

SAMA INSIDER

DECEMBER/JANUARY 2015

**National Council
– moving forward
and making plans**

**Prof. Denise White
elected President
for 2016**



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EDITOR'S NOTE

DECEMBER/JANUARY 2015



Diane de Kock
Editor: *SAMA INSIDER*

Moving forward

As we publish the last edition of *SAMA Insider* for 2015, it seems apt that we focus on the National Council meeting (page 4) held in October and welcome a new President of SAMA, Prof. Denise White, for 2016 (page 6).

On page 8, Dr Grootboom provides some historical background to the HPCSA and puts Dr Aaron Motsoaledi's recent announcement, that he had instructed that new legislation be drafted to establish a statutory council for medical doctors and dentists, into context. SAMA has, for years, campaigned and lobbied for just such a statutory council and congratulates the honourable Minister for his courage in taking this bold step.

We meet Dr Nirvadh Singh on page 10, celebrity doctor and woman extraordinaire and on page 11 you can read about SAMA's representation, as the only African member, at WMA conferences and working group meetings.

We are delighted to publish, on page 18, our first 'Letter to the Editor' and hope that this will encourage readers to put 'pen to paper' in the future.

Until the next time ...

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

Editorial Enquiries: 083 3018822
Advertising Enquiries: 012 481 2069
Email: dianed@hmpg.co.za

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

Block F, Castle Walk Corporate Park,
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National Council – moving forward and making plans

Marli Smit, Senior Legal Advisor

The South African Medical Association held its annual National Council meeting on 29 - 31 October 2015 at the Birchwood Conference Centre in Kempton Park. The agenda spanned over three days and the event was attended by more than 100 SAMA National Councillors and other invitees.

The agenda – what transpired?

The first day of the meeting, commencing at 14h00, was devoted to SAMA branch matters. SAMA branch chairpersons provided feedback on matters of importance which affected SAMA members in their respective areas and on national level. Ways in which to increase the effectiveness of communication between branches and the SAMA head office were given due consideration.

Various branch reports were presented by branch chairpersons or their *secundi* and the Road Accident Fund delivered a presentation on the new Road Accident Benefit Scheme Bill. On the second day, Prof. Denise White was announced as the new SAMA President for the 2015/2016 term. Prof. White could unfortunately not attend the inaugural president's dinner held on the evening of 30 October 2015. The event therefore served solely as a farewell occasion, honouring the outgoing President for the 2014/2015 term, Prof. Lizo Mazwai.

The second and third days of the meeting comprised reporting by the various SAMA committees and other general matters. Finance and risk reporting indicated that the Association's financial situation was stable, although it remained of cardinal importance to recruit and retain members.

The reports of membership and professional affairs standing committees reflected on their activities since the previous National Council meeting in May 2015 and provided insight into their goals for the year to follow.

Subsidiary reports were presented which provided information on the status, standing and successful functioning of the relevant subsidiary companies, including the Foundation for Professional Development (Pty) Ltd (FPD) and the Health and Medical Publishing Group (Pty) Ltd (HMPG).



Dr Mzukisi Grootboom (right), SAMA Chairman, handing Prof. Lizo Mazwai (SAMA President 2014/2015) a token of appreciation

SAMA policies and guidelines on a variety of topics were adopted or, where applicable, referred back to the committees they originated from for revision.

Operational report

The General Manager of SAMA, Mr G Steyn, presented his operational report for the period under review and highlighted the following:

- SAMA remained committed to the development of future doctors. In this regard a resolution was adopted to increase both the number of medical students assisted by SAMA and the amount of money provided to these students to ensure that they can study without financial concerns. (Refer to "Resolutions" below.)
- SAMA's recently redeveloped website provided a platform to create membership interaction. Items at that stage under development included online membership registration, branch web pages and the ability to run and report on online polls.
- SAMA branches were the contact point for most SAMA members. The resolution adopted in respect of an ideal branch (set out below) would incorporate functions such as marketing activities, finance and budgeting, operations, branding and the interaction between SAMA's largest membership groups - members employed in the public sector and members active in the private sector.



