SAMA Trade Union
1st elective congress –
quality public healthcare in our lifetime
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Zukiswa Nomnganga

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Interesting times ahead for SAMA, which are likely to impact both healthcare professionals and patients alike. After a long compliance process, SAMA is now a fully fledged and recognised trade union. Doctors in the public service can now rest assured that SAMA is geared up to be more forthcoming in as far as advocating for change in the public sector environment. Core to this will be influencing government policy, negotiating better and improved conditions of employment for our members and dispute resolution – change will be evident in the health sector.

The SAMA Trade Union will host its first elective congress later in the year with a well-fitting theme - Quality Public Healthcare in our lifetime - which is significant to the current state of our healthcare today. This will also enforce policy changes that will have a positive reflection on the profession. Indeed a lot of changes are to be expected and it will certainly not be business as usual for SAMA, as indicated in Dr Ramathuba’s article on the new Trade Union Constitution highlighted in this issue.

The Congress will come shortly after SAMA’s sought-after conference in August; make sure that you have reserved your seat to be enthralled with relevant topics and well-known and influential speakers in the health sector. It’s not every day that doctors get awarded for their excellence and achievements for their remarkable work done for the profession. A call for nominations is out for SAMA members to nominate their fellow colleagues who deserve to be recognised at the Doctors’ Awards this year.

On the lighter side, the SAMA/IMPS Photography Competition for 2013 has kick-started. The theme for this year is A Day in a life of a Doctor; the idea is to catch a glimpse in our doctors’ day-to-day lives, capture those special moments shared with patients and fellow colleagues. While we embrace change at SAMA, let us all work towards the Association’s core value, that is, uniting doctors for the health of the nation.
Report back: WMA council meeting

One issue, which was of particular importance to the SA delegation, was to get the WMA to make a statement about Prof. Cyril Karabus. We received considerable support from colleagues from around the world. Dr Grootboom had already lobbied for an advisory from the WMA in one of the sub-committees on which he serves, and this was discussed at the Council. The initial suggestion was a very modest condemnation of Prof. Karabus’ current situation, but the SA group managed to persuade our colleagues that the WMA needed to add an advisory about working in the UAE. This was subsequently done and circulated to all members of the NMAs featured on the WMA website, and was sent to over 700 newspapers.

SAMA congratulates Professor Sathekge on international society appointment

Prof. Mike Sathekge, professor and head of the Department of Nuclear Medicine at the University of Pretoria

Prof. Mike Sathekge, who has served several terms on the South African Medical Association (SAMA) board of directors as chairperson of the Education, Science and Technology (EST) committee, was elected following ISOBRE’s fifth congress held at the university in late May as the successor of the former president of ISOBRE, described Prof. Sathekge as one of the leading physicians in the area of infection and inflammation imaging, who is not only an outstanding physician, but also one of the rare scientists in the global nuclear medicine community: “His contributions in this dynamic field are not limited to infection and inflammation imaging,” said Prof. Ocker, “He has initiated novel techniques and has introduced very valuable methodologies and new radiopharmaceuticals in nuclear medicine. There is no doubt in our minds, as the ISOBRE presidium, that we are very fortunate to have him as our president.”

Prof. Matthew Thakur, the Founding President of ISOBRE, which is based in Philadelphia, USA, also acknowledged the contribution made by the University of Pretoria’s Department of Nuclear Medicine to the radio-labelling of blood cells: “I am looking forward to Prof. Sathekge’s labelling white blood cells and taking it further to stem-cell labelling using gallium-68 (g-68).”

Patient care threatened by Free State doctor ban

SAMA Communications

The sudden move by the Free State (FS) Department of Health to ban public sector doctors from working in the private sector was not only in breach of current Remunerative Work Outside the Public Service (RWOPS) agreement, but also a threat to patients relying on their services.

RWOPS is a global public sector policy applicable to all employees appointed on a permanent basis in the public sector. The FS Provincial Government gave notice that it had withdrawn the approval for RWOPS during office hours with immediate effect.

SAMA reported that this was done without any prior consultation with the affected staff. “Due to the previous approved and supported group practice model in the FS, many doctors in the public sector have patients booked well in advance in the part-time private group practice in which they participate,” an angry Dr Deon Menge, President of the FS branch of SAMA, said in his reaction to the banning.

"Withdrawal of the services will compromise the healthcare of these patients. RWOPS,’ Dr Menge stressed, ‘adds invaluable experience and exposure to interventions not available in the public sector. This contributes not only to the motivation, but also to the retention and improvement of the skills of these colleagues. Doctors utilising this model have to date never fallen foul of the required provisions’.

SASA (Senior Doctors’ Association of SA), a SAMA specialist interest group of which Dr Menge is an executive committee member, also expressed “horror” at the unilateral and immediate withdrawal of RWOPS in the FS, “notably because the doctors are bound by contracts currently held with the healthcare providers.”

“RWOPS,’ Dr Menge added, ‘is seen as a mechanism for bridging the division that exists between the public and private sectors, by encouraging healthcare workers to work across sectors. We believe that RWOPS is not the problem, it is the management thereof that poses a challenge. The RWOPS model in the FS is providing a necessary service – the unilateral withdrawal thereof places patient care at risk. Furthermore RWOPS has added the ability to retain necessary public-sector skills. Loss thereof will reverse this”.

