triage system into this busy hospital's emergency room.

What's new in the management of drug-resistant TB?

Dr Norbert Ndjeka, MDR-TB Director, NDoH

Drug-resistant (DR)-TB is a severe form of TB. The most common form of DR-TB is multidrug-resistant (MDR)-TB. MDR-TB is a form of TB with strains that are resistant to rifampicin and isoniazid (INH) – the strongest drugs used in the treatment of drug-susceptible TB. The most severe form of DR-TB is called extensively drug-resistant (XDR)-TB. XDR-TB patients have strains that are resistant to rifampicin, INH, any injectable agent and any fluoroquinolone.

The WHO estimates that during the year 2017, 558 000 people developed TB that was resistant to rifampicin (RR-TB). Of these 558 000 individuals, 82% were estimated to have MDR-TB, with 160 684 cases of RR/MDR-TB detected and notified. 139 114 of these individuals (87%) were enrolled in treatment globally. Of RR/MDR-TB patients who began treatment in 2015, only 55% were successfully treated, and of XDR-TB patients, 34%.

The treatment success rate for the SA RR/MDR-TB cohort was 55%, with the treatment success rate for the XDR-TB cohort above the global average, at 48%. The 2016 cohort for XDR-TB in SA has shown an improvement, at 58%. SA is the global leader in the implementation of regimens that contain new and repurposed TB drugs.

The introduction of GeneXpert as a diagnostic tool for all presumptive TB cases during 2010 helped to improve the case-finding strategy, as it is possible to diagnose RR-TB within 2 hours in the laboratory. In addition to GeneXpert, all patients found to have RR-TB are tested using first- and second-line line probe assays (LPAs 1 and 2). LPA 1 helps to make a diagnosis of INH-resistant TB, and LPA 2 helps exclude or confirm resistance to second-line agents.

The WHO guidelines for the introduction of the shorter 9 - 11-month regimen for MDR-TB were released in 2016. In a phased approach, starting in 2017, SA began implementing the shorter regimen (kanamycin, moxifloxacin, clofazimine, ethionamide, high-dose INH, pyrazinamide and ethambutol) for patients with MDR-TB, with no demonstrated second-line drug resistance.

SA is the global leader in the implementation of regimens that contain new and repurposed TB drugs

Until recently, aminoglycosides were considered core drugs in the treatment of RR/MDR-TB. The SA TB Control Programme, however, took a decision to remove injectables as core agents from patients' treatment regimens. The shorter MDR-TB regimen includes bedaquiline, levofloxacin, linezolid, clofazimine, high-dose INH, pyrazinamide and ethambutol. Patients on the longer treatment regimen are now treated for 18 to 20 months with bedaquiline, clofazimine, linezolid, levofloxacin and, no longer 24 months. ECG is now used routinely. Hearing tests are only done in patients who are receiving aminoglycosides. Between 2010 and 2016, the death rate among RR/MDR-TB patients in SA fluctuated between 15% and 23%, with an average of 20%. The XDR-TB cohorts in SA have shown a decrease in mortality from 48%

in 2012, to 21% in 2016 (after the introduction of bedaquiline).

SA is the only country in the world that provides injection-free DR-TB treatment for both longer and shorter regimens. A retrospective cohort analysis recently conducted in SA has shown a two- to threefold reduction in mortality among RR/MDR-TB and XDR-TB patients. This is the first time that an intervention in DR-TB has been associated with mortality reduction in at least a decade, or more. Another retrospective cohort analysis that looked at the effect of bedaquiline as a replacement agent among RR/MDR-TB patients on longer treatment regimens in Cape Town showed that bedaquiline replacement was associated with more favourable outcomes in comparison to those who remained on injectable agents.

The SA National TB Control Programme, in partnership with the National Clinical Advisory Committee, has established the Bedaquiline Clinical Access Programme, which aims at improving treatment outcomes for pre- and XDR-TB patients. The interim analysis of this study showed that TB culture conversion was close to 80%. A final analysis indicates a treatment success rate of 73% among these very-difficult-to-treat patients.

The core drugs for the treatment of DR-TB are bedaquiline, linezolid, clofazimine and levofloxacin. Terizidone is back in the longer regimen. Delamanid has just been registered, in March 2019, and we are looking forward to using it as a replacement drug in our longer regimen. This is a promising drug.