Drs Hussain and Abbas



Mr Gert Steyn, General Manager of SAMA

- Planning was already underway for the SAMA Conference to be held on the 21–23 October 2016 in the Sandton Convention Centre.
- SAMA's financials for the year 2014 were adopted at the Annual General Meeting held on the second day of the National Council meeting.
- Continuous efforts were expended by management to ensure that revenue is maximised and expenses are curtailed.

SAMA submissions in respect of pending legislation were noted and made available to attendees on compact disc. These included SAMA's submission to the Health Market Inquiry Panel, a submission on the low cost benefit option suggested by the Council for Medical Schemes to the Department of Health, a submission to the Department of Trade and Industry on the proposed Liquor Act Policy and submissions regarding proposed changes to Regulations 5 and 8 of the Medical Schemes Act and the scope of practice of Clinical Associates in answer to comments requested in the applicable Government Gazettes.

The SAMA Chairman, Dr Mzukisi Grootboom, provided detailed feedback on the state of the SAMA's national and international stakeholders and explained the importance of SAMA's involvement in matters which not only affected its members, but also its stakeholders.

Reports on a number of meetings of the World Medical Association (WMA) (of which SAMA is the only African member) and its subcommittees were provided. SAMA enjoyed representation at international WMA conferences and working group meetings on, among others, health databases and bio-banks, healthcare in danger (supported by the International Red Cross Association in conjunction with the WMA), climate change, the revision of post-graduate medical education (with the support of the World Federation for Medical Education), and physicians' wellbeing. During 2015 SAMA also actively supported the Israeli Medical Association in its stance against legislation that would force doctors to participate in force-feeding practices in relation to prisoners on hunger strike.

The President and Chairman represented SAMA at the WMA Council Meeting in Norway in April 2015 and the WMA General Assembly in Russia in October 2015.



Dr M Naidoo and Dr S Mametja



Dr S Maweya, Dr TO Sadiki, Dr M Mzukwa, Dr PZ Buthelezi Mlambo, Dr GGZ Mbambisa, Dr S Toni (MC) and Mr Ndumiso Lindi

National Councillors reaffirmed SAMA's commitment to establish an independent medical and dental council.

Resolutions

The National Council resolved on, among others, the following:

- Industrial relations advisors had to be appointed on a provincial basis to effectively address industrial relations issues experienced by employed SAMA members.

- A scholarship to specifically support a master's degree on a research topic of relevance to SAMA had to be implemented.
- Where branches were unable to support all the activities of their members with their available subvention monies, they had to apply to the branch assistance fund for additional funds.
- District demarcations of branches and direct input by SAMA members in various regions had to be taken into consideration in the Constitutional Matters Committee's

geographical branch border realignment project.

- The General Manager had to conduct a gap analysis between current branches to ascertain the characteristics of an ideal branch and craft and cost a branch development plan to implement in respect of those branches who had not yet reached the level of an ideal branch.
- The number of SAMA bursary recipients had to increase to at least one candidate per medical school each year, with priority given to historically disadvantaged candidates, but not to the total exclusion of other races. Bursaries were to be offered over six years and bursary amounts had to increase to cover full tuition fees.
- The SAMA Conference programme had to be adapted to allocate more time for questioning and engaging with the speakers, and should contain less academic content.
- The SAMA Trade Union NEC was a



*At the Presidential Dinner on 30 October 2015
The theme was "Winter Wonderland"*

membership committee of SAMA, as were the General Private Practitioners and

Specialist committees, and had to follow the provisions of the SAMA Memorandum of Incorporation and Company Rules.

Closing

The SAMA National Council meeting spanned three days and covered the full range of SAMA's activities on national and international level.

It addressed matters which affected its branches, its members and its subsidiaries.

