

SAMA INSIDER

OCTOBER 2015

**Transformation in higher
education: What is to be
done?**

**Impaired practitioners:
Who is responsible?**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

**SOUTH AFRICAN
MEDICAL ASSOCIATION**

Register now for one of our exciting CEU programmes!

METABOLIC SYNDROME

CLINICAL MANAGEMENT OF THE METABOLIC SYNDROME

Metabolic syndrome is a combination of the medical disorders that, when occurring together, increase the risk of developing cardiovascular disease and diabetes. Some studies have shown the prevalence in SA to be estimated at 61% of South Africans who are overweight, obese or morbidly obese.

This comprehensive programme shifts away from the limited and often a skewed term obesity to metabolic syndrome which is a better defined and more medically orientated than the often thought of cosmetic corpulence. This course is an interactive, activity based workshop. Medical knowledge changes daily and this course will serve to keep the participant updated as it includes numerous website links and cross references and as these sites evolve and grow with new information so does the content of the course. We believe that this course will serve to be entertaining, user friendly, informative and spark an interest and controversial debate around metabolic syndrome.

COURSE CONTENT

This course covers the following modules:

- Measurement modalities
- Anatomical anomalies
- Pathophysiological phenomena
- Psycho-social associations
- Aetiologies
- Congenital
- Acquired
- Presentations of diseases
- Co-morbidities, measurements and management
- Specific medical management
- Ethical and legal considerations
- Controversies

ACCREDITATION

Accredited according to the HPCSA CPD Guidelines for Health Professionals - November 2006, for 22 CEUs on level 2.

COURSE FEE, DATES AND VENUE

R 3 770 (Inclusive of all VAT and taxes where applicable)
This amount includes everything except travel and accommodation.

DATE VENUE

17 - 18 October 2015 Cape Town
14 - 15 November 2015 Pretoria

REGISTRATION

EVELYN MAHLANGU / ASANDA DAANTJIES

Tel: (012) 816 9000 / 9105
Fax: 086 502 2071
Email: evelynm@foundation.co.za
asandad@foundation.co.za
Address: P.O. Box 75324 Lynnwood Ridge 0040
Website: www.foundation.co.za

DIAGNOSTIC ULTRASOUND

SHORT COURSE IN DIAGNOSTIC ULTRASOUND

In a report of a WHO scientific group on the future of new imaging technologies in developing countries it was stated that "the difficulties in making accurate diagnosis from ultrasound images are such that the purchase of ultrasound equipment, without making provision for the training of an operator, is contrary to good healthcare practice and is unlikely to be cost effective. Proper training and experience is required, preferably with facilitators who are highly skilled and who have practised ultrasound for many years.

COURSE CONTENT

After completing this course participants will be able to:

- Choose ultrasound equipment;
- Identify the organs in the abdominal cavities, normal abdominal and gynaecological ultrasound anatomy;
- Recognise abdominal structures in multiple planes;
- Recognise the sectional ultrasound anatomy in the transverse and longitudinal planes;
- Describe the patient preparation and position;
- Interpret ultrasound findings in common abdominal gynaecological pathologies;
- Document ultrasound;
- Demonstrate ultrasound imaging;
- Understand the criteria for quality and
- Understand the capabilities and limitations of ultra-sound.

ACCREDITATION

Accredited according to the HPCSA CPD Guidelines for Health Professionals - November 2006, for 30 CEUs on level 2.
(Workshop: 10 CEUs, Assessment 20 CEUs)

COURSE FEE, DATES AND VENUE

R 5150 (Inclusive of all VAT and taxes where applicable)
This amount includes everything except travel and accommodation.

DATE VENUE

24 - 25 October 2015 Cape Town
21 - 22 November 2015 Durban

REGISTRATION

Phindile Mahlangu
Tel: 012 816 9174
Fax: 086 567 0279
Email: staceys@foundation.co.za
phindilem@foundation.co.za
Address: P.O. Box 75324, Lynnwood Ridge, 0040
Website: www.foundation.co.za

CONTENTS

OCTOBER 2015



"Winter workerbee" - Mark Oliver

- 3 **EDITOR'S NOTE**
Transformation, trust, respect,
change, challenge, support, coping
and money!
Diane de Kock
- 4 **FROM THE PRESIDENT'S DESK**
Going international
Prof. Lizo Mazwai
- FEATURES**
- 6 Transformation in higher education:
What is to be done?
Dr B Pityana
- 8 'Supersession' evokes an emotional
response
Julian Botha
- 9 Doctors' Disrespecting Syndrome
Dr Mahlane Pahlane
- 11 2015 CMS report – a wake-up call or a
cry in the dark
Dr Solly Motuba
- 12 Clinical Associates: Who are they and
what are their roles?
Selaelo Mametja
- 15 Scholarship recipient now able to
direct her energy meaningfully
Diane de Kock
- 16 **MEDICINE AND THE LAW**
An easy guide to income tax for
public sector doctors
Jonathan Hayden
- 17 Impaired practitioners: Who is
responsible?
Marli Smit
- 19 Slipping through the cracks
Medical Protection Society
- 20 **BRANCH NEWS**



SAMAREC/CPD SERVICES AVAILABLE:

- South Africa Medical Association
Research and Ethics Committee -
SAMAREC
- South African Medical Association
Continued Professional
Development Accreditation
- Our Mission:
 - Empowering Doctors to bring
health to the nation
 - Excellent Service
 - Quick Turnaround
 - Efficiency



WHAT WE ARE ABOUT

SAMAREC:

Evaluating the ethics of research protocols developed for clinical trials conducted in the private healthcare sector. Ensuring the protection and respect of rights, safety and well-being of participants involved in clinical trials and to provide public assurance of the protection by reviewing, approving and providing comment on clinical trial protocols, the suitability of investigators, facilities, methods and procedures used to obtain informed consent.

CPD:

Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association is one of the institutions that have been appointed by the Medical and Dental Professions Board of the Health Professions Council of SA to review and approve CPD applications.

For further information please contact the SAMAREC/CPD Secretariat on 012 481 2000 OR email us on samarec@samedical.org or cpd@samedical.org

EDITOR'S NOTE

OCTOBER 2015



Diane de Kock
Editor: *SAMA INSIDER*

Transformation, trust, respect, change, challenge, support, coping and money!

Transformation in higher education is taking centre stage in educational institutions across the country, a point emphasised by Prof. Barney Pityana, who delivered the 2015 Steve Biko memorial lecture at the University of The Witwatersrand on 11 September. A lawyer, theologian and notable human rights academic and activist Pityana's lecture acknowledged the radical approach of some students at South African universities, but he emphasised the importance of accommodating many voices in moving towards change. He noted that: "Students and [their] voices are not and need not be, and should not be uniform ... Each one though is often expressed as if it's the only thing possible, a sole truth and nothing but the truth." Excerpts of his lecture are printed on page 5 and 6.

In keeping with our contemporary zeitgeist the key words in this issue of *SAMA Insider* are transformation, trust, respect, change, challenge, support, coping and money – a fair reflection of the circumstances facing medical doctors in South Africa today. On page 8, Julian Botha takes a look at the emotional response 'supersession' evokes in medical doctors and the importance of trust. Dr Pahlane warns readers of a worrying 'doctors disrespecting syndrome' on page 9. The recently published CMS report is analysed by Dr Solly Motuba on page 11 and our new head of knowledge, management and research development, Selaelo Mametja looks at the role of clinical associates on page 12 and 13. The huge challenge of practising medicine in South Africa is the subject of Marli Smits article on page 17. Some doctor's cope with stress in whatever way they can and others become impaired by challenging circumstances. How this impairment is dealt with is vitally important in assisting colleagues to maintain a high level of care to patients and the community. A happy account by Dr Justine Cole on page 15 tells us how a SAMA scholarship changed her experiences as a postgraduate student.

SAMA Insider is your voice – thank you to all who contributed to this edition. We look forward to hearing more voices in future.

Editor: Diane de Kock
Head of Sales and Marketing: Diane Smith
Production Editor: Diane de Kock

Editorial Enquiries: 012 481 2041
Advertising Enquiries: 012 481 2069
Email: dianed@hmpg.co.za

Design: Carl Sampson. Health & Medical Publishing Group (HMPG)

Block F, Castle Walk Corporate Park,
Nossob Street,
Erasmuskloof Ext 3, Pretoria

Published by the Health & Medical Publishing Group (HMPG)
www.hmpg.co.za | publishing@hmpg.co.za | Printed by TANDYM print

DISCLAIMER

Opinions, statements, of whatever nature, are published in *SAMA Insider* under the authority of the submitting author, and should not be taken to present the official policy of the South African Medical Association (SAMA) unless an express statement accompanies the item in question. The publication of advertisements promoting materials or services does not imply an endorsement by SAMA, unless such endorsement has been granted. SAMA does not guarantee any claims made for products by its manufacturers. SAMA accepts no responsibility for any advertisement or inserts that are published and inserted into *SAMA Insider*. All advertisements and inserts are published on behalf of and paid for by advertisers.

LEGAL ADVICE

The information contained in *SAMA Insider* is for informational purposes and does not constitute legal advice or give rise to any legal relationship between SAMA or the receiver of the information and should not be acted upon until confirmed by a legal specialist.

Going international



Prof. Lizo Mazwai, President, SAMA

As my term of office as President draws to an end soon I thought we might reflect on the role of SAMA, on the international scene, regarding a few global topical issues as next month is the General Assembly of WMA in Moscow (11-18 Oct). I thought to pick a few excerpts from the report of the General Secretary Report at the Council Meeting of April 2015 in Oslo.

The health-related MDGs have raised the profile of global health, mobilised political support and contributed to the achievement of significant improvements in health outcomes

I will highlight a few of these which may have immediate relevance to the South African situation in terms of National Health Policy and Service Delivery. More importantly to reflect

on what role SAMA might play nationally in meeting some of these challenges.

Database and biobanks

In March 2014 the WMA Declaration on Ethical Consideration Regarding Health Databases considered ethical problems connected with health databases and biobanks. These are regulations of their use with special emphasis on personal autonomy, in particular the protection of personal information, and on the informed consent necessary for research or other use of such repositories. As South Africa prepares for NHI the question of database and biobank repositories has to be resolved. This is against the background that health institutions records will be fully computerised (paperless).