Recent changes are bold and in line with the END TB strategy, which aims to eliminate TB by 2035.

References available on request.



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Purchasing SAMA products

Tebogo Sanyane, membership liaison officer, SAMA Private Practice Department

The Private Practice Department (PPD) strives at all times to promote and strengthen the clinical independence of private medical practitioners in SA, in order to allow them the freedom to provide a world-class service to their patients. The PPD is tasked with the critical responsibility of continually updating and publishing the Medical Doctors' Coding Manual (MDCM; previously Doctors' Billing Manual), eMDCM browser and the ICD-10 browser on an annual basis, and the Complete CPT [Current Procedural Terminology] for SA (CCSA) and the eCCSA browser every second year.

Step 1: To purchase these products, please go to the SAMA website, www.samedical.org. For SAMA members, in the top right-hand corner you enter your username and password, or if you have not registered on the website, click on "register" and fill in your details (see Fig. 1).

Fig. 1.

Step 2: Once you are successfully logged into the website, you will be eligible for SAMA discounted rates on all our products, and the first licence of the eMDCM is available free to all members. On the subheading of the website, please click on "SAMA products" for a list of all available products (Fig. 2).

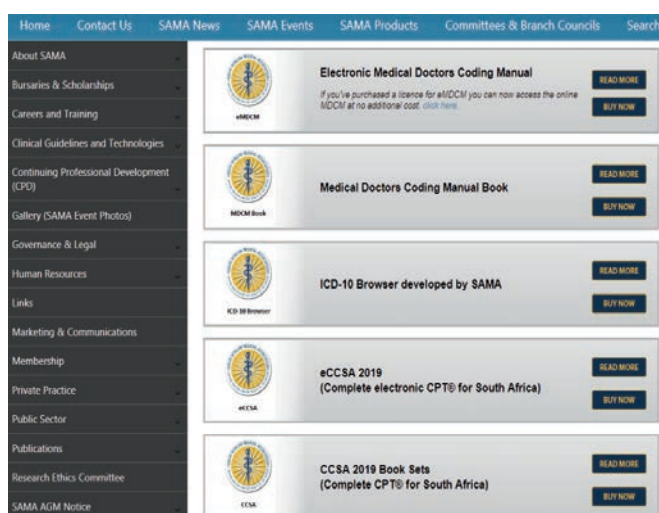


Fig. 2.

Step 3: Click on "buy now" on the product of your choice and fill in all the required information for purchase. The payment options screen is shown (Fig. 3). Remember to accept the terms and conditions to continue with purchasing the product.

Step 4: After a successful online sales transaction you should receive an email from the SAMA website with your invoice and product details:

Fig. 3.

- If you used a credit card, you will receive this immediately after the transaction was successful.
- If you chose to pay by means of an electronic funds transfer (EFT), the system will automatically generate an invoice that will be sent to you at the email address (donotreply@samedical.org) that you provided, from SAMADONOTREPLY (sometimes this email goes directly to your spam or trash emails, so please check there if the email has not been delivered within 48 hours).
- Once the payment is made, please forward the proof of payment to samaproducts@samedical.org.
- Should you not receive this email within 48 working hours after payment, please contact SAMA's Coding Division on 012 481 2073.

Step 5 (electronic products): The SAMA electronic versions of our products (eMDCM, eCCSA and ICD10 Browser) use a Windows-based program, and require the following operating system to run and install on:

- Windows XP/Vista/7/8/10
- Windows.NET framework (this will install automatically if not already on your computer)
- a valid SAMA licence activation key.

Please take note that the electronic versions can only run on Windows. Apple users will not be able to download this program.

The eMDCM browser and ICD-10 browser are updated annually, and are valid from 1 January until 31 December of the year of implementation of the product. For example, the eMDCM 2019 is valid only until 31 December 2019, with a 2-month grace period until 29 February 2020. For eCCSA, the valid period is 2 years, from 1 January 2018 until 31 December 2019, with a grace period until 29 February 2020.

For all SAMA electronic products, you will receive an email from SAMADONOTREPLY with the download link and the activation key. Once you have successfully downloaded the product you should be prompted to the screen shown in Fig. 4.