The meeting also confirmed the high level at which SAMA functions when dealing with stakeholders and interested parties.

SAMA remains the voice of medical practitioners in South Africa and continues to build a reputation as a respected and trustworthy association through which real issues in the field of medicine can be debated and solutions found.

The SAMA slogan remains as important and relevant today, as it has been for the past 88 years: "Uniting doctors for the health of the nation".

Prof. Denise White elected SAMA President for 2016

Chris Bateman

Keeping a cool head and listening and communicating while being 'relevant and realistic', is what the new President of the South African Medical Association (SAMA), top psychiatrist, Professor Denise White, a 12-year veteran of SAMA leadership, hopes to bring to her executive and council.

Battle-hardened in the trenches of the unprecedented June 2009 doctor strike (while acting as SAMA chairperson) and a pivotal negotiator for huge improvements in doctors' salary packages via changes to commuted overtime a decade earlier (as Chairperson of SAMA's public sector committee), White, now 70, is both 'honoured' and ready for a more ceremonial role. Her calm composure and steady hand in the face of thousands of angry, striking young public sector doctors, outraged by two years of government heel-dragging in implementing the Occupation-Specific-Dispensation (OSD) and at odds with SAMA over tactics to bring about change, won her widespread respect among both medical 'friend and foe'. What was a

short-lived but highly effective revolution (striking doctors kept one step ahead of their employers by networking via Facebook to orchestrate wildcat nationwide unprotected strikes, at one stage even commandeering SAMA's HQ to stage a press conference), led to the first decent increases for doctors in decades, with White and the SAMA exco subsequently championing the defence and job reinstatement of hundreds of young physicians.

She changed an aspect of global psychiatry practice, receiving international recognition early in her career when she and a colleague identified a link between patients admitted to Groote Schuur's psychiatric wards with catatonic illness and neuroleptic malignant syndrome (NMS) – with an associated 20% mortality rate. By probing why some patients developed NMS and others not, they identified the administration of neuroleptic drugs to patients with a catatonic illness as the major culprit. When the international scientific and cultural embargoes were lifted



Prof. Denise White, new SAMA President

on apartheid South Africa, she immediately became a highly sought-after speaker at international psychiatric conferences.

White was described as 'an inspirational negotiator, a quiet and dedicated leader and clinician of immense skill and intuition', on receiving this year's South African Society of Psychiatrists Distinguished Service Award. As to her willingness to accept the appointment as the President of SAMA, White says 'I think I can add some value. Obviously I am very humbled being elected as President. It is a ceremonial, titular role, and I think I have an advantage in knowing the organisation inside-out. As vice-chair I sat next to five or six different presidents. I won't be in the front-line politically, but hopefully I can lend some experience and insight to processes that won't be unfamiliar to me'. Two years before leaving the SAMA leadership cadre in 2009 White was appointed to the Medical and Dental Professions Board (MDB) where she served two five-year terms and was appointed to several subcommittees of the Board dealing with matters of professional conduct, as well as serving on the health committee of council (assessing and ruling on 'impaired' practitioners), tasks she says she found 'very worthwhile'.

'It felt like I was really making a contribution to the profession as a whole. As a Board member our mandate was largely non-political and carried out strictly within the legislative framework governing the operations of the HPCSA,' she adds. Asked her opinion on the ministerial probe led by her UCT colleague, cardiologist Prof. Bongani Mayosi into dysfunction within the statutory Health Professions Council of South Africa (HPCSA, under which the MDB, one of 12 professional boards, falls) she had this to say: 'The most pertinent issue is that any recommendations they make are put into effect. The report must not just gather dust'. SAMA has a strained relationship with the HPCSA, given that the MDB pays the lion's share of its costs but suffers vastly diluted bargaining power. There are long-standing calls by SAMA for the MDB to step outside the HPCSA and form its own council (like the nurses and pharmacists) giving it far more autonomy and individual voice. Of the HPCSA dysfunction probe, White said that with many 'critical, experienced' people having left the council (shaken by administrative fraud scandals and charges of not carrying out its statutory duties), a great deal of institutional memory had been lost – when the entire structure was dependant on efficient and effective administration.

