

SAMA INSIDER

NOVEMBER 2015

**Medical professionals
are the sum of all the
parts – SAMA
conference**

**SAMA Bonitas House Call
Award winners**



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

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SHORT COURSE IN DISPENSING FOR DOCTORS (DISTANCE)

This course is based on the recommended standard for the dispensing course for prescribers in terms of Act 101 of 1965 as amended, which was developed by the South African Pharmacy Council, in consultation with the other statutory health councils. Licensing with the relevant authority as a 'Dispensing Health Care Professional' can only take place once the certificate is awarded.

The Dispensing Course is available through the Foundation for Professional Development (FPD) in association with the Health Science Academy.

ASSESSMENT

Participants will be assessed through:

- Portfolio of evidence
- Written questionnaire
- Dispensing Practical Exam - scheduled on a specific date

COURSE STRUCTURE

The Dispensing course leads to a certificate of completion at a National Qualifications Framework (NQF) level 6. To obtain the certificate a minimum of 30 credits must be obtained. Each credit represents about 10 notional learning hours. The course is taught through distance education, training workshops are provided on request.

ENTRANCE REQUIREMENTS

All Medical Practitioners.

STUDY MATERIAL

Participants will receive a comprehensive 'resource guide' covering all the study units and annexure containing 'additional' information which may be required. You will also receive an 'assessment documentation guide', consisting of learning activities, multiple choice and short questions that need to be completed.

COURSE OBJECTIVES

To enable health professionals to dispense and ensure the quality use of medicines prescribed to the patient.

At the end of the course the participants will be able to:

- Identify and apply ethical, legal and therapeutic considerations in all facets of dispensing.
- Evaluate prescription and assess patient profile.
- Dispense the prescription.
- Manage the procurement and storage of medicines.
- Advise patients to ensure quality use of medicines and improve health status.

CERTIFICATION

Successful participants will receive a Course Certificate of Completion from the Health Science Academy should they successfully complete the assessment process. This certificate must then be submitted in terms of regulation 18 of Act 101 of 1965, as amended. The course is accredited through FPD for 30 CPD points.

COURSE FEE

R2 300 (Inclusive of all VAT and taxes where applicable) the course fee includes all study material, assessment, practical examination and certification.

The practical examination will be scheduled on a specific day, participants will be notified about the date, venue and time. A minimum group of 20 participants will be needed to schedule a practical examination.

Study material will be posted as soon as full payment has been received.

REGISTRATION

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EDITOR'S NOTE

NOVEMBER 2015



Diane de Kock
Editor: *SAMA INSIDER*

A new era dawns

At the SAMA conference last month National Health Minister, Dr Aaron Motsoaledi said that the NHI White Paper is complete – it just has to be presented to cabinet before he makes it public. This is expected to happen before the end of October. "We have given it to the Treasury (for a financing model) and at the next cabinet space I have, I will present it. Technology, different business models and a change in behaviour in public health facilities will all be central to changing public healthcare in South Africa," said Motsoaledi. The White Paper is set to map out how the NHI will be introduced and is a document that is expected to alter the healthcare landscape in South Africa permanently.

We congratulate Prof. Denise White who has been elected as the new President of SAMA for 2016. A long-standing friend of SAMA in the Western Cape and at national and executive level Prof. White was the recipient, on 17 October, of the 2015 South African Society of Psychiatrists Distinguished Service award. In her citation at the awards Dr Larissa Peter said: "Denise, as most of you know her, is a gracious, eloquent, understated, hardworking colleague and friend. She is deeply admired for her wisdom, her generosity of spirit, her loyalty and her good measure. She is an inspirational negotiator, a quiet and dedicated leader and clinician of immense skill and intuition". The Dec/Jan *SAMA Insider* will include more in-depth coverage of Prof. White's appointment.

In this issue of *SAMA Insider* we feature the SAMA conference on page 5, the Bonitas House Call Award winners on page 7 and a tribute to retired SAMA president, Dr John Terblanche on page 13.

We await your feedback and are ready to address your concerns.

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Social determinants of health: Compounded and redefined



Prof. Lizo Mazwai, *President, SAMA*

The subject of social determinants of health has always been discussed traditionally in the context of strict socio-economic factors. However, the problem will not be resolved until we deal effectively with the underlying causal factors. Furthermore the problem looms large and is compounded by additional man-made environmental factors and lately climate change. Hence the use of the terms compounded and redefined.

In terms of infrastructure, housing, water and sanitation it is obvious that intergovernmental collaboration is necessary

Going back to the underlying factors it would be useful to categorise them, in order to deal with them effectively. Having

said this, it is also important to realise that these socio-economic factors have strong intersectoral ramifications and therefore need a collaborative approach. Taking an analytic approach to the problem also brings into focus societal, community, family and individual health issues and re-emphasises the need for preventative medicine, health education and health promotion.

Three broad categories emerge: socio-economic factors, environmental factors and lifestyle factors.

Socio-economic factors revolve around education and social infrastructure which includes housing, roads, water supply and sanitation and lately energy supply. Given all of these, the underlying common denominator is poverty, fuelled by unemployment and in the background lack of education. Social grants, as a safety network, play an important role in alleviating poverty but are not enough as a long-term sustainable solution. Another intervention is access to free healthcare for vulnerable groups. In terms of infrastructure, housing, water and sanitation it is obvious that intergovernmental collaboration is necessary. This challenge is complex and needs a coordinated intersectoral approach and overarching departmental programmes. An example is how poor or insecure housing exposes the population to the effects of the elements and environmental factors – if emergency rescue and medical services are required, the situation can sometimes be compounded by poor road access.

Environmental factors often involve unmitigated natural elements on a vulnerable community. Rurality is often an aggravating factor as there is often the challenge of remoteness and poor accessibility. Broader issues related to the National Development Plan have to do with spatial planning for safe communities with safe environments. Road safety and road traffic accidents are a major cause for concern with high mortality and morbidity, as the statistics reveal in our country.

The last and most alarming factors are the man-made environmental hazards of

pollution. Industry and manufacturing such as mining continue to pollute water systems which poison fish, domestic and wild life. In turn, these pollutants will affect human health directly or indirectly in the long term. Other pollutants such as insecticides used in agriculture and domestically (for example DDT) had to be banned. The effects of nuclear radioactive fallout are well documented from Hiroshima, Chernobyl and lately in Japan. The biggest and most sinister silent threat is air pollution, not only from the established effects on the respiratory system but the effects of carbon emission on global warming and its catastrophic effect on life on planet earth. Climate and health has become a big debate globally; every country, society, community and individual must do their bit to reduce their carbon footprint and alternative sources of essential energy must be found sooner rather than later.

The most alarming factors are the man-made environmental hazards of pollution

Finally lifestyle factors, though very individualistic, have a bearing on societal values, the environment and family upbringing. There is no gainsaying that non-communicable diseases are assuming epidemic proportions in the least expected communities in developing countries. This is not just a problem for the doctors and the Department of Health to solve but for the individual to make the right choices. Diet and exercise are key areas for education and intervention. Low salt, low fat and a low calorie diet coupled with appropriate physical activity are important. No doubt avoidance of alcohol, smoking and drug abuse will also go a long way in providing a better quality of health.

Medical professionals are the sum of all the parts – not just single entity clinicians

SAMA Conference the ideal event for healthcare professionals to learn about developments in the field

To limit our understanding of medical professionals as simply being 'clinicians' is a mistake. Doctors specifically, in both private practice and public service, are much more than this; every day they navigate multiple disciplines to perform their core duties.

Consider that many doctors at some stage may be faced with end-of-life decisions affecting their patients, or that they may have to contemplate legal issues before and after administering care. Take into account that they also have to be informed of the latest pharmaceutical developments, and negotiate financial spreadsheets or deal with human resource issues. When considering these factors (and there are many more) then our understanding and definition of medical professionals begins to change.

At issue is not the fact that medical practitioners are overworked (although many are) but rather that the scope of their work extends far beyond consulting patients. And this aspect of providing a service to the public must be managed. To do this, medical healthcare professionals must continually learn, and gather the skills which will make them better administrators and clinicians.

"A long time ago we recognised the value of providing healthcare professionals with information that is aimed at improving their understanding of the profession. For this reason the South African Medical Association (SAMA) has held an annual conference for many years to give experts in different fields an opportunity to speak to our Members. It's an invaluable exercise as doctors across the disciplines are given information from experts in the medical field but also from lawyers, accountants, ethicists and many others, that

they can apply to their different situations," said Dr Mzukisi Grootboom, Chairman of SAMA.

Health Minister opens SAMA Conference

This year's event, held from 18 - 20 September at the Sandton Convention Centre, saw experts from a range of specialities addressing delegates. The Minister of Health, Dr Aaron Motsoaledi, was among the speakers and provided Members an important opportunity to engage with the government's top health decision maker.

Opening the conference on Friday, Dr Motsoaledi said a big problem with healthcare provision in South Africa remained a lack of understanding and empathy among healthcare professionals. But, he said, this was among the issues that would be tackled with the implementation of National Health Insurance (NHI) across the country.

"We are using the National Development Plan as a basis for the establishment of NHI which will see the strengthening of primary healthcare in South Africa. While we have not distributed the White Paper on NHI which details how this will be implemented, I can tell you that a lot is happening behind the scenes ahead of the roll-out in the near future," he said.

