A doctor’s journey through Gaza

Why doctors are not punching bags

Dispensing licences become permanent
The prevalence of allergy is increasing worldwide, particularly in urbanised communities. Asthma is thought to occur in at least 1 in 10 people, and allergic rhinitis may occur in 1 in 5, irrespective of race or socio-economic status. Therefore, all family practitioners, irrespective of which communities they serve, will probably see patients with hay fever every working day. In many instances the diagnosis is made easily, but sometimes the diagnosis is difficult to make and investigations will help to confirm the diagnosis of allergy and the attendant inflammatory airway disease. The wide range of allergy tests available requires a logical approach to selecting the most cost effective and appropriate test for each individual.

This course will cover the following modules:

- Allergic rhinitis
- Respiratory allergy
- Skin allergy
- Systemic allergy
- Food allergy and intolerance.

**COURSE FEE, DATES AND VENUE**

R 3400 (inclusive of all VAT and taxes where applicable)

8 - 9 March 2014 - Durban

Dealing with patients who present in an emergency department or as urgent appointments at a doctor’s consulting rooms can provide complex diagnostic challenges. The symptoms may be atypical and yet potentially life threatening. Normal routines are disrupted and the clinician has to cope with many interruptions and distractions. Unfortunately, in such settings significant mistakes can be made. This course has been specially developed by experienced emergency medicine experts to equip doctors and nurses to understand the main reasons for diagnostic errors, the types of patients and the kinds of problems that are the main reasons for missing a potentially life threatening diagnosis.

This course will cover the following modules:

- The Emergency Department as an error prone environment (including equipment).
- Medical mistakes and high risk patients.
- Clinical reasoning.
- High risk presentations.
- Safety in triage, disposition and discharge.

**COURSE FEE, DATES AND VENUE**

R 1500 (inclusive of all VAT and taxes where applicable)

29 March 2014 - Bloemfontein

Contact us for all your clinical and management training requirements
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Website: www.foundation.co.za
Twitter: @FPD_SA
Facebook: Foundation for Professional Development

The Foundation for Professional Development (FPD) was established in October 1997 by the South African Medical Association one of the oldest not-for-profit organizations in South Africa.

FPD is currently the largest self funding educational provider in the health sector in South Africa. All workshops are offered nationwide throughout the year.

FPD is an accredited service provider for continuous professional development (CPD) by the Medical and Dental Professions Board of the Health Professions Council of South Africa (HPCSA).
Helping the helpless

It doesn’t take the average medical graduate long before they realise how much the real world differs from medical school. Within the space of a few short months, they are plucked from an often self-congratulatory atmosphere of academic prestige and late nights hunched over Grant’s Atlas of Anatomy and dropped in a high-pressure environment of 18-hour shifts where the slightest mistake could lose someone their life. There are as many horror stories as there are doctors: plugging arteries with one’s fingers, performing surgeries on the floor due to a lack of beds or not being relieved for 48 hours.

After such a nightmarish day at work, it is no wonder many doctors feel their salaries are small compensation for the trauma they have had to endure, and some choose to forego compensation altogether. There has been a surge of interest in medical volunteer organisations lately, with many doctors devoting their time to treating disadvantaged persons at home and abroad. We take a look at one doctor’s recollections of her time among the war-wounded in Gaza on pages 6 and 7.

We also check in with the SAMA Trade Union’s General Secretary, Dr Mahlane Pahlane, who writes about the national doctor-bashing mentality on pages 8 and 9, while former SAMA chairman Dr Norman Mabasa keeps members informed about dispensing licences on pages 16 and 17.

SAMAREC/CPD SERVICES AVAILABLE:

- South Africa Medical Association Research and Ethics Committee - SAMAREC
- South African Medical Association Continued Professional Development Accreditation

Our Mission:
- Empowering Doctors to bring health to the nation
- Excellent Service
- Quick Turnaround
- Efficiency

WHAT WE ARE ABOUT

SAMAREC:

- 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

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## End-of-life decisions – some ethical considerations

### From the President’s Desk

Prof. Ames Dhill, President, SAMA

**M**y first duty as President was to represent SAMA day after my inauguration on the television programme Rights and Recourse. The agenda was a debate on legalising euthanasia and four of us participated in the show. Two were vociferous on the merits of legally allowing such a practice. The other was a psychiatrist, a bridge of clinical data, and I was the only one voicing the need for life. My responses were informed by ethical analysis and drew from international and local guidelines and codes.

The issue of euthanasia resurfaced in South Africa after Professor Sean Davison, an academic from the Western Cape, faced a charge in New Zealand of attempting to murder, in 2006, his terminally ill mother. His High Court trial ended late in 2011 with the Court withdrawing the attempted murder charge and Davison pleading guilty to a lesser charge of procuring and inciting his mother’s death. Dignity South Africa, an organisation founded by Davison on his return to South Africa, has lobbied for assisted suicide to be legalised in the country.

From the international perspective, I drew on four sets of guidelines from the World Medical Association (WMA) which we as SAMA members subscribe to: They are:
- The WMA Declaration of Venice on Terminal Illness (adopted by the 35th WMA Assembly, Venice Italy October 1983 and revised by the 57th WMA Assembly in SA, October 2006);
- WMA Declaration on End of Life Medical Care (adopted by the 63rd WMA Assembly in Montevideo, Uruguay, October 2011);
- WMA Declaration on Euthanasia (adopted by the 38th WMA Assembly, Madrid, Spain in October 1987 and reaffirmed by the 170th WMA Council in Divonne-les-Bains, France May 2005); and
- WMA Resolution on Euthanasia (adopted by the 53rd WMA Assembly, Washington, USA, October 2002 and reaffirmed with minor revision by the 194th WMA Council in Bali, Indonesia, April 2013).

The Declaration of Venice recognises the fact that complex ethical issues will arise when dealing with end-of-life care and therefore questions regarding euthanasia and physician-assisted suicide are inevitable. However, the WMA condemns both these acts as unethical. It states that while advances in medical science have improved the ability of physicians to address many issues associated with end-of-life care, the latter is an area of medicine that has not received the attention it deserves. The dying process must be recognised as integral to a person’s life and hence dying is integral to living. The primary responsibilities of the physician are to assist the patient in maintaining an optimal quality of life by addressing their psychosocial needs and controlling their symptoms so that they remain comfortable and retain their dignity until the very end. Therefore, assistance can be administered by appropriate clinical pain management, or even by using sedative drugs, while ensuring that other issues are addressed. The Declaration states that the act of assisting to die is not to be equated with assisted suicide, as such a practice is not morally acceptable. Furthermore, palliative sedation cannot be used for this purpose. This places an obligation on practitioners to follow the directives and the designation of substitute decision makes in the event that the patient is not able to communicate. The Declaration further states that the HPCSA finds assistance is adopted into law in some countries, and that physicians should refrain from participating in such activities.