Public health

The areas of concern are around four major topics:

Non-Communicable Disease (NCD)

WHO member states have made commitments according to the 2011 UN Political Declaration on Prevention and Control of NCDs.

In response to this UN Political Declaration, WHO also established the Global Monitoring Framework as a Global Coordination Mechanism on the Prevention and Control of Non-communicable Diseases. The scope and purpose is to facilitate and enhance the coordination mechanism, which was launched in March 2015. Therefore the WMA, together with the members of the World Health Professions Alliance (WHPA), has developed a campaign to help prevent NCDs by targeting common risk factors and social determinants of health.

Social determinant of health (SDOH)

The Rio Political Declaration on Social Determinants of Health identifies five action areas for health. One of these action areas emphasises the role of the health sector in reducing health inequities. On 24-25 March 2015, the WMA hosted an international meeting on social determinants of health at BMA House in London. The goal is to produce two main resources; a meeting

report highlighting the best practices in clinical SDOH interventions from around the world, and a series of recommendations for action by NMAs at the national and international level.

From millennium development goals to sustainable development goals

The health-related millenium development goals (MDGs) have raised the profile of global health, mobilised political support and contributed to the achievement of significant improvements in health outcomes, particularly in low and middle income countries. The current post 2015 deliberations set out a broad framework of four pillars:

- Inclusive economic development
- Environmental sustainability
- inclusive social development (including health)
- Peace and security, underpinned by human rights, equality and sustainability

The COP21 represents a major milestone in advancing sound international agreement on climate disruption

Climate, environment and health

In December 2014, the Global Climate and Health Alliance organised a Climate and Health Summit.

The upcoming UN Climate Change Conference (COP21), which will take place in Paris in December 2015, represents a major milestone in advancing sound international agreement on climate disruption. The WMA is in contact with members of the Global Climate and Health Alliance in order to explore the best ways to be included in the negotiations.

SAMA news in brief

Is SA ready for euthanasia? SAMA conference tackled the issue

Is South Africa ready for euthanasia and physician-assisted suicide (PAS)? These are among several burning topical issues which were tackled at the SAMA annual conference at the Sandton Convention Centre in September. Minister of Health, Dr Aaron Motsoaledi opened the gathering after which an expert put the case for euthanasia. Other hot topics included the 'forgotten' epidemic of depression facing the country, the growing obesity epidemic, an update on the 'terrible twin' diseases of HIV and TB and the ethical aspects of social media.

Euthanasia moved centre-stage this April when the Supreme Court granted individual PAS status to a terminally-ill Cape Town advocate, Robin Stransham-Ford, setting binding precedent for Gauteng Province and rendering the judgment 'legally persuasive' in other provinces. Judge HJ Fabricius strongly recommended that existing law be developed to bring it into line with the Constitution. He stressed that existing law would pertain until such time as the Supreme Court of Appeal or the Constitutional Court had ruled on the matter (government is appealing the ruling) – or parliament passed enabling legislation. The ruling has set Bioethics, Philosophy and Legal departments abuzz with debate and seminars being held at university campuses across the country, including reviews of 'liberalised' euthanasia laws and PAS practice abroad. SAMA has publicly voiced its opposition

to both practices within the context of a dysfunctional public healthcare system, supporting and affirming palliative care.

Other topics discussed were the Ethical Aspects of Social Media, as dramatically illustrated by the current professional conduct hearing of a popular sports scientist and top local proponent of the high-fat/low-carbohydrate diet (HF/LC aka Banting). Dr Tim Noakes, an A-rated scientist and household name, allegedly provided 'unconventional' advice on breastfeeding to a diet-curious mother on a social network (Twitter) last year. His hearing this June came after a complaint by the Dietetics Association of South Africa, and will continue amid huge public interest later this year.

This discussion happened during a session entitled; 'Ethical and Legal Requirements – their Effect on Clinical Practice'. The conference also covered Medical Aid Fraud, the subject of heated debate between healthcare providers and funders, and Women's Health, which has strong links to the growing obesity epidemic. Hundreds of doctors from around the country converged on Sandton to hear some of the country's top experts deliver papers and opinions.

The conference also featured the SAMA-Bonitas House-call Doctor's Awards, putting several of the country's oft-neglected and unsung medical heroes in the spotlight after being nominated for recognition by their peers. Categories ranged from Human Rights and Health, Equity and Justice, Women and

Children's Health, to Community Service and distinguished service.

More in-depth coverage of the conference will follow in our November issue. Winners of the SAMA Bonitas House Call Doctor's awards will also be announced.

Doctors call for saving lives, not just time on our roads

The South African Medical Association Trade Union (SAMATU) in the Eastern Cape sent condolences to the families that lost their loved ones on provincial roads in September. "Our noble profession dictates that all medical professionals should stop at accident scenes for emergency medical intervention."

To achieve this act of nobility SAMATU therefore calls for the following:

- All healthcare workers should be provided with first aid kits for medical intervention at the accident scenes.
- Healthcare workers who stop at these accident scenes should be protected from medical litigation. The fear of litigation is becoming a serious obstacle for doctors to assist patients outside their work areas.
- Improvement of rural roads for safety of all people and easier access of emergency medical service vehicles will go a long way in curbing disabilities and deaths from motor vehicle accidents.
- We further propose that basic life support training be offered at high school level as part of the curriculum of Life Orientation and Sciences.

An invitation to all SAMA members

Letters to the editor

From the November issue of *SAMA Insider* we would like to feature a 'Letters to the editor' page. This new feature will give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare which you feel should be shared with your colleagues and fellow readers.

Please note that letters:

- Should be no longer than 300 words
- Can be published anonymously, but writer details must be submitted to the editor in confidence
- Subject matter must be pertinent to healthcare delivery
- Should be submitted before the tenth of the month in order to be published in the next issue of *SAMA Insider*.

Please email contributions to Diane de Kock: dianed@hmpg.co.za



Transformation in higher education: What is to be done?

Dr Barney Pityana delivered the annual Steve Biko Bioethics lecture on Friday 11 September at Wits University. We have printed excerpts from his address below. The full address is available online at: http://www.wits.ac.za/academic/health/centres/bioethics/news%20&%20events/27296/professor_pityana_s_talk_.html. Dr Pityana is a lawyer and theologian and a notable human rights activist.

The lecture began with Dr Pityana putting the debate in context: "I have a feeling that the debate has somewhat got stuck in a welter of verbiage and political point scoring. In some respect the word 'transformation' itself is in danger of losing all meaning, to the extent that to everyone who uses it, it become what I want it to mean. For a start we could use the word with some care and acknowledge that in using it we reflect often our own contexts and pre-occupations.

"What I would love to see as a prior acknowledgement though is that for many university Vice Chancellors and Councils in South Africa today there is recognition of the imperative of transformation. As I often say, however, higher education is a different and complex creature in our days than it has ever been in recent times. For one thing it evokes much sentiment and expectations. It is, if one likes, a sentiment of belonging and ownership by a variety of stakeholders, and from various angles there are vested interests and expectations alike. For obvious reasons the Vice Chancellor is charged with the task of balancing these interests and to lead the direction in which the institution is to traverse with all the attendant risks, excitement and opportunities.

I believe that the transformation of higher education is necessary and urgent

"The second affirmation I wish to make is that we are in a very exciting era to be a student in South Africa today and to be an academic. There is a sense one feels that South African universities are being thought through afresh. This is assisted, I think, by the apparent radicalism and impatience of the student voices. This has the potential of the student voices shaping the debate and profiling the probable outcomes. Precisely because it is the student voice, we must note two possible directions. One, we do well to remember that students and student voices are not and need not be uniform. By its nature these are varied and pluriform ideas in a variety of systems of ideas. Each one though

is often expressed as if it is the only thing possible, the sole truth and nothing but the truth. The second point for us to note, is that notwithstanding the fact that students are by nature a transient community, their ideas may last and linger long after that generation is no more. What this means is that ideas developed by students as we saw in many student revolutions throughout history is that they do not last nor are they necessarily translated into concrete deliverables and effective strategies for change. At the end of the day, therefore, higher education transformation is the business of the entire academic community."

Prof. Pityana went on to draw some lessons from the Black Consciousness (BC) philosophy and look at how BC developed and applied its ideas. "What BC did achieve remarkably in a short space of time was to build a cadre of activists who were confident in themselves and their human origins. It imbued a generation of students with a radical spirit and a will to live their lives in a singular purpose to change the world and their human circumstances.

"What sets us apart is not just our tribe or nation, but our African consciousness. This is a critical paradigm because it takes us away from any narrow tribal or nationalistic chauvinism. It sensitises one about some of the fetishes we have built around ourselves in terms of ethnicity. It helps us to understand that so much of the geographical prisons we have set for ourselves were never meant to liberate but were in fact a colonial construct intended to parcel out African territory to feed the greed of the colonial nations and to reduce competition and conflict among them.

"One then brings in two matters that one tends to associate with the struggles of today for transformation in higher education. The first is contextuality and relevance. Is it not the case that a more rigorous critique of those sociological structures of society that have become embedded in our social reality and politics need to be interrogated? It seems that what is taken-for-granted needs interrogation in order to determine its relationship with the past historically, and consistency in terms of the vision, culture and ethics of struggle. The second is to more properly understand what we mean by 'blackness' today. I do not believe that 'blackness' today means much the same thing that it did for Bantu Stephen Biko in 1970. This requires, in



my view, the harder task of acknowledging that South Africa today is in a different period in terms of relations and social environment. It also means that black people have a different relationship to power than they did those many years ago under apartheid. What, then, does it mean to be black today? If that is so, as I believe that it is, then should we not rather take responsibility for us to change or re-construct the relations of power in a manner that expresses our social relations today as well? Rather than complaining, I fear that the harder task is to work hard at changing the social relations. One of the great lessons of BC was that black people must take responsibility for the change they want. That is as true to day as it ever was."

Prof. Pityana then focused on the subject of the lecture: "There is much that we can agree upon about the extent of the advances made towards transformation in South Africa's higher education system. This transformation is reflected in the legislation and the policies successive ministries have put together in advancement of the Constitution. And yet South Africans will also agree that much still needs to be done. In the area of student admissions, it is now generally agreed that almost all higher education institutions show a vast increase in student numbers from the previously disadvantaged communities. The executive management corps of higher education institutions is largely integrated. A growing number of women and black people are finding spaces at the highest echelons of our universities.