Asked what lessons she had learnt and could bring in her counsel of the SAMA

'Communication is hugely important. To listen and communicate around issues and to be realistic and relevant in dealing with matters. To keep channels of communication open with various stakeholders is essential. SAMA is a collective – teamwork is necessary in brainstorming and decision making.'

executive, White replied: 'Communication is hugely important. To listen and communicate around issues and to be realistic and relevant in dealing with matters. To keep channels of communication open with various stakeholders is essential. SAMA is a collective – teamwork is necessary in brainstorming and decision making. We have to put personal issues aside for the greater good of health in SA. SAMA is a critical roleplayer and we have to stay internally intact as a team when big matters such as the NHI are discussed'. She said the organisation was challenged by the fine line it has to tread between politics and professional issues as well as the need to keep its 'ear to the ground', to ensure it was fulfilling its mandate for members. 'The challenge is being effective for very disparate groups. To be a trade union and to represent the interests of both public and private sector doctors. It's not an easy task. This is not an organisation where you can step up to any leadership position being timid or naive – you have to don an asbestos-shield to deflect the heat of a crisis and remain cool.' She said she was fortunate to no longer be in the day-to-day political decision-making engine room and hoped she could be 'that person who can add a perspective in times of crisis or decision making'.

Unsurprisingly her 'signature theme', during her year-long presidential tenure will be mental health. With the lifetime adult prevalence of common mental disorders in SA standing at 30%, a full 11% of citizens experiencing substance abuse problems and maternal mental disorders three times higher in low-income areas, her advocacy will be highly valued by coal-face organisations. Says White: 'The maternal mental disorder statistic (for one) is totally unacceptable. Again, it appears the country is not focussing on developing

its resources. The multi-professional team is essential for the delivery of good mental health. You need mental health workers out there in the community clinics and rural areas. It can't just be hospital based. We need to work out ways of task-shifting with doctors supervising those who actually do the work. I don't think we've developed an effective and adequate human resources plan – we have the research but what comes of it? Unfortunately mental health is the Cinderella of the healthcare professions, always the Oliver Twist'.

Grossly inadequate and uncoordinated government spending on the treatment of mental illness – which affects one in six South Africans – is costing SA 2.2% of its annual GDP. It is also failing to reduce the 230 attempted suicides recorded daily while 48% of people living with HIV/AIDS continue to suffer from a mental health condition. Mental health disorders comprise five of the 10 leading causes of health disability in SA. According to research published by White's colleagues, UCT head of Psychiatry, Prof. Dan Stein and his associate, Prof. Crick Lund, mental health issues cost the South African economy six times the cost of its treatment. Over the past two decades, a seemingly progressive national policy shift to decentralisation of care has reduced the number of mental hospitals – with no corresponding increase in community-based mental health facilities – leading to 7.7% fewer beds across all provinces and a downward spiral in delivery.

White takes over the SAMA presidency reins from groundbreaking medical educationalist, former Medical Research Council Chairperson, advisor on upgrading academic hospitals and Eastern Cape Healthcare Planning Commissioner, Prof. Lizo Mazwai.

HPSCA: A history observed, a future in the balance

Dr M Grootboom, SAMA Chairman

The origins of the Health Professions Council of South Africa (HPCSA) can be traced back to the late 19th century. Officially established in 1928 to regulate the medical and dental professions, the South African Medical and Dental Council (SAMDC) was an esteemed body on which it was considered an honour to serve. During apartheid the SAMDC came under increasing criticism; it had only a few black members, and the other professions within it played second fiddle to the much larger and all-powerful medical and dental professions. Its inappropriate handling of the Steve Biko affair was considered to be the result of influential members supporting the stance of the Nationalist government of the day. The perceived political bias, and the Biko affair in particular, motivated those who developed the new vision of the HPCSA, namely 'to protect the public and guide the professions' and to de-politicise the organisation as much as possible. Initially there were promising signs that this could be achieved. However, in the evolution through several transitions into the present HPCSA it is sad and ironical to record that later post-apartheid versions of the HPCSA have been even more politicised than they were in the past.