Under South African law euthanasia is not legal and is considered to be murder. The End of Life Decisions Bill, which if passed as an Act would have legalised euthanasia, was debated in parliament in 2000 but has not progressed any further. With regard to ethical guidelines for the professions, the HPCSA’s Booklet 12 on Guidelines for the withdrawing or withholding of treatment states that the HPCSA finds euthanasia, or the willful act of causing the death of a patient, by a practitioner unacceptable. While there seems to be a lack of clarity among some members in the legal fraternity regarding the acceptability of the Living Will, the HPCSA gives credence to this document when it states that patients should be given the opportunity and encouraged to indicate their wishes regarding further treatment and to place in writing their directives for future care in possible critical circumstances. It further states that an appropriately drafted living will may be used for this purpose. This places an obligation on practitioners to follow the directives and wishes of the patient as contained in the living will. Failing to do so, would be tantamount to disrespecting the patient’s choices and autonomy.

During the television programme, I became clear that the massive strides made in the discipline of palliative care are not understood and appreciated by many. Living life in dignity right to the very end is a reality. The answer should perhaps be that more energy and focus be directed to improving access to high-quality palliative care.

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**SAMA INSIDER**

**February 2014**
Healthcare in besieged Gaza

Aayesha J Soni, Vice Chairperson, Media Review Network

The views expressed in this article are not necessarily those of the South African Medical Association.

Volunteer for a good cause

I n today’s increasingly profit-driven health sector, many doctors are becoming disillusioned with the contrast between the actual world of medicine and the lofty ideals of the Hippocratic Oath. Even conservative and outdated research indicates that doctors are nearly twice as likely to commit suicide than members of the general population. Rates of chronic depression and stress-related disorders are also markedly high among physicians, and understandably so – a constant exposure to pain and death on the one hand and cynical money-making – a constant exposure to pain and death on the other is hardly conducive to mental equilibrium.

For this reason, many doctors have decided to volunteer their time to worthy causes – for the benefit of their fellow man return with a sense of purpose and fulfilment not often encountered in everyday medical practice. Most can unanimously endorse the power of this transformative experience, so do yourself a favour and consider volunteer work at least once in your career.

Volunteer Recruitment office

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Doctors are not punching bags
Dr Mahlane Pablane, General Secretary, SAMA Trade Union

There is a growing and gnawing tendency in South Africa where anyone thinks that doctors can and should be reduced to a punching bag of some sort. It seems to give some people great joy if they make the life of a doctor more disastrous and distasteful. Doctors are only considered essential service workers when their goodwill is misused or even abused. The convenient status of being essential is discretionary, used only as a weapon to blackmail doctors into submission or slavery, and quickly discarded when doctors deserve some basic needs and decent treatment. It is pivotal to remember that charity begins at home, and that it is because of the character and behaviour of most medical doctors that we find ourselves in this shocking state. No one would even dream of doing these kinds of things to teachers or municipal workers, but we have reduced ourselves to a soft target and a punching bag for everyone. We are often apathetic, selfish to the core by thinking that doctors can and should be treated as less than nobles. We must urgently address this issue before it becomes too late to correct.

If doctors really were essential workers their requests for equipment would not fall on deaf ears
• Most doctors do not even have a restroom or a kitchen at their workplace; compare this with the five-star facilities in the management buildings in the same hospitals.
• Simple and cheap things like shaded parking are a luxury to the doctors; money would rather be wasted on obsolete technological systems or equipment.
• The call rooms for most hospitals are inhabitable; dirty, poor hygiene, breaking furniture and lack of basic things such as a study table, a fridge or even a fan. This is in stark contrast to the big flat screens in the boardrooms, or even in labour wards where it is3Sister interested in watching TV.
• There is no danger allowance for doctors despite their work being a daily fighting with diseases and death itself; how many doctors have been assaulted, raped or even killed while on duty, without any compensation? How many doctors have contracted TB while at work without any compensation?
• Doctors are allocated to institutions without consultation, thrown into departments by force, put on the call roster with indifference.
• Most doctors are thrown to the wolves when they relocate to new jobs, compare with this the relocation benefits given to other civil servants: people are given a travelling allowance and accommodated in hotels for months.
• Doctors are forced to work extra-overtime with no pay; and the new trend is to even cut down or completely abolish it for certain departments without any consultation or consideration.
• The general hatred of a doctor is visible; tangible and palpable from the hospital gate to the porch corner offices of management and even in the corridors of power. People only appreciate doctors when they have their loved ones needing medical treatment, especially emergency medical care.

Let us compare this with the overtime forms administrators submit for doing work they were supposed to have done anyway during normal working hours. It is ridiculous to say certain specialties do not do much work at night, though it indeed will never be the same, but overtime work is overtime work regardless of the department. Why are people working in other departments, such as the mortuary, not subjected to the same treatment when it comes to overtime? No one will be punished for doing work in the mortuary because there were so many dead bodies received for a particular night, but why should doctors be punished because there were not that many patients on a particular call? We have never heard of any bomb squad members or firefighters losing their salaries because there was little or no work done by them during a particular period.

It is a great tragedy when even the politicians can carelessly label doctors “a bunch of tsotsis” with impunity. It gets excruciatingly painful when the reports from the regulatory body are sensationalised with headings such as “doctors are drunkards and drug addicts.” The brutal and painful truth is that a medical doctor is reduced to nobody, a non-essential worker and a punching bag. The biggest tragedy is when all these missiles directed at medical doctors and the medical profession itself are now targeting the very core of its existence: politicians interfering and management dictating to the doctors who, where, when and how to treat patients.

If doctors were essential workers then their requests for life saving equipments and medication would not fall on deaf ears and blind eyes, in preference for non-value adding things such as landscaping. If indeed their worth in saving life was fairly considered then rewarding them handsomely for the work done would not be such a big problem.

