

SAMA INSIDER

DEC 2013/JAN 2014

SAMA attends WMA
general assembly

Cuban programme
sparks debate

Trade Union publishes
member update



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CONTENTS

DEC 2013/JAN 2014



- | | |
|---|--|
| <p>3 EDITOR'S NOTE
SAMA gives doctors a unified identity
Conrad Strydom</p> <p>5 FROM THE PRESIDENT'S DESK
DoH previews NHI White Paper
Prof. Ames Dhai</p> <p>7 FEATURES
WMA – a leap forward in global health
World Medical Association</p> <p>8 Response to 'Our man in Havana'
Dr D Maasdorp and Dr M T Nodikida</p> <p>10 Trade Union: Making a difference in members' living and working conditions
Mpotlana D Madiba and Ntokozi Sibeko</p> <p>11 Member profile
Dr Langanani Mbodi</p> <p>13 In memory of Prof. Peter Jacobs
Prof. Wim de Villiers</p> | <p>14 FPD making a difference
Foundation for Professional Development</p> <p>15 SAMA members gain access to two CPD courses
Medical Practice Consulting</p> <p>16 CPD Unit oversees continuing medical education
Lisa Reid, SAMA CPD Unit</p> <p>SARA NEC do charity work</p> <p>17 DoH holds health communications forum
Zukiswa Nomnganga</p> <p>18 Annual Report 2012 available online
SAMA Legal and Governance Department</p> <p>19 MEDICINE AND THE LAW
Persistent pain in the leg
Medical Protection Society</p> <p>20 BRANCH NEWS</p> |
|---|--|



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EDITOR'S NOTE

DEC 2013/JAN 2014



Conrad Strydom
Editor: *SAMA INSIDER*

SAMA gives doctors a unified identity

Whenever I read a Jeremy Clarkson article and he describes the latest sports car as Usain Bolt's mutant cousin or a shoddy skorokoro as the equivalent of a granny on a tricycle, I reach for some way to personify the South African medical field. The best I can come up with is that the health sector is a bit like one of those clever kids who struggle though life despite their endowments, almost like the maths prodigy from *Good Will Hunting*. There appears to be almost limitless potential, but somehow factors both internal and external have prevented its emergence.

In this case, it is perhaps best to see SAMA as the concerned friend who gives our aimless hero a lift when he needs to get to work. The struggle for equal healthcare and unity among doctors will not and has not been taken up by any other non-governmental organisation. Over the past year, SAMA has contributed to the healthcare sector in many ways, whether expanding its relationship with the DoH, launching its Positive Practice Environment (PPE) campaigns, and advocating for its members on such crucial issues as RWOPS and the controversial GP contracts.

This issue of the *Insider* includes a report from the World Medical Association's recent general assembly in Fortaleza, Brazil. SAMA was very active at the event, which was attended by newly-elected president Prof. Ames Dhai and SAMA chairperson Dr Mzukisi Grootboom. We also feature an issue which has sparked some surprisingly heated debate: the Cuban doctor programme. 2013 has undoubtedly been the year of the SAMA Trade Union – we recognise their activities on pages 10 and 11.

For medical practitioners 2014 looks both ominous and promising. However, until the future has come to pass, SAMA wishes you pleasant practice, a merry Christmas and a happy new year.

Erratum: The authorship of the image on the cover of the November 2013 Insider was not known to us at the time of print and was therefore published unattributed. We have since learned that the photograph was taken by Dr Basil Stathoulis. We apologise for any inconvenience caused.

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DoH previews NHI White Paper



Prof. Ames Dhai, President, SAMA

On Friday, 8 November, the Department of Health held a Consultative Meeting on the National Health Insurance (NHI). The four main themes for the consultation were enhancing quality of care; strengthening the service delivery platform; strengthening partnership; and improving access to medicine. Minister of Health, Dr P A Motsoaledi's message was clearly spelt out at the very outset: for the NHI to be successful the current health system has to be overhauled and system failures need to be sorted out. Moreover, a response was necessary for the social barriers that afflict society. Built into his message was the importance of ensuring that the six building blocks of universal coverage as espoused by the World Health Organization (WHO) were satisfied.

The WHO views health systems financing, essential medicines and health technologies, governance, health work force, health information and resources and health systems service delivery as essentials of universal health coverage. It is understandable why these six are deemed to be the building blocks when one considers the definition of universal health coverage, namely: "... ensuring that all people have access to needed promotive, preventive, curative, and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services." (WHO). In many countries across the globe, universal health

coverage has become a major goal for health reform and since the publication of the World Health Report in 2010, more than seventy developing countries have embarked on the journey to implement universal coverage, which is also a priority objective of the WHO.

The WHO constitution of 1948, when declaring health to be a fundamental human right, solidly entrenched universal healthcare coverage as a foundational principle. Moreover, universal coverage was on the Health for All agenda set by the Alma-Ata Declaration in 1978. If properly implemented, universal coverage will achieve equity in healthcare access in line with the ethical principle of justice. However, for the principle to be comprehensively satisfied, equity must be coupled with a high quality standard that will allow for the improvement of health for those that receive the services. Furthermore, justice and equity will mean that the cost of healthcare will not result in financial burdens to people who require care.

NHI seems to be reasonably firmly on the agenda for South African healthcare and has been extensively debated since the Green Paper was issued in 2011. While the White Paper was expected early last year, there is as yet no sign of the document. Needless to say, much speculation has ensued as to when South African society will have access to it. The NHI National Consultation informed delegates that the White Paper has reached the final stages. So, we continue the waiting game. However, some information as to the contents of the White Paper was shared at the Consultation. To achieve the principles of the NHI, structures like the National Public Health Institute (NAPHISA), and the Office of Health Standards Compliance (OHSC) would be set up.

The OHSC is provided for by the National Health Amendment Act (Act No.12 of 2013), which was assented to by the President on 24 July this year. The objectives of the OHSC are to protect and promote the safety of patients (sec78), and this is to be achieved by the Office monitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister in relation to the national health system. In addition the Office is to expeditiously consider, investigate and dispose of complaints that relate to non-

compliance with the prescribed norms and standards in a manner that is procedurally fair. The Office will be responsible for regulatory and policy matters for quality healthcare. At the Consultation, Dr C Marshall, Cluster Manager: Office of Standards Compliance discussed the role of this office in relation to the NHI. The Office will inspect and certify all health establishments. Compliance and accreditation will be necessary for funding from the NHI.

Considering the current state of public sector establishments, it will be interesting to observe how many will be funded and how the situation regarding healthcare delivery to the index population group will be achieved if such an establishment cannot be accredited or has its accreditation withdrawn. Where will these patients receive their healthcare from?

Corruption will have to be converted into a nightmare of the past

Quality access and equity will be achieved if inter alia our health systems are strong, efficient and well run, essential medicines and technologies are available and there are adequate numbers of healthcare workers. Corruption will have to be converted into a nightmare of the past and healthcare will of necessity shift from being the ambulance waiting for casualties and victims at the bottom of the cliff. Health cannot be viewed in a vacuum. It is very much dependant on its social determinants.

Besides, while the focus of the NHI is that of primary healthcare and general practitioners from the private sector are being contracted into the health establishments as service providers, the role of the private specialist in the delivery of quality healthcare must be highlighted. Meaningful private-public partnerships at all levels will have to be recognised as being essential to the success of universal coverage in South Africa.