"Public universities are state institutions. They draw support and funding from the state to the extent that the fiscus allocates revenue. The deal is that universities will enjoy institutional autonomy and academics academic freedom. In other words universities are not there simply to execute government policy. Universities have a duty to provide learning and to advance knowledge.

"It is true, though that, to the extent that universities were part of the functional system of a colonial system, they somehow become the conveyors of that system of knowledge and being associated with the knowledge and learning environment wherein they thrived. They reflect, therefore, in large measure some of those cultures taken-for-granted in that society. In situations where those prescripts are under challenge then the university rightly become a boxing ring for the contestation of ideas and ideals, that society has not resolved for itself. And yet, in South Africa, this debate has been alive since the Commission on Higher education was established in 1995 and through the series of episodes in which those reports were considered and implemented. It is also fair to say that what is now being presented with some urgency are both the failings of that system and the ease with which it catches up with the mood of the nation.

"Africanisation of the curriculum, for example, has long received at least theoretical acceptance at many of our universities. There does tend, however, to be a mischaracterisation of this as exclusive rather than inclusive, essentialisation rather than engagement with.

"Ngugi wa Thiong'o tells the story of the English Department at the University of Nairobi in 1968. Black lecturers contested the idea that the teaching of English literature would be taught from the perspective of the classics of English literature. Instead they advocated that literature must be taught from the perspective of the culture, language and social environment that the students were familiar with. They believed that that environment should then be the central basis and vantage point from which all knowledge is discerned and interrogated. To make their case they called for a stronger resort to oral literature and story telling. In that way learning will take place in the environment familiar to the students and that could become the platform for engaging the world of literature. Similar efforts have been undertaken in South Africa most notably in indigenous knowledge and its systematisation and advancement. Yet, it must be conceded that all this often sounds exotic to the ears of academics seasoned in the strictures and arrogance of Western knowledge systems.

"It does need to be stated that academic life at a university is less about ease and acceptance

as it is about challenge and engagement that can be painful. University students should never run away from the challenge of getting their own cognitive world put under stress and challenge. Understandably at a university much of what we bring into the learning environment might bring discomfort and pain, and the process of discovery may well be like labour pains.

"The end of education is the achievement of that perfection ... I believe that that is as true today as it was at the time Cardinal Newman expressed it. What we should be searching for in our times is precisely that, that sense of what it is to be an educated being? Beyond the skills one acquires and the accumulation of knowledge, at the end of the day education is what gives one the capacity to think creatively and critically, to make informed and ethical judgment, and ... the emotional intelligence to act or behave as

We are in a very exciting era to be a student in South Africa today

a companion, as a citizen, as a friend, and to pursue a life of leisure and wholeness of being.

"Without labouring the point, I understand transformation therefore to be a desire to design institutions both in terms of their organisational and ordered life, as well as in the content of what they teach and how learning, research and the pursuit of knowledge takes place, as well as an abiding concern, or ideological commitment to be of service to others and to shape a worthy and quality humanity that makes a difference.

"On this basis then I believe that the transformation of higher education is necessary and urgent. It is correct that higher education institutions should be judged and subjected to critique about the extent to which they ultimately serve the common good, or that in all their systems and processes of learning and research whether they are imbued with that sense of purpose that will create a better South Africa and Africa. Transformation in higher education, dare I suggest, seeks to preserve and to affirm the true essence of education and of the role of a university in moulding a new, transformed society. That idea of essence is Aristotelian and assumes that there is a thing called "university" that expresses everything by that name. It does not exist. Therefore, every society in and for its own time establishes institutions that serve the common purpose and advancement of humanity. The point of this paper is that two prerequisites must be borne in mind – one,

the moral and philosophical grounding of any human action that seeks to achieve a purpose; and two, the political, strategic and human resources necessary to achieve that purpose.

"Let us face it. Today the trigger for 'transformation' is that a growing number of young people at our campuses are disaffected from the mainstream political thinking. They are also anxious about the future – their future. They have no sense of relevance between what they do, at home and on campus, with what they will experience in life. They are also morally disaffected by a society that is so ordered and arranged to exclude and to deny opportunity.

"We are fast drawing towards a society that denies hope to so many. They are angry that we have allowed the promise of liberation to be corrupted to the extent that it has been in our country today. As in almost all situations such disaffection by the most sensitive and perceptive of society, the students, almost always the seeds of revolution gets planted. Disillusionment runs deep in our country. One trusts that we are heading towards just such a revolution of ideas and to that extent the university campuses are the right locale for such debates. But it cannot end there because ultimately it is less about the university than it is about a society at breaking point.

"I agree with many who have discovered this, that BC has relevance not just for the struggles for human affirmation in our time and at our universities, but that BC is sorely needed for us as a nation to drive the wheels of social and political change, and to insert a quality of being in the manner in which we exercise our responsibilities as politicians, civil servants and as professionals. Perhaps, if we do so, there would be lower levels of corruption, less violence and anomy, and more love and respect for the people who are most needy, oppressed (now by us) and alienated.

"A word of caution. Whatever we may do about higher education transformation, ultimately, we do well to discern and possibly agree upon the purpose of the university for us. That means that transformation will be counter productive if at the end it produces a university system that produces party cadres of a narrow ideological design, or tribal initiation schools to build *izimpi* whose purpose is to destroy others and advance the ambitions of the powerful overlords. My sense is that universities as transformed moral institutions for the common good are necessary for any society to advance knowledge, build character and connect the academic community collectively with the highest ideals of humanity. I believe that we have an opportunity today to grow the universities as the kind of institutions we desire. What is it? Is that in fact not the crisp question we should be asking ourselves and finding collective answers?"

‘Supersession’ evokes an emotional response

Julian Botha, Strategic Accounts Manager: SAMA Private Practice Department



"Supersession refers to the practice of taking over the patient of another doctor without informing the other practitioner in situations where the patient has not terminated the other healthcare provider's services."

This definition is clearly less emotive and crystallises the issues at hand. However, there is no absolute prohibition on supersession. Rule 10 of the Ethical Rules of Conduct published in terms of the Health Professions Act reads as follows:

10. Supersession

A practitioner shall not supersede or take over a patient from another practitioner if he or she is aware that such patient is in active treatment of another practitioner, unless he or she -

(a) takes reasonable steps to inform the other practitioner that he or she has taken over the patient at such patient's request; and

(b) establishes from the other practitioner what treatment such patient previously received, especially what medication, if any, was prescribed to such patient and in such case the other practitioner shall be obliged to provide such required information.

This rule clearly shows that superseding, or taking over the patient, is, in fact permissible where the requirements contained in the Rule (at sub-paragraphs (a) and (b) are met). Therefore, an accusation that one healthcare practitioner has superseded and 'stolen away' the patient of another practitioner would only be considered unethical conduct and a breach of Ethical Rule 10 if there was non-adherence to the requirements laid out in the Rule.

The important factor that must be borne in mind is the principle of patient autonomy, a principle which is emphatically protected in our legislation. Ethical Rule 10 does not, in any way, inhibit this principle, it reinforces it while placing an obligation on the 'new' doctor to take reasonable steps to make contact with the 'old' doctor and to obtain relevant and pertinent clinical information about the patient in question.

Patient autonomy is a principle that pervades South African health legislation and is reinforced in our case law. Ultimately it is the patient's right to choose from whom they receive healthcare. It is therefore in the hands of the patient to make that decision. Ethical Rule 11 prohibits practitioners from impeding a patient when obtaining a second

opinion and potentially electing to continue their care under the practitioner who provides that second opinion or any other practitioner. Rule 11 states:

11. Impeding a patient

A practitioner shall not impede a patient, or in the case of a minor, the parent or guardian of such minor, from obtaining the opinion of another practitioner or from being treated by another practitioner.

In many instances the accusation of supersession is levelled against practitioners where there may not be actual contravention of the Ethical Rule.

An example can be found in the occupational health environment. Where a worker, who for the sake of either convenience or cost saving, will consult with an occupational health practitioner for a minor ailment instead of consulting with their own general practitioner, the question is raised whether that occupational health practitioner is superseding the patient from his or her general practitioner.

Applying the principles above, it would be difficult to see that the occupational health practitioner is contravening Ethical Rule 10. In this scenario, the treatment and care of the patient is not being taken over on a permanent basis. However it would be advisable and collegiate for the occupational health practitioner to contact the worker's general practitioner to inform the GP of the consult and treatment rendered to the patient.

Another example of an unfounded allegation of supersession occurs when practitioners accuse the medical advisors of medical schemes (who are usually medical practitioners themselves) of supersession where those advisors decline to grant authorisation for treatment and/or medication for a medical scheme member. This is not actually supersession. The medical advisor is not taking over the care and treatment of the patient or scheme member. Instead that advisor is applying the medical scheme rules in respect of whether or not the scheme will fund the treatment or medication concerned. As frustrating as this may be for the patient's doctor, it is not a contravention of the Ethical Rule.

In conclusion, it can be seen that Ethical Rule 10 must be read as a whole and that supersession is not prohibited, but it is regulated.

There are few words which evoke such an emotional response from medical doctors than 'supersession'. In a profession where collegiate relationships form one of the cornerstones of practice, the violation of trust implicit in the 'stealing away' of a patient from one doctor by another is an almost unforgivable sin.

It is, however, important to fully understand the concept of supersession and the circumstances and context in which supersession is acceptable, before one can accuse a doctor of acting unethically or unprofessionally.

Firstly it may be helpful to examine what the word actually means. Various definitions are available in general terms and then more closely in the context of medical practice:

Collins Dictionary: Supersede verb (transitive)

1. to take the place of (something old-fashioned or less appropriate); supplant
2. to replace in function, office, etc; succeed
3. to discard or set aside or cause to be set aside as obsolete or inferior

This dictionary definition certainly casts a negative light on that which is being superseded. However, before we lose our heads completely, let us look at a more appropriate definition for application in medical practice, supplied by David McQuoid-Mason and Mahomed Iqbal in their book: *The A-Z of Medical Law*:

Doctors' Disrespecting Syndrome

Dr Mahlane Phalane, General Secretary: SAMA Trade Union

There is a syndrome that is devastating doctors in South Africa; its causes are intrinsic, extrinsic, and idiopathic at times. In our individual and collective ways, we often cause or suffer from Doctors' Disrespecting Syndrome (DDS). This syndrome is so dilapidating and destructive emotionally, physically, financially, professionally and psychologically. It steals away doctors' happiness, work satisfaction, financial success and professional excellence.