- Refer back to the email from which you downloaded the eMDCM.

Fig. 4.

At the end of the email, you will find an activate key.

- Copy this activation key by double-clicking on the numbers. Alternatively, record this unique key and keep it handy to type into the activation box.
- Return to the SAMA eMDCM and paste/type the activation key into the box provided.
- When you have inserted the activation key, click on “activate”. The program should activate your licence.
- You will now be able to work in the SAMA eBrowser program.

Step 6 (hard-copy books): The SAMA book sets (MDCM and CCSA) have four

different methods of delivery, according to your choice:

- postage (please note that we are experiencing delays with using the postal service – we suggest that you rather use courier door-to-door services to ensure speedy delivery)
- courier (3 - 5 working days)
- collection at SAMA head office (lock F, Castle Walk Corporate Park, Erasmuskloof, Pretoria (office hours 08h00 to 16h30, Monday to Friday)
- collection at HMPG head office (suite 11 Lonsdale Building, Lonsdale Way, Pinelands Cape Town (office hours 08h30 to 16h30, Monday to Friday).

Coding-related queries

The SAMA Coding Division appreciates the fact that doctors are often faced with challenging and difficult scenarios when it comes to coding, not only in their practices, but also when they are off site.

In many instances, doctors are not sure how to bill for a specific case. Therefore, for all SAMA members, for any query or clarity on a specific code, please contact us directly on 012 481 2073. For non-SAMA members, we can only assist via email: they can direct all their coding queries to coding@samedical.org and the turnaround time may be 3 - 5 working days. This time frame is also dependent on the volume of emails the division receives.

Recruitment and selection processes for the employer

Phumzile Gwala, *industrial relations advisor, SAMA Public Sector Department*

An employer’s managerial prerogative (or the right to make decisions and to manage its organisation) in terms of recruitment and selection processes relates to the ability to choose a manager, or to appoint an employee of its choice. The person or organisation with the prerogative has a right that others – such as employees or job applicants – do not have. This right is weighed against the question of whether a job applicant has a right to be appointed to a position, and whether he or she can therefore challenge the managerial prerogative of the employer or manager, and demand to be appointed. Therefore, to what extent, if any, is the decision-making power of the employer curtailed by labour law, and by claims of fairness by employees?

In “The concept of managerial prerogative in SA labour law”, Jean Chrysostome Kanamugire discusses managerial prerogative in two respects:

- the power to manage industrial capital; and
- the power to command labour.

This basically means that an employer owns the capital, and has the power to decide how to control its affairs. In the workplace set-up, an employee works in order to survive; on the other hand, the employer allocates tasks to employees, which must be done adequately.

Since 1994, managerial prerogative has been severely restricted by the legislature, to protect both employers and employees. An employer has the right to appoint or recruit employees in the workplace. The Employment Equity Act No. 55 of 1998 (EEA) requires employers to have an explicit employment policy that implements affirmative action (AA), to benefit previously disadvantaged groups.

“There is no right or entitlement to a promotion or an appointment to a post”

The right to appoint an applicant belongs to the employer; however, this right is not absolute. The employer must comply with the principles of fairness, and cannot contravene legislation, for example, the EEA or the Basic Conditions of Employment Act No. 75 of 1997 – and this right is also limited by the right of the job applicant not to be unfairly discriminated against.

In practice, the employer, subject to legal obligations and fairness, retains the

prerogative in terms of whom to appoint. AA is not a right that employees have. In *Dudley v City of Cape Town*, the court stressed that AA is collective in nature; it is not a right, but rather a means to achieve equality in the workplace. The employee can therefore not sue the employer for not appointing him or her as an AA candidate. The employer, however, can use AA as a shield to explain why preference is given to a designated employee over a non-designated employee.

In exercising its managerial prerogative in recruitment and job appointment, an employer has to take not only its own internal values, such as efficiency, economic realities and employee loyalty, into account, but, because it is part of broader society and for economic reasons, also demonstrate concern about being socially responsive, and simply being a good corporate citizen. It may therefore validly look at external values such as AA. At the workplace, the employer has the prerogative to vary the manner in which employment decisions are made; this prerogative must, however, be applied fairly, and within the law.