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WMA General Assembly – a leap forward in global health

Editorial provided by the World Medical Association

Delegates from more than 45 national medical associations (including SAMA president Prof Ames Dhai and chairperson Dr Mzukisi Grootboom) attended the annual General Assembly of the WMA in Fortaleza, Brazil from 16 to 19 October. Among the issues discussed were:

Declaration of Helsinki

The Assembly adopted a revised Declaration of Helsinki.

Syrian healthcare

An emergency resolution was approved urging all parties in the Syrian conflict to ensure the safety of healthcare personnel and their patients, as well as medical facilities and medical transport. Delegates expressed their alarm about the attacks in Syria on healthcare institutions and the fact that healthcare personnel had fled the country. The meeting heard that more than a third of the country's hospitals had been destroyed and 15 000 physicians had fled the country.

Dr Margaret Mungherera, president of the WMA, said: "All parties in this conflict have legal and moral duties not to interfere with medical care for wounded or sick combatants and civilians, and not to attack medical functions. Physicians and other healthcare personnel must act as neutral and be considered as neutral and must not be prevented from fulfilling their duties."

Prohibition of chemical weapons

A ban on the development, production, stockpiling and use of chemical weapons was called for and nations were urged to support the safe destruction of all stockpiled chemical weapons. The meeting supported the United Nations initiatives to identify anyone who was responsible for the use of chemical weapons and to bring them to justice. And it issued a reminder that the use of chemical weapons constituted a crime against humanity, whether used against civilian or military people. Delegates also urged states using chemical agents in riot control to carefully consider and minimise the risks and, wherever possible, to refrain from their use.

Moratorium on use of death penalty

The Assembly agreed to support the United Nations General Assembly Resolution calling

for a moratorium on the use of the death penalty and said that it is unethical for physicians to take part in capital punishment. In a statement it made clear that the WMA Declaration of Geneva obliges physicians to maintain the utmost respect for human life, while at the same time acknowledging that the views prevalent in the countries of some of its members prevent all members unconditionally opposing the death penalty.

Criminalisation of medical practice

Government attempts to control physicians' practice of medicine, including criminalising medical decision making were condemned. Delegates protested that governments had tried to prevent medically indicated procedures, to mandate medical procedures that were not indicated and to mandate certain prescribing practices. In addition, criminal penalties had been imposed on physicians for various aspects of medical practice, including medical errors, despite the availability of adequate non-criminal redress.

National medical associations were urged to oppose government intrusions into the practice of medicine. The resolution opposed criminalising medical judgment, healthcare decisions, including physician variance from guidelines and standards, and medical care provided to patients injured in civil conflicts.

Dr Mukesh Haikerwal, chair of the WMA, said: "The WMA believes that doctors who commit criminal acts which are not part of patient care must remain as liable to sanctions as all other members of society. Serious abuses of medical practice must be subject to sanctions, usually through professional regulatory processes.

"But criminalising medical decision making is a disservice to patients and will have detrimental effects on healthcare."

Support for the Brazilian Medical Association

The Assembly called on the Brazilian government to work with the country's physicians on medical education, physician certification and the practice of medicine, and to respect the role of the Brazilian Medical Association. It adopted a resolution condemning any policy and practice that disrupted the accepted standards of medical



SAMA's marketing and communications manager Zali Mbombo, board chairperson Dr Mzukisi Grootboom, newly-elected WMA president Dr Margaret Mungherera, and SAMA president Prof. Ames Dhai

credentials and medical care. It urged the Brazilian government to respect the WMA's International Code of Medical Ethics.

The resolution was adopted against the background of the 'Mais Médicos' programme in Brazil to create more medical schools, extend the duration of the medical course, compulsorily place last years medical students to work in public services and attract foreign physicians to work in remote and poorer areas of the country.

New policy documents were adopted on:

- Women's rights to healthcare and relating to mother and child HIV infection;
- Forensic investigations of the missing;
- Right to rehabilitation of victims of torture;
- Human Papillomavirus vaccination;
- Fungal disease diagnosis and management.

President and president elect

Dr Margaret Mungherera, president of the Uganda Medical Association, was installed as president for 2013/14 and Dr Xavier Deau, president of the European and international delegation of the French Medical Council, was elected unopposed as President elect.

New members

Applications for membership from the national medical associations of Cameroun, Italy, Montenegro and Sudan, were accepted, bringing the total number of World Medical Association NMA's to 106.

Response to ‘Our man in Havana’

There has been quite a heated response to the article entitled ‘Our man in Havana’ in the *SAMA Insider* of October 2013. The article, which took the form of an interview with Dr Mzu Theo Nodikida, a member of the national executive council of the Junior Doctors Association of South Africa (JUDASA), defended the Cuban-South African medical training exchange programme which has for some time now been used to supplement the number of South African medical graduates. The following is a letter by Dr Donald Maasdorp, an OB/GYN who works in Johannesburg, which refutes many of Dr Nodikida’s claims. It is followed by Dr Nodikida’s response to Dr Maasdorp.

Good day,
I have read your article about Cuba and for some reason it got my back up in an unusual way. Some of the comments are not fair and as a doctor who has to deal with the products from Cuba I think the article is misleading.

The young doctor may not know the history behind the programme other than ‘we need more doctors’. Cuba has done very well in transforming their healthcare system, but they now use it as a financial tool. They have 25 medical schools and produce, depending on what you read, 4 000 to 11 000 doctors annually most of whom are foreigners or will end up in foreign countries. For our students to study in Cuba we had to agree to a few conditions. The students who were selected are predominantly from previously disadvantaged backgrounds and the entry requirements were lower than what it would be in South Africa. The conditions include qualified doctors from Cuba working in SA and getting paid very little – 37% of that income goes to the Cuban government. However, we were asked to provide accommodation, food and a white lab coat to one doctor among other things. I had the pleasure, very early in my career, of working with an obstetrician from Cuba, and was very impressed.

Currently the doctor to patient ratio in Cuba is even better than the USA, so exporting doctors is a major ‘industry’ for them. They may have many medical professionals, but they still have issues not unlike SA including shortages of equipment and medication.

They train young doctors who come back to SA having come mostly from rural areas, learned Spanish, and now have to pass medical exams in English (the article mentions that some terms cannot be translated). I find the students have to translate into Spanish what they are asked, convert it into their own ‘local’ language, think about it and translate it again from Spanish to English to answer a question. They may know the work, but in an exam situation and during teaching they are left behind as “we are not as close to our students” as they are in Cuba. At Rahima Moosa we have tried to overcome that as the HOD speaks Spanish, but it is still difficult. The highest ranked university in Cuba is only ranked 1 544 in the world.

Some of the comments are not fair and as a doctor who has to deal with the products from Cuba I think the article is misleading

If the focus in Cuba is on primary healthcare then the curriculum is not the same, and cannot be considering what we face daily. As this young doctor may know TB is a medical indicator of poverty and the highest stats in the world are from the Western Cape. Cuba has a population of 11 million – hardly comparable. I agree that our patients are not yet educated enough to take preventative medicine seriously, and that’s why I still see so much HIV and cervical cancer presenting very late and so many patients with preventable diseases. Some of my friends and former classmates are doing very well by treating and not preventing. We are far from having enough doctors, nurses or allied medical professionals and maybe Cuba will contribute, but it has multiple loopholes not too unlike the GEMP programme currently offered in some universities. The cost of

producing a doctor is very high but we are making advances. For example, plans are afoot to build more universities.