The greatest tragedy comes when even the politicians can carelessly label doctors “a bunch of tsotsis” with impunity
There is an onslaught on the salaries of medical doctors; it is starting right under our noses. We ignore it at our own peril, or we will perish as the entire medical profession. First it was the abolition of the RMDP, then the issue of extra-overtime, and now it is on the commuted overtime itself. What a mess! How many doctors can survive without their commuted overtime salaries? These abrupt and unilateral changes in the work and salary structure of medical doctors are unfair, disruptive, demoralising and downright provocative.

If you are not affected personally yet, it is a matter of time, soon you will be screaming for help. All of us need to have a reality check; we need each other more than we think, unity is power. Let us not fall into the divide and rule strategy of those plotting our demise. We cannot afford to do nothing. Leadership without strong membership on the ground is powerless. Let us start a bottom up crusade to champion the interests and rights of doctors. An injury to one doctor should be an injury to the entire medical profession. If we achieve this, we can reverse all the ill and prevent future bigger ills threatening our noble profession.

Steve Biko Centre awarded prestigious titles
The Steve Biko Centre for Bioethics was recently awarded the World Medical Association Co-operating Centre status and appointed to the South African Unit of the UNESCO International Network in Bioethics.

These accolades come at a time when the director of the Centre, Professor Arnes Dha, has been working relentlessly with the World Medical Association (WMA) on the revision of the Declaration of Helsinki, a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data. Two prominent international awards such as these are evidence that the Centre is recognised for its current academic standards both locally and globally.

The central role that the South African Medical Association (SAMA) has played in the Centre’s WMA achievement must be highlighted. SAMA recognised the expertise in the Steve Biko Centre and both facilitated and funded the nomination of the Centre in the WMA Working Group of the Declaration of Helsinki. This is a clear example of the important role SAMA plays in supporting academia.

The Steve Biko Centre for Bioethics at Wits is the fifth centre to be given WMA Cooperating Centre status, joining the Centre for Global Health and Medical Diplomacy at the University of North Florida on Medical Leadership and Medical Diplomacy, the Centre for Study of International Medical Policies and Practices at George-Mason University in Fairfax, Virginia, USA on Microbial resistance and development of public health policy, the Institute of Ethics and History of Medicine at the University of Tubingen in Germany, and the Istituto de dritto della salute at the University of Neuchatel in Switzerland.

“One of the past one and a half years Professor Dha has participated in the World Medical Association’s revision of the Declaration of Helsinki. As such the WMA has come to recognise the contribution that she can make to their work,” says Professor Mkhulu Lalelhle, Head of the School of Clinical Medicine at the Wits Faculty of Health Sciences.

“Being a WMA Cooperating Centre will add substantially to the international and national profile of the Centre and is in line with compliment to the Centre, the country and the continent for what it stands for and what it does in the medical world. It is quite an achievement and one I am extremely proud of,” says Professor Dha.

The Steve Biko Centre publishes the South African Journal of Bioethics and Law, a bi-annual peer reviewed journal that covers matters related to ethics, law and human rights. You can download the journal (open access) via the journal website: http://www.sajbl.org.za
Social networks important for seriously ill children

Just Footprints Foundation

The most frequent concern expressed by children who are being treated for cancer is disappointment in missing activities and time with friends. This is of greater concern for them than treatment procedures or side effects.

This research finding, by USA-based SeriousFun Children’s Network (formerly Association of Hole in the Wall Camps) underlines the experience of the Just Footprints Foundation, a South African organisation that provides camping experiences for children with serious health and life challenges. Just Footprints camps are modelled on those of SeriousFun Children’s Network.

Just-Footprints-Champion, Leonie Jooste, says that children who are undergoing treatment for serious illnesses often miss out on school and social events because of the time spent receiving treatment, and recovering from its side effects.

“
This leaves them feeling isolated from their peers, which in turn leads to loneliness and depression.

“Our aim at Just Footprints Foundation is to create a fun-filled time for these children, in which they are surrounded by other children with similar life challenges. Our camps provide many opportunities for children to receive and give each other social support, whether through counselling by volunteers, or through the friendships they form with their peers on camp,” she adds.

Ms Jooste said that the experience of the Just Footprints camps correlated with those of SeriousFun Children’s Network camps in the USA in that they provide children an opportunity, as an important context in which children build strong networks of social support and feel socially connected to peers, counselors and other campers.

SeriousFun Children’s Network research involved a survey of and interviews with families of children who attended camps organised by the USA organisation.

“Social support at camp was associated with increased feelings of self-esteem and self-worth, positive emotions and the use of effective coping mechanisms. Interactions with peers, older children and adults provided opportunities for campers to feel socially connected to networks of social support.

Moreover, children viewed older campers and counsellors as role models. Having role models gave children an opportunity to see others coping with and adapting to many of the same struggles they faced, and helped them to think about what they may encounter as they grow older.

“Role models also provided children with models for how to cope with the stresses and challenges related to serious medical illness. These relationships also provided children with hope for the future as well as more appreciation for their own experiences, and increased their gratitude and sympathy for those who were suffering from more severe illnesses.”

The research also highlighted the opportunity that camp provides for children to increase their sense of independence and experience a healthy separation from their families.

“Children with serious medical illness spend a significant amount of time in close contact with their families and, for many, this was their first experience away from home for such a lengthy period of time (not including hospital stays). Although the separation was initially difficult for most children, feedback indicates that their sense of independence and self-confidence increased during this separation.”

Since the founding of Just Footprints Foundation in 2008, nearly 1500 children have been given the experience of a lifetime, at no cost to the children, through 32 camps in three provinces.

The five-day camp programmes are designed to leave an indelible footprint on the lives of the children attending them. For most of them, the challenges they face have all but stripped them of the opportunity to be just children, to experience all the fun and sheer joy of life that should be part of childhood.

Many of them are fighting an heroic battle with a serious illness. Some of them may need the help of assistive devices. Others may need to be always close to medical attention. Still others may be living with HIV and a strict regime of medication. Or they may be part of a sibling-headed household for which every day is a battle to survive in a hostile world.

A sparkling time is in store for the children on our camps as their days are filled with the joy of childhood. Whether through the creativity of an arts and crafts workshop, the fascination of story-telling, the bonding of team work – everything is geared towards making this a special and memorable time for each child.

FPD Business School – training tomorrow’s leaders

The Business School has been a part of the FPD journey for the past 15 years, reaching new heights every year in establishing a footprint of training excellence.

We pride ourselves on choosing faculties based on their exceptional skills, experience and ability to continuously research, explore and apply new and dynamic practices in the classroom.

