



ISSUES IN MEDICINE

How has the OSD affected our state hospitals?

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The long-awaited occupation-specific dispensation (OSD) process for state-employed doctors has now been concluded. The final offer, signed and accepted in the bargaining chamber despite being rejected by 92% of doctors in a SAMA survey, has not received much attention or fanfare. At the conclusion of this process, which has been drawn out over several years, many points have emerged that are extremely worrying for the future of health care in this country.

Firstly, the authorities have provided no incentive for doctors to stay in the state services after completion of their studies. The aim of the OSD as per clause 4.1 of PSCBC 1 of 2007 was 'to negotiate and implement salary structures in order to attract and retain professionals and specialists in the Public Sector'. A SAMA survey showed that public service doctors are currently remunerated at levels approximately 50% below other professionals with similar qualifications in the South African public sector. The final OSD agreement for doctors singles out specific groups of doctors who will receive meaningful salary increases. This includes the junior doctors (interns and registrars) and the most senior doctors (principal and chief specialists). However, the largest groups of permanent medical staff in state hospitals include medical officers and junior and senior consultants. In practice it is these groups who form the majority of permanent staff in district and academic hospitals and provide the majority of the teaching to students, registrars and junior doctors. Many of these doctors should have risen to promotion on the basis of their proven achievements, but have never advanced owing to lack of available posts. Under the new OSD, these groups have been awarded token increases only – certainly not increases of the order that would persuade them to stay on in the public health services rather than

heading for the private sector or overseas after qualifying. In recent weeks, the resignation of several well-qualified specialists and senior specialists at academic hospitals has escalated concern that we are losing skilled personnel we can never replace.

The next point is that if we do not provide any incentive for doctors to stay in our state services, who is going to train our doctors and specialists of the future South Africa? In several provinces there has already been a total collapse of the teaching system. Posts cannot be filled, junior doctors work under no supervision whatsoever, and patient care and training have collapsed. Tertiary services have been stripped to their bare bones and in many centres the ethos of professional medical practice has been undermined by lack of adequate staff and updated equipment. The OSD has failed to address these issues at all. In South Africa, we currently have doctors in many areas with skills and expertise to match the best in the world, and yet the government has not used the OSD to ensure that these doctors stay in our state institutions and teach our future generations of state and private sector doctors.

Lastly, during the OSD bargaining process we have realised that as doctors we have limited bargaining power and no final decision-making power while we borrow seats from larger unions that may not have our interests at heart. Maybe the time has come to ask whether this level of representation is adequate. Is it appropriate for our professional body, SAMA, to be borrowing seats in the bargaining chamber and asking representative doctors to act as our trade union officials? SAMA is charged with a number of important tasks that detract from the above function – maintaining a journal, setting ethical norms, representing the private sector for fees, etc. In contrast, trade unions are to a large extent about politics, and this includes securing membership numbers, strategic networking and effective bargaining. At present SAMA is not able to attract sufficient members for a threshold level of representation in the bargaining chamber. Furthermore, there are many issues common to doctors and other groups and it may be appropriate for a common union to jointly address these.



So what is the answer to these issues? We would support change from within. Perhaps we should consider a basic tier of SAMA membership which is cheap, recruits members actively from all sectors of medical and allied medical staff, functions effectively as a union (with dedicated staff) and forms strategic partnerships with other organisations. Membership of the important professional limb of the organisation could be separate and additional. Creating the impetus for such fundamental changes would involve co-operation at many levels.

We invite open and active debate on this topic in order to try to find a way forward that would achieve the necessary representation for doctors. The Health Minister has made vague promises about rectifying some of the injustices of the OSD in April 2010. However, we need to ensure that we are able to bargain effectively so that we retain experienced doctors in our public health care system and leave a legacy of high-quality teaching and optimal health care in all sectors of our country.

PERSONAL VIEW

Medical electives in South Africa

Matthew Anthony Kirkman

The elective is a highlight of most medical students' undergraduate training. Medical electives in South Africa are well known for hands-on clinical experience; however, I was not expecting the level of responsibility that I experienced.

It was the beginning of another 24-hour on-call shift in a trauma and surgery department of a Gauteng hospital when I was called to assist a specialist registrar in theatre. The patient was a 24-year-old male victim of violence. His legs had been doused with petrol and set alight, and he had deep burns to both legs requiring regular debridement and dressing; this was his third such procedure.

I understood my role as holding and passing equipment when required, with no active involvement in the surgery; responsibility which I had been afforded previously and felt comfortable with. When I arrived, the patient was under general anaesthetic, and I was unsure whether consent had been obtained for my role as assistant. During the procedure, the doctor complained incessantly that he had gone without food for 12 hours; as the final pieces of debris were cleared from the patient's left leg, he ripped off his gloves, declaring: 'I'm going to eat before I collapse. Can you finish?' and left before I was able to respond. The wounds were left debrided but undressed, exposed to air. The staff remaining in theatre were the anaesthetist and theatre assistant.

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One can discuss the ethics of allowing doctors and medical students to work long shifts without breaks and the effect on patient care, and of a doctor foregoing his professional commitment to a patient because of hunger. However, my concern was the ethics of myself, as an unqualified medical student, dressing wounds without patient consent. Asking the doctor to return was futile, according to my colleagues in theatre, and attempts to find another doctor to help failed. Bringing the patient out of anaesthesia to ask for consent seemed pedantic, and neither the theatre assistant nor the anaesthetist would complete the procedure. I therefore used my limited experience of observing wound dressing to complete the procedure (successfully).

Official guidance for health care professionals in South Africa is found in the National Patients' Rights Charter, published by South Africa's Department of Health,¹ and guidelines from the Health Professions Council of South Africa^{2,3} which – ironically – contained verbatim statements from the UK General Medical Council's 'Good Medical Practice' Guidance.⁴ To my horror, this literature practically condemned my actions. The legal literature revealed that, by touching the patient without consent, I could be sued for battery, without being able to claim exemption as a student.

The ethical principles (autonomy, beneficence, non-maleficence and justice) are important considerations in such a scenario.⁵ Beneficence concerns itself with doing good for patients and acting in their best interests, and we are taught that these lie at the heart of medicine and the doctor-patient relationship, but *who* judges *what* is best for a patient? I felt that the patient's best interests were to reduce his infection risk