Lastly, the South African culture ensured that 137 students went on a strike in Cuba this year and while I’m not clear on their ‘demands’, it indicates that all is not ‘hunky dory’ in Cuba.

My reason for this letter is not because I want them to scrap the programme, but rather to look at how we can improve on it and learn from it.

Regards,
Dr Donald Maasdorp

*Dear Dr Maasdorp,
I think you are misinformed about a number of issues regarding the SA-Cuba medical collaboration.*

You clearly do not understand the basis of the collaboration between our countries. It can be traced back in history to the apartheid years on the battlefields of Cuito Canavale in Angola. At the dawn of our democracy President Mandela approached President Fidel Castro and they discussed possible new ways of collaboration. Healthcare became a natural point of collaboration, especially in the rural areas, which were hit hard by the apartheid system, with missionary hospitals that were built without considering issues of accessibility and few or no doctors at all.

In 1995 President Mandela and President Castro signed a Declaration of Intent and on 30 October 1996 the Cooperation in the Fields of Health and Medical Sciences Agreement was signed. The original agreement was to recruit doctors to serve in rural SA. In 1997 the agreement was revised to include medical students in Cuba, because at some stage Cuban doctors would have to go back home or to other missions and SA had less than nine medical schools for more than 40 million people.

In 2001 it was revised to allow students to come back for integration. This was done for obvious reasons, particularly that one would like to train students in the country they will practice in, but there was no space in SA thanks to universities’ admission quotas. The

two governments just recently signed a new agreement on 25 May 2012.

Cuban doctors are working in areas where healthcare used to be only a dream. They do this around the world and this requires that a percentage of their salary goes to the Cuban government. This is because education and health are free in Cuba from grade R to specialisation. In a third world country like Cuba the money for this subsidisation needs to come from somewhere; however, that is a policy of the Cuban government, not a condition on SA-Cuba medical collaboration.

Secondly the students were obviously from previously disadvantaged backgrounds, but it is not true that they would not have met the criteria of South African medical schools. Some of the students were already in universities and some already in medical school but had dropped out on financial grounds, so it is disingenuous and inaccurate to portray the students who have been trained or training in Cuba as a bunch of students who were just grabbed roaming around the rural areas, unable to express themselves in English. Yes, most of the students are from rural areas, but their poverty stricken background has served as an inspiration for many to become the doctors and the responsible citizens that we are today.

Students who had academic problems in Cuba will obviously have problems in South Africa. Patients are not interested in where you were trained, they need a doctor. Obviously the Cuban trained will have more challenges because they have been trained differently in a completely different setting hence they struggle to adjust. The situation is made worse by the hostile environment they find in the SA universities when they come back.

These students should actually serve as an example to stay in environments where learning and training is provided with passion and high levels of patriotism. The objective should be to produce a highly integrated professional with a social not an individual conscience – students will thrive and the country will benefit.

Any student who gets a scholarship is entitled to accommodation, food and all the necessary things that one needs for training. In Cuba it’s no different so it’s not a condition that is only applicable to the SA-Cuba medical collaboration.

In Cuba we take close to six months to learn Spanish. We study medicine in Spanish, and when we get home it’s obvious that our medical knowledge is in Spanish therefore it is

wishful thinking, based on unrealistic hopes, to think that we would be just like the students who started their first year in SA. For someone to learn a foreign language in less than a year, study medicine in that language and, like some of us have done, go on and specialise with the colleges of medicines in SA – I would think twice before questioning someone like that’s intelligence.

English is not our first language, therefore our thinking has always been in our mother tongue, not English.

Why question the intelligence of someone who learns Spanish in less than a year, studies medicine in that language then goes on to specialise in a local medical college?

The Cuban government has made healthcare and education a priority – a basic right of all Cuban people. They also realised very early that the best way to deal with human disease is to prevent it from happening, and they invested a lot into research looking for the best suitable approach for their public health – the fruits of their hard work are for everyone to see. Cuba did not ignore the curative aspect of medicine but instead strengthened it. Cuba is one of a few third world countries who do not fly out their president when sick. They have a cardio-centre right in the middle of a small town that caters not only to Cubans but also foreign patients.

Yes, their emphasis is on a preventive approach simply because it makes economic sense and is sustainable, but the theoretical and clinical practice in hospitals is basically the same, with the exception of trauma cases, gunshot wounds and multiple trauma patients. The year of integration in SA provides

us with more than enough necessary exposure to those things.

With regard to the rankings, I am very sceptical about them. As Dr Maasdorp may or may not know, Cuba has been under an economic embargo for more than four decades by the US and its cronies so the objectivity of any ranking of a Cuban university will have to be taken with a pinch of salt.

“In SA our universities are among the best in the world” – by whose standards? In terms of the health outcomes of a country, what do we have to show?

Unfortunately the centres for specialisation are in big cities and Cuban-trained doctors want to grow in the profession like everyone else. The country needs all the specialised skills it can get so until the centres of study are brought closer to the majority of people, you will see the doctors in cities growing in the profession having worked a year or two as MOs in their areas of origin.

In my opinion what the Cubans are doing works for them regardless of how low the imperialist world ranks them. They continue to rank us (SA) highly and we spend 8.5% of our GDP – more than what the WHO (World Health Organization) recommends (5.5%) on health, yet our outcomes are still terrible.

The NHI is a clear demonstration of how SA has realised that curative orientated and hospi-centric medicine is economically impossible to sustain, ethically difficult to defend and therefore a failure.

The system has failed our people over and over again. It is time for a paradigm shift to a more integrated health system with more emphasis on prevention of diseases and promotion of healthy lifestyle without ignoring the need for state of the art equipment for research and complex curative procedures.

Lastly, TB may be a medical indicator of poverty but then Cuba is a third world country that has eliminated it. Something is wrong with stats that point to the highest levels of pulmonary tuberculosis in the Western Cape because I would imagine the Eastern Cape and Limpopo would be the ones with the highest prevalence of poverty related diseases.

Obviously SA must get its house in order in terms of increasing the intake for medicine and building more medical schools. Until then the Cuban programme will continue to contribute to our health system in whichever way possible.