Dr Motsoaledi added that there are three key areas that need to be considered to improve public healthcare. These are keeping up with the latest technology in medicine, a review of different business models to ensure proper provision of public healthcare, and a change in behaviour of healthcare providers to ensure a more sympathetic approach is adopted in providing this care.

The Minister also touched on other issues such as the investigation into the management of the Health Professions Council of South Africa ("Not one doctor in South Africa won't be touched by the findings of that investigation.") and the fact that African leaders must not travel to Europe for medical care, a situation he described as 'untenable'.

The Minister also addressed reports that he was criticising doctors in the media, in reference to remarks he made about doctors at the Evander Hospital in Mpumalanga who performed a caesarean section on a woman in a normal ward instead of in a theatre.



Dr Motsoaledi opens the conference

"I respect the profession, but if a doctor acts like a hooligan I will act and not sit by and do nothing. I will not allow that," he said.

Ethical issues

The morning session following the Minister's opening address dealt with the contentious ethical issue facing many healthcare professionals: End of Life Decisions. Prof. Ames Dhai, the Director of the Steve Biko Centre for Bioethics at the Faculty of Health Sciences at the University of the Witwatersrand noted that although this is an issue that strongly divides opinion, and that there are compelling arguments for and against euthanasia, national and international guidelines condemned the practice.

Her sentiments against euthanasia were echoed by Dr Liz Gwyther, the CEO of Hospice Palliative Care Association of South Africa (HPCA) and the incoming chair of the Worldwide Hospice Palliative Care Alliance (WPCA).

"There are ways to manage pain in sufferers and we do not have to kill the sufferer to ease the pain. If we legalise euthanasia in South Africa we are crossing a line and agreeing that it's okay to kill another person, which is not okay," Dr Gwyther noted.

Apart from the issue of End of Life Decisions, the first day's session covered topics such as hypertension, pathology testing, HIV and diabetes. In his presentation Prof. Solomon Rataemane, the Chairperson of the Ministerial Advisory Committee on Mental Health in South Africa said depression is a forgotten epidemic.

"Depression is an extremely painful disease and must be taken seriously as it affects us all. Depression is under-recognised and



Dr Grootboom, chairman of SAMA



The Bonitas stand at the conference



SAMA Board of Directors, from left: Prof. SNE Mazaza (SPPC chair); Dr MR Abbas (Fincom chair); Dr MS Poee (SAMATU 2nd deputy president EDOPS); Dr MJ Grootboom (chairperson); Prof. A Dhali (HRLE chair); Dr LJ Mphatswe (GPPPC chair); Dr MM Stoltz (Constitutional Matters committee chair); Dr S Maweya (SAMATU acting president and health policy chair); Dr Y Baldeo (S&E Chair, Social and Ethics); Dr S Sham (SAMATU 1st deputy president public sector)

inadequately treated, especially as many patients won't highlight this as a problem and point to a physical ailment instead. As doctors we must be aware of this," he said.

Prof. Rataemane said it is significant that by 2020 depression will rank as second only to cardiovascular disease in the world, a statistic that amplified his call for medical professionals to take it more seriously.

National Health Insurance

National Health Insurance (NHI) remains a somewhat unknown quantity for many healthcare professionals, an issue conference organisers recognised with the inclusion of Dr Aquina Thulare as a speaker on day two. Dr Thulare is a Technical Specialist on Health Economics for the NHI in the Department of Health and spoke on how the NHI model relates to finance and how it will affect both private and public service medical practitioners.

Dr Thulare stated that one of the main objectives for the implementation of NHI was to ensure equity in resource distribution, efficiency in providing public health care, and transparency and accountability through the system.

"The NHI is based on the principles of the National Development Plan, a message you will hear over and over again as we begin to roll-out NHI. Through the NDP and NHI we have set ourselves the goal of providing a healthcare system that produces positive healthcare outcomes **and** is accessible for all in South Africa by 2030," she said.

In addition Dr Thulare said while the White Paper on NHI was still to be released, it would make provision for people to receive free healthcare when they needed it most and that South Africans who used the system would receive entitlements to the services provided.

While no date for the release of the White Paper has been announced, it is expected to be released before the end of 2015.

Day two of the conference concluded with presentations from Prof. Gerhard Lindeque and Dr Padaruth Ramlachan.

Prof. Lindeque, the Head: Obstetrics and Gynaecology at the University of Pretoria, delivered a paper on Women's Health saying being born a woman leads to a difficult life for many.

"Many girls in South Africa skip out on being adolescents because they fall pregnant or are



The ABSA stand

tasked with heading households in the absence of adults. It's a problem. What's worse is that nearly 100 000 girls of school-going age are pregnant. It's a disaster," Prof. Lindeque lamented.

Dr Ramlachan, the President of the African Society for Sexual Medicine delivered a powerful presentation on Multimorbidity and Sexual Dysfunction. With reference to the previous day's topic of palliative care he noted that even terminal patients need sex before dying. He also noted any man with erectile dysfunction is a cardiovascular patient until proven otherwise.

Law, finances and taxation

The final day of the conference provided interesting presentations to delegates on topics related to practice management.

The thorny issue of supersession was discussed in detail by Mr Julian Botha, Senior Legal Advisor to SAMA. Supersession relates to doctors consulting or taking over the patients of other doctors. Mr Botha's informative presentation proved to be a popular topic as he fielded many questions from the floor on this issue.

Mr Werner Swanepoel, managing director of Medical Practice Consulting and Mr Hassen Kajie, a Chartered Account and Income Tax Assessor to the Special Income Tax Court closed the day with their presentations dealing with financial management and taxation issues affecting doctors.

"From the line-up of speakers presented and the range of topics they discussed, it's clear that the conference reached its goal of providing our Members a broad snapshot of the latest developments in medical healthcare. I think the success of the conference lies in the fact that doctors walked away with a deeper understanding of their profession, and other important aspects such as law and finance that will, ultimately, improve them personally and their practices," said Dr Grootboom.

All the presentations from this year's conference are available at <https://www.samedical.org/2015cp>

SAMA Members can follow SAMA on Facebook at <http://www.facebook.com/groups/samedical/> or on Twitter at <https://twitter.com/SAMedicalAssoc>.

SAMA Bonitas House Call Award winners

A highlight of the SAMA conference was the awarding of the SAMA Bonitas House Call Doctor's Awards that recognise medical heroes in South Africa who have been nominated by their peers in their profession. Congratulations to the following winners:



Dr G Z Mbambisa received the **Loyalty Award** which is given to individuals who have contributed distinguished service to SAMA of an extraordinary nature. Dr Mbambisa is a specialist obstetrician and gynaecologist and previous lecturer in Obstetrics and Gynaecology at the then University of Transkei medical school. He has been a loyal and dedicated member of SAMA since its inception and is currently the chairperson of the Transkei branch.

He has also been the General Secretary of the Transkei Branch and represented the Transkei Branch yearly at the SAMA National Council Meetings. At branch level, he is passionate about organising at least four CME meetings per year by inviting a range of specialists from different medical schools in South Africa to update and assist doctors working in this rural province to keep abreast of recent advances in medicine and also assist in obtaining the annual CPD points required by the HPCSA. When the branch experienced financial challenges Dr Mbambisa offered the use of his room, staff and secretarial services free to SAMA to keep services to members active.

Besides his dedication to SAMA he is involved in other ventures to upgrade the health services in his region, for example, being active in reducing maternal mortality and the programmes that are run by the province. His influence is evident both in public and private spheres and this reflects well for SAMA. Dr Mbambisa has truly led the Transkei Branch from the front.



Prof. Andrew Argent received the **Lifetime Achievement Award**, awarded for dedicated and single-minded pursuit of medicine as a career, with distinction. Prof. Argent is head of the Paediatric Intensive Care Unit (PICU) at the Red Cross War Memorial Children's Hospital in Cape Town. Over the last decades he has developed this unit into a world-class facility providing comprehensive, excellent care to children, and undertaken highly relevant research, developed and run new training programmes and advocated strongly for critical care services for children in need.

The PICU is a unique and model facility, as the only dedicated paediatric intensive care unit in the country. This is a national asset, providing outstanding services for children with severe or complex medical or surgical conditions. Despite the very high turnover of patients, severe illness and poor socioeconomic living conditions from which most patients come, the outcomes of this unit are comparable to those in the best units in high-income countries – attesting to the extraordinary care and teams that Prof. Argent has developed.

Under his leadership, this unit has been at the forefront of research that is highly relevant to African children. He has more than 100 peer-reviewed publications, and has supervised several masters and PhD students. Through all these activities, this unit has a large footprint nationally and in Africa.

Prof. Argent is a leader in paediatric critical care nationally and internationally. In 2008, the Critical Care Society of SA recognised his extraordinary contributions by awarding him their highest honour, the President's Award. Over his lifetime he has developed a remarkable unit, providing care to thousands of children, grown unique teaching and training programmes, undertaken cutting edge research highly relevant to our setting and developed much capacity for critical care in South Africa and in Africa.



Dr Hendrik Jacobus Hamilton received the **Rural Doctor Award** which is presented for extraordinary service to community or nation extending beyond the field of medicine. Dr Hamilton has worked at the McCords Hospital. His time in the bush was preceded by a year in Durban which was a very important forming year for him.