The many changes to which the HPCSA has been subjected, through legislation, creation and changes of its Professional Boards, as well as the inclusion of many new fields within Medicine and the Allied Health Professions, unfortunately resulted in the obtaining of complete control of its processes by the Department of Health (DoH). Even health professionals' rights to nominate representatives to their respective boards were removed during the post-apartheid era, in 2007. The then Health Minister Manto Tshabalala-Msimang engineered a change to the Health Professions Act to ensure that representatives of the 12 boards would be appointed by the Department of Health, not their professions, despite the fact that members pay annual fees to the HPCSA. In doing so, she ensured that council representatives answered to government rather than the professionals that they are supposed to govern.

Not only was the voice of the medical profession drowned out through these developments, but a steady escalation of complaints made against the HPCSA

by individual practitioners, professional associations like the SAMA, training institutions and other organisations, as well as HPCSA employees, indicated its eventual disgraceful and dysfunctional nature. These complaints painted a picture of poor communication by the HPCSA, unacceptable prolonged delays in the processing of registration applications, unfair processes followed in professional conduct enquiries, failure to provide guidance in resolving challenges affecting health professions, maladministration, irregularities, mismanagement and poor governance.

It came as no surprise that the Ministerial Task Team appointed by the Minister of Health in February 2015 to investigate the above-mentioned complaints entitled their executive summary released on 6 November 2015 'A Case of Multi-System Failure'.

History of the medical profession and Medical Councils in the 19th century

The Colonial Medical Council of the Cape Province (following the British model) was founded in terms of Section 18 of the Medical and Pharmacy Act of 1891. The first meeting of this council took place on 4 January 1892.

The 1890s saw a lull in the efforts of the medical profession to unite themselves. Despite attempts at the formation of a South African medical association in 1883 and the start-up of a South African medical journal in 1886, these efforts faded out. Only branches of the British medical association were left in Cape Town, Kimberley and Grahamstown.

At that time debates were already taking place which related to the administration of the medical profession and whether it would be best to have medical practitioners do so themselves.

Dr A J Gregory set out in great detail what he believed to be the desired content of an improved Health Bill when he addressed the Congress on Health legislation. His view included definitions of the functions of both local authorities and the central authority. He was not happy about the suggestion that the Act should be administered by a medical officer.

'A medical man best fulfils the highest functions of his profession by acting the part of adviser. For the business of administrator he is but ill fitted both by reason of his want of special administrative knowledge and by

the character of his early training, and so far as my experience serves me – and I have had many opportunities of observing – the medical administrator is a miserable failure. There are, of course, brilliant exceptions but they are few and far between, and the chances are against their occurrence.'

The Natal Medical Council was eventually created in terms of section 18 of the Medical and Pharmacy Act of 1896, holding its first meeting on 9 October 1896.

Ironically enough, the Ministerial Task Team's conclusions, 120 years later, hold the opposite view:

'There are institutional problems in relation to skills mix. The HPCSA employs more lawyers than health professionals. There is apparently not a single medical practitioner (or a member with a medical background) in the legal department that is responsible for professional conduct enquiries – most of which relate to the medical profession. The professional conduct enquiries are dominated by lawyers and proceedings adopt an adversarial legal approach rather than a professional conduct enquiry that is required by its mandate. Therefore, there are insufficient health professionals within the HPCSA to guide the health professions.'