Intrinsic manifestations of DDS have various forms; public doctors disrespecting session doctors or private GPs. The disparaging comments we make about each other when we give opinions about each other's work is disrespectful. Public doctors feel and think like they are the genuine doctors, while they view GPs in a negative light. GPs also show symptoms of DDS by viewing public doctors as lazy, unaccountable and working hard for peanuts. Then there is a sad manifestation of DDS when doctors within the public sector disrespect each other, observing them fighting over who should manage patients in casualty is very depressing. A small matter like drawing a call roster becomes a monumental fight.

First the argument will be about the age of the patient, whether a 13-year-old patient belongs in the paediatric or internal medicine department. The fights over whether diabetic foot should go to surgery or internal medicine, whether acute psychosis is family medicine, internal medicine or family medicine. It gets more complicated when the patients get admitted to ICU, whether the anaesthetists or the specific department should manage ICU patients. Listen with total dismay as dermatologists ridicule surgeons, orthopaedic surgeons disrespecting physicians, gynaecologists mocking nuclear physicians, pharmacologists taking a swipe at pathologists.

This syndrome would have been a dismissible wild imagination of the author had it not been so real and tangible. It is because of DDS that negotiating salaries for public sector doctors or medical aid payments for private specialists is impossible. Trauma surgeons demand to earn more commuted overtime than radiation oncologists, physicians question if family physicians are specialists, and the vicious cycle continues. It is because of DDS that transferring or referring a patient is such a depressing nightmare. The DDS attitude manifests itself in how best can the receiving doctors ridicule, or refuse to help the referring doctor. Then the referring doctor returns

the favour when the patient is referred back with disrespectful comments.

Doctors' Disrespecting Syndrome makes us fight among ourselves for system failures. We disrespect ourselves to the point of resentment. Nelson Mandela succinctly describes resentment as someone who takes a poison hoping that the enemy will die from it. Doctors take out their work, financial and psychological frustrations on each other, hoping that they will get healed from their own ordeals. We miss the point that unity is power. We suffer together, stay together and succeed together. DDS is the biggest threat to the medical profession, bigger than any bad legislation, policy or medico-legal litigations.

It is little wonder that everyone is taking advantage of this disempowering syndrome to take advantage of doctors. It is often a doctor who will advise patients to sue another doctor. When a doctor seems to do well financially, it is common to hear other doctors making serious accusations of fraud against any colleague who is more successful than them. It is as if it is wrong for a doctor to be successful through honest means. It is doctors who are leading the charge about the price of private GPs and specialists; no one is saying a word about the high pharmaceutical or private hospital costs. There is no doctor who sees anything wrong with medical aid administrators making more money than doctors. However, as doctors we are quick to demonise each other for making more money than other colleagues. We disrespect each other even in areas where we should be praising and supporting each other. Instead of constructively engaging a colleague for a research paper well done, we would rather prefer shooting it down in the dustbin of medical sciences.

The extrinsic manifestations of DDS are more hurtful than the intrinsic ones. Pharmacists or even pharmacist assistants have garnered more strength and power to disrespect doctors. Listening to some of them insulting doctors' prescriptions is just so sad. Some nurses are learning bad habits under the disguise of their rights by withdrawing from assisting doctors in clinics or ward rounds. It is common to find doctors working alone without the support of nurses. The worst form of DDS is found in human resources department; denying doctors their occupation specific dispensation pay or notch progression, rejecting doctors' performance bonuses, and at times paying newly appointed doctors late is the norm.



Dr Mahlane Phalane

Managers and politicians refuse to be left out on DDS; it is becoming fashionable for managers and some politicians to insult doctors and the medical profession. Some call us "tsotsis" or criminals; others deal with our mistakes in the harshest way possible. The most dangerous metastasis of DDS is when managers and politicians undermine clinical autonomy and independence. Politicians and managers, some without any health qualifications, feel superior to doctors to can even venture into dictating how, when and where doctors should treat their patients.

The axiom none can dare challenge is that DDS is mainly caused by actions and/or omission by doctors themselves. We ignore key issues that affect our profession, we do nothing when things go wrong, we disrespect our noble role by omitting to advocate for our patients. The DDS has become like learned helplessness, we have learned to sacrifice and improvise to the point of compromising our professional and ethical principles. We rather opt for conformity and comfort by conceding to corrosive attacks on the medical profession than standing up for our profession. One or a group of few doctors rather make a deal with the devil by entering into a contract that serves their narrow, myopic and selfish interest, even if that is at the expense of the entire medical profession.

It is doctors who cause DDS by our omissions or commissions. We have allowed opportunists to reduce healthcare into a tendercare or profit-care. We should be the first to say "No" in the name of our noble profession. We should start treating ourselves out of DDS by inculcating the sense of self-love, mutual respect to colleagues, and uncompromising advocacy for our patients. The consequences of DDS will be dire; the entire healthcare system may collapse, the status and value of the medical profession will be eroded even further, the working conditions will get worse, unfortunately people may become disabled or die because of DDS.



Additional Member Benefits



Alexander Forbes

Herman Steyn

012 452 7121 / 083 389 6935 | steynher@aforbes.co.za

Offers SAMA members a 20% discount on motor and household insurance premiums.



Automobile Association of South Africa (AA)

AA Customer Care Centre

0861 000 234 | kdeyzel@aasa.co.za

The AA offers a 12.5% discount to SAMA members across its range of AA Membership packages.



Barloworld

Lebo Matlala (External Accounts Manager: EVC)

011 052 0167

LeboM@hwmr.co.za

Barloworld Retail Digital Channels offers competitive pricing on New vehicles; negotiated pricing on demo and pre-owned vehicles; Trade in's; Test Drives and Vehicle Finance.



Legacy Lifestyle

Patrick Klostermann

0861 925 538 / 011 806 6800 | info@legacylifestyle.co.za

SAMA members qualify for complimentary GOLD Legacy Lifestyle membership. Gold membership entitles you to earn rewards at over 250 retail stores as well as preferred rates and privileges at all Legacy Lifestyle partnered hotels and further rewards back on accommodation and extras. Claim your membership at www.legacylifestyle.co.za/SAMA, all you need is your mobile number to earn or redeem rewards. Travelling SAMA members can book their travel online or speak with our concierge service at Travel By Lifestyle (www.travelbylifestyle.co.za) Legacy Lifestyle, the rewards you've earned will pay for the Lifestyle you deserve.



Medical Practice Consulting

Werner Swanepoel

0861 111 335 | werner@mpconsulting.co.za

20% discount on assessment of Practice Management Applications (PMA) and Electronic Data Interchange (EDI) systems.

SAMA and Merck Serono are offering SAMA members a first-of-a-kind and FREE FPD online CPD courses on Fertility and Hyperthyroidism on www.mpconsulting.co.za. Each course is worth 3 CPD points. The benefit is a saving of R465.00 per member per course.



Medport

Shelly van Dyk

087 550 1715 | support@sosit.co.za

A personalised portal website; an optional public webpage to make their services known (Private Practice); access to a HPCSA accepted CPD Manager; a consolidated e-mail account; online data storage space; unique applications to manage their medical career; additional applications to download onto your portal page; easier and user friendly access to the internet; listing of your Private Practice on the SAMA Geomap Directory.

MEMBER BENEFITS

2015 CMS report – a wake-up call or a cry in the dark

Dr Solly Motuba, *Head of SAMA Private Practice Department*



The recently published 2015 Council for Medical Schemes Report (CMS Report) is a clear demonstration of the devaluing of the GP currency. It reads like a horror story and in some quarters, may be the signal of a death knell for the present day GP. A worrying factor is that the stats are based on 2014 figures and the situation could have worsened in the intervening period. Unfortunately, that will only come to light during the third quarter of 2016, with the release of the 2016 CMS report.

Over the years, being a GP has evolved from being one of the most lucrative careers this side of Limpopo to being in the doldrums of the medical profession, and the Cinderella of all careers, in a little over a decade. GPs have moved from being the blue-eyed boys of the profession to the poor cousins of the healthcare industry. The question is:

What went wrong and what can be done to turn the tide?

Facts and figures

According to the recently released 2015 CMS report:

- Total benefits paid amounted to R124.1 billion – up from R111.7 billion in 2013 – 11.1% increase
- GPs accounted for 6.6% of the total medical schemes expenditure for 2014 – down from 7% in 2013.
- Specialists accounted for 23.5% of the total medical schemes expenditure.
- Hospitals accounted for 37.6 % of the total medical schemes expenditure.

GPs as always, are at the short end of the stick, while hospitals continue to claim greater market share. This is a clear demonstration of the hospi-centric nature of healthcare delivery, instead of a more sustainable patient-centric care.

The truth is that statistics do not lie and patients vote with their feet. Until the GPs see the light, they will continue to feel the heat.

Where to from here?

GP visits are inversely proportional to hospital admissions or directly proportional to a decrease in hospital admissions. That is, GPs need to do more to keep patients out of hospital. For this to happen, GPs will need to adopt and embrace care coordination as the only meaningful tool or antidote to hospi-centricity. It is through care coordination that GPs can begin to reverse the tide and to reclaim the market share that they have lost over the years.

The profession cannot and should not expect funders to address their woes through adjusted or negotiated tariffs. The GPs should ensure that they are firmly in the driver's seat in their quest towards reclaiming their rightful place as the fulcrum of the healthcare continuum.

Suggested turnaround strategy – the ten-point plan

• Mine your current patient data.

According to the CMS report, on average, 18% of the medical aid population are on chronic medication. That is, for every 1 000 beneficiaries that are on your database (hard drive or Optiplan cabinet), you can safely assume that 180 are on chronic medicine. The truth is that most GPs have more than 3 000 family files translating to up to 10 000 beneficiaries (based on an average family size of 3.3) leading to an estimated 1 800 chronic patients.

• Flag all your chronic patients.

It is important that every chronic patient is flagged and put on a database for chronic patients. The information should be cleaned to ensure that the contact details are accurate. This will make them more easily contactable and reachable. This database should be jealously guarded.

• Register them on the chronic programmes of their respective schemes.

Ensure that every one of the chronic patients is registered on the disease management programmes of their respective schemes. This will ensure that they are able to access their chronic or CDL (Chronic Disease List) benefits, without affecting their day-to-day or acute benefits limits. This will in turn prolong the annual day-to-day benefits.