We also enable independent learning through our distance courses as well as the self-study aspect of our combination courses. Our workshops are facilitated in a problem-based and integrated approach through case studies and role-play.

The Business School emphasises translating management and theory into practical workplace skills. This is ensured through our educational approach, our panel of national and international subject expert faculty and our willingness to customise training programmes for our market.

Enrol now for an inspiring experience that will renew your leadership potential and strategic direction in life! Courses include the ever-popular Certificate in Practice Management (CPM), aimed at practice managers and health professionals in private practice, or who plan to go into private practice, the Diploma in Advanced Health Management (DAHM) aimed at individuals who hold management positions in the healthcare environment and the Certificate in Risk Assessment and Management (CRAM) aimed at healthcare managers and hospital care managers.

There are also plenty of short courses available. Often these courses comprise a self-study module coupled with a one or two day interactive workshop. Available short courses include courses on corporate governance, HR management, marketing and communications, personal effectiveness, project management, strategic planning, conference organisation, resource mobilisation and donor relations, B-BBEE, clinical issues in health risk assessment and diversity management.

Every course the FPD Business School offers is aimed at improving the leadership ability of healthcare providers and increasing the efficiency of the organisations they serve.

The FPD is registered with the Department of Education as a Private Institution of Higher Learning under the Higher Education Act of 1997, so you know you are getting a recognised, quality education whenever you sign up for one of these courses.

Since 1998, no less than 233 000 students have received qualifications through the FPD. In 2013 alone 32 525 students enrolled for courses. With such a track record, it is no wonder that medical doctors, nurses, educators, law counsellors and healthcare managers all view the FPD as their training institution of choice.

For more information, phone 012 816 9900/9099 or email: fdpadm@foundation.co.za

SEDASA congratulates first group of AHMP candidates

Dr Kallie Spenser, SEDASA

The Senior Doctors Association of South Africa (SEDASA) would like to congratulate the first group of graduates to complete the Advanced Health Management Programme (AHMP) which is co-certified by the Yale School of Public Health and the Foundation for Professional Development (FPD). This is an intensive management development short course (it takes one year to complete) that is tailor made for African healthcare executives and professionals in the public or not-for-profit sector.

This course has been customised for healthcare managers working in the field of HIV/AIDS and is designed to take into account the time constraints of managers who work full-time. The programme is designed to develop the participants’ strategic management capabilities by broadening their views of their roles in the HIV sector and developing key managerial competencies required to successfully manage in such an environment.

With the onset of the National Health Insurance, SEDASA encourages the position of healthcare managers to be filled by doctors.

Courses like these educate and empower doctors to successfully perform these functions. This group of students were the product of a successful partnership between the SEDASA (Senior Employed Doctors Association of South Africa) and FPD.

According to SEDASA Chairperson, Dr Zamaere Bery, “These doctors represent the first step in a long journey and commitment to empowering health care managers in South Africa. We believe that healthcare should be managed by those who understand it well and are able to create environments that encourage patient and staff wellbeing similarly.”

We would proudly like to congratulate the following SEDASA members who have graduated from this programme:

• Dr H Chirwa
• Dr Joubert

Dr H Chirwa is passionate about hospital management and health systems, with a desire to become a health systems specialist.

• Dr Joubert is a specialist physician at Kimberley Hospital.

Dr M Obida. Dr Obida works at Tshihlimbini Regional Hospital as a Family Medicine specialist.

• Dr E Osiakwe. Dr Osiakwe currently works at Ngwelezeana Hospital.

• Dr S Peters: Dr Peters works at Mahatma Gandhi Memorial Hospital in Phoenix.

SEDASA congratulates first group of AHMP candidates

Dr Kallie Spenser, SEDASA
SAMA Trade Union calls for ‘stay in school and succeed’ campaign

Dr Phophi Ramathuba, President, SAMA Trade Union

The South African Medical Association Trade Union calls for all school-going children in general, and township and rural school children in particular, to stay in school and make success a success of their schooling. We call upon all stakeholders to make Nelson Mandela’s legacy and values on education a reality as he strongly believed that “education is the great engine of personal development. It is through education that a daughter of a peasant can become a doctor, that the son of a mine worker can become the head of the mine, and that the child of farm workers can become the president of a great nation. It is what we make out of what we have, not what we are given, that separates one person from another”. We are indeed fully aware that the only way we became doctors and managed to escape extreme poverty.

We call upon all doctors to visit their nearest schools and offer their services and time. We call upon all doctors to adopt at least one school and provide mentorship, career guidance and health education. There is currently a tremendous shortage of workers in the healthcare sector and doctors should encourage school learners to strive for careers in this sector, whether as nurses, doctors, researchers, administrators or allied service workers. We further expand this noble call to all other professionals and organisations that share the same ideals and hope to work together for a more significant and positive impact on our education system.

[Doctors] need help young people deal with challenges that prevent them from getting a high quality education

We invite all doctors to visit their nearest schools and offer their services and time. We call upon all doctors to adopt at least one school and provide mentorship, career guidance and health education. There is currently a tremendous shortage of workers in the healthcare sector and doctors should encourage school learners to strive for careers in this sector, whether as nurses, doctors, researchers, administrators or allied service workers. We further expand this noble call to all other professionals and organisations that share the same ideals and hope to work together for a more significant and positive impact on our education system.

Pay your annual HPCSA fees

SAMA Legal and Governance Department

The Health Professions Council of SA (HPCSA) published Board Notice 1 of 2014 in the Government Gazette on 3 January 2014 and intends to prescript the annual fees payable by registered practitioners as set out in the schedule. The amount of the annual fee payable for 2014 by medical practitioners is R1 318 and that for medical practitioners as specialists is R1 343.

The schedule of all annual fees payable to the HPCSA is available on the Council’s website under http://www.hpcsasso.co.za > fees > Annual fees.

The annual fees payable by persons registering with the Council for the first time, in terms of the Health Professions Act 1974, will be a pro rata amount of the applicable annual fee and will be calculated according to the month of registration after the due date for payment of annual fees.

We wish to remind members of the South African Medical Association that the annual fees payable by persons registered with the Council is due and payable with effect from 1 April 2014.

New online service eases Compensation Fund claims

Department of Labour

In an effort to improve service delivery, the Compensation Fund introduced a number of new online services in December 2013.