On the other side of the Orange River, the 'Medical and Pharmacy Council' of the Orange River Colony resulted from Ordinance 29 of 1904 and the Council met on 13 July 1904 in the Council Chamber of the Railway Bureau in Bloemfontein.

The Transvaal Medical Council was established in terms of Ordinance 29 of 1904, holding its first meeting on 4 January 1905 in Pretoria.

Origins of the HPCSA

The HPCSA's origins date back to 1928 when, in accordance with Act 13 of 1928, the SAMDC was appointed to fulfil the functions of the four former provincial councils.

Act 13 of 1928 made provision for two statutory councils: the South African Medical Council (SAMC) and the South African Pharmacists' Commission (SAPC). The SAMC was also responsible for the registration of nurses until the South African Nursing Council (SANC) was established as a separate council in 1944. Likewise, the registration of dental technicians was the responsibility of the

SAMC until the formation of the South African Dental Technicians' Council (SADTC) in 1945.

The Medical, Dental and Pharmacy Act 13 of 1928 replaced the provincial councils and made provision for two statutory councils, namely the SAMC and the South African Pharmacists' Commission.

Until 1944 the SAMC was also responsible for the registration of nurses as well as dental technicians. In 1944 the SANC was created by the Nursing Act (45 of 1944). In 1945, the SADTC was formed and this body took over the registration function.

Act 56 of 1974 replaced Act 13 of 1928, in terms of which the SAMDC, now renamed the HPCSA, continues to exist as a separate legal entity.

The first meeting of the Council was held on 22 October, 1928 in Pretoria and was opened by the late Dr D F Malan, the then Minister of National Health and later the fourth Prime Minister of the Union of South Africa.

Although Act 13 of 1928 made provision for the SAMC and the South African Pharmacist's Commission to exist as two statutory councils, these two Councils actually had a common Registrar for a number of years.

The first register of medical deputies was established in 1947 and attempts aimed at making registration of these professions compulsory, later paramedical and supplementary health service professions, has a history of its own.

Act 13 of 1928 was amended in 1971 and made provision for Professional Boards to be established and which would be registered with the Council.

This was done for the so-called "supplementary health professions" and included: Physiotherapy, Optometry, Medical Technology, Podiatry, Health Inspectors, Dietetics, Opticians, Occupational Therapy, Psychology, Radiography, Medical Orthotics and Prosthetics, Speech Therapy and Audiology, Oral Hygiene, Clinical Technologists.

The report from the Ministerial Task Team

To date there have been several legislative changes of the Health Professions Act, which has had the effect that the Council had changes in power, in accountability and in the manner in which the power of the Council could be exercised.

To this extent, the HPCSA have been through an array of public reproach where patients and doctors alike, have raised their

disgust with how non-existent the service of the HPCSA is.

Doctors provide terrifying accounts of their experiences, which includes the futile attempts to find any one person within the HPCSA to be accountable more than once for managing a query or assisting with a professional request.

The Minister of Health, Dr Aaron Motsoaledi, called for a full investigation into the HPCSA's conduct in 2014. He requested that all complaints of alleged maladministration, irregularities, mismanagement and poor governance at the Council, be investigated.

A Ministerial Task Team was appointed, led by Prof. Bongani Mayosi, to obtain information on the issues faced by the HPCSA and why.

On 5 November 2015, Dr Motsoaledi held a press conference in which he described the state of the HPCSA as being 'dysfunctional'.

The task team found that the HPCSA is in a 'state of multi-system organisational dysfunction' which resulted in the body's failure to function effectively.

Task team recommendations

The recommendation made by the task team was that an interim executive management team be appointed to begin the clean-up process.

The HPCSA's chief executive, COO and head of legal services were found to be unfit for their jobs and the recommendation was that 'appropriate disciplinary and incapacity proceedings' be instituted against them along with possible suspension from their jobs.

The most important recommendation made by the Ministerial Task Team was that the HPCSA be split into two bodies, where one would be for allied health professionals and another separate body will be for medical practitioners and dentists.