• Get the Care Plan for each registered chronic patient.

Most if not all registered chronic patients will have a care plan. The care plan will outline the amount of GPs and specialists visits that will be paid from risk benefits or from the PMB basket. Phone the medical aid and obtain the care plan for each of your chronic patients. The care plan will typically have 2-4 pre-approved GP visits and 1-2 specialists' visits. These visits are paid out of the risk pool and payment is almost always guaranteed, especially with PMBs. This could translate into up to 7 200 per annum (per 10 000 beneficiaries) additional visits, with guaranteed payment. Aptly translated, given our index case, this could be as high as 600 additional visits per month; again this assumes that this model is new to the index GP and was hitherto either unknown or not done to the self-same tune.

• Send reminders.

The database once cleaned, should be populated on calendar driven reminder software, that is enabled to send out a reminder SMS every time a new visit is due, as per the populated care plan. This will increase compliance levels, reduce the number of complications, increase the GP's revenue while reclaiming market share from hospitals through decreased hospitalisation. The reminders will be for review consultations, HBA1c, viral loads, ECG, the list is endless and depends on the underlying illness and its care plans.

• Dedicate time for the screening of all patients on the database.

Screening is the committal step towards building a healthy database of chronic patients. In addition, screening constitutes a consultation in its own right and helps identify chronic ailments before they complicate. Annual screening should be the norm and virtually all medical aids pay for screening and related tests. This is after all the heartbeat of care coordination.

• Discover new chronic patients.

Screening will help the GP discover new chronic patients and increase the pool of patients that are on care plans. It should be the mainstay of the practice and a routine drill for the GP staff.

• Register the new chronic patients.

The pool of chronic patients that are newly diagnosed should also be registered on the disease management programmes following an iterative process.

• Accept your limitations.

GPs are not specialists and should know their limitations. Complicated patients, especially uncontrolled ones or those with co-morbidities are best left to specialists. This will ingratiate the practice with other patients and help build credibility for the practice.

- **Code and charge correctly.** Most GPs do not code correctly and are therefore often accused of code farming or up coding. The truth is that a vast majority of GPs have little or no knowledge of how to code correctly and how to ensure that they validate all visits and get paid what is due and payable

to them. This area is best left to a reputable medical aid bureau or trained personnel. Practices that use reputable bureaus with proper infrastructure tend to do well. The bureau fees although sometimes prohibitive, are often offset by better debt management.

Conclusion

Our view is that instead of crying foul, year after year with the release of the CMS report, we can now fight back and reclaim our market share. In so doing, our patients will see the obvious benefits of patient-centricity, instead of hospi-centricity.

Clinical Associates: Who are they and what are their roles?

Selaelo Mametja, *Head; Knowledge Management and Research Development: SAMA*

Many countries are facing critical challenges related to shortage, mal-distribution and uneven performance of health workers, hindering the provision of essential health services required to achieve the health Millennium Development Goals and Universal Health Coverage.

Mid-level health workers (MLHWs) typically have two to three years of post-secondary school healthcare training and undertake tasks usually carried out by doctors, such as clinical or diagnostic functions.

Internationally, the mid-level workers generally improve access to healthcare. In developing countries, they are increasingly being used to render services autonomously, particularly in rural and remote areas, to make up for the gaps in health workers with higher qualifications. Mid-level workers are not only employed in developing countries. Developed countries such as Canada and USA have mid-level workers commonly referred to as physician assistants. In the USA Physician Assistants employment started in the 1960s in the army and extended to the general population. In the physician programme, however, the workers tend to be incorporated in multidisciplinary teams.

Despite their growing role, the evidence on the efficacy of MLHWs, and on appropriate deployment and support strategies to facilitate their integration in health systems, remained fragmented.

In December 2002 MinMec (now called the National Health Council) took a decision that mid-level medical workers should be developed for South Africa (SA). This decision was confirmed on 8 January 2004. A conference was held in March 2004 and served as a wide consultative process. The conference was widely attended by medical schools, several statutory councils, professional organisations, departments of health and speakers from USA and Tanzania.

The overall purpose of SA's clinical associates is to strengthen healthcare at district hospitals. It

was anticipated that a well-trained MLHW would be employed in a district hospital to relieve the workload of both doctors and nurses in terms of diagnosis, treatment and care including diagnostic and surgical procedures. A district hospital setting was selected to avoid uncertainty and overlapping with PHC nurses who also diagnose and treat

Quality of care provided by midlevel workers

Generally the mid-level workers add value in a healthcare system. Their impact includes improving access to healthcare, improving processes of care and reducing waiting times.

A study by Chilopera *et al* in Malawi reported on similar outcomes between caesarean section performed by MLHWs (Clinical Officers) and medical practitioners. A similar study by Mc Cord *et al*, was conducted in Tanzania and there were no differences in maternal and child health outcomes. This study also compared the outcomes between missionary and government hospitals. The differences existed in the type of facilities with government hospitals having a high mortality rate. This is an example of how overall health structure can affect the performance of MLHW.

In USA, quality of HIV care between physician assistants (PAs) and clinicians was similar. Care for metabolic diseases however, differed. Practices that employed the nurse practitioners vs. PAs were more likely to collect HbA1c levels and lipid in patients with metabolic disease. In geriatric care PAs were associated with improved case detection. The findings suggest that incorporating PAs in supplemental roles for target populations can increase case finding, assessment, and referral for previously underdiagnosed and treated conditions. Patient satisfaction surveys were similar between nurse practitioners, PAs and medical doctors in primary healthcare. The study also reported an increase in the uptake of deep vein thrombosis (DVT) prophylaxis and postoperative antibiotics, and a reduction in waiting periods for surgery when

the PAs are utilised. Utilisation of PAs also reduced delayed consultation of emergency patients by surgeons by almost three and half hours.

A Canadian study by Bohm *et al*, PAs reduced waiting times in emergency departments by 1.9 times and reduced number of patients that left without being seen by an orthopaedic surgeon by half. PAs increased surgical throughput of primary joint replacements by 42% a year and reduced waiting times for surgeries by 14 weeks. They saved the surgeons equivalent of 240 hours a year in administrative and other patient-related tasks.

Training of clinical associates in South Africa

Clinical associates are trained for three years, the training is both didactic and practical throughout the three years of training. Training is problem based, patient-centric with a focus on common illnesses and emergency conditions. The training is generally offered by departments of family medicine. Training is broad to encompass all age groups but not as in-depth as medical practitioner training and they earn a Bachelor of Clinical Medical Practice (CMP).

At the end of the three-year training students will graduate with variable level of experience depending on exposure during training. They are expected to obtain history, request investigations and perform diagnostic and therapeutic procedures.

Based on the University of Witwatersrand training curriculum. The following are the learning outcomes:

- Perform a patient-centred consultation across all ages in a district hospital
- Apply clinical reasoning in the assessment and management of patients
- Perform investigative and therapeutic procedures appropriate for a district hospital: The clinical associates are trained in basic investigational procedures such as lumbar puncture, lymph node biopsies, Pap smears, etc. Therapeutic procedures include assisting in theatre, suturing of wounds.

- Prescribe appropriate medication within scope of practice
- Provide emergency care
- Facilitate communication and provide basic counselling
- Function as an ethical practitioner
- Produce and maintain clinical records among others.

Scope of practice

The Minister of Health has recently published draft regulations on scope of practice for clinical associates. This is a welcome intervention as clinical associates have been operating without a scope of practice to the frustration of the clinical associates. Many medical practitioners were frustrated by lack of knowledge regarding the training, skill set and what task could be safely delegated. The implied responsibility of supervision was also unclear. Clinical associates are currently operating under no scope of practice. This has led to confusions among other health workers of their roles, level of responsibility and supervision requirement.

Draft regulations defining the scope of practice of clinical associates summarised

- Obtaining a patient history and performing a physical examination of the patient in accordance with his or her level of education, training and experience;
- Ordering and/or performing diagnostic and therapeutic procedures for common and important conditions in South Africa and in accordance with his or her level of education, training and experience;
- Performing list of procedures under supervision of a registered medical practitioner and in accordance with his/her level of education, training and experience.
- Performing and/or ordering various basic pathology tests, ECG, and X-rays etc. A detailed list is applied in the regulations;
- Developing, implementing and monitoring a comprehensive management plan for common and important conditions;
- Issuing sick certificates for a period not exceeding three days and that should contain the name and contact details of the supervising registered medical practitioner;
- Prescribing medicines for common and important conditions according to the primary health care level Essential Drug List (EDL) and up to schedule IV, except in emergencies when appropriate drugs of higher schedules may be prescribed;
- The prescription must contain the name of the supervising registered medical practitioner. In the case of drugs not on the

EDL the prescription must be countersigned by a registered medical practitioner;

- Being the required assistant at surgery;
- Making appropriate admissions, discharges and referrals;
- Performing any act delegated by the supervising medical practitioner in accordance with the education, training and experience of the clinical associate;
- Assisting medical practitioners within district level health are services and with the focus on primary healthcare;
- The clinical associates may not replace the medical practitioner and may not conduct an independent medical practice. The regulations require all the pathology, investigations, investigative and therapeutic procedures be performed under continuous supervision of the medical officer.

Concerns regarding the scope of practice

- The regulation defines a supervision as the acceptance of liability by a supervising practitioner for the acts of another practitioner. This definition is of concern in that it fails to define the definition in terms of support and guidance provided to the clinical associates by medical doctors.
- Liability falls solely on the shoulders of the supervising practitioner. Liability *per se* must be defined. Limitations to such liability must also be included in order to protect the supervising practitioner against possible unfair labour practices and negligence of clinical associates.
- While the term supervision has been defined, a definition of a supervisor was not provided for.
- In a system that is perpetually understaffed, supervision may actually result in increased work load for the practitioner with a risk of inadequate or inability to supervise and support the clinical associates. Inevitably, clinical associates will perform some tasks without supervision, due to national shortage of independent medical practitioners.
- Healthcare is a dynamic environment. Scope of practice will be affected by changing burden of disease, introduction of health technology, advances in healthcare training etc. Outlining task in the regulations may result in unintended consequences of delayed response in amending the scope of practice in accordance with the change in health needs of the population and the increased experience and competency gained overtime.
- The tasks outlined in the regulations had different levels of complexity. Some of the tasks could not be delegated safely to the clinical associates due to their complexity, while others could be carried out independently.