Regards,
Dr Mzu Theo Nodikida

Trade Union: Making a difference in members' living and working conditions

Advocate Daniel Madiba and Ntokozo Sibeko

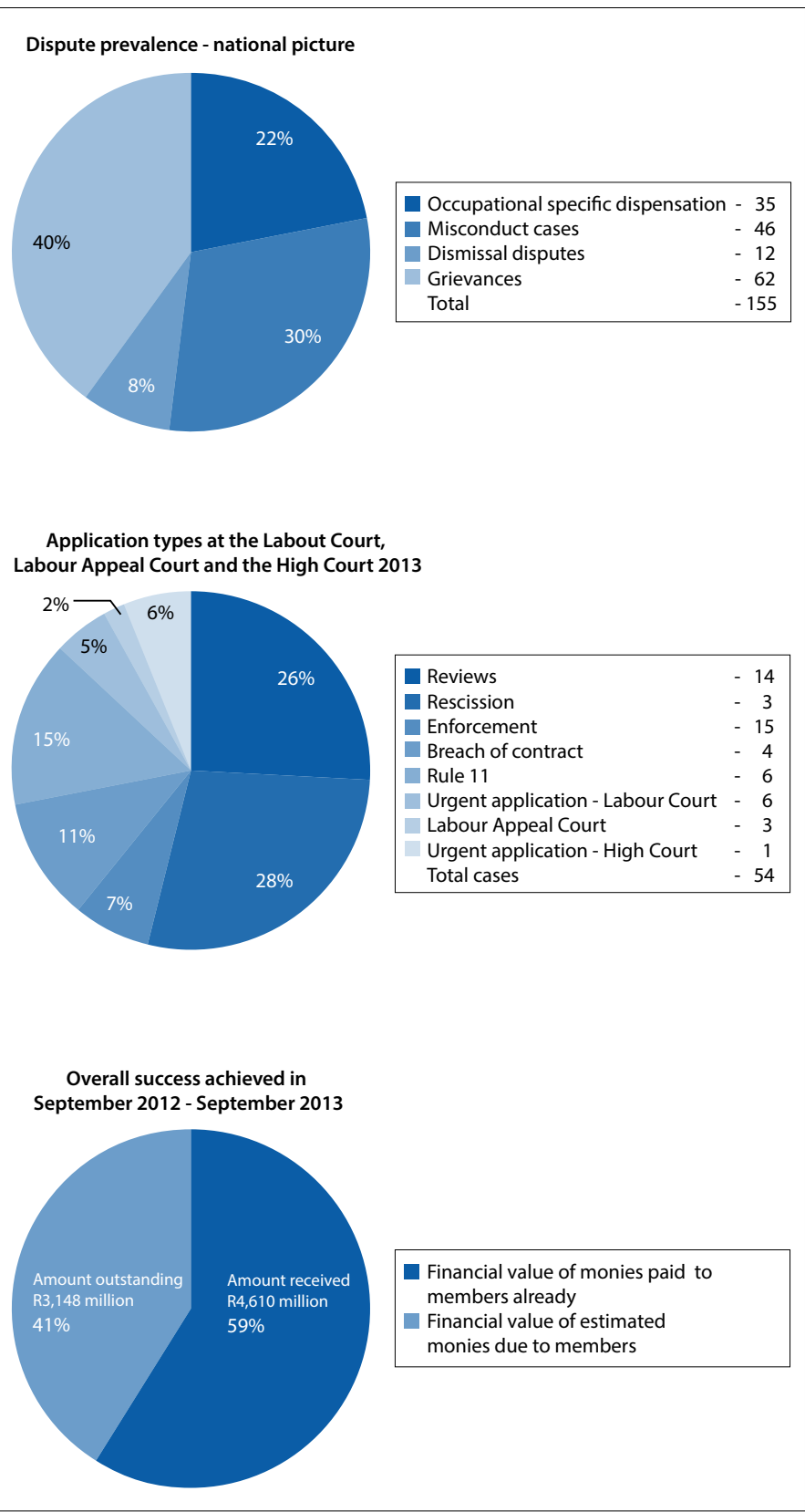
The dawn of the year 2013 saw significant changes being made by the Association in the manner in which business is done in SAMA – ensuring that services are improved and become more membership orientated. A special general meeting of all SAMA members was convened and the New Memorandum of Incorporation and Company Rules was adopted. These rules recognised that the Association has an independent trade union constitution that facilitates the independent functioning of trade union affairs. More particularly the rules aimed at serving the employed members of the Association better.

On 2 March 2013, a special general meeting of all employed SAMA members was convened at SAMA head offices to consider and approve the Trade Union Constitution. The members present at the meeting engaged on this vitally important matter and resolved to adopt the Constitution of the SAMA Trade Union. The adoption of the constitution ensured that the Trade union was registered in November 1996 to become fully compliant with all legal prescripts relating to trade unions. The constitution was then lodged with the Registrar of Labour Relations and ultimately certified on 18 April 2013. The provisions of the constitution took legal effect immediately on certification.

The scope of the Trade Union's functions was extended to include SAMA members who are employed in sectors other than the public service. The broadened scope extends to any other members of the Association who, by definition, are employees rendering service to employers anywhere else including NHLS, SABS and the Mines, just to mention a few.

During 2013

Given the new developments in the Association, the Public Sector department, which is the central hub of trade union business, continued to ensure that not only do we ensure continued protection of our members' employment rights through dispute prevention and resolution but also advance and improve their general conditions of employment through collective bargaining in the public service bargaining councils as well as through advocacy and influencing policy direction.



Dispute management (Industrial relations)

The Trade Union handled the following types of cases in the dispute resolution forums other than the Courts in 2013 (see the Dispute Prevalence graph on page 10).

The cases can be broken down in the following manner:

Occupational Specific Dispensation	35
Misconduct cases	46
Dismissal disputes	12
Grievances	62
Total:	155

In terms of matters handled on behalf of our members in the Courts, the breakdown illustrated in the graph 'Application Types at the Labour Court' on Page 10 paints the picture.

The following numerical breakdown may be deducted from the matters handled:

Labour Court, Labour Appeal and High Court 2013	
Reviews	14
Rescission	3
Enforcement	15
Breach of Contract	4
Rule 11	6
Urgent application – Labour Court	6
Labour Appeal Court	3
Urgent application – High Court	1
Total cases	54

Financial gain directly to members

The Trade Union, in handling all cases on behalf of members, contributed significant financial gains to members in respect of case outcomes obtained in favour of members in the Bargaining Councils as well as the various Courts. The graph on the bottom of page 10 is a breakdown of the financial gains made and paid directly to members as well as those where payment is still outstanding.

The members have over the 2013 financial year enjoyed significant payments directly into their pockets which may be broken down in the following manner:

- Payments made in favour of members: R 4 610 000. 00
- Outstanding payments to members: R 3 148 058. 00

A total sum of nearly seven and half million rand was raised in favour of members this year. These gains signal a positive contribution towards improving the living and working conditions of SAMA members.

Ending 2013

As we move towards the close of 2013, it is evident that the contribution of the Trade Union to members has been nothing less than significant over the year 2013; however more still needs to be done to achieve more favourable conditions for members into 2014 and beyond.

Member profile: Dr Langanani Mbodi



How did you become involved in medicine?

I was born in a village called Tshikovha in Limpopo Province. As a child, I was lucky enough to be surrounded by people who affirmed my status as an individual. I was raised to believe that I was destined for better things, and this developed my confidence as a child, so that setting my sights on a medical career never seemed impossible. I first enrolled at the Venda Nursing College and obtained a Diploma in Nursing in 2000 and worked at Buffelshoek Clinic in Bochum for a year. But I needed a bigger challenge, so in 2002 I went to Medunsa to study medicine. During my first year I met my beautiful future wife, Dr Lebogang Mogashoa-Mbodi.

What drives you?

I like to put my dreams into action. As a doctor, being able to tangibly change the course of people's lives is very rewarding. Medicine remains a unique degree and a profession that does not only teach or equip you with skills to treat people and save lives. It teaches you how to live with yourself, other people and to appreciate the little things you get from life. This is a very challenging career, but on the

plus side it does give you an opportunity to constantly improve yourself. That – and my family – keeps me motivated.

What are the challenges facing the medical profession today?

The country's medical sector has experienced a massive brain drain and there is an overall sense of dissatisfaction among those who have remained in the country. The state of the education system demotivates children with little resources from attempting to become physicians, and this is a great shame. I did not have access to a library or laboratory while I was at school, but I managed to push through and realise my dreams. It pains me to think that many disadvantaged children do not realise that being a doctor is within their grasp.

The youth of this country should be afforded the right to dream big no matter where they are in the social strata. Good things don't come to those who wait, but to those who make an effort. If you have a vision of where you want to be and some patience, your success is inevitable. As we say where I'm from, "Nga zwituku nga zwituku, ri khou sendela" (little by little, we will get there).