In the context of unfair labour practices (as defined in section 186 (2) of the Labour Relations Act No. 66 of 1995), an employee does not have a remedy against unfair conduct on the part of the employer



in respect of appointments or filling of vacant posts. This means that if a dispute is about an appointment (or, in most cases, a non-appointment), the Commission for Conciliation, Mediation and Arbitration (CCMA) does not have jurisdiction. The difference between filling a vacant post and appointing a new applicant arises from the fact that the two candidates may have a different relationship with the decision-maker. The former is an employee of the decision-maker, who claims an unfair act relating to the appointment process, whereas the latter has no existing employment relationship with the decision-maker, and wants to be appointed to a particular position.

If the applicant cannot establish that a specific fact, for example, a lack of promotion, falls within the ambit of an unfair labour practice, then the issue will be about the failure to appoint, which cannot be regulated by the CCMA or the Labour Court. This dispute is then in essence one of "interest" and not one of "right." The employee or applicant has an interest in being appointed, but no right that can be judicially enforced by way of action in the CCMA or the Labour Court. The employer's managerial prerogative to appoint the most suitable candidate still maintains, however, within the framework of fairness and legal principles, as set out in labour law and legislation.

Case law

In *Ngcobo v Standard Bank of Southern Africa*, the Labour Court held that "there is no right or entitlement to a promotion or an appointment to a post. Arbitrators and courts must be reluctant to interfere with the employer's prerogative to promote or appoint unless there is unfairness. The employee not appointed to a position failed to show unfairness in the process of selection." In paragraph 33 of this judgement, the court reiterated that "the CCMA and this court should not be used as avenues to willy-nilly appoint and promote employees who have a sense of entitlement when they cannot match that with competencies. This court in particular should show its displeasure at such abuse." The review application was dismissed with costs.

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SAMA position on Caster Semenya and the IAAF

SAMA Communications Department

SAMA has been following with concern the case of Caster Semenya and the International Association of Athletics Federations (IAAF)'s new rules to regulate testosterone levels in female athletes. The following media releases were issued on 26 April and, following the Court of Arbitration for Sport's rejection of Semenya's challenge, 2 May, stating SAMA's position on the matter.

SAMA backs call for physicians not to implement IAAF rules on classifying women athletes

SAMA welcomes the call by the WMA for physicians around the world to take no part in implementing new eligibility regulations for classifying female athletes.

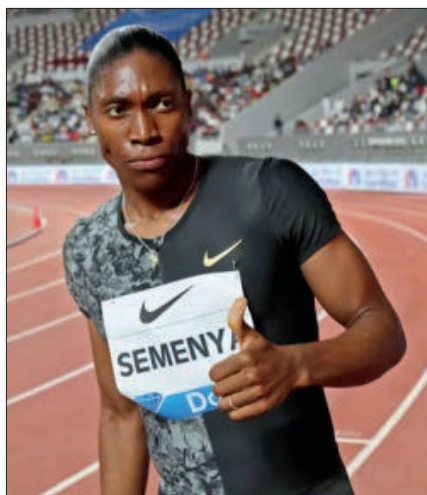
In a statement released on 25 April 2019, the WMA noted, "The regulations from the IAAF require women athletes with specific differences in sex development (DSDs) to medically reduce their natural blood testosterone level if they wish to continue racing as women in a few restricted events."

The WMA referred to the case involving SA's Caster Semenya, who has had to undergo gender verification testing to confirm her eligibility to compete in the women's division.

The Court of Arbitration for Sport is due to issue a decision on the IAAF regulations. "Not only do we welcome this call by the WMA, we endorse its demand for the immediate withdrawal of the DSD rule, which was introduced last year. In a statement we issued in February we noted that these practices by the IAAF constitute a systematic affront to the dignity of all female athletes, a position we still firmly hold," says Dr Angelique Coetzee, chairperson of SAMA, who recently attended the WMA Council meeting in Santiago, Chile.

At the meeting, the WMA demanded the immediate withdrawal of the regulations. It said that they constitute flagrant discrimination based on the genetic variation of female athletes, and are contrary to international medical ethics and human rights standards.

The WMA further noted: "Following an initiative by the South African Medical Association, the WMA fears the regulations would constrain the athletes concerned to take unjustified medication, not based on



medical need, in order for them to be allowed to compete, and accordingly require physicians to prescribe such medication."