For him it all started at Bethesda in 1998 where he fell in love with the beautiful mountains that were looking down on the Makhathini flats. He decided there and then that he could stay there forever, and he may have if it was not for meeting his amazing Swiss wife. He started a homebased care programme and loved flying to the surrounding clinics. He later had the privilege of taking over an eye programme and had the life-changing experience of staying with a Zulu family in the community. Dr Hamilton was welcomed by the Nhlekos, whom he fondly refers to as his Zulu family. He stayed with them for three years and it changed his life! But what meant the most to him was that he learned to see the Zulu people as people, to love and trust them and to come to realise that he is not better than them.

After two years at Bethesda he was hungry for some medical input, and so he spent seven months at Edendale hospital with Prof. Collin Cook, and six months with Paul Rollinson at Ngwelezana Hospital doing orthopaedics. He gained a lot of experience during that time and it influenced the way he practised all other aspects of medicine. Whenever he is on call and feels sorry for himself at two in the morning, he thinks back to his calls at Ngwelezana and his self-pity immediately stops.

As a person who loves challenges, he accepted the opportunity to lead the doctors and allied professionals at his hospital. He credits the management team for the success of the last seventeen years in rural medicine.

The following doctors were awarded **Spirit of Medicine Awards: Dr Geoff Govender, Prof. Johann du Plessis, Prof. Gerald Peter George Boon and Dr Stephen Grobler.**

This award is made for extraordinary service to community or nation extending beyond the field of medicine and is dedicated to doctors who have distinguished themselves both in the field of medicine and also in areas beyond in creating an enabling environment and/or living habitat, or working in the wider interests of mankind.



Dr Govender qualified as a medical doctor in 1981 at the then University of Natal in Durban. He has been a general practitioner in private practice since 1983. He completed the construction of the multi-disciplinary healthcare centre (Famhealth Medipark) in Gelvandale on 28 November 2008 and is currently the managing director. Dr Govender is a member of the Nelson Mandela Metropolitan University (NMMU) Council and CEO and chairperson of Ecipa Healthcare: an organisation of 90 medical doctors in Port Elizabeth.

Community upliftment programmes being conducted at Famhealth Medipark include a joint venture with the NMMU, with a common vision to train visionary, competent and ethical leaders for tomorrow. There's also work with the Hope Foundation which is a non-profit community-based organisation. Caregivers look after the sick and elderly at home and in old age homes. Many of them have secured work in healthcare and outside of healthcare.

His list of awards includes the Herald-GM Citizen of the Year 2011 in the category of sustainable development, an award for service during the Northern Areas Uprising in 1990 and the PE Rotary Club: Citation for Meritorious Service in PE, 2015.

Dr Govender was chairman of the South African Managed Care Cooperative, chairperson of the Eastern Cape Independent Practitioners Association, and also chairperson of SANCA for three years.

His illustrious career includes courses, submissions and participation in various conferences. He drafted and presented submissions on the Health Charter to the SA Department of Health, a negotiations skills course and national presentations on managed healthcare and also attended many overseas healthcare conferences.



Prof. Dionisius Johann du Plessis obtained an MB ChB degree in 1966 from the University of Pretoria and in 1974 the M Med cum laude and FCS (Urology). In the same year he was awarded the Brebner medallion.

After his internship year he opened a private practice in Port Elizabeth. In February 1970 he was appointed as clinical assistant in Urology at the HF Verwoerd Hospital and the University of Pretoria and as First Urologist at the Kalafong Hospital and the University of Pretoria until 1977.

As a visiting professor, he visited many universities, among others, the Helsinki University Central Hospital in Finland, the University of the Free State, the University of the Witwatersrand and Buenos Aires. The honour of exceptional awards and bursaries was bestowed on Professor du Plessis on various occasions. His most recent awards were the Albert Schweitzer Golden Medal, presented to him by the Presidium of the Albert Schweitzer World Academy of Medicine, on 4 May 2001 in Warsaw, Poland.

Dr Du Plessis was the head of the Department of Urology for 25 years and then became Dean of the Faculty of Health Science of the University of Pretoria for eight years. He later became Group Medical Director for Netcare where he implemented clinical governance. He is widely recognised for his role in promoting cost effective and quality care for people and promoting general practitioner upskilling and training.

His specialties range from medical practitioner, urology, andrology, urinary incontinence, clinical governance and implementation to health presentations. Dr Du Plessis is now retired but serves on several boards and consults in the medical industry.



Prof. Gerald Peter George Boon was born on 18 March 1952, in South Africa. He qualified with

an MB ChB degree from the University of Cape Town in 1975 and acquired a diploma in Child Health from the College of Medicine of SA in 1980 and FCP Paed in 1983.

Prof. Boon is registered with the South African Medical and Dental Council (speciality Paediatrics) and the Ciskei Medical and Dental Council. His academic status ranges from Honorary Senior Lecturer, Department of Paediatrics and Child Health, University of Cape Town to Acting Director Postgraduate Studies, East London Academic Platform of UNITRA.

He has been an examiner for the Diploma in Child Health at the South African Colleges of Medicine and an associate professor in the Department of Paediatrics and Child Health at the Walter Sisulu University for a long time and is also an honorary clinical associate, Faculty of Pharmacy at Rhodes University. Professor Boon's wide-ranging publications include *Letters on Carbon Monoxide Poisoning*, *Mushroom (Amanita phalloides) Poisoning in Ciskei*, *Prevalence of HIV antibodies in antenatal clinic attendees in the Ciskei* and *Foreign-qualified doctors: A significant contribution*.

He also provided his literary skills as editor of various publications and is an esteemed member of committees. Prof. Boon has received numerous awards in his career, notably the certificate of appreciation from the East London Hospital Complex and the health excellence award in 2007.



Dr Stephen Paul Grobler obtained his medical degree from the University of the Free State in Bloemfontein. An honorary research fellow in the department of surgery at the University of Birmingham from 1990 to 1992, his current responsibilities are clinical and research activities in the gastroenterology unit and supervision and training of surgical gastroenterology and medical gastroenterology subspecialty certification. He is now a specialist surgeon at the Universitas Private Hospital in Bloemfontein.

His membership of professional bodies, committees and leadership roles are numerous and wide-ranging, with both contracted research

and publications. These include the Association of Surgeons of South Africa and the South African Gastroenterology Society. Dr Grobler was the president of the South African Society of Endoscopic Surgeons from 1999 - 2002 and vice chair of the Specialist Private Practice Committee, SAMA since August 2014.



Prof. Leslie London was awarded the **Equity and Justice Award**, awarded for the cause of justice and equity in the face of personal sacrifice, material loss or threat to security. Prof. London has been a stalwart for social justice and a champion of transformation across multiple institutions in the South African health sector for more than three decades.

In the field of human rights and health in South Africa, Prof. London steered the call in the mid-1990s for the Truth and Reconciliation

Commission to hold special hearings on the role of the health sector under apartheid, obtaining funding from the Swedish NGO Foundation for Human Rights to support this process.

This then led him to investigate how the MASA was complicit with the apartheid worldview, practising racial discrimination and failing to uphold professional ethics. So great has been the role that Prof. London played in ensuring the transformation of MASA to SAMA that it is no coincidence that SAMA now pays tribute through these annual awards to doctors who uphold human rights.

Prof. London is a renowned teacher and mentor at the University of Cape Town, founding a health and human rights programme in the Faculty of Health Sciences. A generous colleague and supportive friend, Leslie London typifies the spirit and intent of this SAMA award.

Prof. Bongani Mayosi received the **Medical Scientist Award** which recognises international acclaim of excellence in the practice of medicine both as an art and a science – championing the cause of healthcare despite obstacles. Prof. Mayosi is head of the Department of Medicine at the University of Cape Town, chief specialist at Groote Schuur Hospital and president of the South African Heart Foundation. He qualified in medicine from the University of KwaZulu-



Natal and trained in internal medicine and cardiology in Cape Town. He was the Nuffield Oxford Medical Fellow in cardiovascular medicine at the University of Oxford from 1998 to 2001. His research interests include genetics of cardiovascular traits, treatment of tuberculosis pericarditis and prevention of rheumatic fever. He has been honoured with numerous awards including the Order of Mapungubwe in silver, one of the top 25 influential leaders in healthcare in 2007 and the prestigious membership from the Academy of Science of South Africa.

His immediate past president professional memberships include National Medical and Dental Association, the Azanian Students Organisation and president of the College of Physicians of South Africa and vice president of the Pan African Society of Cardiology.

LCBO concerns as published in the CMS Circular

Selaelo Mametja, *Head of Knowledge Management and Research Development*

The Council for Medical Schemes (CMS) has published the Low Cost Based Options (LCBOs) framework, to be implemented from January 2016. The LCBOs are intended for members with an annual income below the SARS tax threshold who would normally consult for cash or use public hospitals. The possible advantage of bringing this population under formalised medical schemes is to capitalise on existing mechanisms to ensure funds are pooled together for the benefit of the beneficiaries.

For risk pooling of funds to work effectively and equitably, there should be open (mandatory) enrolment, community rating and mandatory benefits (PMBs). The mandatory benefits are intended for the financial and health protection of members, as well as allocative efficiency between the public and private sector.