THE SOUTH AFRICAN MEDICAL ASSOCIATION



GENERAL MANAGER

The South African Medical Association (SAMA) is seeking to appoint a General Manager at their Head Office in Erasmuskloof, Pretoria.

Job Purpose:

The General Manager acts as the Head of the SAMA Head Office Structures/ Secretariat and is responsible for the operational success of SAMA. Taking the strategic direction set by the Board, the General Manager ensures that the implementation thereof maintains SAMA's relevance to its members, accomplishes SAMA's mission and vision, and adheres to SAMA's accountability and responsibilities to its diverse constituents.

The Board delegates responsibility for management of SAMA's affairs and day-to-day operations to the General Manager, and s/he has the authority to carry out these responsibilities, in accordance with the direction and policies established by the Board. The General Manager also provides direction to the Board and supports the Board in the carrying out of its governance functions.

Term: Full time – performance agreement over a period of 3 years

To apply: submit a covering letter and a detailed CV to Ms Dudu Mashinini.
Email: dudum@samedical.org

For more details on this position please visit our SAMA website on www.samedical.org.

Closing date: 13 December 2013

Trade Union NEC determines future course

The national executive council (NEC) of the SAMA Trade Union held their first general meeting on 18 October at the Birchwood OR Tambo Hotel in Boksburg. Members of the Trade Union NEC met with representatives of the Trade Union's affiliate bodies, the South African Registrar's Association (SARA), the Junior Doctors Association of South Africa (JUDASA), the Senior Doctors Association of South Africa (SEDASA) and the Academic Doctors Association of South Africa (ADASA) to discuss the union's immediate goals.

One of the first decisions taken was to set up Trade Union structures in all the provinces and establish shop stewards in every hospital in South Africa. This was seen as a vital first step towards solidifying the union's presence in the national health sector. Next on the agenda were the issues of RWOPS and commuted overtime. The Trade Union NEC decided to keep pushing the national Department of Health (DoH) to adopt SAMA's policies on these matters, which have not been receiving the urgent attention they require.

The medical litigation crisis was discussed at length, with legal options to combat the growing scourge being tabled. Also



Front row, from left to right: Dr Zameer Brey, Dr Mahlane Phalane, Dr Langanani Mbodi, Dr Courage Khoza, Dr Phophi Ramathuba, Dr Bulelani Matha and Dr Mbulelo Diba. Back row: Dr Louis Du Pisani, Dr Shailendra Shem and Prof. Soomnarin Naidoo

mentioned were the Positive Practice Environment (PPE) campaign which SAMA is spearheading in conjunction with the Democratic Nursing Organisation of South Africa (DENOSA). The most recent PPE campaign was launched in Gauteng, and the campaign has received a lot of positive responses so far. Another issue which was discussed was the growing international

relations between the SAMA Trade Union and its international sister unions, especially in Africa.

A health promotion event was hosted by the Trade Union on 5 December in Kathlehong. A mini marathon, to raise awareness of HIV/Aids among the community, was held at the event which was attended by SAMA members.

In loving memory of Emeritus Prof. Peter Jacobs

Prof. Wim de Villiers, Dean, Faculty of Health Sciences, UCT



It is with sadness that I inform you of the passing of Emeritus Professor Peter Jacobs on Monday, 18 November 2013. He had been unwell for the past year, and passed away peacefully at home in the presence of his wife.

Peter Jacobs had a long and eventful career after becoming the foundation head of the Department of Haematology at UCT in 1972, a post he held until his retirement from UCT in 1994.

He then continued to work in private practice and developed the Bone Marrow Transplant Unit at Constantiaberg hospital which he ran until his final retirement in February 2011.

He was central to the development of haematology as a discipline in South Africa and was instrumental in the development of bone marrow transplantation in this country. He contributed to many professional societies

and was the recipient of many awards for his unstinting efforts as a teacher and innovator in the field of haematology.

A life-long and esteemed member of SAMA, Prof. Jacobs received an award for Fellowship in the Art and Science of Medicine at the SAMA-Bonitas Doctors Awards.

His energy and work ethic were legendary in the Faculty during his years in office, and he will be fondly remembered by scores of students who benefited from his approach to both undergraduate and postgraduate teaching during his long academic career.

His family will be arranging a private cremation and a memorial ceremony will be held at an appropriate time.

We wish his wife, Di, and two sons, Sean (UK) and Wayne (Australia), much strength during this time of sadness, and will keep them in our thoughts, prayers and meditations.

FPD making a difference

Sixteen years ago SAMA established the Foundation for Professional Development (FPD) with the vision of building a better society through education and development. From modest beginnings with three staff members and an annual budget of R600 000 FPD has grown into a 700 people institution with a R 400 million annual turnover. FPDs mission is to catalyse change through developing people, strengthening systems and providing innovative solutions to healthcare challenges driving the expansion of FPDs activities to 16 countries in Africa.

FPD's educational programmes include both formal qualifications and short courses to address the managerial and clinical development needs of the healthcare sector. In 2013 they reached more than 45 000 participants. To date more than 245 000 students have enrolled in FPD courses – making it one of the largest health sector training institutions in Africa.

Conferences are another conduit that FPD uses to effect change through debate and by creating a platform to profile major public health issues. FPD is also increasingly focussing its activities on addressing youth unemployment through learnership and apprenticeship programmes.

Since 2005 FPD has also been involved in substantial health system strengthening activities including:

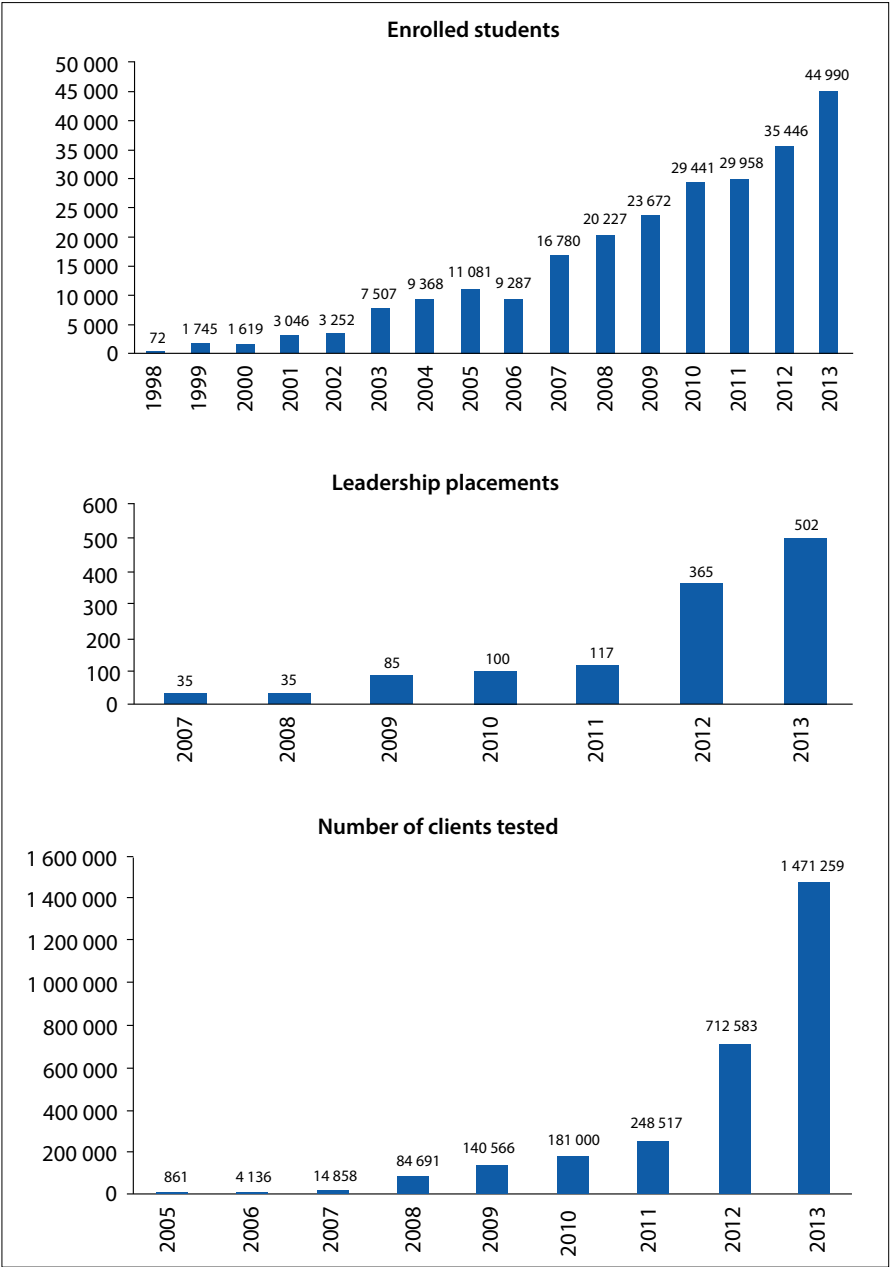
- A PEPFAR/USAID funded partnership with government that has supported treatment initiation of 397 616 people living with AIDS and provided free HIV tests to 2 858 471 clients.
- Supporting the public sector by recruiting 2 600 healthcare professionals for public sector facilities.
- Supporting the University of Pretoria to establish an Infectious Diseases Dept.
- Establishing a healthcare professional toll free hotline for AIDS treatment at the University of Cape Town.
- Supporting the establishment of an Pharmacovigilance Unit at Medunsa.
- Supporting the Info4 Africa project at the University of KZN to publish the national series of HIV service delivery directories.

In 2012 FPD expanded its PEPFAR funded health systems strengthening project to include partnering with nine districts in South Africa to provide technical assistance to district management. This five year consultancy and mentoring project will improve service delivery to 21% of the country's population.

In 2013 FPD increased its activities around gender based violence, and has partnered

with USAID, Soul City Institute, Sonke Gender Justice Network and the MRC to support the Thuthuzela rape support project of the NPA.

2013 has been a memorable and successful year and FPD wishes to use this opportunity to thank SAMA, health care professionals and all our funders and partners for all your support in helping us make a difference.



SAMA members gain access to two CPD courses

SAMA members can now gain free access to two CPD short courses designed by The Foundation for Professional Development, sponsored by Merck Serono and hosted online by Medical Practice Consulting.

Medical Practice Consulting (MPC) and the Foundation for Professional Development (FPD) have joined forces to offer South African healthcare professionals online Continuing Professional Development (CPD) courses that are topical and relevant to delivering healthcare services in South Africa. The FPD is registered with the Department of Higher Education and Training (DHET) as a Private Higher Education Institution (PHEI) in terms of Section 54(1)(c) of the Act and Regulation 16(4)(a). The FPD is a subsidiary of the South African Medical Association and also an institutional member of the South African Institute of Healthcare Managers.

The FPD School of Health Sciences has been the leader in training healthcare professionals since 1997 and takes pride in being recognised as pinnacle product leaders and innovators in the healthcare industry. Research has shown that 54% of all doctors have studied with the FPD and continue to do so by earning required annual CEUs through the completion of courses. The FPD receives numerous annual

educational grants, which make it possible to reduce training costs on a large number of training programmes.

The portfolio of Health Science courses are specifically designed to enhance the clinical skills of healthcare professionals and taught through a combination of assessed self-study (with study material and online training) and facilitated workshops, led by national experts. The FPD is accredited by the Medical and Dental Board of Health Professions Council of South Africa as a CPD service provider. All FPD programmes are accredited on an annual basis according to HPCSA rules and regulations to qualify for CEU points.

The Medical Practice Consulting online CME and MCQ system is the only online training solution approved by the FPD. The online CME and MCQ system is easy to use and allows users the freedom to access the system not only from personal computers but also from any Android Tablet or Apple I-Pad. All FPD programmes offered through this medium boast the highest standard – as its alumni have come to expect.

The South African Medical Association (SAMA), MPC and the FPD have joined forces with Merck Serono to offer SAMA members free access to two online CPD short courses:

- Fertility
- Hypothyroidism

All SAMA members have free access to attend the event online as part of their SAMA member benefits. The online CPD courses are accredited as short courses and you will be rewarded with three CPD points upon completion of the short ten mark multiple choice questionnaire (MCQ).

MPC and FPD also offer the following accredited online CPD events at a reduced cost of R456.00 (including VAT) to all SAMA members:

- HIV/AIDS Counselling and Testing Course
- Management of Tuberculosis for Healthcare Professional
- Store Persons Course
- Course in Diabetes Mellitus
- Paediatric HIV/AIDS Management Course
- Sexually Transmitted Infections
- Management of Cardiovascular Disease
- Management of Common Vascular Diseases
- Mental Health
- Clinical Management of Asthma
- HIV/AIDS Management Course for Healthcare Professionals
- Ethics in the Healthcare Environment.

1 Online payment to apply for FPD course

2 Registration form and update of details to FPD

FPD SCHOOL OF HEALTH SCIENCES
BUILDING A BETTER SOCIETY THROUGH EDUCATION AND DEVELOPMENT

Registered with the Department of Education as a Private Institution of Higher Education under the higher education act, 1997. Registration number: 2002/HE07/013

Short Course in Hypothyroidism
FPD Registration Form

Return

Certain student information is required to enable FPD to report on student achievements to the authorities as required. We appreciate your assistance in ensuring that our records are complete

Title: Mr

MPC, the FPD and Merck Serono are offering SAMA members free access to online CPD courses in fertility and hypothyroidism

CPD Unit oversees continuing medical education

The South African Medical Association (SAMA) is an official CPD (Continuous Professional Development) Accreditor, appointed by and registered with the Health Professions Council of SA (HPCSA). The role of the SA Medical Association's CPD Unit is to review and approve applications for the provision of CPD activities within the ambit of the health profession.

In this regard the Unit reviews applications by organisations and individuals without accredited service provider status in order to monitor these activities and to revise the continuing education units (CEUs) allocated. As a CPD Accreditor SAMA can also provide accredited service provider status in respect of the annual curricula of service providers meeting certain prescribed criteria.

Each registered health professional is required to engage in CPD activities and to accumulate at least 30 CEUs per 12 month period, of which at least five CEUs should

be for ethics, human rights and medical law. CEUs accrued for CPD activities will be valid for a period of 24 months from the date that the activity took place or ended. Health professionals should therefore aim to accumulate a balance of 60 CEUs by the end of their second year of registration and thereafter. The requirement for compliance is to reach and maintain a level of 60 CEUs, of which at least ten CEUs should be for ethics, human rights and medical law.