Recommendations to the Minister regarding the draft the scope of practice

The Health Policy Committee of SAMA, supported by knowledge management and research, and legal and governance department at SAMA made a submission to the Minister of Health regarding the scope of practice of clinical associates. The following recommendations were suggested:

The definition of the words 'supervision' and 'supervisor' was suggested. Details are available in the SAMA submission available from the website. A tiered level of supervision was suggested as follows:

- **General supervision.** This will be tasks that involve less risky diagnostic and minor surgical procedures (e.g. suturing, skin biopsy, venepuncture and management of medical conditions for which national and/or local guidelines are available providing clear instructions). The task should generally be associated with low risk therapeutic and diagnostic procedures.
- **Direct supervision.** These are the tasks that can be performed independently with the supervisor in close proximity or available telephonically. These tasks involve procedures with moderate risk.
- **Personal supervision.** These are the tasks that can only be done under personal supervision of a medical practitioner. Examples may include assisting in surgical or invasive risky procedures.

The level of supervision required was recommended for the tasks in regulation 2 in accordance with the tiered supervision level. Crude methodology to identify level of supervision required was also outlined.

Due to overlapping functions of scope of practices among healthcare professionals, clinical associates be integrated as part of multidisciplinary teams, and tasks allocated according to team member competencies and scope of practice. This will increase efficiencies especially in the environment where an integrated team approach is emphasised.

HPCSA should engage other regulators such as nursing and pharmacy councils to address potential conflicting areas to ensure successful integration of clinical associates.

Clinical associates are a valuable resource to the improvement of district health services. As access to healthcare in district hospitals improves these practitioners should be employed in regional and tertiary hospitals with an intention of improving access and quality of healthcare in secondary and tertiary facilities.



Additional Member Benefits



Mercedes-Benz

Mercedes-Benz South Africa (MBSA)

Lebo Selumane

012 677-1855/082 412 7229

Lebogang.matlhare@daimler.com

Mercedes-Benz offers SAMA members a special benefit through their participating dealer network in South Africa. The offer includes a minimum recommended discount of 3%. In addition SAMA members qualify for preferential service bookings and other after market benefits.

MTN Service Provider

Oswin Lottering

083 222 1954

Lotter_o@mtn.co.za

Melissa Adriaanse

083 212 3905

Adriaa_m@mtn.co.za



We are pleased to offer SAMA members 18% discount. The discount however only applies to new additional contracts and also when the user is due for upgrade. Discount will not apply to International Roaming and Dialling, SMS' and Data packages. Please note that this is extended out to the family and the discount is on VOICE packages only as well.

Monthly Service Charge: less 18% (eighteen percent) discount.

Usage Charge: less 18% (eighteen percent) discount (excluding international calls, international roaming, SMS, MMS and data Usage Charges).

SAMA eMDCM

Zandile Dube

012 481 2057 | coding@samedical.org



SAMA eMDCM™

67% discount on the first copy of the electronic Medical Doctors Coding Manual (previously known as the electronic Doctor's Billing Manual).

SAMA CCSA

Leonie Maritz

012 481 2073 | leoniem@samedical.org



CCSA: 50% discount of the first copy of the Complete CPT® for South Africa book.

SOSiT

Shelly van Dyk

087 550 1715 | support@sosit.co.za



20% discount on Information Technology support and a 24/7 callout service.

Tempest Car Hire

Corinne Grobler

083 463 0882 | cgrobler@tempestcarhire.co.za



SAMA members can enjoy discounted car hire rates with Tempest Car Hire.

V Professional Services

Gert Viljoen

083 2764 317 | gert@vprof.co.za

10% discount on medical practice bureau service through V Professional Services.



Vox Telecom

DJ Viergever

Sales - 087 805 0003 / Technical - 087 805 0530 | sales@voxtelcom.co.za/ help@voxtelcom.co.za



Provide email and internet services to members. Through this agreement, SAMA members may enjoy use of the samedical.co.za email domain, which is reserved exclusively for doctors.

MEMBER BENEFITS

Scholarship recipient now able to direct her energy meaningfully

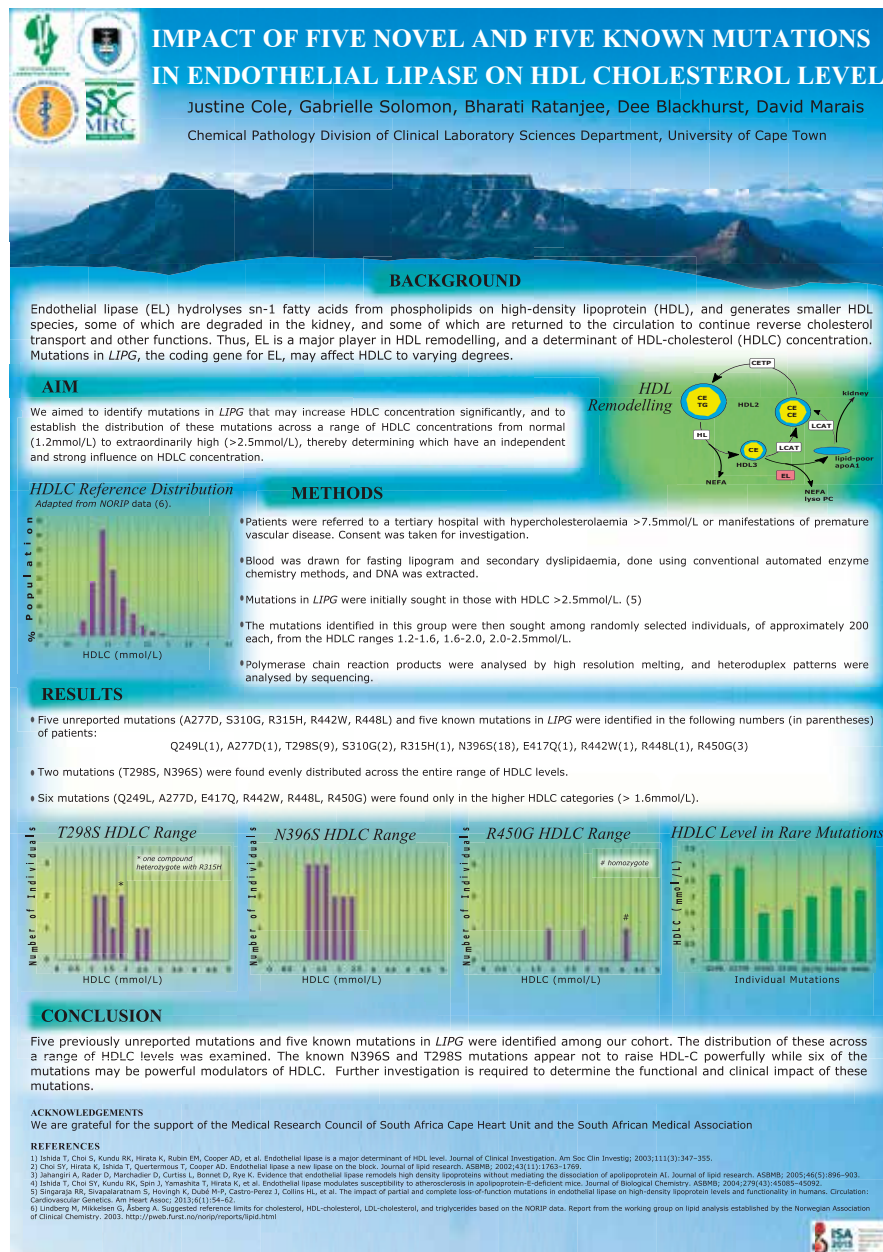
Diane de Kock



Dr Justine Cole (above), a recipient of the SAMA PhD Supplementary Scholarship and the NRF Innovation Doctoral Scholarship this year, sent us this account of how these awards have changed her experiences as a postgraduate student.

"In 2014, the first year of my PhD, I had to work part-time as a result of the fact that I only came to this path after the closing date to apply for funding. My project expenses were covered by a grant that had been awarded to the lipidology group several years ago, and I covered my personal expenses through weekend locums in emergency rooms, facilitating medical students' group learning activities and assisting in surgery. During the course of the year, we discovered that the grant would not be renewed, leaving my project at risk. I was also regularly absent from the laboratory owing to the necessity to earn an income.

"As a result of being awarded the SAMA PhD Supplementary Scholarship, as well as an NRF Innovation Doctoral Scholarship, my experience of postgraduate studies has been entirely different this year. I have had sufficient sleep to enjoy productive days at my bench, to regularly attend chemical pathology registrar tutorials and academic meetings, and I have been able to purchase the consumables necessary to continue my work. I have attended and presented at two conferences: the SEMDSA Congress in Bloemfontein, where I won an award for Best



Poster Presentation; and the International Symposium on Atherosclerosis in Amsterdam, which was made possible by the SAMA Scholarship (see poster above).

"This funding has also allowed me to make time for other interests, and I am particularly grateful to have increased my participation in rescue operations with the Mountain Club of South Africa's Search and Rescue team, and I have also recently begun training with the Wilderness Search and Rescue Helicopter Technical Group. In addition, I have been

broadening my educational experience through MOOCs (massive open online courses) and the occasional lunchtime lecture at the UCT Science Department, as well as being involved in a high school learners' mentorship programme. I thank SAMA that I've been able to direct my energies in these fulfilling and meaningful ways that are aligned with my ultimate purpose, and that I have been able to take exciting opportunities, while continuing work on my project."

An easy guide to income tax for public sector hospital doctors

Jonathan Hayden

This is the first of two articles on tax – the second on income tax for doctors in private practice will follow in the next edition of SAMA Insider

This article will assist hospital doctors in claiming the allowable deductions for tax purposes. Each individual's financial situation is unique, therefore no tax returns (i.e. form IT12) submitted to the SA Revenue Service (SARS) are the same. The Income Tax Law taken into account refers to the tax year ending 28 February 2015.

SA resident taxpayers are taxed on their worldwide income.

Income exemptions – individuals

- Dividends received or accrued from South African companies or JSE dual listed non-resident companies are generally not subject to income tax. 15% dividend tax is deducted by the Company and the shareholder receives 85% net of the dividend declared.
- South African sourced interest received by natural persons:

Persons under 65 years R23 800 exempt
Persons 65 years and older R34 500 exempt
Interest includes distributions from property unit trusts as well as foreign interest but foreign interest is not exempt.