SAMA welcomes the recommendations made by the task team and wants to thank them for placing the wellbeing of the medical profession and the patients at the forefront when determining the actual capacity and ability of the HPCSA to do what is expected from it by law.

Conclusion – and independent Medical and Dental Council

For SAMA, having lobbied for an independent Medical and Dental Council for almost two decades, the Ministerial Task Team's report and recommendations are indeed worth

celebrating. SAMA is especially encouraged by the following comment:

'It is the view of the MTT that the best interests of the health system are not served by the current structure and organisation of the HPCSA. The MTT recommends that consideration be given to the unbundling of the HPCSA into at least two entities: the historic Medical and Dental Council (which constitutes a third of the current membership of the HPCSA) and a Health and Rehabilitation Council (for the rest of the professional membership of the HPCSA). These new Councils would join the South African Pharmacy Council, the SANC and other autonomous councils in the Forum of Statutory Health Professions Councils.'

SAMA is looking forward to the implementation of a separate Medical and Dental Board which will emanate from this report and to build a new, highly functional, developed and competent council which will ensure a dramatic increase in service delivery to both medical and dental practitioners and their patients.

However, there is no time for SAMA to relax the pace – we will double our efforts to ensure that the members of the envisaged Medical and Dental Board are elected by their peers to guarantee the best possible representation of both the medical and dental fraternities, in turn facilitating the much-needed medical expertise to fulfil the functions initially envisaged for the HPCSA. SAMA is in full support of the principles expressed in the WMA Declaration of Madrid and would like to reaffirm that professional autonomy and self-regulation are essential components of high quality medical care, are for the benefit of our patients and must be preserved. Any member of the medical profession who supports any government or body or funder in interfering with the above principles will be acting unethically.

SAMA has the expertise and knowledge to play a cardinal role in the establishment of a fully functioning independent Medical and Dental Board and the sustainability thereof.

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Dr Singh, celebrity doctor

Vernon Kinnear, SAMA Marketing Officer

Nirvadha Singh is a medical doctor, public health specialist, health columnist, motivational speaker, poet and a World Peace Ambassador. As an international public figure with a huge global following, this celebrity doctor currently holds various esteemed positions as a medico-legal advisor to King Edward VIII Hospital; Chairwoman of the Ethics Committee and Board Director to KwaZulu-Natal United Music Association (KUMISA); member of the Executive Committee SAMA KwaZulu-Natal Coastal Branch; and Health Columnist to an international newspaper *The Daily Kashmir Reporter* newspaper.

Her recent accomplishment as Publisher and Editor of *The Health Chronicle*, a free online health and wellness magazine, has created a buzz on the social media platform. Her compassion for a healthy community has led her to bring together teams of healthcare professionals including SAMA doctors to write health promotive articles for the community to uplift their quality of life. She explains that the team write in a simple language for the non-medical person to understand the content and this has made her website popular with over a million viewers per month. The launch of the magazine was warmly received and attended by Dr Mergan Naidoo, Chairman of SAMA KZN, Dr Mangosuthu Buthelezi (MP) and Mr Logie Naidoo (Speaker of the eThekweni Municipality) amongst other doctors, specialists, hospital and medical managers.

Singh explains that her innovative website, which now has its own You Tube channel, is creative and easily responsive to both computers and mobiles. She recently did a mini video production of the Public Health Association of South Africa (PHASA) annual conference where SAMA National Councillor Dr Shailendra Sham was interviewed. The video was to highlight the conference to the community and this has now sparked Dr Singh's interest in health media. With the new responsive state of the art online site, Singh has moved from print to playing on the electronic space. She advocates that she is pro-environment hence the Go-Green principle has been implemented.