The organisation acknowledged that the recently highlighted abuse of RWOPS by some in other provinces is recognised and is not acceptable. However, the deep failure of managing that process is at the root of allowing that problem to develop: the FS actions are yet another example of failed management. The unilateral behaviour of the FS Government can never be regarded as acceptable and unwise years of relationship-building between doctors and the Provincial authorities.

SAMA, Dr Menge pointed out, upholds the principles of honesty, integrity and patient-centeredness and does not condone any unethical practice by its members. However, blanket allegations and rash decisions taken without consultation, he warned, will not improve healthcare delivery in SA. Instead, it will drive highly qualified and desperately needed clinicians out of the public sector.

...numerous, very controversial issues were discussed...

This meeting was interesting and provocative, and it is obvious that involvement with our colleagues internationally brings new insights and emphasises the importance of reviewing the views from around the world. It is obvious that the WMA has a wide constituency; therefore, there are some major discrepancies in developing projects and plans. For example, in SA the death penalty is not acceptable, but even in a first world country such as the USA this continues to be part of their judicial process.

We look forward to the WMA General Assembly in Durban next year and are confident that there will be opportunities for interaction on that occasion. Undoubtedly, this was an important and very valuable meeting and the sympathetic input that we received about Prof. Karabus’ situation in the UAE and with global input on the matter, the Professor has been released and returned to South Africa.

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The World Medical Association (WMA), established in 1947, has attempted to bring together National Medical Associations (NMAs) in a forum where mutual problems may be discussed and controversial issues may be reviewed. The latest Council session took place in Bali, Indonesia, in April 2013 and was attended by representatives from the South African Medical Association (SAMA) and our current chairperson, Dr Muuko Grootboom, a member of the WMA Council.

There are numerous debates as to whether the SA group managed to persuade our colleagues that the WMA needed to add an advisory about working in the UAE. This was subsequently done and circulated to all members of the NMAs featured on the WMA website, and was sent to over 700 newspapers.

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SAMA Conference 2013

The registrations are now open for this year’s SAMA Conference, themed “Changing the Future of Healthcare.” The conference is set to take place at the Birchwood Hotel, Boksburg on 15 – 17 August 2013. The key objective is to bring together policymakers, academics and practitioners to address the way forward in changing the future of healthcare in South Africa.

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Doctors’ awards

The SAMA Doctors’ Awards, administered by SAMA and Bonitas, represents the Association’s annual recognition and acknowledgement of excellence and achievement by the country’s doctors. SAMA members who know of fellow colleagues who have made a remarkable contribution to servicing both the profession and patients, and who are deserving of such recognition, are encouraged to nominate such doctors by contacting SAMA or nominate via the Awards site: www.samomedical.org/awards.

SAMA welcomes Professor Karabus home

The South African Medical Association (SAMA) welcomes Prof Cyril Karabus back home after a protracted ordeal in the United Arab Emirates (UAE). SAMA is delighted at his return, following numerous interventions by health organisations and professionals both locally and globally.

Nine months of Prof. Karabus’ life were consumed, 2 months being spent in jail, after he was arrested in August 2012 at Dubai airport while in transit to South Africa (SA). The manslaughter charges dated back to September 2012 following his retirement from a lifelong career in the SA public health sector.

He was consequently exonerated of all charges. “We express our relief and delight at his return and we would like to express our happiness and joy for his family and thank everyone for the collective effort in supporting the campaign that put pressure on the UAE authorities to release Prof Karabus,” said SAMA Chairman, Dr Mosiuoa Lekota.

Prof. Karabus’ ordeal has once again highlighted that if you stand on principle, everyone for the collective effort in supporting the campaign that put pressure on the UAE authorities to release Prof Karabus,” said SAMA Chairman, Dr Mosiuoa Lekota.

New era: SAMA Trade Union Constitution certified by the registrar of trade unions

Therefore, SAMA will have to conduct its business according to the constitution. We want all members to feel the presence of the constitution through proper representation, which they have been longing for in our medical fraternity. We aim to build a strong medical union in order to bring quality healthcare service to our patients who are ultimately the reason for our existence as doctors.

Branches are currently electing their councils and, for the first time in the history of SAMA, they will be expected to elect a shop steward – a trade union representative – who will be based at the local branch to deal with all trade union related matters at a branch level. The trade union branch chairperson is expected to be elected to deal with workplace representation as well as to act as a shop floor representative who will attend all of our workplace meetings and be able to address doctors’ issues at the hospital or branch level. These cadres will be the basic unit of the organisation. Their existence will also guarantee us organisational growth.

We hope that members are participating in these crucial branch elections to transform the Association. Where provinces have more than one branch, it is expected that the branches will merge and establish the Provincial Executive Committees (PECs). In cases where we only have one branch, the leadership will automatically be the NEC.

Our interest groups are now subcommittees of the trade union namely: JUDASA, SARA, ADMSA and SEDASA; they will have their provincial representatives as part of the PEC.

The first elective congress of the trade union will be held this year, from 30 August to 1 September, as part of compliance of the trade union constitution and thereafter occur every three years.

Delegates of the national congress will comprise of the leadership of subcommittees of the trade union representatives, all 21 branches, the current public sector leadership and representatives of doctors employed outside the public service.

These men and women will spend three days debating issues hampering progress towards developing quality healthcare services. They will help in shaping the future of healthcare and finally elect their national office bearers of the union. This will comprise of the President, two Deputies, the General Secretary and Treasurer.