Deductions – employees

There are not many allowable deductions for hospital doctors to claim. Salaried employees' deductions from their remuneration are:

- Pension and retirement annuity fund contributions
- Donations to certain public benefit organisations (PBOs)
- Premiums paid in terms of an allowable insurance policy
 - to the extent that the policy covers the person against loss of income as a result of illness, injury, disability or unemployment, and
 - in respect of which all amounts payable in terms of the policy constitute income as defined
 - this allowable deduction ceases from 01.03.15 onwards and the benefits and/or payouts will also be tax free from that date.

Deductions – pension/retirement

Current pension fund contributions

Limited to 7.5% of remuneration from retirement-funding employment or R1 750,

whichever is the greater. Remuneration from retirement-funding employment refers to income which is taken into account to determine contributions to a pension or provident fund.

Excess contributions are not carried forward to the next year of assessment but are accumulated for the purpose of determining the tax-free portion of the lump sum upon retirement.

Arrear pension fund contributions

Up to a maximum of R1 800 per year. Any excess may be carried forward.

Current retirement annuity fund contributions

Limited to 15% of taxable income from non-retirement-funding employment excluding any retirement fund lump sum benefits, or R3 500 less current contributions to a pension fund, or R1 750, whichever is the greater. Any excess may be carried forward.

Reinstated retirement annuity fund contributions

Up to a maximum of R1 800 per year. Any excess may be carried forward.

Alignment of retirement fund contributions

As from 1 March 2016, the tax treatment of pension, retirement annuity and provident funds will be changed so that contributions made by the employer will be a fringe benefit in the hands of the employee.

The total contributions deductible by an employee is limited to 27.5% of the greater of remuneration or taxable income (excluding lump sums received), but capped at an annual limit of R350 000. Excess contributions are carried forward to the next year of assessment. All fund to fund transfers have no tax consequences.

Pension, retirement annuity and provident funds will all be subject to the one-third lump sum and two-third annuity rules, unless the lump sum is below R150 000.

Lump sums from provident funds will be apportioned to ensure contributions prior to 1 March 2015 and the resultant growth may be paid out as a lump sum not subject to the new annuitisation rules.

No limit is placed on the employer with regard to the deduction claimable for contributions made to these funds on the employee's behalf.

Deductions – donations

Donations to certain designated PBOs qualify for a tax deduction:

Individuals – limited to 10% of taxable income, excluding retirement lump sum payments and severance benefits, and before the deduction of donations and medical expenses.

Employees may also enjoy PAYE reductions when regular donations are made by way of salary deductions not exceeding 5% of net remuneration.

As from 1 March 2014, donations in excess of the 10% threshold may be carried forward to the next year of assessment.

Tax rates – individuals – 2015

Taxable income	Rates of tax
R0 – R174 550	18% of each R1
R174 551 – R272 700	R 31 419 + 25% of the amount over R174 550
R272 701 – R377 450	R 55 957 + 30% of the amount over R272 700
R377 451 – R528 000	R 87 382 + 35% of the amount over R377 450
R528 001 – R673 100	R140 074 + 38% of the amount over R528 00
R673 101 +	R195 212 + 40% of the amount over R673 100

Tax – rebates

Amounts deductible from the tax payable 2015

Persons under 65	R12 726 p.a.
Persons over 65 and under 75	R19 836 p.a.
Persons 75 and over	R22 203 p.a.

Medical aid – rebates/credits for medical aid premiums paid

Monthly amounts deductible from tax payable 2015

Main member	R257 p.m.
Main member with one dependant	R514 p.m.
Main member with two dependants	R686 p.m.

Most hospital doctors' income is at the 40% marginal rate of tax. This means that SARS subsidises any tax-deductible expense by

reducing your tax by 40% of the expense claimed.

Therefore, do not forget to claim any tax-deductible expenses on your annual tax return.

Each additional dependant qualifies for a further rebate or credit of R172 per month.

There are further medical expenses that can be deducted on a formula basis including for an immediate family member who has a tax defined disability.

SARS are currently required to collect ± R1 000 billion rand each year from all the SA taxpayers. In recent years SARS have become more pro-active in collecting the required revenue. In order to achieve this, taxpayers are receiving many more tax queries, reviews and audits.

If SARS makes a mistake or disallows legitimate expenses claimed, leading to more tax payable or tax refunds being reduced to the taxpayer then this would require the taxpayer to make a valid notice of objection timeously and possibly later a valid notice of appeal to SARS.

We, the taxpayers only have one chance to lodge a valid objection and/or appeal

correctly to SARS with the correct wording, explanations, arguments and referral to the relevant sections of the Income Tax Act.

Doctors and even some accountants do not have the knowledge and the experience to deal with these matters successfully with SARS.

I would therefore strongly recommend that doctors consult with a SARS registered tax practitioner.

They are best equipped to do it right the first time and could save you a lot of money and stress. This will usually be very cost effective for the doctor.

You could also ask the tax practitioner to show you their SARS tax practitioner registration certificate before consulting with them.

Jonathan Hayden CA (SA), Professional Accountant (SA) and CFP initiated an accountancy firm which specialises in tax, accountancy and investment services including financial planning for the medical, dental and paramedical professions. jhayden@telkomsa.net

Impaired practitioners: Who is responsible?

M Smit, Senior Legal Advisor: SAMA

"Man becomes great exactly in the degree in which he works for the welfare of his fellow-men." Mahatma Ghandi



The circumstances, under which medical practitioners have to function in South Africa, are shocking compared to other countries where medicine, medical equipment and enough staff are readily available to assist when the situation requires.

Dr O Wiese remembers one incident from his community service year:^[1]

"I remember very clearly an incident during my community service, when I walked into the trauma unit at a day hospital in Cape Town one morning and found a patient lying on the trolley, bleeding profusely from a knife wound. I picked up the patient's file and read: stab wound to the chest – assault. This was after I had already spent the entire weekend at the hospital, working two full night shifts from 7 pm to 7 am attending to similar cases.

Holding the file in my hands I wondered what on earth I was doing there. This had become a pattern, day in and day out. After enduring this relentless onslaught for months on end, I was close to breaking point. It was at that point that I decided I wanted out as soon as my year of community service was over. Five months later

I exited through the dusty swinging doors of the day hospital and vowed never to return to state medicine.

Sometimes I think I could have coped if I had support from the hospital, or if it were just run better. Simply employing more doctors would have helped significantly but, regardless of how busy the hospital was, management would always put only one physician in the trauma unit during the day, and two at night. I often saw more than 100 patients during a single night."

Our doctors work unrealistic hours; shifts often exceed 36-48 hours at a time. Then they also deal with the emotional strain, which is present during these expanded work hours when having to deal with death, family members and feeling overwhelmed.

This has had an impact on how many medical practitioners learn to cope with the circumstances they are faced with daily. Some make time for exercise, others often go away to tranquil places where there are few other people or distractions, many find solace in

The extreme level of stress, which is generally involved in practising medicine, is raised even higher when practising medicine in South Africa.

their faith, family and spending time with friends.

Unfortunately there are those who become impaired in their practice, be it because of a lack of support professionally or personally, or because they are not able to utilise the avenues available to them to obtain the skills they need to cope with their high level of stress.

The other problem is that, in most cases, there is little to no support for young medical practitioners who struggle to cope with the mammoth tasks they are sometimes expected to complete. Employee-assisted programmes are available in some places but mostly, there is no forum for young medical practitioners to get the support they need when they reach breaking point. This is something which should be revisited and made a priority in order to create a holistic approach to solving the problem of impaired practitioners.

“Sometimes I think I could have coped if I had support from the hospital, or if it were just run better”

When this happens, these practitioners are often left hanging on a very thin thread. Their colleagues are aware of the situation in most cases, but nobody wants to be the person to deal with the issue. The fact is, in not reporting this and not speaking up, the impaired practitioner is not receiving the assistance and support he or she needs to again become fully functional in their practice.

The excuse, which is most often raised, is that doctors are never really sure whether the behaviour of a colleague qualifies as being ‘impaired’, or not.

Definitions

In terms of South African legislation, ‘impairment’ is defined as a condition which renders a practitioner incapable of practising a profession with reasonable skill and safety.^[2]

The Medical Board of Australia^[3] defines impairment as follows:

‘Impairment’, in relation to a person, means the person has a physical or mental impairment, disability, condition or disorder

(including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect –

(a) for a registered health practitioner or an applicant for registration in a health profession, the person’s capacity to practise the profession; or

(b) for a student, the student’s capacity to undertake clinical training –

(i) as part of the approved program of study in which the student is enrolled; or

(ii) arranged by an education provider.

Who is responsible?

When a medical practitioner becomes impaired or is identified by his colleagues as being impaired, there are different types of responsibilities which come to the fore.

The Health Professions Council of South Africa (HPCSA) provides clear guidelines^[4] on what is required.

These guidelines include:

- The responsibility of a student, intern or practitioner to report impairment in another student, intern or practitioner to the HPCSA Board if he/she is convinced that such student, intern or practitioner is impaired;^[5]
- The responsibility to report his/her own impairment or suspected impairment to the board concerned if he or she is aware of his/her own impairment or has been publicly informed, or has been seriously advised by a colleague to act appropriately to obtain help in view of an alleged or established impairment;^[6]
- The responsibility to report any unprofessional, illegal or unethical conduct on the part of another student, intern or practitioner.^[7]

Should any person as mentioned above, fail to report the impaired practitioner, disciplinary steps can be taken against them by the HPCSA.

These rules place a positive duty on students and practitioners, in terms of the Health Professions Act,^[8] to report colleagues to the HPCSA whom they are “convinced” are impaired in terms of the Act. It also requires them to report their own impairments if they are “publicly informed” or “seriously advised by a colleague to act appropriately or obtain help.”^[9]

The ethical dilemma faced by many colleagues on the issue of reporting an impaired practitioner is that of having to choose between protecting the privacy of the

practitioner on the one hand and the safety of patients on the other.^[9]

Conclusion

The responsibility therefore for reporting an impaired practitioner, lies as much with the practitioner as it does with their colleagues.

In reminding ourselves of the duties each medical practitioner has to his or her patient,^[10] it is imperative that medical practitioners support each other to maintain their ability to do so.