SAMA believes that very little value has been added to prospective beneficiaries by the new LCBOs approved by the CMS. We demonstrate that in implementing the

LCBOs framework as published in Circular 54 of 2015, Council would have failed in the following functions as outlined in Section 7 of the Medical Schemes Act of 1998:

- Protect the interests of the beneficiaries at all times;
- Control and coordinate the functioning of medical schemes in a manner that is complementary with the national health policy.

Concerns regarding LCBOs framework

Exemption framework

Healthcare regulation is there mainly to protect consumers and promote public health objectives of equity, affordability and access to health services. In South Africa regulation of medical schemes is intended to improve allocative efficiency between the public and private sectors and protect members against out-of-pocket expenditure in case of serious illness.

The Council for Medical Schemes did not clearly outline the purpose of LCBOs. Is it to increase CMS levies, increase incomes of profit

making entities or improve healthcare coverage of patients? Clearly outlining the objectives provides clear guidance to the public, medical schemes and providers, and provides the basis for monitoring and enforcement.

Analysis of impact and unintended consequences of exemptions

According to MSA (1998) **Section 29(1)(n)**: The terms and conditions applicable to the admission of a person as a member and his or her dependants, which terms and conditions shall provide for the determination of contributions on the basis of income or the number of dependants or both the income and the number of dependants, and shall not provide for any other grounds, including age, sex, past or present state of health, of the applicant or one or more of the applicant's dependants, the frequency of rendering of relevant health services to an applicant or one or more of the applicant's dependants other than for the provisions as prescribed.

In Accordance with MSA (1998) **Section 29(3)(a)** A medical scheme shall not

provide in its rules (a) for the exclusion of any applicant or a dependant of an applicant, subject to the conditions as may be prescribed, from membership except for a restricted membership scheme as provided for in this Act;

Exemption from section 29(1)(n) and 29(3)(a) will result in risk selection (cream-skimming), which occurs when insurers try to counter adverse selection or maximise profit by discouraging sicker individuals from purchasing insurance or by finding ways to insure only lower-risk individuals. The proposed benefit package further discriminates against those who are HIV positive as this prevalent condition is not covered as a prescribed minimum benefit.

Section 33(2)(a): The Registrar shall not approve any benefit option under this section unless the Council is satisfied that such benefit option (a) includes the prescribed benefits.

Exemption from these sections 33(2)(a) means Council is taking away health and financial protection offered by PMBs. This is only acceptable if the purpose of the exemption is to provide good quality primary healthcare. This exemption is further confirmed by proposed package which exposes prospective beneficiaries to financial exploitation and poor quality healthcare.

Section 29(1)(p): No limitation shall apply to the reimbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as contemplated in paragraph (o) and may not be different from the entitlement in terms of a service available to a public hospital patient.

This exemption means that schemes will not be forced to reimburse healthcare in the public hospitals; this might also apply for a defined package. When patients are on medical aid or have a single income of >R72 000 or family income of >R100 000, the public sector considers them full paying patients. This exemption will result in out of pocket expenditure (uniform patient fees - UPFS) when the public sector is used voluntarily or involuntarily. Exemptions from this section further exacerbate allocative inefficiencies between private and public sector and exposes beneficiaries to catastrophic health expenditure in public sector.

Section 29(1)(o): The scope and level of minimum benefits that are to be available to members and dependants as may be prescribed.

Prescribed benefits are the pillars of the act. Exemptions from the PMBs essentially expose the members to inadequate health protection with consequent "dumping" to public sector.

Section 65: This section allows the Minister of Health to prescribe broker fees, with an intention of regulating the non-healthcare costs.

At face-value it seems CMS will prescribe lower brokerage fees for this category; however on deeper analysis, it is evident that these beneficiaries will be paying high proportion of contributions as non-health care expenditure. Currently CMS aims to reduce total non-health expenditure to 10% of total expenditure for the entire industry. In 2015 broker fees were limited to R75 per month or 3% monthly of contributions monthly whichever is lesser. CMS has prescribed broker fees of 5% to 10% of contributions up to a maximum of R25 per month. While the rand amount is less, the proportion relative to contributions is high meaning the beneficiaries may have less money available for healthcare after levies, broker, managed healthcare and administration costs have been deducted. Therefore this exemption will protect financial interest of administrators rather than healthcare needs of the beneficiaries. It is necessary to ensure contributions predominantly fund health care expenditure

Regulation 28(2): Compensation of brokers (1). No person may be compensated by a medical scheme in terms of section 65 for acting as a broker unless such person enters into a prior written agreement with the medical scheme concerned. This exemption does not make sense, who then will act as broker? Can anybody claim broker fees, how can this exemption benefit members.

Package does not provide sufficient health protection

Out of the 26 conditions in the Chronic Disease List (CDL) in the current Prescribed Minimum Benefits (PMBs), the package for LCBOs include treatment for only five diseases: diabetes mellitus 1&2, hypertension, asthma, and hyperlipidaemia. Common conditions in the target population such as HIV/TB have been excluded. Others, such as cardiac failure, have been excluded despite their treatments being effective, cost-effective and affordable and medicine listed in Annexure A. The pathology, formulary and diagnostic radiology do not correlate. For example, fracture diagnosis is a PMB but not appropriate management at PHC (e.g. plaster of paris, slabs, etc.)

Principles of social solidarity, community rating and open enrolment are compromised

Section 29(1)(n) exemption will allow the scheme to deny enrolment based on age, sex, gender, race, etc. The LCBOs are likely to attract those who are not affected by HIV/TB or non-communicable diseases such as ischaemic heart disease and heart failure. Some conditions such as acne treatment (although desirable) is not essential. The included benefits will typically attract young, healthy HIV-negative people, which undermines the principle of community rating and open enrolment that are pillars of the Medical Schemes Act. Although the package requires reimbursement in full (within five consultations), lack of meaningful essential healthcare as a minimum benefit disadvantages low-income members.

In South Africa, populations in quintile 4 and 5 need less care compared to quintile 1 and 2. However, they use the most resources. This group of patients will come from lower quintiles compared to the existing medical scheme population. Their healthcare needs are expected to exceed affordable contributions.

Singling out this group from main medical schemes compromises the solidarity principles where there is cross-subsidisation between the rich and the poor, the young and the elderly, and the healthy and the sick. The fact that this group is exempted from paying tax means that they require appropriate cross-subsidisation. It is also known that health needs are higher in the lower socio-economic strata compared to higher ones. Simply put, this group is too poor and too sick.

The package is not aligned with National Policy, Sustainable/ Millennium Development Goals and ethical principles

Currently medical scheme patients are provided with antiretroviral treatment although TB treatment and care must be obtained from public sector clinics despite TB being at PMB level of care. Failure to integrate TB and HIV is as a result of regulatory failure as CMS has allowed schemes not to reimburse TB care despite it being a PMB. With the recent published LCBO excluding HIV/TB care it is evident that CMS discriminates against HIV-positive patients; a serious concern as South Africa has made good strides to eliminate discrimination against people living with HIV.

Exclusion of HIV/TB from mandatory benefits will not assist the country in reducing the burden of disease and associated maternal, infant and child mortality rates. The package does not support the overall vision of increasing life-expectancy to 70 years. In the absence of HIV treatment in pregnant women, the included antenatal and post-natal care may be ineffective as HIV remains number one killer in our mothers. Fragmenting HIV and antenatal care will erode gains in mother-to-child transmission rate.

The exclusion of management of complications (which may be due to medical treatment or disease progression) is unethical and contrary to the Integrated Management of Chronic Diseases Plan implemented by NDOH in 2011. Exclusion of management of complications incentivises scrupulous schemes to offer inferior cover as poorly managed and complicated patients can be 'dumped' to the public sector.

Exclusion of prevalent conditions and treatments that are effective, cost-effective and affordable is unethical, unjustified and harmful to the society. Providing for screening without treatment linkages is against public health principles. Beneficiaries have access to PSA which is not a national priority and government has not planned resources to deal with early treatment of prostate cancer. Public hospitals will be overloaded by poorly thought fragmented package.

Impact on the doctors and other healthcare providers

The prescribed package is likely to result in poor quality and fragmented care, with doctors carrying the burden of providing unfunded health care or being unable to serve patients in accordance with current evidence. This is even perpetuated by the fact that CMS has not been transparent about anticipated health and non-healthcare costs.

Designated service provider arrangements promote inequitable access to healthcare

Large organised clinics may be more able to negotiate favourable contracts because of their economies of scale. These contracts may marginalise migrant labourers' families and rural communities who are essentially served mainly by solo practitioners. Also allowing schemes to register based on DSP

arrangements ensures that those who live in urban areas and have access to healthcare continue to benefit more than rural communities. This is inequitable and families of migrant labourers and rural communities are further disadvantaged from participating in meaningful health insurance.

No continuity of care

This group of patients will be admitted in public hospitals as there will be no private hospital cover. As the package provides less than the standard level of government primary healthcare the GPs will be forced to refer patients back to community clinics. This uncoordinated healthcare is regressive, wasteful and not cost-effective.

Allocative inefficiency

In the absence of health protection and financial protection the public sector remains responsible for essential healthcare in this population whom SARS have exempted from paying tax. Therefore they are subsidised by the rest of tax payers. The fact that SARS provides exemption says a lot about affordability of essential services in this population. If they cannot afford to contribute towards national tax, can they afford to purchase their essential healthcare? If it is their desire to purchase healthcare, with their affordability levels, can they purchase decent healthcare?