The WMA also said it is in general considered unethical for physicians to prescribe treatment for excessive endogenous testosterone if the condition is not recognised as pathological.

"Based on this, we support the WMA's call on physicians to oppose and refuse to perform any test or administer any treatment or medicine that is not in accordance with medical ethics, and that might be harmful to the athlete using it, especially in artificially modifying blood constituents, biochemistry or endogenous testosterone," says Dr Coetzee.

WMA president Dr Leonid Eidelman concurs.

"We have strong reservations about the ethical validity of these regulations. They are based on weak evidence from a single study, which is currently being widely debated by the scientific community. They are also contrary to a number of key WMA ethical statements and declarations, and as such we are calling for their immediate withdrawal," he concludes.

SAMA disappointed, shocked at Semenya ruling

SAMA expresses its deep disappointment with the loss of the court challenge by Olympic champion Caster Semenya at the Court of Arbitration for Sport in Geneva, Switzerland. Semenya challenged the International Association of Athletics Federation's rule forcing female athletes to regulate their testosterone levels.

SASOP statement: Caster Semenya

The International Association of Athletics Federations (IAAF)'s proposed new rule at the end of this month [April] on testosterone limits for female athletes is medically unethical and a violation of human rights, and fails to recognise the evidence for natural variation in human gender, says SA's professional body for psychiatry.

The SA Society of Psychiatrists (SASOP) said gender verification technologies had revealed "a broad diversity of anatomical, genetic and hormonal conditions that go beyond binary gender as applied in sport, and make eligibility rulings based on anatomical or chromosomally assigned sex impossible".

SASOP spokesperson Dr Anusha Lachman said the IAAF's stance contributed to discrimination and stigma attached to naturally occurring differences in gender and sexual identity, sexual development and orientation.

"Such discrimination deprives people with differences in sexual development of their basic human rights, limiting them in achieving personal, social and occupational fulfilment, and can lead to their marginalisation from society.

"The IAAF rule is being imposed on questionable grounds of 'health', and has no basis in scientific fact. Forcing athletes to medically alter naturally occurring hormones ignores the potential negative consequences to their physical and mental health, and is an invasion of their privacy and right to dignity," Dr Lachman said.

She said the IAAF was violating the long-standing principle that athletes compete on the basis of natural talent, by "imposing an artificial intervention to alter their natural ability".

SASOP supports the SA government's #NaturallySuperior campaign to back Semenya in her fight to compete in her natural state, Dr Lachman said.

"We supported the WMA's demand for the immediate withdrawal of the differences of sex development rule, which we believe constitutes a systematic affront to the dignity of all female athletes. This ruling today is both shocking and disconcerting. This certainly cannot be the way forward for sport," says Dr Angelique Coetzee, chairperson of SAMA, in reacting to the news.

Dr Coetzee says SAMA will stand firmly behind Semenya should she wish to appeal

the ruling in the Swiss Federal Tribunal. Semenya has 30 days to lodge her appeal, should she wish to do so.

"That a world-class athlete has to endure this level of discrimination is unacceptable, unnecessary and harmful," notes Dr Coetzee.

The WMA has reiterated its advice to physicians around the world to take no part in implementing the new eligibility regulations for classifying female athletes.

SA Minister of Sports and Recreation Tokozile Xasa said on 13 May that the government will support Athletics SA's appeal against the outcome at the Court of Arbitration for Sport. Semenya has 30 days from 1 May to file an appeal. Xasa also announced that he intends to approach the UN General Assembly to sanction the IAAF for "violating international human rights instruments".

Your financial health

Gert Viljoen, *VPROF*

This month Gert Viljoen updates us on tax and solar energy and the broadening of the VAT base for electronic services (e-services).

Solar energy: You can deduct costs upfront

Solar power is often touted as a key factor in reducing the damage we are inflicting on our environment. South Africans will also be looking for ways to reduce the very serious impact of loadshedding, which regrettably seems likely to continue plaguing both our business and our personal lives for some time to come.

The good news is the tax relief available to businesses on the costs of solar energy plants. We summarise a recent SARS binding ruling that set out what deductions will be allowable, and which confirmed that SARS will allow the costs of solar power units. The capital costs that may be deducted are:

- photovoltaic solar panels
- AC inverters
- DC combiner boxes
- racking
- cables and wiring.