All health professionals must ensure they are in possession of a certificate of attendance for every activity they have attended. These certificates should be kept for at least two years for auditing purposes. All health professionals must maintain a record of their own learning activities and document these on official HPCSA Individual CPD Activity Record Forms.

The purpose of CPD is to assist health professionals to acquire and maintain new and

updated levels of knowledge, expertise and ethical attitudes that will benefit them in practice and will promote professional education.

Health professionals practising in South Africa and attending an academic meeting or activity abroad should take cognisance of the fact that they need to have the overseas activity accredited by an Accreditor in South Africa, in order to obtain the CEU point equivalents for HPCSA audits. SAMA is able to accredit these activities.

Guided by the principle of beneficence, health professionals should aspire to standards of excellence in health care provision and delivery. Continuing Professional Development (CPD) enables the maintaining and updating of professional competence to ensure that the public interest will always be promoted and protected, and that the best possible services delivered to communities.

For all your CPD queries please contact Lisa Reid on 012 481 2082 or cpd@samedical.org

SARA NEC do charity work at Atteridgeville school

On Saturday 2 November, members of the South African Registrars Association's (SARA) national executive council visited Holy Trinity Catholic Secondary School, an independent school in Atteridgeville, west of Tshwane. Holy Trinity was established in 1950 by Catholic missionaries.

"Like many other schools in previously disadvantaged areas, this one does not have the well-resourced facilities that independent schools in urban areas enjoy," said SARA's Dr Lehnolono Majake.

Despite its obvious setbacks, Holy Trinity has consistently maintained a 100% Matric pass rate and has been instrumental in grooming many of Atteridgeville's current community leaders. The school has 340 children in total – 56 % boys and 44 % girls.

The SARA NEC chose this school as one of its social responsibility projects. "Our desire as SARA is to see every individual reach their scholastic potential. Our aim is to maintain this initiative as SARA's annual project whereby

various other schools of this calibre will be assisted," Dr Majake said.

"Education is the most powerful weapon which you can use to change the world." These are the words of our former president Nelson Mandela – the SARA NEC would like to observe these words and be true leaders of change in the world of academia. To this end,

they contributed their time to the rebuilding of the school's facilities.

SARA plans on refurbishing the school's library facilities. At the beginning of the year, the school library had no roof and was in a severely dilapidated state. SARA has since provided a roof for the building and hired labourers to repaint the library.



From left to right: The South African Registrar's Association's Dr S Jiyana, Dr L Majake, Dr O Mosiane, Dr N Masinga, Ms Girly Moseki, Dr JJ Jeme and Dr B Matha

DoH holds health communicator and health promoters' forum

Zukiswa Nomnganga

The National Department of Health (DoH) recently hosted its first forum specifically for health communicators and health promoters who support the national department's health programmes. The three-day conference was held at the OR Tambo Protea Hotel in Kempton Park from 11 to 13 November 2013 and carried the theme, 'Towards an integrated health communication and health promotion effort'.

According to Dr Motsoaledi: "The agenda that health communicators should be pushing is that of the prevention of diseases and health promotion"

The forum aimed at identifying ways in which both the communicators and health promoters can effectively communicate health programmes and included how health workers are to address these programmes and promote health in the communities in which they work.

The health communicators' forum was well-attended and included the National Minister of Health, Dr Aaron Motsoaledi and Director General, Ms Precious Matsotso, as key guest speakers.

Director General Matsotso addressed delegates on strategic guidance for communication and health promotion in achieving the department's strategic goals. In her speech, the Director General stressed that communication was essential to public health and that primary health was key to health promotion. She added that communication plays a pivotal role in influencing the norms and behaviours of health communication.

The speakers highlighted key areas that have a major impact on health promotion

and primary care, and their communication thereof. Social and cultural behaviours were one of the key points highlighted that need to be thoroughly looked at when approaching primary healthcare.

The National Minister of Health, Dr Aaron Motsoaledi, said: "The national dialogue in our country is not about health. We should create our own health agenda". He also added that, "the agenda that health communicators should be pushing is that of prevention of diseases and health promotion".

The Minister also highlighted the six building blocks of the healthcare system, as outlined by the World Health Organisation (WHO), which each health system should work towards. The building blocks are: leadership and governance, access to essential medicines and other commodities, health workforce or human resource, health system financing, healthcare information and research and lastly the health service delivery system.

Dr Motsoaledi urged communicators to define these blocks in relation to their own country which will assist in pushing the country's own health agenda. With this health agenda, health communicators should start engaging the public on the importance of universal health coverage with its main objective being; access to good quality and affordable healthcare for all citizens.

A representative from John Hopkins Health and Education South Africa gave a presentation on key lessons from health communication and Prof Laetitia Rispel addressed delegates on the key lessons learned from health promotion

in South Africa. Other health promotion organisations represented at the forum included, Soul City, Community Media Trust, Mindset and loveLife.

Delegates were exposed to how the department of health communicates health promotion programmes to achieve quality healthcare and improve health literacy among rural and disadvantaged communities.

The national department of health, together with Mindset and Health –e-News, launched a pilot film for the National Health Insurance TV channel which aims to improve communication with service users, healthcare providers and stakeholders. The roll-out of the channel will mainly be used by healthcare providers, programme managers, the general public and district clinical specialist teams.



Minister of Health Dr Aaron Motsoaledi addressing the Health Communicator's Forum in Kempton Park



Director General of Health Precious Matsotso with Dr Motsoaledi

Annual Report 2012 available online



Dr Mzukisi Grootboom, SAMA chairperson

SAMA's Legal and Governance Department has released the association's annual report for 2012 on the SAMA website (www.samedical.org/sama-annual-report-and-agm-minutes).

The report provides an overview of the association's current structure, including its various committees and subsidiaries, before reviewing the annual financial reports up to 31 December 2012. The reports were independently audited by PriceWaterhouseCoopers and are presented in a clear, easily-understood manner. Also of note is a report by Dr Mzukisi Grootboom, the chairperson of SAMA, outlining the struggles faced by the association. Dr Grootboom highlights the continued lack of unity among South African doctors as a major threat to doctors' interests and pledges to commit SAMA to the cause of unity.

An Annual General Meeting (AGM) was held on 29 November at the City Lodge at OR Tambo International Airport. SAMA members were invited to fill in proxy forms that were available online if they could not attend in person. Should the AGM not be quorate on 29 November, it would have been postponed to 6 December 2013. Please contact Sonette Viljoen for more information on 012 481 2039.

From the Chairman's Report

"There remain several challenges with regard to the private sector, particularly in the sphere of tariffs. The national Department of Health (DoH) is intent on fixing the prices that doctors may charge in the private sector and to this end has used the Health Professions' Council of South Africa (HPCSA) and the Competition Commission (CC) as proxies. Whilst SAMA acknowledges the role of the HPCSA in adjudicating in those instances of overcharging SAMA feels that its involvement in the determination of a Guideline Tariff is not only misplaced but *ultra vires*."

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Bristol-Myers Squibb (Pty) Limited. Reg. No. 1956/001115/07. Woodmead North Office Park, 54 Maxwell Drive, Woodmead, 2191, South Africa. PO Box 227, Sunninghill, 2157. Tel: (011) 808 5000. Fax: (011) 808 5301. AstraZeneca Pharmaceuticals (Pty) Ltd. Reg. No. 1992/005854/07. Building 2, Northdowns Office Park, 17 Georgian Crescent West, Bryanston, 2191. Private Bag X23, Bryanston, 2021. Tel: 011 797-6000. Fax: 011 797-6001. www.astrazeneca.co.za. Onglyza® is a registered trademark of BMS. For full details relating to any information above, please refer to the local prescribing information. Exp date: OCT 2014. Log number: COR 11/12/007.

