



Legal, but is it right?

To the Editor: The letter by H J Kirby in a recent issue of the Journal¹ begs a response.

I quote a sentence that cuts right to the heart of the matter: 'Surely informed consent in private sector medicine includes telling the patient how much money they are going to have to pay over and above the amount their medical aid will contribute?'

As colleagues will no doubt be aware, this view is shared by many (most?) patients and is dead wrong. I stand to be corrected, but I am not aware of any other profession where the fee structure is determined by an outside, totally unrelated, institution. The normal fees charged by doctors should be those prescribed by their peers, i.e. the South African Medical Association. Ironically, patients should actually be informed if abnormal (medical aid) rates will be charged, not the other way round.

Especially in view of ever-increasing premiums, patients may eventually start requesting medical aids to explain how they can justify contributing such a small portion to medical bills.

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1. Kirby HJ. Legal, but is it right? (Letter). *S Afr Med J* 2005; **95**: 816-818.

Is tele-facilitation a viable alternative to conventional face-to-face facilitation?

To the Editor: Telemedicine has become a priority tool in the delivery of health care. Telemedicine facilities were used in a pilot study at four hospitals in the Ukugona Outreach project for the implementation of kangaroo mother care (KMC) in KwaZulu-Natal.¹ One hospital was the broadcast site and the other three receiving sites.

Seven broadcasts of 1 hour each were scheduled, with 2-week intervals between broadcasts. The first broadcast was an introductory link-up. Each subsequent broadcast

included introductions and 'ice-breakers', a request for new topics, discussion of topics, new discoveries to share, participants' learning for the day, how tele-facilitation could be improved, and date, time and topic for the next broadcast. The pedagogical approach was one of self-directed, interactive learning, site-specific implementation, and the encouragement of critical thinking. Participants had to find their own solutions.

Continuous evaluation of the process included regular discussions between team members, observations during tele-broadcasts, a progress-monitoring visit to each hospital at the end, and an in-depth evaluation by two external evaluators.

Thirteen of the 21 scheduled broadcasts took place and just over half (11 out of 21) of the planned broadcasts were technically successful (Table I).

The three pilot hospitals showed evidence of practice of KMC (> 10 out of 30 points), when scored with the standard progress-monitoring instrument.² This demonstrated the possibility of using video conferencing as an alternative to on-site facilitation in the implementation of new health care interventions. To ensure success all participating health workers should have sufficient preparation time for sessions and the same participants should attend all sessions. However, without improved technical and educational expertise and support at grassroots level, it may currently not be a feasible strategy for province-wide implementation projects.

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1. Pattinson RC, Arsalo I, Bergh A-M, Malan AF, Patrick M, Phillips N. Implementation of kangaroo mother care: A randomised trial of two outreach strategies. *Acta Paediatr* 2005; **94**: 924-927.
2. Bergh A-M, Arsalo I, Patrick M, Malan A, Pattinson RC, Phillips N. Measuring implementation progress in kangaroo mother care. *Acta Paediatr* 2005; **94**: 1102-1108.

Table I. Technical difficulties encountered*

	Hospital 1	Hospital 2	Hospital 3	Total
Number of planned sessions	7	7	7	21
Number of connected sessions	5	3	5	13
Poor sound (connected sessions)	1	0	1	2
Poor vision (connected sessions)	1	0	0	1
Number of technically successful sessions	4	3	4	11

* Introductory session excluded, where all technical aspects were good.