In addition, related allowable costs of installation are:

- installation planning expenses
- panel delivery costs
- installation expenses
- installation safety officer costs.

If the solar unit per site generates less than 1 megawatt of power, the full cost is allowable in the year that the plant was commissioned, according to the ruling. If the equipment

generates 1 megawatt or more, then 50% can be deducted in year 1, 30% in year 2 and 20% in year 3. Note that if the company is a small business corporation (SBC), the capital allowances under the SBC tax allowance regime (i.e. 50/30/20) must be claimed.

Remember that the normal rules apply in terms of qualifying for a deduction: the plant must be owned by the taxpayer; it must be used for the purposes of trade by the taxpayer; and it must be brought into first time use by the taxpayer.

This is good news for people tired of load shedding.

VAT for e-services from foreign suppliers

The VAT base for e-services has been considerably broadened with effect from 1 April 2019, and both suppliers (who may well now need to register for VAT) and their customers ought to know how the new provisions will affect them.

Of particular significance are the new definition of electronic services (which, having been specifically listed in the draft regulations, are now defined very widely) and the inclusion of business-to-business (B2B) supplies.

Businesses in particular should understand both how wide the net is now cast, and what exclusions from the definition still apply. This has been causing waves since SARS stated its intention to make e-services subject to VAT last year. Now, the final regulations have been published, and are in effect as of 1 April 2019.

Of significance is the change in the definition of electronic services – in the

original draft regulations, e-services were specifically listed, but the new definition is very wide: "any services supplied by means of an electronic agent, electronic communication or the internet for any consideration".

Furthermore, the inclusion of B2B supplies is a significant departure from the global trend to only include business-to-consumer supplies, as the former is an "in-and-out", increasing the tax administrative cost rather than tax collections.

The exclusions from the definition remain:

- educational services supplied from a place in an export country and regulated by an educational authority in terms of the laws of that export country; or
- telecommunications services; or
- services supplied from a place in an export country by a company that is not a resident of the Republic to a company that is a resident of the Republic, if:
 - both those companies form part of the same group of companies; and
 - the company that is not a resident of the Republic itself supplies those services exclusively for the purposes of consumption of those services by the company that is a resident of the Republic.

If in doubt, speak to your accountant about this.

VPROF is a medical practice administrator, medical bureau and professional accounting firm dedicated to supporting the business activities and patient care of independent medical practices around SA.

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.

Our thanks to Dr Wim Beukes for his letter below and to Hanneke Verwey for her response.



Re: May one charge for cancellations and no-shows?

Thank you for the featured article on the conundrum we face for no-shows and cancellations of appointments. The change in the HPCSA's ethical ruling still leaves some vague questions around practicality and the definitions in some of the statements. The article has four bullet points underpinning the process:

- The time frame for a cancellation before an appointment seems fair.
- On the second point, I would like to know what evidence you need to provide to confirm you could not fill the appointment space, especially if it was a no-show. For

specialists, the time frame allocated for a patient is very often hourly. In GP practice it is only 15 minutes, so logistically not filling it is practically impossible to do or to prove.

- The third point is valid and fair – it is stated in the contract the patient signs at GP when new patients/families are enrolled.
- The fourth point seems unfair to the service provider. It is not the provider's responsibility to establish reasons for a no-show or cancellation. If death or hospitalisation is the cause, then yes, I agree. I would argue that if the patient/

user is informed of the no-show/cancellation policy, they should be billed for no-show. We are reimbursed for the time of the consultation. The other fact to remember is that the fee for a no-show is less than half of a consultation, not even full reimbursement.

The ruling seems fair and practical for cancellations, but no-shows should have a fee payable.

Dr Wim Beukes

Family Physician, Malmesbury

The query above from Dr Beukes is in response to the article "May one charge for cancellations and no-shows?" published in the April 2019 edition of SAMA Insider. See response from Hanneke Verwey below. Ed

In terms of a recent notice published by the HPCSA, practitioners may charge fees for patients who do not show up for appointments or who do not cancel appointments timeously, provided that the practitioner complies with the requirements set out in the Council's notice.