The office bearers will, together with the chairs and vice chairs of subcommittees, form the National Executive Committee that will, in between congresses, be responsible for the day-to-day running of the affairs of the trade union.

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This article aims to create the understanding that the adoption of this constitution means that it cannot be business as usual for SAMA.
T he development of the constitutional documents of SAMA has been a continuing “work-in-progress” ever since SAMA was formed through an Agreement of Understanding between the then MASA and several partner organisations in September 1997. Over the past two years, the documents were again altered and shaped by all SAMA members. The 2012 amendments included changes suggested by members, as well as those changes that pertained to legislative compliance, i.e. bringing the documents (previously known as the Company’s Articles of Association) in line with the requirements of the new Companies Act.

The names of SAMA’s constitutional documents were also changed – the previous Memorandum and Articles of Association became the Memorandum of Incorporation (MOI) and Company Rules. In 2013 the final amendments were effected with the participation of the membership and the SAMA branches, under the leadership and guidance of the Constitutional Matters Committee.

### SAMA Trade Union

The Registrar of Trade Unions (RTU) alerted SAMA that the company’s status as a trade union (TU) and insisted on a number of alterations to be made to SUA’s structures. By 2 March 2013, filed at the Registrar of Companies and Intellectual Property and has subsequently been approved and registered by the RTU.

The amendments to the MOI and Company Rules have the following effects:

a. Compliance with the new Companies Act
b. Legally incorporating the TU into SAMA

c. Ensuring representation from the TU at board level and in all other SAMA structures

d. Regulations of the population and functioning of SAMA committees and structures as set out in the Rules (c.f. below)

The Company Rules were formulated in terms of Section 15(1) of the Act, which dealt with matters not addressed in the Act and/or Memorandum of Association and would regulate the operational affairs of the company.

Important provisions contained within the Company Rules include the following:

- The incorporation of the TU into the already existing structures of SAMA
- Participation by TU representatives in the National Council and at board level
- Redefining election processes and member numbers representing standing committees
- The composition of branch councils to include TU representatives
- The composition of all SAMA structures to incorporate the founding groups (partner organisations)

### How will this impact on existing SAMA structures?

The integration of the TU structures into the existing structures meant changes within the Company Rules and minor amendments to the MOI to reflect this integration, particularly regarding the composition of the Board of Directors.

### National Council

The SAMA National Council will remain the highest authority. In the present version of the Company Rules, the National Council is comprised of 46 SAMA Branch representatives, 15 Speciality Group representatives, 9 General Practitioner representatives and 14 Public Sector Doctors representatives (drawn from the Public Sector TU Subcommittees).

To integrate the senior leadership of the TU into the highest authority within SAMA, the National Office Bearers of the SAMA TU will now have seats as National Councilors. As there are only 5 National Office Bearers, the estimated costs involved would not be unduly increased; in addition, there would be an increase of public-sector representation that would be more reflective of the actual public-sector membership of SAMA.

### Board of Directors

The SAMA Board of Directors is elected from within the ranks of the National Council. It is elected by the President, the Chairperson of SAMA, the Vice Chairperson of SAMA, and the chairpersons of each of the standing committees and three additional members who are elected to ensure proportional representation of historically disadvantaged South Africans, female doctors and young doctors.

The President and two Deputy Presidents of the TU would be ex officio board members. Again, this would mean an increase in the size of the Board, but would ensure proper integration of the TU component into the functional leadership of SAMA as a white collar branch.

### What is a shop steward?

A shop steward is the representative of a registered trade union in a workplace, elected by the members of the respective trade union who are employed at that workplace. The Labour Relations Act (LRA) does not use the term “shop steward,” but refers instead to a “trade union representative” (section 213). The role of a shop steward is three-fold.

Firstly, as the union’s representative in the individual workplace, the shop steward is the “face” of the union, he/she will thus have to promote the union amongst their fellow employees, answer questions and ensure that the rights and duties within the union are respected.

Secondly, by virtue of being an employee among other employees, the shop steward is the “eyes and ears” of the TU in the workplace. On the more informal side, the shop steward is a witness to everyday labour practice by the employer, and has first-hand experience of the realities of being employed at this workplace. Abusive practices, breaching of regulations or discriminatory treatment of employees by the employer might be observed and reported to the appropriate authority by the shop steward.

Thirdly, the shop steward is the voice of the union in the workplace. This applies on an individual level, where the shop steward might assist an employee who faces disciplinary action in an advisory role. Over and above this, the shop steward is a member of the recognised labour council/workplace forums (LRA section 79).

What regulations govern the function of shop stewards and their interaction with the employer?

The basic legal framework for the election of shop stewards and their function within the LRA section of employers and their employees has been set out in the LRA (No. 66 of 1995) as amended. According to the LRA, each union must determine in its constitution (section 95) the specific modalities of election of shop stewards and representatives in the workplace (section 14).

For the purpose of collective bargaining, the Public Sector Co-ordinating Bargaining Council (PSCBC) has been created and registered in accordance with Sections 35 and 36 and Schedule 1 of the LRA. As a sectoral bargaining council (LRA section 37), the Public Health and Social Development Bargaining Council (PHSDBC) has been established and registered within the legal framework of the LRA, an employer and the relevant labour union can enter into an organisational rights agreement.