Government will remain responsible for their burden of care and especially for HIV/TB and non-communicable diseases. The package includes treatment of conditions with low morbidity and mortality at the expense of life-saving, cost-effective and affordable treatment.

Non-health expenditure

Failure to provide guidance on acceptable levels of non-health expenditure may result in high non-healthcare expenditure, which further reduces the proportion of health expenditure. There is a risk that the scheme may use these uncontrolled levels to increase profits of managed healthcare and administration organisations.

While the CMS suggested contribution amounts, they did not provide healthcare needs, estimated health- and non-healthcare costs. Estimated costs will provide sufficient information to determine if contributions are reasonable and can sufficiently provide reasonable healthcare coverage and related non-health expenditure.

Recommendations

SAMA welcomes the retraction of LCBOs for review as per CMS Circular 62 of 2015. SAMA further recommends that the CMS should:

- Review the purpose of section 29(1) n) and 29(3)(a) exemption. This exemption will result in "cream-skimming" by the schemes.
- Ensure financial and health protection of beneficiaries in accordance with Section 7(a) of the MSA.
- Include HIV and TB to align with National Policy as required by Section 7(b) of the MSA of 1998
- Include public sector hospitalisation as a PMB, which will protect members against catastrophic expenditure or alternatively obtain exemption from UPFS.
- Adopt primary healthcare EDL (2014) as a minimum package for LCBOs as this is the national policy for primary healthcare.
- Should CMS not adopt Primary Healthcare EDL (as is) as a minimum benefit, methods used by CMS for selection of the package and costing estimates must be published for peer review. This is in accordance with section 3(4) of the MSA which required Council to be transparent.
- Ensure a significant portion of contributions cover health expenditure.
- Allow cross-subsidies from current medical schemes plans as they have previously allowed cross-subsidies between plans.
- Ensure migrant rural labourers and their families have access to the necessary care and DSP.
- Monitor the impact of these plans by monitoring quality of healthcare and outcomes.

Conclusion

We applaud CMS interventions to increase medical schemes beneficiaries. We believe that the concurrent implementation of the long awaited compulsory enrolment and risk equalisation has better potential to increase beneficiaries, reduce claims ratio and contributions, and therefore improve access to private healthcare.

Getting members with reasonable incomes above the tax threshold will also ensure meaningful cross-subsidies.

The low cost-benefit options will be able to provide meaningful care in the presence of mandatory participation.

Impairment and Ethical Rule 25

Julian Botha, Strategic Accounts Manager: SAMA Private Practice Department

Ethical Rule 25, printed below, is prescriptive and unambiguous and places a direct obligation on a student, intern or practitioner to report, among others, the impairment of either themselves or a colleague. There is no latitude or discretion, the report must be made. The question now arises – what happens next?

Ethical Rule 25 states as follows:

"25. Reporting of impairment or of unprofessional, illegal or unethical conduct

(1) A student, intern or practitioner shall -

(a) report impairment in another student, intern or practitioner to the board if he or she is convinced that such student, intern or practitioner is impaired;

(b) report his or her own impairment or suspected impairment to the board concerned if he or she is aware of his or 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, and

(c) report any unprofessional, illegal or unethical conduct on the part of another student, intern or practitioner."

The approach of the statutory council in dealing with impairment is actually less punitive than one might suspect. It is rehabilitative in nature.

In terms of section 15(5)(f) of the Health Professions Act, the Health Committee is established. The Health Committee is a non-punitive committee which was established to manage the compliance of the practitioners while also protecting the public.

The purpose of this committee is to regulate and advise impaired practitioners who suffer from a mental or physical condition or the abuse of or dependence on chemical substances, which affects the competence, attitude, judgment or performance of a student or a person registered in terms of the Health Professions Act.

The Health Committee has a number of functions which include the following:

It establishes policies and procedures and enlists cooperation and support for the prevention or alleviation of circumstances which may lead to impairment in students and practitioners. In addition, mechanisms and procedures are put into place for the early identification of impairment in students and practitioners.

The committee implements procedures for handling crisis situations which may threaten

patient safety and care. It also undertakes informal assessments of reports on alleged impaired students and practitioners, to make findings with regard to impairment and, if required, to impose conditions of registration or practice on such persons aimed at protection of patients and treatment of impaired persons.

The Health Committee has the power to appoint investigation committees on an *ad hoc* basis to undertake formal investigations into reports on alleged impairment in the absence of voluntary cooperation of students or practitioners, to make findings with regard to impairment and, if required, to impose conditions of registration or practice aimed at protection of patients and treatment of impaired students or practitioners.

In closing, the Health Committee may consider applications by students or practitioners who were found to be impaired to have their conditions of registration or practice amended or to have such conditions revoked. It oversees the implementation of treatment programmes of impaired students or practitioners and reviews the position of each such student or practitioner at least every three years.

How the Health Committee functions

When a complaint regarding alleged impairment of a practitioner is received by the secretariat of the Health Committee, it is placed on the agenda for the next meeting of that committee. The Health Committee then launches an informal investigation. The practitioner concerned is informed of the complaint/report and is requested to undergo an assessment by a specialist of his/her choice and another specialist who is appointed by the committee. The specialists are provided with reporting guidelines which must be followed in the assessment. Once completed, the appointed specialists submit their assessment reports to the committee for consideration.

In the event that the committee is satisfied that there is impairment of the practitioner, the practitioner will be declared impaired. This impairment is then processed on the HPCSA administration system against the practitioner's name.

The practitioner will then be required to work under supervision and to undergo treatment with the treating practitioner/institution approved by the committee.

In the event that there is no evidence of impairment, the health committee will dismiss

the complaint and inform the practitioner of the outcome of their findings.

Where a practitioner refuses to participate in the informal process described above, the committee has the power to commence a formal investigation in terms of section 51 of the Health Professions Act.

A notice will be sent to the practitioner requiring that the practitioner make him or herself available to undergo an assessment within 30 days of the date of the notice. If the practitioner refuses to comply with the requirements of the notice issued, that practitioner's name will be suspended from the register of health practitioners until such time that the practitioner is assessed by the two specialists and properly diagnosed.

Assessment and rehabilitation

The assessment and confirmation of impairment represents the first phase of the responsibilities of the Health Committee. It is also responsible to monitor the impaired practitioner's progress and ensure compliance with the limitations imposed on that practitioner.

Progress reports should be submitted to the Health Committee by the treating doctor and the supervisor every three months for a period of one year. The committee must consider each of these reports. Should these initial reports show that the practitioner is making progress in their rehabilitation, six monthly reports must be submitted during the second year by the treating doctor and supervisor.

If progress is observed and the practitioner is complying with all the requirements, only an annual report from the treating doctor and the supervisor must be submitted to the committee for the third year. After which, an interview is conducted by the Health Committee and depending on the progress made in achieving rehabilitation, the conditions of service imposed upon the practitioner may be lifted.

If the practitioner does not comply with conditions of service, his or her name is suspended from the register until compliance is observed.

It can be seen that the purpose, processes and functions of the Health Committee are to assist, sometimes with a firm hand, the impaired practitioner in rehabilitation. This approach serves not only the interests of the public but does show an intention to assist those practitioners in overcoming difficulties.

Tribute to retired SAMA president, John Terblanche

Stuart Saunders

My children call him Uncle John. Even now as middle-aged parents themselves there is a happy lilt in their voices when they speak of Uncle John because he is associated with all the values of good friendship and happy times shared. I can attest to Emeritus Professor John Terblanche's skills as an oarsman in a small dingy in the South Atlantic and to his ability to find the holes where a net will capture lurking crayfish. I can also attest to his downing a few beers and smoking a good pipe in the sixties but that is not where his fame lies. John Terblanche is one of the most distinguished surgeons of his time. Born in Cape Town on 10 September 1935, he married the charming Anne in 1960 having first spotted her while swinging from a chandelier.

John qualified at UCT MB ChB in 1958 and ChM in 1964. He obtained the FCS (SA) in 1964 and won the Douglas Award and Gold Medal. In 1965 he became a Fellow of the Royal College of Surgeons of England. After his internship and training as a registrar in surgery at UCT and Groote Schuur Hospital he was a senior surgical registrar in Bristol and was appointed as a lecturer in surgery at the University of Bristol. He returned to UCT in 1967 as a senior lecturer in surgery and became the second professor of surgery in 1973. He was appointed professor and head of the Department of Surgery at UCT in 1981, a post he held until he retired in January 2001.

John's research interests were in the field of liver disease. He had cut his teeth in research working with Chris Barnard while he was a registrar. When he returned to South Africa from Bristol in 1967 he joined me as joint director of the Liver Research Group. This proved to be a very productive association between the Department of Medicine and the Department of Surgery. His special areas of interest were portal hypertension, where he made original observations on the treatment of bleeding oesophageal varices, in biliary tract disease especially in regard to carcinoma and strictures, in liver regeneration where he made important experimental observations in animals and in liver transplantation. In transplantation John made important observations in liver transplantation in the pig while he was in Bristol and these experiments continued when he returned to Cape Town, the pig tolerating liver transplantation more than most species. This work resulted in the



Prof. John Terblanche with the author Stuart Saunders

successful liver transplantation programme in Cape Town. It also brought to light malignant hyperpyrexia in a strain of Landrace pigs which resulted in the development of a successful treatment for it in humans and the publication of a classic citation. There were many other publications in peer-reviewed journals – 256 in fact and 243 papers presented at major international meetings, 110 invited chapters in books, 316 abstracts in journals, books and letters in major medical journals and 20 invited editorials. He edited four books.

