

An honour and a privilege

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R S du Toit, MB ChB, MMed (Surg), FCS (SA)

President of the Association of Surgeons of South Africa, 2011 - 2013

Corresponding author: R S du Toit (dutoitrs@ufs.ac.za)

I would like to thank all members of the Association of Surgeons of South Africa for the honour of serving you as President during the past two years. It has been an honour and a privilege that I will cherish for the rest of my life.

I wish to assure fellow members that our Association is sound, has been managed with discipline and wisdom, and strives to efficiently resolve matters that affect us all. On behalf of the Association, I would like to thank the executive committee (especially the chairman, Professor Martin Veller, the secretary, Dr Mike Klipin, and the treasurer, Dr Ines Buccimazza, whose meticulous accounting has ensured healthy finances) for their hard work during the last two years. I would also like to thank you personally for your camaraderie. It has been a privilege working with you. I have learnt a lot from you by observing the manner in which you handled difficult issues, from your professionalism, and from the priority you place on matters that may benefit our Association.

Two important matters need attention, namely the membership situation of our Association and the current state of Remuneration for Work Outside the Public Service (RWOPS).

Membership: 'What does ASSA do for me?'

Eight hundred and eighty surgeons are currently registered with the Health Professions Council, of whom 200 are dormant. However, only around 400 of the remaining approximately 700 active surgeons are members of our Association, and of these 400 only 50% are fully paid up. Why is this? Membership fees and the existence of multiple surgical societies are contributory factors. Belonging to several societies can represent a substantial financial burden, and membership of ASSA is by far the most expensive. Busy clinicians many neglect to pay their fees, and eventually cannot be bothered if they go into arrears.

FoSAS (the Federation of Surgical Societies) may have a role to play in this respect in the future. Under consideration is the possibility of a surgeon making one payment, which is then distributed to the various societies he or she belongs to. This will be a more convenient situation if FoSAS can arrange it. A central administration office may also have the potential to combat escalation of fees in the future.

'What does the Association do for me?' is a question one often hears. Some surgeons in private practice say that ASSA has no teeth when it comes to negotiating fees. These surgeons are either not members of our association or not informed about its activities. Let me briefly tell you what ASSA has to offer to you.

Through our close relationship with Surgicom we keep a close eye on fees. Surgicom, as the business arm of ASSA, sits on the Exco of our association and has a standing point on our agenda, which proves ASSA's commitment to the matter. We also liaise with the Private Practice Forum either directly or through Surgicom and with the South African Medical Association if necessary regarding fees. May I also remind you of the research ASSA conducted a couple of years ago, on fee structures for surgeons in the public and private sectors? This process, which was driven by Sats Pillay, benefited us all, as it provided sound arguments for negotiating fees.

ASSA organises a congress every second year to provide access to up-to-date knowledge and to expose members to new developments. The Association maintains contact with the international arena by inviting accomplished international guests to its meetings, and through relationships with a number of societies elsewhere on the continent and around the world. We also maintain contact with the Health Professions Council of South Africa and the Medical Protection Society regarding ethical and other matters that affect us directly. We have dialogue on a regular basis with SAMED, which represents the medical device and technology industry. This contact with the industry addresses matters that affect our daily practice and enables sponsorship for our congresses, which is pivotal if we want to continue organising them in future. The Association has a relationship with the College of Surgeons and academic departments of all our medical schools, and it supports the SAJS, which you get free if you are a fully paid-up member. It converses with the National Department of Health as required, and in the latter regard we will play our part in the implementation of National Health Insurance, which will affect all of us in the coming years. In summary, ASSA is actively involved in all matters pertaining to private and full-time practice. It is concerned about academic and professional development issues and it keeps us in contact with the international world. Finally, it keeps an eye on new matters arising and on policies concerning our daily lives.

I hope that you get a sense of the many fronts on which ASSA serves you. This Association is the only organisation that performs such a broad spectrum of functions, other surgical societies having a narrower focus. I would like to urge members to promote ASSA actively and in so doing recruit non-members in their environment to the Association. We are living in a world where numbers mean power. ASSA needs your support, and you need a strong organisation to negotiate on your behalf and to fight for your rights. To be on your own individual mission serves no

purpose, and I query whether it is ethically correct to reap from the benefits of all ASSA's efforts while not being a member.