Persistent pain in the leg

The Medical Protection Society shares a case report from their case files

Mr P, a 49-year-old taxi driver, had recently visited casualty with chest pain. He ended up being transferred to the local cardiac unit where, according to his brief discharge advice note, he had "emergency coronary bypass surgery (full discharge letter to follow)".

Three days later after getting home he developed aching discomfort in his right lower leg and reattended casualty, taking the discharge note with him. He was seen by Dr B who examined his lower leg and noted that the wound from his saphenous vein harvest site looked inflamed. He documented that there were no clinical signs of a deep venous thrombosis and discharged Mr P home with a course of oral flucloxacillin.

The following evening Mr P re-attended casualty as he was still getting intermittent pain and was seen by Dr A. After examining him Dr A obtained the notes from the previous day's visit and felt able to reassure Mr P that he simply had not given enough time for the antibiotics to work.

Mr P specifically asked about the possibility of deep vein thrombosis, but Dr A advised him that her colleague had considered that on his previous visit and felt it was very unlikely. Dr A noted in a statement she wrote for the subsequent investigation that she discharged Mr P with some stronger painkillers.

During the next two days, Mr P rang his General Practitioner Dr X on two occasions. Dr X went through his symptoms on the phone and noted that the casualty unit had "excluded a DVT" (he had not received any communication from casualty and had not yet received a full discharge summary from the tertiary unit). He reassured Mr P that he was happy with the assessment in casualty and that he should continue taking the antibiotics and the painkillers prescribed.

The following night Mr P, unable to sleep because of the pain, re-attended casualty. By now his leg was cold, pale and mottled. Further investigation identified an embolus occluding his femoral artery, which had arisen from the site of a coronary angiography he had had performed via the right groin. Despite the best efforts of the vascular surgical team he went on to require an above knee amputation.

Mr P made a claim against all the doctors who had been involved in his care prior to his last casualty attendance. The claim was settled for a substantial sum.

Learning points

- Examine your patient properly and fully – had the entire leg been assessed the femoral arterial puncture site would have been seen and may have led to earlier diagnosis of arterial problems.
- Earlier and fuller discharge letters might have similarly alerted the doctors involved to the fact that a coronary angiography had been carried out.
- Re-attending patients can easily be perceived as a nuisance, but should instead prompt consideration of why they are re-attending.
- Do not rely on a colleague's earlier diagnosis – they may have been wrong or things may have developed further, providing clues that they did not benefit from when they assessed the patient.
- Beware of blinkered decision-making. Doctors often use heuristic pattern

recognition to make rapid diagnoses, e.g., one's intuition, but this can lead to errors if the wrong pattern is recognised and alternate diagnoses are not considered.¹ Keep an open mind. Do not be afraid to rethink your original diagnosis.²

- Pain, out of keeping with the clinical findings or diagnosis, should always prompt review – and merits more than telephone advice, especially when a patient has undergone major surgery.

References

- Croskerry P, *Clinical cognition and diagnostic error: applications of a dual process model of reasoning*, *Adv in Health Sci Educ* 2009; 14:27–35, DOI 10.1007/s10459-009-9182-2
- Williams S, *Tunnel vision*, *Casebook* (May 2011)

The original case report can be found in MPS's edition of Casebook Vol. 21 no. 1 – January 2013 at <http://www.medicalprotection.org/southafrica/case-reports-january-2013/persistent-pain-in-the-leg>



KZN Coastal hosts memorial lecture and gala dinner

The KZN Coastal Branch held its annual memorial lecture and gala dinner on Saturday 23 November at the Southern Sun Elangeni Hotel in Durban. The event attracted a lot of attention and was attended by the provincial MEC for Health Dr Sibongiseni Dhlomo.

The memorial lecture was dedicated to the spirit of former Alan Taylor Residence leaders who endured blatant racism during their time as medical students at the Durban Medical School during the 1960s and 70s. The Alan Taylor Residence became a hub of activity for students interested in the emerging black consciousness and congress movements and contributed greatly to the national liberation struggle against apartheid.



Dr Ayanda Ntsaluba, Executive Director of Discovery Holdings



KZN Coastal Branch chairperson Dr Mergan Naidoo with Dr N Hira



Dr Fred Silongo, Dr KM Mazibuko, Dr NM Saraji and Dr LJ Mphatswa attended the gala dinner

Gauteng holds awards dinner

On 7 November the SAMA Gauteng branch held the first of its awards dinners. The dinner, brainchild of Prof. Martin Veller, aims to honour members of society for their significant contributions. The nominees are people who work mostly behind the scenes and whose contributions often go unrecognised. Candidates were nominated by the SAMA Gauteng members. These nominations were reviewed by the branch council and a recipient for each of the five categories selected. The awards will be held every two years.

The event, held at the Houghton Golf Club, was well attended by both branch members and special guests. Dr Kalli Spencer, branch chairperson, provided a brief welcome and

overview of a few of the branch's activities to date. Prof. Martin Veller continued the proceedings by introducing the awards recipients. The awards were presented by Dr Phophi Ramathuba, president of the SAMA Trade Union and Mr Hope Papo, the Gauteng MEC for Health.

The award recipients for 2013 were:

- Colleague Award – Prof. Moosa Patel
- Junior Colleague Award – Dr Kalli Spencer
- Medical Student – Ms Sule Burger
- Allied Health Professional – Prof. Laetitia Rispel
- Member of Society – Mr Mark Lubner



From left to right: Dr Phophi Ramathuba, Prof. Moosa Patel, Mr Hope Papo

Gauteng North ends 2013 with a bang



Dr Wilma Lotter receives an award from branch vice-chairperson Prof. R F Chauke

The Gauteng North branch saw off the year in style at its AGM and gala dinner on 15 November. Held in the peaceful surrounds of the Shokran Events Venue on the outskirts of Pretoria, the evening had a Moroccan theme and was well attended. After the general meeting concluded, attendees were treated to an evening's entertainment that included a stand-up comedian and a belly dancer who wowed the

audience with her abdominal prowess and fire-juggling skills. The branch also honoured some of its most illustrious members, including Dr Wilma Lotter and Prof. Mike Sathekge. Dr Lotter was honoured for her years of dedicated service to the community via her Sunnyside practice, particularly her work with street kids, while Prof. Sathekge was recognised for his cutting-edge research work in the field of nuclear medicine.

Year	Projected Retirement Income (R)
2013	100,000
2014	105,000
2015	110,000
2016	115,000
2017	120,000
2018	125,000
2019	130,000
2020	135,000
2021	140,000
2022	145,000
2023	150,000
2024	155,000
2025	160,000
2026	165,000
2027	170,000
2028	175,000
2029	180,000
2030	185,000
2031	190,000
2032	195,000
2033	200,000
2034	205,000
2035	210,000
2036	215,000
2037	220,000
2038	225,000
2039	230,000
2040	235,000
2041	240,000
2042	245,000
2043	250,000
2044	255,000
2045	260,000
2046	265,000
2047	270,000
2048	275,000
2049	280,000
2050	285,000
2051	290,000
2052	295,000
2053	300,000
2054	305,000
2055	310,000
2056	315,000
2057	320,000
2058	325,000
2059	330,000
2060	335,000
2061	340,000
2062	345,000
2063	350,000

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