Some of our readers have pointed out that it will, practically, be very difficult to comply with the requirements, especially

the requirement that one must "provide evidence" of a failure to find an alternative patient between the time of receiving the cancellation notice and the time of the cancelled appointment, "sufficient proof" that the patient was informed about the cancellation of appointments policy and first "establish the reasons" for the patient's failure to cancel or honour the appointment.

SAMA agrees that complying with these requirements will place an additional burden on administrative staff, and that depending on what the Council means by "proof" and "evidence", it might not be possible at all, in some circumstances. It will likely require, at the very least, that the practice make a

note in the practice diary that an alternative patient could not be scheduled in that time slot. Patients may need to sign the cancellation policy, or might have to be informed of the policy upon making the appointment. At the minimum, a conspicuous notice detailing the policy could be displayed at the practice. Prior to sending the patient the account, staff might have to contact the patient to inquire about the reasons for not honouring the appointment.

SAMA is engaging with the HPCSA for further guidance in this regard, and we will keep our members updated.

Hanneke Verwey

Legal advisor, SAMA Governance and Legal Unit

Problematic pacemaker placement

The Medical Protection Society shares a case report from their files

M r U, a 29-year-old teacher, was referred to Dr N, a specialist cardiologist, with a history of several episodes of dizziness, perspiration and palpitations. A 24-hour ECG had shown episodes of tachycardia and bradycardia, and second-degree Mobitz type II heart block was demonstrated when symptomatic.

It is important to take extra care suturing the leads during a revision procedure

Dr N recommended a procedure to insert a permanent pacemaker, to which Mr U consented. The procedure was straightforward, with the post-procedure chest X-ray and pacemaker check both recorded as satisfactory. Mr U was discharged home.

Six weeks later, a routine pacemaker check demonstrated a high threshold in the ventricular lead (which could signify potential pacemaker failure), despite satisfactory positions on the chest X-ray. Dr N prescribed a short course of steroids.

The following month, Mr U was admitted to hospital with left-sided chest pain and episodes of tachycardia and bradycardia. Dr N undertook an exploration of the pacemaker system and replaced the ventricular lead. Dr N reviewed the post-intervention chest X-ray and felt that it was satisfactory; the patient was discharged.

Mr U was readmitted by ambulance late that evening: a pacemaker check demonstrated that the ventricular lead did not capture the ventricle.

The following day, Dr N re-sited the ventricular lead and re-advanced the atrial lead. Again, the post-procedure chest X-ray and pacemaker check were judged by Dr N to be satisfactory. Mr U was kept under observation for 2 days, and advised to keep



his arms still. Dr N's notes stated that he suspected Twiddler's Syndrome, which occurs when a patient manipulates the pacemaker's pulse generator and dislodges the leads from their intended location.

A week later, another pacemaker check demonstrated a failure of the pacemaker and the ventricular lead. Mr U, unhappy with his care so far, asked to see a second cardiologist.

He was referred to Dr B, who undertook a revision of the pacemaker. She found that the suture sleeves were loose and that both leads were mobile. Following the procedure, a pacemaker check and chest X-ray were both satisfactory, and Mr U was discharged home. He had no further problems with his pacemaker following Dr B's intervention.

Mr U made a clinical negligence claim against Dr N, alleging that in the second and third procedures, he had failed to secure the leads to prevent them from moving, and that he had failed to check appropriate lead positioning during and after the procedures.

Expert opinion

The Medical Protection Society sought expert opinion from a specialist cardiologist. The expert was critical of several aspects of the care provided by Dr N.

First, the expert found that the post-procedure chest X-rays from the second and third procedures showed unsatisfactory lead positions, which would have made lead dislodgement likely. Also, she could find no evidence of Twiddler's Syndrome on any chest X-ray.

The expert also noted that, in the fourth procedure, Dr B could not find evidence of lead sutures, suggesting that the leads were not secured adequately.

Based on the expert opinion, the case was deemed indefensible, and was settled for a moderate sum.

Learning points

It is important to take extra care suturing the leads during a revision procedure, especially if there has already been an episode of lead migration.

Twiddler's Syndrome is a well-known but infrequent cause of pacemaker malfunction. A chest X-ray would usually show the two leads migrated to the same degree and rotation as the pulse generator, so making the diagnosis.



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



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