John Terblanche's international standing is reflected in his membership of prestigious organisations and the roles he played in them. These include membership of the Executive Council of the International Association for the Study of the Liver (IASL), vice president and later president of the IASL and currently a senior member, President of the African Association for the Study of the Liver, President of the International Federation of Surgical Colleges, and a member of the nominations committee of the International Society for Diseases of the Oesophagus. He is a member of the British Liver Foundation, the International Transplant Society and of E-AHPSA for his outstanding contributions to the field of hepato-pancreato-biliary surgery.

Honours and awards also reflect John Terblanche's international standing. He is an honorary Fellow of the Royal College of Physicians and Surgeons of Glasgow, of the American College of Surgeons, of the American College of Physicians, of the Royal College of Surgeons of England, of the Royal College of Physicians and Surgeons of Canada, of the Royal College of Surgeons of Edinburgh,

and of the Royal College of Surgeons in Ireland. He is an Associate Estranger of Le Academie de Chirurgie, France, an honorary member of the International Society of Surgery and received the Digestive Diseases Foundation of India Distinguished Service Award.

He has not gone unnoticed in South Africa. He is, among others, a Life Fellow of UCT, an Honorary Fellow of the Colleges of Medicine of South Africa, received the MASA silver medal, the Colleges of Medicine of South Africa Golden Jubilee Award and the inaugural chairman's award of MASA. He was President of the Colleges of Medicine of South Africa, a federal council member of MASA and President of SAMA, President of the Association of Surgeons of SA, and an elected member of the HPCSA.

Among his special professional appointments are Co-Director of the MRC Liver Research Centre at UCT, Visiting Professor department of Surgery University of Colorado Medical Centre, Visiting Professor and Honorary Consultant Surgeon The Royal Free School of Medicine, and a trustee of the Cancer Research Trust.

John Terblanche is active in his local community and his energetic contributions are appreciated by many. He is a management committee member of the retirement village where he lives.

I have often remarked that during all the years we worked closely together in liver research and in the clinical care of patients John and I never had a serious disagreement and never a cross word. Many would believe a professor of medicine and a professor of surgery working together in harmony is an oxymoron.

John has always had an enormous capacity for fun. He eats well, laughs, talks a lot, and with great enthusiasm throws himself into whatever game is going. Nowadays I believe he is a tireless golf fanatic and not caring much if he loses. I will not mention his handicap. He is a good sport and has been a good sportsman playing rugby for UCT as a student. The analogy for John Terblanche's spectacular career is a hole in one: the outstanding career he achieved with ease with his energy and drive. The hole in one on the golf course has eluded him.

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Functional health committees can boost quality of care

Bernard Mutsago, *SAMA Health Policy Researcher*

The recently ended Public Health Association of South Africa (PHASA) 2015 conference held in Durban in October, themed *Health and sustainable development – the future*, surpassed its target of 300 participants and saw hundreds of public health delegates from South Africa and beyond converging to discuss a diverse cocktail of pressing public health topics. These topics ranged from rural healthcare, gender in health, National Health Insurance, climate change, infectious diseases and social determinants of health to traditional/complementary medicine, medico-legal ethics, and human resources for health, just to name a few. SAMA delegates present networked with other attendees and shared views from a medical and public health perspective. They were Dr Shailendra Sham and Mr Bernard Mutsago, both from SAMA's Health Policy Committee.

Health Committees (HCs) was one of the unique topics receiving attention at the PHASA conference. Prof. Leslie London, head of the Health and Human Rights programme in the School of Public Health and Family Medicine at the University of Cape Town presented on the topic together with his team, anchoring the topic in a human rights context and paving the way for an interesting discussion. Using available evidence and some of his published research findings,¹ Prof. London gave a local analysis of the functioning of HCs in South Africa, focusing on some research work done in the Western Cape.

HCs are a long-standing phenomenon in health systems across the world, and they exist in various forms in different places. These local institutions are one aspect of the broad principle of 'community participation in healthcare' as propounded in the 1978 Alma Ata Declaration on primary healthcare. They are largely intended to serve as a nexus between the health services and the community they serve. One of their key roles is oversight and governance, which includes monitoring the health system. In South Africa, HCs are legal entities that must be established in every healthcare facility, according to the National Health Act 61 of 2003. Sadly, based on local studies as presented by Prof. London, HCs are not functioning optimally in South Africa.

Literature suggests that functional HCs could contribute towards better quality and coverage of healthcare.² This mediation, literature claims, could be through a variety of mechanisms and can only produce positive changes in health quality if there is adequate facilitation, material support and commitment.

The positive impact of HCs on health and healthcare services results from the wide spectrum of roles these structures play in various health systems. These roles include:

- Being an intermediary between the community and facility
- Highlighting community health needs
- Fundraising for the health facility
- Acting as an 'additional' workforce to the facility

- Giving the community control over their own health resources
- Monitoring the health system
- Holding healthcare staff and leadership accountable.

Besides the National Health Act 61 of 2003, the principle of 'community participation' is also enshrined in South Africa's White Paper on Transformation of the Health System and the Batho Pele Code. Prof. London highlighted that inter-provincial disparities existed in South Africa because the aforementioned Act leaves the responsibility of developing specific legislation and defining roles of HCs to provinces. The majority of South African provinces have reportedly not implemented this requirement of establishing HCs. Prof. London shed some light on the status of HCs in the Western Cape, noting that the Draft Policy Framework for Community Participation in Health³ drafted by Western Cape stakeholders is not fully useful as a guide, being less known by many HCs in that province.

Despite HCs' potential instrumentality in improving quality of care, a study by Haricharan³ found that only 55% of facilities in the Western Cape had HCs. Some of the other challenges around HCs reported by the same study included:

- Poorly functioning and unstable HCs
- Communities not aware of HCs
- Communities not understanding the role of HCs
- Skills deficit within HCs
- Limited cooperation with facility management and ward councillors
- Lack of resources and funding
- Lack of commitment from members.

These challenges impact on the quality of care and hamper the realisation of patients' right to health. HCs have great potential and need to be strengthened in South Africa. What has been your experience with HCs? Please share your views.



Dr Shailendra Sham, Mr Bernard Mutsago, and Prof. Leslie London at the 2015 PHASA conference in Durban

¹ Meier B M, Pardue C, London L. Implementing community participation through legislative reform: A study of the policy framework for community participation in the WC province of South Africa. *BMC Inter Health Human Rights* 2012;12:15.

² McCoy DC, Hall JA, Ridge M. A Systematic review of the literature for evidence on health facility committees in low and middle income countries. *Health Policy Plan* 2012;27(6):449-466. [http://dx.doi.org/10.1093/heapol/czr077]

³ Haricharan HJ. Extending participation: Challenges of health committees as meaningful structures for community participation: A study of Health Committees in the Cape Town Metropole. 2011

MSc Med Bioethics and Health Law course for 2016

Steve Biko Centre for Bioethics, University of the Witwatersrand

Steve Biko
Centre for Bioethics

The Steve Biko Centre for Bioethics, at the University of the Witwatersrand in Johannesburg, will be offering a Masters course in bioethics and health law next year. The aim of the course is to train bioethics and medical law experts who will display skill and proficiency in the fields of bioethics and health law. The course aims to develop capacity and excellence in the ethical and legal analysis of issues arising in healthcare and research. Graduates will be able to apply their knowledge to the evaluation and management of bioethical and medico-legal problems and to propose solutions that are ethically acceptable and within the constraints of the law.

Course structure

The course is in two parts. Part 1, the coursework component, entails the successful completion of five taught units.

Part 2 consists of a written research report of at least 15 000, but no longer than 20 000 words in length. Part 1 constitutes 50% of the degree and Part 2 the remaining 50%.

The units are taught in block release form. The block release for each is five days. After the teaching blocks have been completed, students are expected to produce written work in the form of short answer questions and essays. These must be submitted by the specified submission dates before the end of July. Successful completion of the units and the written research report will lead to the degree of Master of Science in Medicine in the field of Bioethics and Health Law. All the units are also offered as Certificate of Competency Courses.

Brief description of the units (Part 1)

Foundations of bioethics

This unit is designed to enable you to analyse and evaluate issues in bioethics within the context of a solid ethical framework. Major theoretical, non-theoretical and other ways of viewing the world will be taught. The course intends to provide a foundational understanding of the relationship between concepts, logic and argumentation and fallacies of reasoning.

Foundations of health law

This unit will cover sources of South African law, the Constitution, statutory and common law in the context of health. Criminal, civil and family law and their interaction with health will be explored. The National Health Act will be discussed as well as the amendments to the Medicines Act. International law in relation to health is included in this unit.

Advanced research ethics

This unit introduces and explains a number of topical ethical issues in research ethics, including what constitutes unethical research, standards of care in a study, authorship guidelines and plagiarism. The role and *modus operandi* of Research Ethics Committees are outlined. Finally, clearly articulated standards of good clinical practice in research relevant to local realities and contexts are provided. These include obtaining valid informed consent, considering specific subgroups, standards of care for trial participants, access to study medications following completion of a clinical trial, issues pertaining to incentives affecting researchers and participants, releasing and publishing research results and the implementation of research findings.

