



## Employment contracts for South African doctors

**To the Editor:** There has been concern about the loss of health care professionals from South Africa, and while there are multiple factors contributing to this, one of them, in my opinion, is that health care professionals work under poor employment terms and conditions.

My brief experience with South African employment after a period of time in the UK led to an unfair dismissal (Commission for Conciliation, Mediation and Arbitration (CCMA) case reference WE3402-04) because I refused to sign a contract that among other issues, included a clause in breach of South African labour law (notice period in violation of the basic Conditions of Employment Act). To illustrate the scenario, a selection of my points of objection follow.

A set of clauses covered hours of service. These were not consistent between the employment contract and the conditions of employment document. Further, a separate clause dealing with out-of-hours work was not specific and did not refer to the clause on total hours of service. I wanted the contract to be consistent and clear about what was expected of my time. Another clause indicated that any submission for publication must be made through the librarian of the organisation. I can see the benefit in having all publications centrally recorded but do not see why the submission should be made through a central service. The contract as a whole had the appearance of a document that had been compiled from a number of other contracts without proper thought or organisation. It had clearly not been reviewed by any person with knowledge of the basic Conditions of Employment Act. While I was in the UK contracts between doctors and the National Health Service were extensively debated and negotiated between the British Medical Association and employers. Accepted understanding of a contract between an employer and an employee is that it clarifies the conditions of service of the employer and helps define the individual's position. The contents of the contract should be discussed and negotiated. In South African health care, contracts are presented to employees and are not negotiable. South African doctors sign these contracts and implicitly consent to poor labour practice.

Apart from employment contracts for doctors, South African health care has many other issues to deal with. However, when health care professionals with access to international positions look at South Africa and find non-negotiable contracts that are poor in quality and incorrect in content they may choose to seek employment elsewhere. In my case I was forced to look for work outside the country as my only potential employer dismissed me.

There is a solution if the South African Medical Association takes up the issue of employment contracts and negotiates

these properly with the different employers. Alternatively, SAMA could challenge the contracts that breach South African labour law in labour court. I would encourage South African doctors to stand up against poor labour practice and challenge their employers. My case took many months to be heard at the CCMA and eventually they found that I had been unfairly dismissed. The CCMA will not allow another case like mine to wait so long before it gets heard. The chances are that doctors will win and employers will have to concede to contract negotiation.

South African doctors are a precious resource to the country. I would urge you to stop allowing poor labour practice to continue unabated in the health care sector.

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## Medical negligence – what is SAMA's position?

**To the Editor:** One sincerely hopes that comments from SAMA chairman Kgosi Letlape quoted in the *Sunday Times* on 5 June 2005 do not represent SAMA's consensus view on medical risk and the rise in number of professional conduct enquiries conducted by the Health Professions Council of South Africa (HPCSA).

In the report entitled 'Dodgy docs need insurance', Dr Letlape commented on the apparent inability of certain doctors to pay fines when found guilty of professional misconduct. In what appeared to be direct quotes, he blamed the 'unbecoming behaviour of doctors on the appalling conditions in which some of them worked', slow payment or non-payment by medical aid companies, and 'refusal of hospital administrators eager to blame doctors for errors, to assume responsibility'.

Even if we accept that medical practice is compromised to variable degrees by the issues highlighted by Dr Letlape, I question whether such factors adequately explain the wide range of misconduct allegations reported to the HPCSA. I am more concerned that the tendency to blame medico-legal disputes primarily on extrinsic factors ignores both the principles and the challenges of safe, ethical practice. In turn, such dismissal denies medical practitioners any opportunity to constructively address the fundamental issues underlying medical error, lawsuits and HPCSA enquiries.

Modern risk-management philosophy rejects both the Just World Hypothesis ('bad things happen to bad people') and the knee-jerk tendency to shame and blame either ourselves or others when mistakes happen.<sup>1</sup> The Bristol Inquiry which shook the British medical establishment, arose from an investigation into the deaths of paediatric cardiac surgery



patients, but the findings published in 2001 emphasised the importance of professional accountability at all levels of any system that provides health care.<sup>2,3</sup> As long as doctors, nurses and hospital managers are human (and long may they continue to be so), the eternal risk of human error will prevail, and the challenge will be to constantly examine, modify and sometimes even re-invent medical practice and behaviour, so as to compensate for the inherent risks that threaten every interaction between provider and patient. If we instead opt for scapegoats, we will never achieve true accountability. If we hide our heads in the sand, the litigators and the HPCSA will both draw a bead on our butts, and relish kicking them black and blue.

The SAMA chairman's words may well be what the Association's members want to hear. But tough love in the form of accepting medical fallibility, and providing clear, meaningful guidance towards individual and collective accountability, may be far more effective in the long term if SAMA truly wishes to keep the medico-legal demons at bay.

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1. Reason J. Human error: models and management. *BMJ* 2000; **320**: 768-770.
2. Bristol Royal Infirmary Inquiry. *Learning from Bristol: The Report of the Public Inquiry Into Children's Heart Surgery at the Bristol Royal Infirmary 1984 - 1995*. London: HMSO, 2001.
3. Coulter A. After Bristol: putting patients at the centre. *BMJ* 2002; **324**: 648-651.

## Holy Communion – chalice or challices?

**To the Editor:** Holy Communion is practised globally as a symbol of holy communication with one's maker. In many congregations a communal chalice is used to serve wine/water/juice to participants. In other congregations a choice exists between a chalice and a chalice (small individual glass).

As we enter the age of immune-deficiency diseases we need to be aware that certain diseases may be transferred via lip sputum, with far-reaching consequences to immune-compromised patients such as those with diabetes, cancer patients on chemotherapy, HIV patients or those who are ill and debilitated. Transferable diseases include: (i) herpes simplex (winter sore); (ii) herpes zoster (shingles); (iii) diarrhoea (viral); (iv) cholera; (v) *Salmonella* (typhoid diarrhoea); (vi) *Shigella* (dysentery); (vii) hepatitis A (infective jaundice); (viii) flu and other respiratory (lung) viruses; (ix) viral encephalitis; (x) bacterial meningitis; (xi) *Streptococcus* group A (sore throat); (xii) *Staphylococcus aureus* (diarrhoea and food poisoning); and (xiii) TB (sputum transfer – all organs may be infected).

A sputum-contaminated chalice requires medical sterilisation in an autoclave to eradicate the possibility of disease transfer.

If individuals feel strongly that they should use the common chalice, they should be made aware of the above possibilities. The church has a moral and ethical obligation to inform participants of the potential risks involved in using the communal chalice.

To be on the safe side, an individual chalice should be used by each participant.

#### J B Janeke

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## Erratum

In the Childhood Atopic Eczema Consensus Document (part 2, June *SAMJ*), there was an error on p. 439 (first line, right-hand column). Trials have shown that pimecrolimus can be used safely in infants as young as 3 months of age (not 3 years as stated).

The corresponding author has however pointed out that pimecrolimus is only approved by the Medicines Control Council for use from 2 years of age.