This is a collective agreement between the employer and the labour unions which stipulates in more detail the interactions between the parties and the rules to which to adhere (LRA section 20). The organisational rights agreement between the Western Cape Department of Health and the labour unions is an example for such an agreement.

### Step 1: Identification of regulatory framework, institution and responsible managers

There is a clear need for SAMA to increase its representation in the workplace. A first step

**Dr Dirk Hagemeister, SEDASA**
Step 2: Establishing the membership base and organising the election event

Once the first preparatory steps are completed, they need to be aligned with the governance of the institution/workplace where the shop steward(s) are to be elected, the confirmation of the number of (SAMA) trade union members at the institution is the first moment of truth.

Generally, there are at least two ways to obtain lists of SAMA members at the respective institution: through the SAMA database or the employer’s database (PERSAL).

The second source of information on union membership is the database used for salary payments (PERSAL). This database can be searched for parameters such as appointment at a specific institution or deduction of membership fees for a specific labour union (e.g., SAMA). This is the authoritative base for the employer when assessing claims of representativeness of a labour union in the workplace, i.e., the human resources department of the employer will run a search to establish how many members the union has among the workforce and determine the resulting organizational rights based on this.

A number of implications:

The members who have not updated their status or changed their mode of SAMA fee payment to a salary deduction will not show in the employer list and thus not count when calculating the number of members the union has among the workforce.

Step 3: Elective meeting of the members

Usually the previously-elected shop stewards at an institution would organize and chair the workplace meeting for the re-election of shop stewards. In the absence of previous elected shop stewards, a SAMA representative, e.g., from the local branch, can stand in here.

Communication is paramount in organizing the elective meeting. The responsible line manager of the institution must be formally informed and included in the planning process. A proper up-to-date list of SAMA members at the institution is essential, ideally with email addresses.

It is a great opportunity for the SAMA branch staff to support the establishment of the democratic participatory structures in our Association.

However, it needs to be admitted that organising a labour union meeting for busy medical practitioners is, at best, a bold challenge. Careful consideration of the best time for the meeting, if possible, has to take place in close proximity to a general doctors’ meeting of the institution (e.g., MEd meeting, journal club) might help to improve attendance (if such ‘piggy-backing’ is allowed by management). Similarly, it might be advisable to identify willing candidates before the meeting, both to alleviate the SAMA members’ fear to be elected “accidentally” when attending the meeting and to avoid the conflict of interest of having to coerce members into candidatures.

As already mentioned, electronic modes of nominating and electing might, in the future, help to avoid some of these struggles.

These techniques are currently piloted for SAMA branch council elections and seem to gain more and more widespread support. However, some legal and administrative questions with regards to “virtual” workplace meetings need to be answered first.

Step 4: Informing the employer and ongoing support of shop stewards

Once one or more willing and enthusiastic new shop stewards have been elected, the employer needs to be formally informed about the new representatives. This is important to ensure that the shop stewards are invited to meetings of workplace forums/organised labour caucus, but also to give them formal legal standing (e.g. when they apply for special leave for labour union activities).

SAMA needs to develop a culture of active support for these representatives, who need to be invited to SAMA branch meetings and other SAMA events to be able to function as links to the SAMA members in the workplace.

In addition to this, we need to create and maintain technical labour union expertise, in which the employer and SAMA shop stewards need to have access to.

Future discussions and legal opinion will have to inform us whether it is possible to have such an election electronically.

What are my goals for JUDASA?

Community-based projects are the cornerstone of my calling in medicine. Hence, becoming the national officer for projects and marketing is befitting.

One of my main focuses will be to expand the established projects, i.e., the Teenage Pregnancy Awareness Campaign and the Male Circumcision Campaign, the former having had more spin-offs (i.e., opportunities for us to present subsequent health-related topics in visits).

With JUDASA turning 21 years this year, the way in which the Association is currently marketed will be challenged. This will be in line with the mother body public sector division registering as a trade union.

With a new paradigm shift in the way JUDASA operates and functions will inject the breath of fresh air that the organisation requires – from being more relevant to our members to broadening our horizons and engaging with other young doctors across the borders.

This is inspired by the change in the disease profiles of our country and how these are influenced by globalisation. The dynamics thereof are what should be key to developing and improving international relations in JUDASA, hence the creation of a portfolio for international relations.

To achieve some of these goals, research from as early as internship will be encouraged. An initiative with the South African Registrars Association (SARA) is currently underway, watch this space to be kept in the loop.

The initiation of leadership camps will also assist in cultivating globally competent healthcare leaders of the future.

JUDASA’s influence

JUDASA members have now been pet-named the “Young Lions” of the medical fraternity. I am sure it was not meant in a condescending manner but more complimentary. This term of office started with new challenges, from dealing with members not being paid timely to the assault and murder of a member. These incidences have created platforms for JUDASA Executive members, SAMA and SARA to work closely together and rekindle the support of shop stewards who will willingly provide advice and share experience when needed.

Dr Mathabo Hlahane, JUDASA Projects Manager
Welcome to the all-new SEDASA column

Dr Kalli Spencer, SEDASA Marketing & Communications

The senior Doctors’ Association of South Africa (SEDASA), is one of the largest groups of doctors in the country, having more than 5 000 members nationally. Its membership includes all doctors who are two years post registration and includes medical officers, medical managers, specialists (junior and senior), foreign qualified doctors and all those doctors employed by organisations such as the National Health Laboratory Service (NHLS), universities and in sectors such as the Defence Force and the aviation industry, to mention but a few.