Advanced health ethics

This unit addresses a number of important issues in bioethics and health law critically and in depth. Three to four important issues will be focussed on each year relating to ethical and medico-legal issues in clinical contexts, reproductive health, policy and public health, resource allocation, genetics, health and human rights, environmental bioethics and others. Students will learn how to apply the ethical theories, ethical and legal principles, and their critical and analytical skills learnt in the foundations units to specific ethical and medico-legal questions.

Research methods

This course will provide students with rigorous training in independently designing, implementing and evaluating research, including research design,

sampling procedures and data analysis. It will cover both research projects of an essentially normative and legal nature, as well as empirical projects (qualitative or quantitative) that include a normative and legal element. Students will be trained in every part of the research cycle (question formulation; literature review; use of secondary sources; primary and secondary argumentation; ethical and legal analysis; methodology to collect and analyse primary data), including the writing of reports. In terms of values and attitudes, the course aims to instil in students a commitment to ethical research. The course will prepare them to produce a research protocol/proposal suitable to their project, and ultimately a research report.

Brief description of the research report (Part 2)

Students apply what has been taught in the research methods course, as well as the other units in the programme, and carry out a supervised research study on an approved topic. This research project may be either essentially normative and legal in nature, or empirical with a normative and legal component.

Course duration

Fulltime students complete all five units and their research report in their first year of registration. Part-time students are advised to complete the four units 'Foundations of Bioethics', 'Foundations of Health Law', 'Advanced Research Ethics' and 'Advanced Health Ethics' in their first year. In their second year they should complete the 'Research Methods' Unit and their Research Report.

**Closing date for applications is
30 November 2015.**

For more information about the Centre and the MSc Med (Bioethics and Health Law) course, please visit the website:

<http://www.wits.ac.za/bioethics> or contact Ms Jillian Gardner +27 11 717 2719/2635. E-mail: Jillian.Gardner@wits.ac.za or Ms Tebogo Dithung +27 11 717 2635. Email: Tebogo.Dithung@wits.ac.za

An introduction to FPD

Foundation for Professional Development

Foundation for Professional Development (FPD) was established in October 1994 by the SAMA. FPD is currently the largest self-funding educational provider in the health sector in South Africa.

FPD prides itself on being one of the few private higher educational institutions that fully engages in the three scholarships of higher education, namely: teaching and learning, research and community engagement. These areas of academic scholarship provide the three focus areas of our work:

Teaching and learning

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Guide to income tax for private and limited private practice medical practitioners

Jonathan Hayden

In addition to all permissible deductions and expenses referred to in my previous article on income tax for hospital doctors, doctors in private practice and those receiving commission income, independent contractors and doctors in limited private practice (LPP) may claim many more allowable deductions. The following are some expenses that doctors often fail to claim: Depreciation on the fixed assets of the home surgery/study/office such as the furniture and fittings, medical and surgical equipment, office equipment, medical library and computer.

When a doctor claims the costs of the home study/surgery, he or she may only claim a portion of the expenses pro rata to the dedicated area used for the home study/surgery as a proportion of the total area of the house excluding, for example, the garage and garden areas.

Expenses should be claimed in terms of Section 11(a) of the Income Tax Act and must be expenditure incurred in the production of the doctor's income.

The motor and travelling expenses that are normally allowable for a doctor in private practice are:

- Travel to attend to patients at their home, in hospitals, clinics and operating theatres.
- Travel from surgery to surgery i.e. if the doctor has a consulting surgery at home, the motor and travelling expenses from the home surgery to another surgery or vice versa would be an allowable deduction.

Except for the latter example above, travelling between home and the surgery is regarded as an expense of a private or domestic nature. In respect of this private use and any further private use of the motor car, a certain proportion of the motor expenses claim must be reduced by such private use on a pro rata basis.

The following is a short but by no means comprehensive list of usual allowable deductions:

- accountant's fees
- administration fees
- advertising for staff
- bad debts
- bank charges and service fees
- cleaning and laundry expenses
- computer accounting services
- computer software
- depreciation of fixed assets including furniture, medical and office equipment, computers, medical library and motor vehicle
- drugs and medicines
- entertainment
- electricity for the surgery
- finance charges and/or interest for the purchase of fixed assets including medical and office equipment, computers and motor vehicle
- flowers and plants in the surgery
- gifts to patients and suppliers
- hire of assets pertinent to the practice
- insurance
- interest on overdrafts and loans
- interest on monies borrowed to finance the purchase of fixed assets and the practice purchase, e.g. goodwill
- leasing of assets pertinent to the practice
- legal or collection fees incurred in attempts to recover outstanding fees from patients
- locum tenens, deputising service and assistants' fees paid
- motor and travelling expenses
- postage
- attendance at medical congresses, courses, seminars – local and overseas
- practice promotion and marketing
- printing and stationery
- professional subscriptions and periodicals including MPS
- recruitment fees – staff
- rent of premises including costs pertaining to the home study/surgery
- repairs to and maintenance of the premises and the fixed assets
- salaries to staff, i.e. the gross amount including bonuses, leave and sick pay
- retirement annuities and contributions to the staff medical aid, pension/provident fund, PAYE and skills development levies.
- secretarial fees
- teas and refreshments
- telephones and cell phones
- unemployment insurance fund contributions
- uniforms and protective clothing
- VAT paid
- Worker's compensation insurance.

If a doctor intends studying overseas for an extended period, the optimum time, from a tax point of view, to begin such studies would be approximately midway through the tax year, i.e. August or September. Correct timing can amount to a substantial tax saving and a tax refund.

Some doctors prefer to reduce their professional taxable income by notching up farming losses. I do not understand this ill-conceived idea of ploughing in good money after bad. Generally, if the farm is running at a loss, the doctor will be required to invest further funds to keep it going. Therefore, a doctor should refrain from this activity for tax purposes unless he or she is well versed in farming. Nature is a very speculative and risky investment.

SARS will disallow farming expenditure if farming is considered not to be a financially viable business venture.

I believe, since a doctor is well trained in medicine and knows and understands it well, that he or she will always make the most money out of the practice of medicine. Thereafter income or wealth creation will depend on what is done with surplus funds earned, and how the funds are saved and invested.

In terms of the law, chartered accountants are not required to carry out an audit of a doctor's practice, so not too much reliance should be placed on the accountant's examination of the practice's books, records and systems. Approximately 60 – 70% of all doctors enter private practice, where they handle large amounts of money. As their training has not equipped them with the knowledge necessary for management, this can lead to inefficiency and wastage of funds. I would therefore like to suggest that formal tuition in practice management, investments, insurances, financing and so on, should be undertaken. Hospital doctors would also benefit greatly from such a course, provided the tuition is structured on basic and practical principles.

Jonathan Hayden CA (SA), CFP initiated an accountancy firm which specialises in one-stop accountancy, tax and investment services for the medical, dental and paramedical professions. Email: jhayden@telkomsa.net

New trends: Registrar contracts

Wandile Mphahlele: Legal Advisor, Labour Relations

This article serves to advise members of SARA who are coerced to sign new registrarship contracts. The new contracts contain several clauses that our members are not content with. The following are the contentious clauses:

- "4.2 Registrars who fulfil all the requirements for registration as Specialists will be required to serve back a minimum period of 1 year in a Specialist post identified by the Department.*
- 4.3 Registrars who have completed the 48 months on the Registrar Programme but do not meet all the requirements for registration as Specialists, may in the event that the Department requires the services of the Registrar, be offered an appropriate post at a facility identified by the Department. The Registrar must then enter into an employment agreement with the Department in respect of the employment in the post at a determined facility and remain in that post for a minimum of a year.*
- 4.4 Should the Registrar not accept the offer of placement as contemplated in clause 4.2 supra, the Registrar will be liable for payback of a minimum of 25% of costs associated with the programme, paid to the Registrar and or any other party.*
- 4.5 Should the Registrar not accept the offer of placement as contemplated in clause 4.3 supra, the Registrar will be deemed to have exited from the Programme and programmatic termination off the programme will be effected?"*

I am required to answer the following questions:

- *"Is it legal that the Department makes the new registrars sign contracts with this clause when it wasn't included in the advert or the letter of acceptance?"*
- *Can the Department legally demand that you work in the province for a year as a form of 'serving' back the money they paid you during your service, as stated in clause 4.3?"*
- *What money is the Department going to demand that you pay for training as you do not gain any extra payment for the training? You are still in a service delivery post. You even pay the university tuition fees to register for MMed. So what money exactly is the department deeming that you have to pay back if you refuse to serve the province*

for a year as a specialist?" (Email from Dr Ati quoted verbatim)

Legal principles on freedom to contract

Generally parties have a right to contract freely and such agreements must be honoured. A contract is only valid if parties are in agreement with the intention, i.e. there should be a meeting of minds.

Restraint of trade agreements are enforceable: A party seeking to escape the restraint has the onus to prove that it is unreasonable and contrary to public interest. In our law, the enforceability of a restraint should be determined by asking whether enforcement would prejudice the public interest.

Even though on the face of it, it can seem as if restraint limits the constitutional right to choose your trade, occupation or profession freely, it has been held by our courts that such a limitation is justifiable unless it is against public policy.

As a result, the employer has no right to determine where they work after becoming specialists

Law to the facts

"Is it legal that the Department forces the new registrars to sign contracts with this clause when it wasn't included in the advert or the letter of acceptance?"