This enables both employers and medical service providers to hand in COIDA-related claims online in an attempt to get rid of the phenomenal backlog of current claims and shorten the time it takes for claims to be processed.

It allows users to request, print or determine the validity of ‘good standing’ letters; report injuries on duty; check on the status of their claims and upload medical reports and bills.

To gain access to these services, go to http://www.labour.gov.za/DOL/Services and create a user account.

If you have difficulty accessing these services, phone 0866 105 350 or email cfcaseinput@labour.gov.za.

Member profile: Dr Meshack Mbokota

SAMA’s Western Cape branch in 2010. He became the youngest-ever acting head of the Private Practice Department at SAMA in April 2013.

After completing his studies at Tuks in 2006, Jacques became an Exco member of the Junior Doctors Association of South Africa (JUDASA) and the honorary secretary of SAMA’s Western Cape branch in 2010. He was appointed Strategic Account Manager in SAMA’s Private Practice Department in 2010. Jacques is very eager to continue the work he started at SAMA in his subsequent career: “In all future endeavours I will continue to strive to improve the lives of medical professionals.”

We wish to remind members of the South African Medical Association, are no longer allowed to publish articles. As a result, we have not made any explicit mention of the role of specialists in these challenges and the general direction of private practice in South Africa.

As the head of SAMA’s Specialists in Private Practice Committee (SPPC), Dr Meshack Mbokota has an insider’s view on some of the most important decisions in South African medicine. As a long-serving obstetrician and gynaecologist in private practice himself, Dr Mbokota has firsthand knowledge of the difficulties that specialists face. We asked him for his take on these challenges and the general direction of private practice in South Africa.

What are the biggest challenges facing specialists today?

Unfortunately, the biggest challenge is the current confusion about tariffs. This is an explosive situation that has been caused by the fact that we, the South African Medical Association, are no longer allowed to publish tariffs in the Doctor’s Billing Manual we publish annually. Instead, a situation has developed where the HPCSA is trying to implement a new set of guideline tariffs without consulting us. This is indeed a great pity. Another thing that troubles us is the fact that there is no explicit mention of the role of specialists in private practice in the NHG Green Paper. We remain hopeful that this situation will be remedied in the White paper, which should be arriving anytime soon.

What are your thoughts about the looming NHI programme?

As a specialist who has watched the NHS develop over time, I am quite optimistic for the simple fact that is it the duty of doctors to fight for the provision of health services to the general population, not only those who can afford it. The NHG will completely level our society in terms of healthcare – rich and poor alike will have access to the same level of basic care, and this is indeed a wonderful thing. Also, if this programme is properly implemented, it will mean that we can finally switch our system from a curative one, which only focuses on symptoms, to a preventative one that will stop diseases from occurring.

What concerns you most about South African healthcare?

The fact that we have an increasing burden of diseases, particularly lifestyle diseases such as diabetes, that are exerting tremendous pressure on our health system. I am also worried about both government and private funding of healthcare. It seems to me that medical fund managers hardly ever remunerate doctors properly, especially in private practice, where the cost of running a practice is never covered in payups. In the end the patient suffers, since the doctors are forced to raise their prices to cover their practice fees. This causes a lot of confusion in the market.
Risk Management in medical practice and hospitals

Negligence is a legal concept. It does not mean neglect or wilful misconduct, but a failure to attain a reasonable standard of care. Any doctor can make an easy mistake, and some are legally indefensible, others are not, what is important is whether the management can be defended by a responsible body of professional opinion. In cases of negligence, the only example available in law is financial compensation: damages are paid to restore claimants to the position they would have been in had the negligent act not occurred. Before damages are payable, however, the claimant must prove all three of the following: a) they were owed a duty of care; b) there was a breach of that duty of care; c) damage was suffered as a result.

Adopt accepted practice

Accepted practice is easy to define in some areas – prescribing in accordance with the recommendations of the South African Medicines and Pharmacology Council. Increasingly, proper practice has to be based on evidence (i.e., determined by systematic methods based on literature review, critical appraisal, meta-analysis and grading of recommendations by strength of evidence).

Accepted methods of investigation and treatment are often described by clinical guidelines. Such evidence-based guidelines improve the quality of clinical decisions, help replace outdated practices, and provide benchmarks for clinical audit. Guidelines are not directives, so in theory you may choose to exercise your discretion by deciding not to follow a particular guideline. In reality, however, you should only deviate from the accepted practice embodied in the guidelines if you have very good reasons for doing so.

If your judgment is called into question, you will have to demonstrate why you were justified in not complying with the guidelines. Conversely, if you follow respectable clinical guidelines and base your decisions on evidence, you will be in a very strong position if a complaint is made against you.

Act within your limitations

Although you are not expected to be infallible, the law expects that, as a doctor, you exercise a reasonable standard of skill and care at all times. As a general rule, you should not undertake tasks that are beyond your competence. The exception is if you find yourself in a situation where a patient will die or sustain severe and permanent injury without urgent intervention and you are the only (or most experienced) doctor available. Ideally, you should ensure that sufficient help and equipment are available for any procedure you undertake, and for the management of all foreseeable complications.

Keep up to date

Under the terms of your registration with the Health Professions Council, you are obliged to continually update your professional knowledge and skills. This usually means enrolling in some form of formal learning programme on a subject relevant to your clinical practice in order to earn credits. It also requires that you keep abreast of developments in your field by regular reading of relevant journals and published guidelines. Successful CPD depends to a great extent on planning, and you should be in working order before beginning any procedure. This advice applies not only to complex machinery and software, but also to identifying those things they have not come across before, and easy to do because it means finding out what you don’t know or, as Maslow put it, your unconscious incompetence. Abraham Maslow, at a later stage of the stages of learning back in the 1940s, and it’s still widely employed by educationalists. It’s a simple model – two acts (unconscious and conscious) and three stages of learning in our competence.

Other things to consider are ensuring that you have replacement, such as batteries and bulbs, available if needed, the cleanliness of the equipment or instrument, whether you know what to do if a crucial piece of equipment – such as a defibrillator machine or a ventilator – fails and whether emergency equipment (e.g., a mask and bag) is available, knowing the whereabouts of back-up equipment, whether you’ve been taught how to use the equipment and know how to run operational checks or troubleshoot common problems.