Any practitioner who provides a service to patients, but is unable to maintain his or her high level of clinical practice and competence as required by legislation, must be responsible enough to seek the appropriate assistance.

The responsibility therefore for reporting an impaired practitioner, lies as much with the practitioner as it does with their colleagues

The stigma surrounding the impaired practitioner as well as the accusing medical practitioner, must be removed through a positive process whereby all parties involved experience an outcome which will add value to their medical practice in the future.

Medical practitioners should not shy away from assisting each other in maintaining their ability to provide a high level of care to the patients and community they serve.

References

1. Wiese O. Why would anyone want to become a doctor? <http://thoughtleader.co.za/readerblog/2015/05/27/why-would-anyone-want-to-become-a-doctor/> (accessed 9 September 2015)
2. Health Professions Act 56 of 1974 (as amended).
3. Information on the management of impaired practitioners and students. 2012. file:///C:/Users/Marlis/Downloads/Medical-Board---Information-Sheet---Information-on-the-Management-of-Impaired-Practitioners-and-Students (accessed 8 September 2015)
4. HPCSA Booklet 2: Guideline on Ethical Rules. Available on the HPCSA website under the section for Professionals.
5. Par 25(1) (a).
6. Par 25(1) (b).
7. Par 25(1) (c).
8. Health Professions Act 56 of 1974 (as amended).
9. Dhali A, Szabo CP, McQuoid-Mason DJ. The Impaired practitioner – scope of the problem and ethical challenges. SAMJ 2006;96(10):1069-1071
10. Health Professions Act 56 of 1974, Section 27A.

Slipping through the cracks

The Medical Protection Society shares a case report from their archives

Mr F, a 45-year-old executive manager in a major sales company, saw his GP, Dr D, for a cold. The GP noted from the records that Mr F had attended three times prior to this for minor ailments. His blood pressure that day was 150/90 mmHg and his BMI was 36. Dr D arranged a cholesterol test, gave some lifestyle advice and asked him to re-attend to recheck his blood pressure. Mr F did not attend the follow up appointment for a blood pressure check.

Six months later, Mr F attended surgery again and was seen by a different doctor in the practice. Looking at the notes, the patient had attended and received treatment for minor ailments six times since his last attendance at the practice.

His cholesterol was significantly raised on the blood test taken six months ago and it appeared a note had been sent to the patient to come in to discuss the result. When asked about this, Mr F explained that he had received the note but that he had had the same test done at his in-house occupational health department, with whom he had discussed the result, and that he had been also seeing them for minor ailments. Once again, Mr F's BP was raised but was significantly higher than before and the GP was concerned, despite Mr F's protests that it was likely because he was a "bit stressed".

The GP and Mr F discussed the best management option and the GP decided to refer Mr F to a cardiologist based on this high reading, and started Mr F on an



antihypertensive. Mr F failed to attend the appointment.

Two months later, Mr F had an episode of indigestion. At the consultation with his occupational health doctor, when asked whether he was on any medication, Mr F said he was taking none. He was given antacids. However, he continued to have pain for three days on and off. He then suffered a cardiac arrest and unfortunately could not be resuscitated. The postmortem showed myocardial infarction.

Looking back over his notes, there had been repeated blood pressures recorded in his notes from various appointments at the practice, the occupational health department and emergency services, and readings had been steadily increasing, without the instigation of a proper management plan and with inadequate follow up.

A claim was made against all doctors involved. The case was settled for a substantial sum reflecting Mr F's age and the fact that he was a high earner.

Learning points

- When patients use multiple health systems for care, there is a risk of concern for their symptoms being diluted by spreading the consultations across a number of healthcare providers. This can be a particular problem with people with demanding jobs, and where employers provide a work-based health service. It is important to work together and communicate with colleagues. The occupational health service should inform the patient's GP, with the patient's consent, and it should be clear who will be following up – usually the GP.
- When patients attend the ED multiple times for minor ailments, it may be worth addressing this in the consultation and explaining alternatives, to avoid a lack of continuity of care.
- Any advice given to non-compliant patients should include the risks of failing to take medication or attend appointments, and should be documented.
- Arranging follow-up for any appointments missed or medication started makes practice safer. In this particular case, the patient missed an outpatient appointment and a GP appointment and was not followed up for either non-attendance to find out what happened.
- With poorly compliant patients, or those who are difficult to track, it is important to take advantage of opportunistic follow-up, and perform routine checks, such as blood pressure.

Eastern Cape elective congress report

Dr Mzu Nodikida

The 22 August 2015 marked a historic day in the healthcare field in the Eastern Cape. A day set aside for a revolutionary shift in medical doctors' activism for the first elective congress of South Africa Medical Association Trade Union (SAMATU). The event took place at Hemingway's Hotel in the city of East London.

The city welcomed different generations of our noble profession in their numbers for the medical profession in the ECP was about to reclaim their rightful place in terms of playing a more active role in determining the direction in which healthcare in the province ought to be going.

Among the invited guests were the following:

- Honourable Minister of Health, Dr Aaron Motsoaledi
- Honourable MEC for Health in the Eastern Cape, Dr Phumza Dyantyi
- The Superintendent General for health in the Eastern Cape, Dr Thobile Mbengashe
- Our alliance partners from Democratic Nurses of South Africa (DENOSA), represented by Comrade Sivuyile Mange
- Medical Women Association of South Africa, represented by Dr Nozipo Jaxa.

Dr Simthandile Toni who is the coordinator of SAMATU Eastern Cape Provincial Task Team presented the Eastern Cape provincial report. The congress elected the leadership that will help carry out the objectives of this forum for the next three years. The Honourable Minister of Health Dr Aaron Motsoaledi also gave a keynote address on the National Health Insurance (NHI).

The Congress

The congress focused on the issue of unity among doctors and emphasised the power that rests in that unity. The Secretary General of SAMATU National Dr Phalane, who gave the opening address at the Congress, spent time explaining the logic behind unionising SAMA. He reassured delegates that the current leadership was not about turning SAMA into something that is foreign to the noble profession of medicine. He also noted that doctors are often

sidelined when major decisions are taken about their very own profession, e.g. the change from SADMC (South African Medical and Dental Council) to HPCSA (Health Professionals Council of South Africa). The salaries of doctors, which are not reflective of the important work that they do, received a lot of attention in his address, with the recognition that doctor's salaries without the overtime allowance were in fact very low. The Secretary General also updated the congress on the issues around the Remunerative Work Outside the Public Service (RWOPS) and Performance Management and Development System (PMDS) and the progress that has been made with provincial structures already in other provinces.

Dr Simthandile Toni gave a brief report on the work done by the provincial task team so far and shared with the congress the issues raised by members: the registrar contract; non-payment of overtime; intern victimisation; RWOPS and PMDS.

All the above are currently being dealt with through the platform that the task team created with the provincial department of health. Lastly the need to train doctors as shop stewards was addressed in Dr Toni's provincial report.

The leadership

The congress took place during a very interesting time in the health sector with National Health Insurance gaining momentum. The paradigm shift that the NHI presents, calls for committed and prudent leadership. The congress had to elect leaders to lead them in this interesting period of healthcare in our country.

The following doctors were elected and tasked with the mandate of leading the province for the next three years.

- Chairperson: Dr Simthandile Toni
- Deputy Chairperson: Dr Jabulani Jeme
- Secretary General: Dr Mzu Theo Nodikida
- Deputy Secretary General: Dr Nombasa Mayeko
- Treasurer in Chief: Dr Bulelwa Mzileni

The mandate to the newly elected leadership was made clear: to build a vibrant trade union movement

among doctors in the province that would help address members' issues. The leadership was also tasked with building branches and workplace structures of the trade union.

The newly elected leaders, were also given full powers to develop a programme of action and consult with membership in order to capture the essence of that which forms the bread and butter issues of our members.

Minister's address

Below is a summary of the issues highlighted in Minister Aaron Motsoaledi's presentation.

- Universal Health Coverage: The minister shared with the congress that the Millennium Development Goals (MDGs) expire in September 2015 but goals 4 (Reducing child mortality), 5 (Improve maternal health) and 6 (Combating HIV/AIDS, Malaria and other diseases) of the MDGs will remain post 2015. He also mentioned that Universal Health Coverage has also been adopted as part of the global health agenda post 2015.
- He spent a lot of time emphasising the challenges within the health financing system. He explained how unsustainable the current health system is.

He introduced a new term which he refers to as "the Americanisation of healthcare in our country" where he says that South Africa has its healthcare roots in Britain but when it comes to the healthcare financing system SA adopts the American model. The Minister highlighted the progress made in the NHI pilot sites and challenges faced. He concluded by giving a presentation on how lack of regulation of private hospital leads to uncontrollable price hikes.

The congress was indeed historic and significant in that it not only elected leadership but also provided a platform for interaction on crucial health issues in the country. The event marked an important step towards active participation of doctors on health policy issues in the province. The future looks bright but as emphasised at the congress the power of unity among doctors will define our success.

Western Cape elect new branch president

At a presidential dinner, held at 'On the Rocks' in Blouberg, SAMA Western Cape honoured outgoing president Prof. Bongani Mayosi and elected incoming president Dr EV Rapiti.



Outgoing president Prof Bongani Mayosi (left) with incoming President Dr EV Rapiti



CCRC
CRITICAL CARE
REFRESHER COURSE
PORT ELIZABETH 2015

CRITICAL CARE REFRESHER COURSE

20 - 22 November 2015

Boardwalk Hotel and
Convention Centre
Port Elizabeth

www.ccrcc2015.co.za



When seeing friends turns into seeing patients, it's time.

When your life changes, so should your insurance. As a medical professional, your success requires hard work, determination and dedication, which is something we at Sanlam can relate to and respect. That is why we'll help protect your greatest asset – your ability to earn an income – with Sanlam's Income Protector.

It will pay you a monthly income if you are unable to work due to illness or injury, giving you the peace of mind that you can provide for your family, maintain your lifestyle and pay your bills. And, because we value you as a professional, it is available to you at a preferential rate.

So, ask yourself: Does your insurance cover you for the life you used to live or the life you live now? Protect your future with Sanlam's Income Protector today. Speak to your Sanlam financial adviser or accredited broker, or call us on 0860 118 888.

Wealth

www.sanlam.co.za

Sanlam is a Licensed Financial Services Provider.

 **Sanlam**
Wealthsmiths™