An advert does not constitute a contract; it is an alert that a position is available. A letter of acceptance in principle binds both parties; however, it only becomes operational if parties reach consensus on the formal contract.

"Can they legally demand that you work in the province for a year as a form of "serving" back the money they paid you during your service, as stated in clause 4.3?"

This is the restraint clause that has been affected by the new contract, as stated earlier; such clauses are enforceable unless our members can prove that they are against public policy.

In this regard, we already know the department's argument, and that is the aim is to keep specialists in the province as they are few and there is a high demand.

Our argument mainly will be that as registrars, our members are employees; they render services which they are remunerated for, and both parties benefit from this employment relationship. Our members pay their own tuition fees. As a result, the employer has no right to determine where they work after becoming specialists.

Accordingly, this is a value judgment; I am inclined to be on the side of our members that the restraint is unjustifiable in the circumstances.

In my view, the only thing that the employer provides is the space in which registrars work, this is in any event one of the requirements for a valid employment contract, that is the employer must provide tools for the employee to operate.

The answer will obviously be different in the event that the employer was the one paying the tuition fees.

"What money is the department going to demand that you pay for training as you do not gain any extra payment for the training? You are still in a service delivery post. You even pay the university tuition fees to register for MMed. So what money exactly is the dept deeming that you have to pay back if you refuse to serve the province for a year as a specialist?"

As already stated above, the employer rightfully provides the space for registrars to work, the registrars correctly utilise the space to serve the employer. I am not aware which costs the employer is referring to in Clause 4.4, if they refer to remuneration, then it's a misplaced clause because remuneration is in exchange for the work done, accordingly this clause must be rejected.

Please feel free to engage the office should you be affected by these issues.

Mishandling major surgery

Medical Protection Society

Mr A, a 63-year-old retired farmer, had suffered from severe gastro-oesophageal reflux disease for many years. His symptoms were partially controlled with long-term anti-secretory medication but after a number of years, he had reached the point where his gastroenterologist recommended antireflux surgery.

He saw Dr X, an upper gastrointestinal surgeon, who arranged a repeat endoscopy. This demonstrated a 10cm area of Barrett's oesophagus with no obvious macroscopic abnormality above a 5cm sliding hiatus hernia. Dr X went on to perform a laparoscopic Nissen fundoplication, after which the patient made an uneventful recovery.

At a review appointment three months later, Mr A reported a significant improvement in his symptoms and no longer required his medication. He next saw Dr X for a surveillance endoscopy seven months later. The fundoplication was intact and the long segment of Barrett's appeared unchanged.

On this occasion, multiple biopsies were taken and were subsequently reported by pathologist Dr H as demonstrating high grade dysplasia (HGD). Dr X reviewed the patient shortly thereafter and explained that the findings were likely to indicate the development of cancer. He recommended that Mr A should undergo an oesophagectomy.

Postoperatively, the patient was managed jointly by Dr N, a respiratory physician, and Dr X on the intensive care unit. Dr X had arranged to go on holiday the day after the procedure and spoke to a colleague, Dr B, about managing the patient in his absence. Details regarding the handover and cover arrangements were subsequently disputed. Specifically Dr B allegedly told Dr X that he could not look after the patient until the following day.

In the afternoon after Dr X had departed, the patient developed intra-thoracic haemorrhage. Another surgeon, Dr F, was called to perform an emergency right thoracotomy and successfully stopped the bleeding by ligating an aortic bleeding point.

Postoperatively, the patient developed severe gastric distension and pneumonia. Dr B (who was now available) inserted an NG tube to decompress the stomach, confirming its position by chest X-ray. However, the

NG tube failed to drain any fluid and Dr N subsequently discovered, when performing a bronchoscopy, that it had been placed in the right main bronchus. Dr N placed it correctly into the stomach under direct vision.

There then ensued a protracted period of ventilation and multi-organ support on the intensive care unit. Dr X returned from leave and continued the patient's care. A stepwise deterioration occurred with worsening pneumonia, sepsis and multi-organ failure and Mr A died in the intensive care unit 14 weeks after the operation. The final pathology report from the specimen demonstrated multi-focal HGD with no signs of invasive carcinoma and all margins clear.

Mr A's family made several claims of negligence by the clinicians involved in his care. They alleged that Dr X had failed to biopsy the Barrett's segment at the patient's initial endoscopy leading to an unnecessary fundoplication and delay in the finding of high grade dysplasia. They also complained that Dr X had failed to adequately discuss alternative management options for HGD other than surgery and that he had also not arranged adequate cover for his planned absence after the operation.

Allegations of negligence also centred on Dr H and Dr X relying on a single pathologist's assessment for the diagnosis of HGD. Criticism was made of the other surgeons involved in Mr A's care for failing to place a nasogastric (NG) tube at the time of each operation to prevent gastric distension.

Expert opinions for MPS and the claimant agreed that biopsies of the Barrett's segment should have been obtained at the initial endoscopy performed by Dr X, although they accepted that previous endoscopic biopsies did demonstrate entirely benign Barrett's epithelium.

They also agreed that the standard approach to the finding of HGD should warrant further independent pathological review and assessment of biopsy material before acting upon the findings. However, it was noted that the diagnosis here was correct, as several pathologists confirmed the findings of HGD in the resected oesophageal specimen.

It was accepted that at the time the case occurred, the finding of HGD in Barrett's in a fit patient was an indication for consideration of oesophagectomy. Other therapies,

including endoscopic mucosal resection and radiofrequency ablation, have now become more accepted treatments as an alternative to surgery.

There was considerable criticism of Dr X's decision to schedule such major surgery a day before he was on holiday and his subsequent arrangements for colleagues to cover. The absence of an NG tube placement at the initial operation and subsequent procedure was also criticised, as was Dr B's misplacement of the tube and his misinterpretation of the X-ray findings. The case was eventually settled for a moderate sum.

Learning points

The diagnosis and management of HGD in Barrett's oesophagus remains a controversial area with a number of different therapies available. It is now common practice for specialist multidisciplinary teams that include surgeons, gastroenterologists and pathologists to manage these patients. This approach may improve the accuracy of diagnosis and staging, and facilitates a consensus on the optimum management for each patient.

It is not always possible for a surgeon to be constantly available for the postoperative management of a patient. In periods of extended absence, robust arrangements must be made for adequately qualified colleagues to cover the care of a patient. The patient, relatives and all relevant staff involved should be informed.

Even so, surgeons undertaking major or high risk elective surgery before a planned holiday are likely to be at risk of criticism when something goes wrong in their absence. The duration of time that can elapse between events and subsequent litigation, as highlighted in this case, demonstrates the need to maintain accurate and detailed notes as the cornerstone to any medicolegal defence.

It is common practice to place an NG tube after oesophagectomy. In this case it may have prevented gastric distension, aspiration and pneumonia. Misplacement of an NG tube is a common error and a potential source of morbidity, mortality and medicolegal problems.

Doctors open their hearts and pockets

Source: Krugersdorp News

The SAMA West Rand branch recently made a generous donation to two local charities on behalf of their 400 members.

This year, Krugersdorp's Cradle of Hope and The Bethany House Trust were selected as recipients by the SAMA branch committee. Melody van Brakel, founder of Cradle of Hope and Gerrit Maritz and Daniel Jonker, representing The Bethany House Trust, met at the SAMA offices in September to accept generous donations of R10 000 each.

SAMA also donated R5 000 worth of blankets to the Winter Hoop project who hand out blankets to street children in winter. "It is an amazing feeling to be able to support local organisations that are in desperate need in tough times. Thank you to all SAMA doctors for making this blessing possible," said Tracey Gurnell, SAMA West Rand branch administrator.



It's all smiles as doctors Van Niekerk, Mpata, Nel, Gurnell, Kruger and Dunne and branch administrator Tracey Gurnell hand over a donation to (front, from left to right) Gerrit Maritz and Daniel Jonker from The Bethany House Trust and Melody van Brakel from Cradle of Hope

Major ailments tackled at annual West Rand branch symposium

Source: Krugersdorp News

The SAMA West Rand branch held a joint CPD/Netcare Symposium on 21 - 23 August at Misty Hills in Mulderdrift, which was attended by 260 doctors.

Doctors from different hospitals were given the opportunity to share new and interesting information and findings, network in a beautiful setting and enjoy some fine cuisine. Medical topics such as non-surgical lower back pain,

Netcare's ethics, occupational therapy, contraception, allergies, health and law ethics, as well as diabetes and cholesterol were discussed.

An information session was given by the Netcare Transplant division to discuss transplant pathways and the law regarding transplants. Dr J Fredericks, a neurologist, ended off the first day with a talk about infantile colic. Discussions the following day touched

on subjects such as how medical schemes accumulate reserves, reflux perspective, the shoulder joint unlocked, the legal aspects and ethics in blood transfusion and appropriate use of blood products, hip arthroscopy, what's new in allergies, the legal aspects pertaining to medical practice and audiology problems.

Each doctor was presented with a certificate for their participation in the symposium.



Dr de Hoog, a physician specialist from Netcare Krugersdorp with Maxwell Dali Ndlovu, chief stakeholder manager Netcare



Tracey Gurnell and West Rand branch chairman Dr Cobus van Niekerk



Delegates at the symposium

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