Delegate appropriately

In the context of multidisciplinary and cross-agency teamwork, it can be difficult to distinguish between delegating and shared responsibility. The question is really one of accountability and clarity about who is responsible for each aspect of a patient’s care. As a member of a clinical team, you will have ongoing responsibilities for the care of patients, some of which you may delegate to staff who do not belong to a registration category in the organisation. In these circumstances you would be held accountable for the actions of those staff members, so you must satisfy yourself that they are competent to take on the duties you are delegating to them and supervise them if necessary. The matter is a little different when you delegate to professional colleagues. You would not be held responsible for the actions of another registered professional, but you would still be expected to delegate appropriately (i.e., to a colleague with the appropriate training and skills) and to have provided them with sufficient information to carry out the task assigned to them. If a colleague delegates tasks to you, make sure that you are properly briefed and if the task lies outside your expertise, say so.

Keep comprehensive records

The medical record is an essential component of patient care. A good medical record will contain all the information one clinician needs to properly supervise and direct another practitioner’s risk, you must seek medical advice and, if necessary, stop or reduce your practice. The safety of your patients should be your prime concern. If you do not already have one, register with a family doctor, apart from simple and obvious conditions such as common colds or sore throats, you should not rely on self-diagnosis and treatment. Your GP will be able to provide a better sense of perspective than you can, and if he thinks you are not fit to work you should heed his/ her opinion.

Check equipment

Be fully conversant with any equipment you use – it is correctly good and good practice is predicated on an accurate assessment of learning needs. Before you can assess your learning needs, however, you need to identify them – something they are conscious of the deficits that easy to do because it means finding out what you don’t know or, as Maslow put it, your unconscious incompetence. Abraham Maslow, at a later stage of the stages of learning back in the 1940s, and it’s still widely employed by educationalists. It’s a simple model – two acts (unconscious and conscious) and three stages of learning in our competence.

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Medication errors account for a high level of

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A zero should be written in

Avoid prescribing errors

Errors should be prescribed only when they are necessary for treatment following a clear diagnosis. Not all patients or conditions need a prescription for drugs. In certain conditions simple advice and non-drug treatment may be more suitable. In all cases carefully consider the expected benefit of a prescribed medication against potential risks. This is important during pregnancy where the risk to both mother and foetus must be considered.

All prescriptions should:

• be written legibly in ink by the prescriber with the full name and address of the patient, and signed with the date on the prescription form;

• have contact details of the prescriber e.g., name and telephone number.

In all prescription writing the following should be noted:

• the name of the drug or preparation should be written in full using the generic name, if they exist;

• no abbreviations should be used due to the risk of misinterpretation. Avoid the Greek µw: µrcg as an abbreviation for medication;

• avoid unnecessary use of decimal points and only where decimal points are unavoidable when writing figures in the front of the decimal point where there is no other figure, e.g., 2 mg not 0.2 mg or 0.5 ml and not 0.5 ml;

• avoid Greek and Roman letter abbreviations which cause considerable confusion – qd, qod, tds, tid, etc. Instead either state the frequency in terms of time (i.e., every 8 hours) or times per day in numerals (i.e, 4x/day).

State the treatment regimen in full e.g.,

• drug name, strength

• dose frequency

• duration of treatment e.g. amoxilin 250 mg 1000 mg tid for 5 days

• in the case of ‘as required’ a minimum dose interval should be specified. e.g., 4 hours as required

• most monthly outpatient prescriptions for chronic medication are for 28 days, check that the patient will be able to access a repeat before the 28 days are up.

• after writing a script, check that you have stated the dose, dose units, route, frequency, and duration for each item. Consider whether the number of items is too great to be practical for the patient, and check that there are not redundant items or potentially important drug interactions. Check that the prescription is dated and that the patient’s name and folder number are on the prescription card. Only then sign the prescription, and as well as signing provide some other way for the pharmacy staff to identify you if there are problems (print your name, use a stamp, or use a prescriber number from your institution’s pharmacy).

Acknowledgement: The above article forms part of the MIPS risk management booklets and has been published with consent from the MIPS.
Dispensing doctors breathe a sigh of relief as all dispensing licences are now permanent

Dr Norman Mabasa, Chairman, National Convention on Dispensing

The National Convention on Dispensing has landed a final blow to the infamous regulations on dispensing licences. You need to have been a dispensing doctor in 1995 and more specifically in 2003 to recall the sequence of events outlined briefly below, in order to appreciate this achievement fully. It all started with the publication of the National Drug Policy document in 1995 which declared that no doctor or nurse or any other persons will be allowed to dispense medicines within a 5 km radius from a pharmacy. If you were lucky to be outside that radius you were required to apply for a licence and fulfil certain criteria in order to get the licence. It was not to be a foregone conclusion that an application would result in a dispensing licence and proved to be more difficult than obtaining a liquor licence. In 2003 the Department of Health (DoH) published regulations which were to guide the process of the commencement of dispensation or annihilation of a dispensing doctor. Needless to say, many doctors stopped dispensing and others left the profession to pursue other interests. Just to recap, the following was required:

Dispensing doctors have won the last of their battles to effectively nullify most of the requirements around dispensing licences in the much contested regulations of the Medicines and Related Substances Act that came into effect in 2003.

From this year, doctors with valid dispensing licences will no longer be obliged to renew them once obtained and these licences will remain valid indefinitely.

Protection of Personal Information Act: What medical practitioners need to know

Rebecca Mooketsi, SAMA LegaAdvisor

The Protection of Personal Information Act seeks to regulate the processing of personal information by both public and private bodies, in pursuance of the constitutional right to privacy entrenched in Section 14 of the constitution. The Act applies to the processing of personal information by or on behalf of a responsible party or on behalf of a responsible party domiciled in South Africa or by using automated or non-automated means in South Africa.

The Act defines ‘personal information’ as information relating to an identifiable, living, natural person, and where it is applicable, information relating to an identifiable, living, natural person, and where it is applicable, the name itself would reveal information about the person.

Dispensing doctors felt the pinch of the first course came at a price. All hell broke loose. There were approximately 7 000 dispensing doctors at the time and the course cost an average of R2 400 per head. At least R1 700 was amassed in one fell swoop. Talk of modern-day tender frauds or a lotto win (no good).

Other paraphernalia formed part of the process and I mention a few below:

• You were to advertise for 30 days before you applied and required to attach a copy of that advert to your application form – many of which got lost and you battled to reconstruct your story. Newspapers charged between R40 and R500 x 7 000 medical practitioners excluding nurses both in public and private sectors. Newspapers even issued adverts offering to advertise dispensing licence applications. This was one of the biggest tenders which would go down in history as the worst exploitation of health professionals by the DoH.