The 2013 SEDASA AGM was held on 5 and 6 April at the Lynwood Conference Centre in Pretoria where the National Executive Committee (NEC) (see table) was elected for 2013/2014. This committee has been elected to deliver on the resolutions that follow, to 2013/2014. This committee has been elected in Pretoria where the National Executive

6 April at the Lynwood Conference Centre

1. To establish a working relationship with those doctors employed by organisations such as the National Health Laboratory Service (NHLS), universities and in sectors such as the Defence Force and the aviation industry, to mention but a few.

The following resolutions were taken:

1. To establish a Constitutional Matters Task Team to revive the SEDASA constitution with the aim of having the amended constitution to be adopted at the next AGM of SEDASA in 2014.

2. To expedite the development of the RWOPS policy for presentation to the Department of Health by November 2013.

3. To expedite the development of the RWOPS policy for presentation to the Department of Health by November 2013.

4. To develop a generic template for the Memorandum of Understanding (MOU) to be used by Medical Practitioners for PMDS purposes and present the template to DPSA by November 2013.

5. To mandate SEDASA Provincial Representatives to assist with the Skills Development of SAMA members by:

- Getting shop steward training programmes established in 50% of hospitals.
- Obtaining skills development plans from hospitals within the province.
- Maintaining programmes for training.
- Disseminating information regarding available skills development to all SEDASA members.
- To bring the retirement age of its members to the attention of the Department of Health through the Committee for Public Sector Doctors and to propose the flexible retirement age to be between 60 and 70 years with due consideration of a career path for junior members of the profession.

Look out for monthly SEDASA News or follow us on Facebook/Twitter*. Website to follow soon. Please contact us with any questions you may have or suggestions for future topics to be covered on this page.

* The twitter account is @SEDASA_SAMA

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### Consent when patients lack capacity

The previous article only covered consent as it applies to adults with decisional capacity. For patients who lack decisional capacity (i.e. children who are too young to understand, and adults with a mental impairment that prevents them from understanding), a proxy may consent on their behalf.

When an adult patient lacks the decisional capacity to consent to a proposed intervention, substitutes may be referred to, in the following order of precedence:

1. An advance directive made when the patient had decisional capacity. A valid advance directive that applies to the circumstances must be honoured, unless there is good reason to believe that the patient changed his or her mind.

2. A proxy mandated in writing by the patient to make decisions on his or her behalf.

3. A person authorised by law or a court order.

4. The patient’s spouse or partner

5. A relative

6. A grandparent

7. An adult child

8. A brother or sister

### Emergencies

The only exception to obtaining consent from a valid substitute is in an emergency. If delayed, this would result in serious harm to the patient, you should act in the best interests of the patient. Legal action against doctors providing treatment without consent in an emergency is extremely rare. In genuine emergencies, doctors are not obliged to provide immediately necessary treatment unless there are clear indications that the patient would object to the treatment.

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Children

Where children are concerned, the consent of the parent or legal guardian is required for children who are under the age of 12 years or who lack the decisional capacity to make the decision. If the treatment entails a surgical procedure, the child’s consent must be supported by a parent’s written consent.

If there are two people with parental responsibility, it is usually sufficient for one of them to give consent, but where decisions may have profound, irreversible consequences, both of them should be consulted where practicable. (See Consent to Medical Treatment in South Africa, an MPS guide for more detailed information about consent issues regarding children, and for a guide to parental responsibility.)

In practice, it is reasonable to seek the consent of any minor with the capacity to understand the nature and implications of the proposed treatment or procedure, regardless of age. This should not present a problem if the child and parents are in accord about a decision to consent to treatment.

“When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account” (UNICEF, a summary of the Convention on the Rights of the Child, Article 12).

End of life decisions

When patients are seriously ill and lack the decisional capacity to make decisions on their own behalf, healthcare professionals are obliged to make treatment decisions in the patient’s best interests. This might include choosing not to intervene if a treatment or procedure would be burdensome and with little benefit to the patient.

Not all terminally-ill patients lose their decisional capacity, and in this case the same principle applies as with treatment for all competent adults – healthcare professionals should respect and, as far as possible, comply with the patient’s wishes.

There are, however, limits to this obligation. Firstly, healthcare professionals are expressly forbidden – by medical ethics and the law – from honouring a patient’s or family’s request to intentionally hasten the patient’s death.

Conversely, the Council states that healthcare professionals are not obliged to comply with requests to continue treatment that they consider futile. In this situation, it advises giving the patient or family the choice of transferring to another institution where the treatment is available. If they refuse, and the futility of the treatment is confirmed by an independent healthcare practitioner, the health team may withhold or withdraw the treatment.

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### RISK MANAGEMENT

Risk management in medical practice and hospitals

The South African Medical Association (SAMA), through its Human Rights, Law and Ethics committee, has taken the initiative to partner with the Medical Protection Society (MPS), in an attempt to bring information to members relating to risk management in medical practice and hospitals. To this end, the MPS has given SAMA permission to publish its risk management booklets in a series of articles in the SAMA Insider.

### Article No. 4

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2. A proxy mandated in writing by the patient to make decisions on his or her behalf.