RWOPS

I will now reflect briefly on the controversial issue of RWOPS. This is my own personal view, and not that of the Exco or our Association. One cannot deny that there has been serious abuse of the privilege, granted by government, to do remunerative work outside the public sector. Fortunately this is perpetrated by only a small minority of full-time specialists, but unfortunately it negatively reflects on and affects the remaining majority of full-timers. Why has this happened? To my mind there are two reasons. Firstly, greed on the part of some individuals has caused them to act unethically, by transgressing the rules and neglecting their full-time responsibilities for the sake of personal gain. When Mammon beckons they are unable to resist, even while earning a decent salary and having good retirement prospects.

Problems regarding administration and regulation of the system constitute a second reason. It is not easy to control the system, because institutions and hospitals do not have the capacity to do so. The main reason why regulation of the system has failed has to do with the history of RWOPS. When it was initiated in 2001, there were very few guidelines put forward as to how it should be implemented and regulated. The minister laid down three principles only to guide the process:

1. The premiers of each province should negotiate with the full-time doctors in their province a workable plan on how RWOPS should function, the condition being that routine functions in the public sector should not be compromised. This means that the responsibility was moved from central to provincial level, and it also explains the lack of uniformity regarding conditions that need to be fulfilled before RWOPS is granted. In following this route the whole process became open to interpretation and cohesion was lost, which eventually impacted negatively on any potential regulating model.
2. Doctors in training are not allowed to engage in RWOPS.
3. Solo private practice is not allowed. In this regard the Department of Health at that time favoured the concept of a full-time specialist associating with a private colleague, on condition that the private practice finances would be open to scrutiny if requested. This condition caused uneasiness, of course, and it hardly ever happens. In my opinion, this is exactly where the problem started. In effect, for some individuals, it represents a ticket to solo private practice, in addition to receiving a full-time salary including overtime remuneration. It also makes regulation of such a system practically impossible.

We are all aware of the negative consequences of RWOPS on full-time practice. Service delivery is jeopardised, the morale of other staff members is negatively affected if one member is abusing the system, and specifically in an academic environment, training and research suffer.

These negative consequences have recently triggered an angry response from provincial and national health departments. Fortunately, threats of stopping RWOPS immediately and altogether have been tempered by the Minister of Health. I

understand that the ministry is in the process of appointing a task team to investigate the system and suggest possible solutions.

If those of us in full-time government positions still want this privilege, we need to engage in it with discipline, cognisant of our primary responsibility. If RWOPS needs to be regulated, I think we need to do it ourselves in an honest and ethically acceptable manner. Having said this, I would like to propose a group practice structure as the best if not the only way to accomplish this goal in a particular institution or setting. A group practice, as I see it, consists of individuals who enter into an agreement or contract regarding their individual professional activities within the practice. This is a legal document that stipulates the rules of practice and the consequences of non-compliance. The practice is managed by a committee with a chairman, who may be elected periodically as agreed. Members who step out of line should appear before the management committee to explain themselves. In case of serious misconduct, a member may be suspended from practice and the case handed over to the relevant institutional head to deal with. This is one mechanism by which members can be regulated within a group practice.

A group practice must have a central billing system, which implies that the practice sends bills, on behalf of its members. Allowing members to do their own billing can again potentially lead to abuse. As the money comes in, it is distributed to the individual members according to the income they generated and claimed for. The finances of each member are of course confidential, but should a question of misconduct arise, the management committee would have the right to scrutinise the books of the suspected member. This is a second mechanism by which a group practice can regulate members' activities.

The practice has its own administrative staff, whose main function is to manage the finances of its members. A practice manager oversees the daily functions of the practice and reports to the management committee. Preferably, the practice should provide the rooms for its members to practise, thus also serving as a regulatory mechanism. All running costs are covered by a levy, which is taken as a percentage from the monthly income of individual members. This levy is flexible and may be changed periodically, depending on the financial status of the practice. The practice is not to make a profit. Finally, an annual audit of the practice finances should be conducted.

In broad terms, this is how I think RWOPS can be properly regulated via a group practice system. I work in a group practice that functions along these lines. We are about 80 members strong, and members belong to all disciplines in our medical school. It works well, our group has no problems with individual members, and our group practice is not implicated in abuse of RWOPS in the Free State. Those who abuse are not members of our group. They resigned from it because the controlling mechanisms built into our agreement made them feel uncomfortable. Another beauty of this concept is that every small hospital can have a group practice, and larger institutions may have more than one.

Finally, I would like to thank all members of the Association for their support, and thank you again for the honour and privilege of serving as President of our Association during the past two years.

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