• You were to motivate to convince the Director-General (DG) why you think you must be given a dispensing licence. In fact some doctors compiled ‘miri-bibles’ to try and compile a convincing story on why they wanted to dispense. Others even appointed law firms to do it professionally (I am serious here).

• You also had to compile a list of all dispensers, including pharmacists, other professionals in your area and give the distances from your intended dispensing rooms. Anybody could object to your application. Pharmacists even established an objection website whereupon sighting your advert in the newspaper they would assay your application to convince the DG otherwise, and indeed such objections are rumoured to have been sent.

• You then had to give measurements of your building.

Once you had been through the whole rigmarole and got your licence you had to pay R800 annually to maintain your licence. Multiply that by 7 000 (now 10 000) medical practitioners.

You were to renew at the cost of R 1 000 in the third year without forgetting your R800 ‘maintenance fee’ so the third year would leave a dispensing doctor R1 800 poorer. On applying for renewal the original paraphernalia of adverts, motivations, objections, etc. applied.

The NCD took the Department to court and won their first victory in 2005 when the Constitutional Court declared the requirement that prevented them from dispensing within a 5 km radius from pharmacies, unconstitutional and invalid. In the following years, the NCD also won their fight against the publication of advertisements, the high annual licence fee and the low dispensing fees.

Enough about this historical nightmare. I am happy to report that all that is now in the past after the NCD engaged the DoH and received a warm welcome, thanks to the Minister of Health Dr Aaron Motsoaledi and the Director-General, Ms Precious Matshoso.

An agreement reached between the National Convention on Dispensing (NCD) and the DoH after the publication of an amendment to the 2003 regulations in the Government Gazette on 14 October last year.

The scrapping of the three-year (now five-year) renewal requirement will effectively save the country’s 10 000 dispensing doctors a total of R10m as they had to pay R1 000 for each renewal. It will also bring an end to the frustrating administration process at the DoH that often delayed renewal notices, resulting in medical schemes not paying doctors for the medicines they dispensed after the expiry date.

There was initial confusion around the interpretation of the amended regulations, which required one more renewal before a permanent licence would be granted. However, in December the DoH accepted recommendations from the NCD that no further renewals will be required from doctors in possession of valid dispensing licences.

Provide that they pay their annual fees. It was also agreed that the Department would issue revised licences with no expiry date reflected to replace existing valid licences without the holders having to submit any further documentation.

The Department has been requested to send statements to all current licence holders reflecting outstanding fees or other amounts owing and give them six months to settle before bringing their accounts up to date. The NCD emphasised that no doctor should be penalised if the Department cannot provide proof that a statement was sent out. It also wants an online database set up of all dispensing doctors with valid licences, which will allow them to verify their details and ensure that they are informed about the Department’s requirements.

The Department sent a letter to the Board of Healthcare Funders (BHFs) in December 2013 to notify medical schemes that the expiry date of all licences will be amended to 2028 and that a doctor’s licence can only be revoked if the BHf is advised by the Department to do so on the grounds of non-payment of the annual licence fee. This is to give the Department time to issue all current licence holders with permanent licences. This process could take twelve months. When the licence regulations were implemented, the annual fee was set at R800 but this was reduced to R200 in 2009 following submissions by the NCD. We saved R60m per year.

The battle is not over yet. The NCD remains in existence to fight for the right of dispensing doctors to get a decent dispensing fee which we believe is currently not equitable. Doctors buy medicines from wholesalers at the same price as pharmacists and yet in the dispensing fee is approximately R200.

The NCD has managed all of this because of doctors’ contributions which have enabled us to go to court and to pay our office expenses. The results are there for all of us to see. Doctors are still encouraged to support the office of the NCD financially as we still have to make sure there is no threat to our existence.

I wish to thank all members of the NCD committee who worked tirelessly to achieve this result and veteran activist, Dr Joe Maitane, for his background role.

To contribute or for any inquiries about NCD please contact Mrs Debbie Emslin on 062 955 1752.
In light of the above there is no doubt that the application of the Act is wide enough and applies to all sectors and all information pertaining to natural persons and/or juristic persons, except where processing is purely in the course personal or household use, where the information has been de-identified and cannot be re-identified, where processing is by a public body regarding national security or prevention and detection, by the Cabinet and Committees and Executive Council, where processing is for the purpose of investigation or proof of offenses, prosecution of offenders, execution of sentences or security measures, for exclusive journalistic purposes, relating to judicial functions of the court or exempted in terms of section 37.

According to Section 10(1) personal information may only be processed if the data subject consents to the processing, where processing is necessary to carry out actions for the conclusion or performance of a contract to which the data subject is party; where processing complies with an obligation imposed by law on the responsible party, where processing protects a legitimate interest of the data subject; or the purpose for collection is fulfilled and the information is obtained from a public record.

Section 25 prohibits the processing of personal information concerning a child who is subject to parental control in terms of the law, or data subject’s religious or philosophical beliefs, race or ethnic origin, trade union membership, political opinions, health, sexual orientation and criminal behaviour.

The only exception to the general prohibition against processing personal information concerning a child who is subject to parental control in terms of the law, or data subject’s religious or philosophical beliefs, race or ethnic origin, trade union membership, political opinions, health, sexual orientation and criminal behaviour is where the consent of a competent person to take any action or decision regarding any matter concerning the child is obtained.

In terms of Section 30 the prohibition on processing personal information concerning a data subject’s health or sexual life, as referred to in Section 25, does not apply to the processing by medical professionals, healthcare institutions or facilities or social services, if such processing is necessary for the proper treatment and care of the data subject, or for the administration of the institution or professional practice concerned. Processing by insurance companies, medical aid scheme administrators and managed healthcare organisations is also not prohibited, if such processing is necessary for assessing the risk to be insured by the insurance company or covered by the medical aid scheme and the data subject has not objected to the processing.

Where Section 30 does not apply, processing of prohibited personal information may only take place with the consent of the data subject as or as provided for in Section 10(1). Sections 32-32 provides for further exceptions to the provisions of Section 25.

It is important to note that a private or public body is responsible for the security and integrity of personal health information collected by it. Security measures need to be in place if a third party will process information on the responsible party’s behalf. Personal health information must be collected directly from a person unless consent to collection has been obtained or the information is derived from a public record.