3. A person authorised by law or a court order.

4. The patient’s spouse or partner

5. A relative

6. A grandparent

7. An adult child

8. A brother or sister

### Emergencies

The only exception to obtaining consent from a valid substitute is in an emergency. If delayed, this would result in serious harm to the patient, you should act in the best interests of the patient. Legal action against doctors providing treatment without consent in an emergency is extremely rare. In genuine emergencies, doctors are not obliged to provide immediately necessary treatment unless there are clear indications that the patient would object to the treatment.

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Children

Where children are concerned, the consent of the parent or legal guardian is required for children who are under the age of 12 years or who lack the decisional capacity to make the decision. If the treatment entails a surgical procedure, the child’s consent must be supported by a parent’s written consent.

If there are two people with parental responsibility, it is usually sufficient for one of them to give consent, but where decisions may have profound, irreversible consequences, both of them should be consulted where practicable. (See Consent to Medical Treatment in South Africa, an MPS guide for more detailed information about consent issues regarding children, and for a guide to parental responsibility.)

In practice, it is reasonable to seek the consent of any minor with the capacity to understand the nature and implications of the proposed treatment or procedure, regardless of age. This should not present a problem if the child and parents are in accord about a decision to consent to treatment.

“When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account” (UNICEF, a summary of the Convention on the Rights of the Child, Article 12).

End of life decisions

When patients are seriously ill and lack the decisional capacity to make decisions on their own behalf, healthcare professionals are obliged to make treatment decisions in the patient’s best interests. This might include choosing not to intervene if a treatment or procedure would be burdensome and with little benefit to the patient.

Not all terminally-ill patients lose their decisional capacity, and in this case the same principle applies as with treatment for all competent adults – healthcare professionals should respect and, as far as possible, comply with the patient’s wishes.

There are, however, limits to this obligation. Firstly, healthcare professionals are expressly forbidden – by medical ethics and the law – from honouring a patient’s or family’s request to intentionally hasten the patient’s death.

Conversely, the Council states that healthcare professionals are not obliged to comply with requests to continue treatment that they consider futile. In this situation, it advises giving the patient or family the choice of transferring to another institution where the treatment is available. If they refuse, and the futility of the treatment is confirmed by an independent healthcare practitioner, the health team may withhold or withdraw the treatment.

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### Table 1: Consent when patients lack capacity

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<thead>
<tr>
<th>Name</th>
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<tbody>
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Do-not-resuscitate (DNR) orders
The decision not to institute CPR if it is likely to be successful should not be taken lightly, or in isolation. If the patient is competent, he or she should be involved in the decision-making, as should the family (with the patient’s consent). Ideally, the whole healthcare team should also be consulted. Ultimately, though, the decision rests with the senior clinician in charge of the patient’s care.

Such decisions should not be made on the basis of assumptions about the patient’s age, condition or perceived quality of life, but on a clinical assessment of the potential benefits and burdens of resuscitation on the individual, taking into account what is known about the patient’s views, beliefs and wishes and those of his or her close relatives.

If a DNR order is made, this should be clearly documented in the patient’s notes, together with the reasons for the decision and the process of decision-making.

Advance directives
An advance directive is a statement made by a competent adult in anticipation of a time when he or she may lack the capacity to make healthcare decisions. Such statements usually take the form of advance refusal of specified treatments, but may also contain information about the patient’s values and beliefs.

The Council states that “where a patient lacks the capacity to decide, healthcare practitioners must respect any valid advance refusal of treatment”.

It recommends encouraging patients with terminal conditions to appoint a proxy to make decisions on their behalf in the event of their losing decisional capacity. Moreover, patients should be given the opportunity to write a directive setting out their wishes regarding their future care to guide those who will be tasked with deciding what is in their best interests.

If there is any doubt about the validity or applicability of an advance decision (e.g. there is reason to believe that the patient might have had a change of mind since drawing up the directive or the current circumstances do not correspond to those specified in the directive), the patient should be provided with care to secure his/her best interests while the issue is resolved, if necessary by reference to the courts.

Documentation
All decisions to withdraw or withhold treatment, either with or without the patient’s consent, should be fully and clearly documented in the patient’s medical record and accessible by all those involved in the patient’s care and should include:

- The relevant clinical findings
- Discussions with the patient and others
- Details of treatment or other significant factors which may affect future care

Summary
When obtaining patient’s consent:
1. Take the patient’s particular circumstances into account when discussing options – including the risks, benefits, cost and expected outcome of each option.
2. Check that the patient understands if the patient lacks decisional capacity, obtain it from someone whom the law recognises as a valid substitute.
3. Be careful not to place the patient under pressure to choose a particular course of treatment. Be transparent about any financial interest you might have in a recommended healthcare facility.

Consequences flowing from a notice of termination of employment
Notice can be given by either party
Notice of termination of employment can be given by either party i.e. the employer or employee. At first glance, it might seem as if employers have the right to decide to terminate the services of an employee, as long as they adhere to the provisions in relation to notice. It is, however, not that easy and the employer may only unilaterally terminate the services of an employee in terms of a fair procedure and for a fair reason related to misconduct, the capacity of the employee or for operational requirements.