Information may not be retained for longer than is necessary to fulfil the original purpose for collection, except with the data subject’s consent or where retention of records is required by law. Records may be retained where the responsible party requires it for purposes of its lawful functions. Personal information must be destroyed or at least de-identified as soon as practicable once the purpose for collection is fulfilled and the information is no longer required.

The above therefore means that personal information may only be processed by responsible parties subject to an obligation of confidentiality by virtue of office, employment, profession or legal provision, or established by a written agreement between the responsible party and the data subject and where no such agreement and/or obligation exists the responsible party must still treat the information as confidential.

Personal information concerning inherent characteristics may not be processed in respect of a data subject from whom the information concerned has been obtained, unless a serious medical interest prevails; or the processing is necessary for the purpose of scientific research or statistics.

The Medical Protection Society shares a case report from their case files on a 36-year-old woman with myopia, consulted Dr R, an ophthalmologist, with a one week history of pain and blurring of vision in the left eye. Dr R diagnosed anterior uveitis and prescribed corticosteroid eye drops, and proceeded to give a subtenon’s injection of 0.5 ml depomedrol local anaesthesia in the lower outer corner of the left eye.

The patient felt minor pain with the local anaesthetic injection but felt exacerbating pain with the depomedrol injection. Within seconds a black spot blocked the central vision in the left eye. The spot expanded rapidly until the vision was completely lost. Dr R continued injecting till the full dose was given. On examining the left eye Dr R found that the eye was filled with fluid – he arranged a follow-up consultation the next day.

Ms J called later that afternoon to ask if she could see Dr R immediately but was advised to return the next day. Ms J chose to see another ophthalmologist who diagnosed a localized vitreous haemorrhage and referred her to a retinal surgeon, who performed surgery eight hours later.

The retinal detachment was caused by a vitreous haemorrhage, penetrating the eyeball and injecting depomedrol into the eye instead of the intended sub-tenon’s space. She underwent surgery to repair the retinal detachment and remove the intraductal drug but complete removal of the steroid was not possible.

Postoperatively, the retina was flat, but scattered retinal haemorrhage and macular nerve fibre layer oedema was noted. About three weeks later, Ms J developed an inferior retinal detachment, epiretinal membrane and retinal necrosis. She underwent further surgery to remove the epiretinal scar membrane and correct the retinal detachment. Her intraocular pressure was raised postoperatively but was controlled with medical treatment.

The iris subsided, the intracocular pressure normalised and the remaining subretinal steroid dissipated completely within three months. Her final visual acuity was hand movement in the left eye and 6/6 in the right eye. The left eye remained painful and uncomfortable. Ms J had difficulty with near work and computer work, suffered eye strain and easy fatigue in the right eye and experienced frequent headaches and imbalance when walking downstairs.

She was assessed as having 20% impair-ment of vision and 20% impairment of the whole person, with 50% loss of capacity. She also developed depression and was under the care of a psychiatrist. She returned to work six months later but, due to mental distress and intense eye pain, she had to work part-time in a less intense position, and with a lower salary.

Ms J made a complaint and a civil claim. The claim was indefensible and was settled for a substantial sum.

Learning points:
• Ample guidance is available through professional bodies and the scientific literature on the management of common eye conditions. Periocular corticosteroid is not indicated for uncomplicated anterior uveits. Where topical corticosteroids are ineffective, a sub-conjunctival injection of a short acting corticosteroid may be considered. Dr R chose the wrong primary method of treatment, the wrong injectable drug and the wrong route of injecting the drug.
• Periocular injections carry a risk of globe penetration that is much higher in myopic eyes. The records showed no evidence of discussion of indication, risks or alter-natives. No written consent was taken. When a non-standard treatment is offered, a thorough discussion of the indications, risks and alternatives is mandatory and written consent is advisable. Guidance on the principles of taking informed consent is available in a number of different countries.
• Dr R failed to discontinue the injection when the patient had severe pain and loss of vision. Even though the globe had been injured, the extent of damage may have been reduced had he stopped immediately. Immediate exclusion of a penetration either by ultrasound or by clinical examination is mandatory when patient symptoms suggest globe penetration. Failure to do this established a breach in the duty of care. Early diagnosis and referral for emergency intervention may have reduced the extent of the irreversible damage.
• Adverse outcomes and complications are part of a doctor’s working life. Responding to these events in a timely manner, showing respect, being open and communicating honestly to help reduce the impact of these events on both the patient’s wellbeing as well as the doctor’s professionalism.
• A patient can withdraw consent at any time during the procedure. When pain is not what you expect, it is good practice to stop and reconsider your treatment.
READERSHIP SURVEY

Complete this SAMA Insider Readership Survey and you could win an EXECUTIVE GIFT HAMPER worth over R500!

The SAMA Insider is SAMA’s in-house member publication. It is distributed solely to SAMA members and is meant to keep them informed of the association’s activities on their behalf and matters relevant to the national medical landscape. In addition, the Insider showcases local and international medical organisations and the impact they have on South African healthcare.

In an effort to improve the quality of service SAMA provides to its members, we would like you to complete this readership survey and return it to us via fax, postage or email. Doctors who participate will be entered into a lucky draw and could win a luxury executive gift hamper worth over R500!

1. Please give the content of the SAMA Insider a rating from 1 to 5.

2. Please give the visual presentation of the SAMA Insider a rating from 1 to 5.

3. What sort of content would you most like to see in the SAMA Insider?

4. Do the articles in the SAMA Insider accurately reflect the South African medical landscape?

5. Does the SAMA Insider cover the concerns of private doctors adequately?

6. Would you prefer to read a physical or digital/online version of SAMA Insider?

To enter this survey competition, scan a completed survey into your computer and email it to conrads@samedical.org, or fax it to (012) 481 2100 (mark it ‘Att: Conrad’), or post it to PO Box 74789, Lynnwood Ridge, Pretoria, 0040. For more information, phone (012) 481 2041.

Closing date: 28 February 2014
BEETHOVEN'S CAREER SHOULD HAVE ENDED WHEN HE BECAME DEAF. HE DISAGREED.

Some of the world's most treasured music would not have existed had Ludwig Von Beethoven not decided to keep working even after he became deaf. We believe that every professional should have that choice, which is why PPS offers disability cover that pays your benefits in full after an incapacitating accident or illness, even if you decide to continue some degree of work. Sickness or incapacity does not have to be the end of your career. Become a PPS member for this exclusive benefit and you will also have your share in all PPS profits through the PPS Profit-Share Account.

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