Remedies available to the employer if an employee fails to give sufficient notice
Legislation does not provide employers with a remedy in instances when the employee does not give notice in accordance with their contract or refuses to work for the entire duration of the notice period. This, however, does not leave the employer without recourse altogether. The Labour Appeal Court, in National Entitled Workers Union vs CCMA & others (2007) 28 ILJ 1223 (LAC), confirmed that legislation does not provide employers with a remedy to unlawful resignation but the employer can sue the employee in terms of the common law for breach of contract and possibly for damages.
Specific provisions in relation to resignations

Notice period

The Basic Conditions of Employment Act (BCEA) No 75 of 1997, as amended at Section 15, prescribes the required notice period as follows:

• One week if the employee has been employed for six months or less
• Two weeks if the employee has been employed for more than six months but less than one year
• Four weeks if the employee has been employed for one year or more

Furthermore, a collective agreement might permit parties to shorten the four-week notice period to two weeks, but no agreement may require or permit an employee to give a period of notice longer than that required of the employer.

Resignation in writing

Section 37(4) prescribes that notice of termination of a contract of employment may be given in writing. It was held in Shihali vs SA Broadcasting Corporation Ltd (2010) 31 ILF 1477 (LC) that a resignation by SMS constitutes communication in writing and therefore makes for a valid resignation.

Payment instead of notice

Section 38 allows the employer to let the employee go without serving the notice or to make payment in lieu of notice in cases where the employee gives notice, but the employee must be paid and if he or she indeed worked the notice period it should once again be said that this does not allow the employer to terminate the services of the employee without following proper procedure and for a fair reason. Provision is made in Section 37(6)(a) for a dismissed employee to dispute the lawfulness or fairness of the dismissal in terms of Chapter VIII of the Labour Relations Act (1995) or any other law.

Payments and deductions on termination

Section 40 states that, upon termination of the employee, the employer may pay the employee for any paid time off and any period of annual leave to which the employee is entitled and has not taken. It is important to note that the employer is not allowed to withhold any part of these payments for whatever reason. Section 34 of the BCEA only allows for deductions from remuneration, including final payment upon resignation, where there is a mutual agreement between parties or if any deduction is allowed in terms of a court order or arbitration award.

Tendering a notice of intention to terminate a contract of employment could go hand in hand with a number of challenges if a party is left to face any of the above-mentioned scenarios. It is therefore wise, for both the employer and the employee, to seek advice if faced with any problems or questions related to a termination of employment.

Labour unrest among healthcare workers – a military perspective

It has always been the prerogative of the members of the South African Medical Association (SAMA) to demand better conditions of service and remuneration, and at times to go on strike. While the strike by the public sector doctors against poor remuneration and bad working conditions in 2009, for example, held the government to account, there have been instances where the government has not handled the situation appropriately. It is therefore important to note the initiatives of National Government at this moment’s notice. It also derives from the general need to encourage better compensation and dispensation as a provider-of-last-resort for the state machinery.

The struggles of health workers are not new to South Africa. Doctors and healthcare professionals have been involved in strikes in various countries such as Canada and the UK in the early 1970s, and in Israel in the 1980s. Just this week, dozens of healthcare professionals walked off the job in Saskatchewan, Canada. And closer to home, the government and our neighbour, Botswana, sought a court intervention after a strike that involved 50 doctors at the country’s biggest public hospitals and the closure of 27 clinics across the country. Hence, in this year, health workers in South Africa have had the opportunity to demand better conditions of service and additional allowances.

While health struggles have been waged in our country over many decades, the motivation, opportunity and manner in which we now embark on industrial action have changed contextually. This is the central theme of my discussion.

To refresh our minds, allow me to take you back to the dramatic media coverage of the 1986 doctors strike, in which our public healthcare workers were also involved. Media headlines and spectacular television footage showed scenes of red-shirt clad, toy-throwing, placard-waving protestors, water cannons (puns颇die), burning barricades, locked gates, rubber bullets, police in full riot gear, stones being thrown at the police; and on occasion, police being hailed as a result of the ensuing violence.

Those of you who are old enough will be forgiven for thinking that you were back in the mid-1980s during the states of emergency of our country in the apartheid era. But these dramatic scenes were playing themselves out 25 years later, and in a thriving democracy.

South African Military Health Service (SAMHS) in support of National Government

During one of the earlier health workers strikes in June 2007, I was part of a high-level delegation visiting Kafalang Hospital near Tshwane. The strike had just entered its second week and we were deploying about 100 members of the SAMHS as healthcare workers and support personnel at the hospital.

SAMHS doctors sought to preserve the rights and health of the general public, and to make the authorities more responsive to the needs of healthcare workers, which had been the decision that had an adverse effect on patient care, among which was the chronic underfunding of public healthcare.

As a result of the strike, doctors sought to preserve the rights and health of the general public, and to make the authorities more responsive to the needs of healthcare workers.

From talking to the abandoned patients in the wards, it became clear that all the sick were afraid of their enslaved caregivers and would have unhesitatingly fled the hospital if it were at all possible, given their health state. They were happy to see the military, not only because we were attending to their healthcare needs, but also because we were protecting them from the strikers.

As our delegation exited the hospital towards our vehicles, the health workers gathered outside were singing “our revolutionary songs of the past. As an activist and as part of the country-wide reaction of anti-apartheid forces in civil society in the 1980s, I remember singing those same songs against the apartheid health system. But not once did we, as doctors, engage in strike actions that would have compromised the care of our patients. As you are aware, we are part of our colleagues, like former medical-student activist, Steve Biko, and Dr Haffejee and Neil Beatty, paid the ultimate price for taking a stand against the then legislative iniquities, including the lack of proper healthcare that our country deserved.

Was this the outcome of the sacrifices made by our predecessors? It was very difficult, for sadly our protectors had turned into perpetrators of violence.

Strikes have not always been about poor salaries. An unprecedented strike in 2004 in the democratic era – by our Cape Town colleagues saw them take to the streets, in their lunch hour or at peak traffic times, to express their concerns about government decisions that had an adverse effect on patient care, among which was the chronic underfunding of public healthcare.

As a result of the strike, doctors sought to preserve the rights and health of the general public, and to make the authorities more responsive to the needs of healthcare workers.

This deployment comprised 2 946 SAMHS members supported by 1 900 SA Army, 179 SA Air Force and 60 SA Navy members.

Similar situations were experienced during the winter of discontent of 2008 and 2009, but to a lesser degree than previously. However, our true test was awaiting us, as our public service colleagues in healthcare went on strike shortly after the 2010 FIFA World Cup.

As a supporting health service, our planning for the World Cup had begun soon after the announcement that South Africa
would be the host country. This entailed a wide range of medical support – from the anxiety attack masquerading as a heart attack to various consultations witnessed in the 2018 public strike. The strike is akin to the idiom, an eye for an eye, which Gandhi is reported to have wisely said, “will only end up making the world blind.” Doctors need to find methods of bargaining other than strikes, whether protected or not.

Forty years ago, during the Canadian Doctors’ Strike, it was suggested that, while the governments were not blameless, the profession had nonetheless been called upon not to act as adversaries. This advice still holds true. From my perspective, the right to strike a position that must surely also be considered in terms of ethical obligations that govern our profession...

Discussion
Profoundly distinguished guests, we take cognisance that a strike by public health workers has a critical distinction from other public service strikes in that, in order to preserve life as enshrined in the Constitution, the quality of the healthcare service has to be assured. Juxtaposed to this position, the right of workers to strike, which is also enshrined in the Constitution, has to be assured. It is clear that those members of the public health sector...

Conclusion
President of the Colleges of Medicine, the University fraternity, representatives of the Department of Health and the Health Professions Council, specialist medical graduates and guests, allow me to conclude with the following:

1. Strikes by healthcare professionals, especially in the essential services, are not only illegal but against the basic ethical principles of the Oath of Professional Conduct.

2. When healthcare workers choose to strike, they willfully participate by omission of care in the possible demise and certain suffering of their fellow human beings, whom we undertook to serve. A strike is a deliberate denial of service."  

3. Such actions cannot, and should not, be tolerated as a matter of human right.

4. Let us be aware of the purpose and trust of the public that we once had.

5. We may have all the rights and ethical principles regulating the profession, but if there is no sanction when these laws and ethical principles are transgressed, it breeds a cadre of doctors who disregard the moral and ethical principles of the Oath of Professional Conduct.

The Hippocratic Oath as a relic of a bygone era clearly states that “a physician must consider the welfare of the patient in all actions.” It is respectfully submitted, therefore, that where this adherence to the profession’s time-honoured traditions falls short, the profession is...
Continued learning: SAMA 2013 CPD meetings

The South African Medical Association (SAMA) is continuing to uphold its vision to empower doctors for the health of the nation. The SAMA Head Office CPD meetings started off with a bang. Our sponsors for this year are Sanlam and Sandoz, who assist SAMA in achieving its vision.

SAMA will be conducting 21 CPD meetings countrywide. Log on to the SAMA website (www.samedical.org) to view the yearly schedule and see when the next CPD meetings will be in your area.

Below are highlights of some of the meetings that have already taken place.

Rustenburg
On 19 March 2013, a CPD meeting was held in Rustenburg at the Hunter’s Rest Mountain Resort. The delegates could not have thanked SAMA more with the exciting lectures that were presented. Dr Osman Ebrahim presented on ‘TB and HIV ‘the terrible twins’. Ulundi Behnel gave an insight on ‘Transfusions: Ethical implications for doctors’. Sanlam being the main sponsor of the 2013 CPD meetings also gave away prizes to 3 lucky draw winners.

Mafikeng
The CPD meeting in Mafikeng focused on the Approach to haematuria, presented by Dr Arnold Mangala, and the Ethics presentation was presented by Mr Gideon Rossouw. The CPD meeting was held on 19 April 2013 at the Protea Hotel Mafikeng.

2013 SAMA/MPS Photography Competition entries now open

The 2013 SAMA/MPS Photography Competition is now open for entries. This long-standing and exciting initiative for both SAMA and MPS has been greatly received by its members, receiving record entries each year.

They say that a picture is worth a thousand words and with this year’s theme for the photography competition, A Day in a Life of a Doctor, we aim to achieve just that. In keeping in line with the theme, entry categories are: Work Environment, Emotions, Nature.

Doctors spend most of their time in hospitals or in their private practices enhancing quality of life and saving lives in surgery rooms; therefore, we are encouraging this year’s entrants to share a glimpse in their day and on some of the special moments and shared experiences with their patients, fellow doctors and nurses. In addition, general entries featuring the tranquil views of nature and/or wildlife are also welcome.

Each category winner will be awarded with a cash prize with the winners’ announcement in August and the formal prize giving taking place at the official Cocktail Reception of the 2013 SAMA Conference on 15 August.

For those wishing to enter the competition, simply complete an entry form and upload the digital image onto the competition website: http://samedical.org/events/photography-home.html.

For more information on the competition and rules, please also log on to the website. The deadline for all competition entries is 26 July 2013.

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