At the launch of *The Health Chronicle*, left to right: Dr Heeren Ranchod (The Health Chronicle Operations); Dr Olaf Baloyi (ex King Edward CEO); Mr Logie Naidoo (Speaker of the eThekweni Municipality); Dr Nirvadha Singh (Editor and Publisher of *The Health Chronicle*); Dr Mangosuthu Buthelezi (MP); Dr Mergan Naidoo (Chairman SAMA KZN Coastal Branch)

Dr Singh made waves earlier this year when the title of Ambassador of World Peace (Shantidoot) in Pilani, Rajasthan, India was conferred on her at The International World Peace Conference (7 September 2013). She was awarded the title for introducing peace education into healthcare and community activities and is the first South African to be awarded this noble title.

Her humanitarian efforts involved many campaigns including raising awareness against drug abuse, HIV, TB, teenage pregnancy, woman and child abuse, violence, cancer and disasters and have incorporated the concept of peace within these activities and included a campaign in prisons to rehabilitate prisoners. Furthermore, Dr Singh has undertaken healthcare talk shows on radio stations including Radio Hindvani and Radio Al-Ansaar to raise both health and peace issues in communities across SA. She has also been interviewed internationally by many newspapers and TV channels including e-News Channel India, the *DNA magazine* and *Times of India* about her introduction of Public Health into Peace for the first time ever.

Her previous accomplishments include the positions of Public Health Advisor to the Department of Health in the Strategic and

Operational Planning of the healthcare system in preparedness for the 2010 FIFA World Cup Soccer in Durban, SA and Governor to the Cancer Association of SA (CANSa).

She has presented at the World Congress in Ethiopia 2012 on disaster management and its public health approach. As a public speaker, she has delivered seminars to major international and nationally known organisations such as ACCORD (The African Centre for the Constructive Resolution of Disputes), the SANDF (South African National Defence Force), the GDT (Gandhi Development Trust), the OSHA (South African Occupational Health & Safety Association) among many others including the Durban Chamber of Commerce.

Her mom is her role model as she had to raise three children single handed after her dad's death: "My mom became mother, father, teacher, cook, driver, counsellor, doctor and pillar of strength. My mom is proof that if a woman can handle a household, she can lead a nation."

Being an academic, she maintains her artistic side by reading poetry and stresses that once you believe, you can achieve.

You can visit her website at www.healthchronicle.co.za

SAMA represented at WMA General Assembly

Dr Mzukisi Grootboom, SAMA Chairman

The General Assembly of the World Medical Association took place in Moscow, Russia from the 14 – 17 October 2015. SAMA was represented by its President Prof. Lizo Mazwai and the chairman Dr Mzukisi Grootboom.

Three members of the SAMA Junior Doctors Association were part of the deliberations of the WMA Junior Doctors Network (Drs Sadiki, Makomo and van Niekerk)

The proceedings were preceded by work group meetings the day before the actual assembly on 13 October.

SAMA took part in the following:

Healthcare in Danger Project

This is a combined project of the International Committee of the Red Cross and the WMA. The project is about the ethical aspects of the practice of medicine in situations of armed conflict and other emergencies. Violence against healthcare is most likely one of the biggest humanitarian problems today, yet it remains a largely understudied and under-recognised issue.

Environmental caucus

The WMA has, in the last few years, been very vocal in highlighting the health risks of climate change starting with the United Nations Climate Change Conference (COP 17) Durban in 2011. SAMA has been in the forefront of those discussions both at that level and locally with our own country. SAMA is cognisant of the serious consequences of climate change and is committed to making a contribution to mitigate and/or adapt to the impact of climate change on health. The WMA issued the following press statement prior to the meeting: http://www.wma.net/en/40news/20archives/2015/2015_31/index.html

Ageing

The WMA is in the process of revising its own policy on the care of the aged and SAMA is part of the work group.

Physician/doctor well-being

SAMA was part of the group to draft the most recent WMA policy on the subject. The WMA press statement in this regard can be accessed

in the following link: http://www.wma.net/en/40news/20archives/2015/2015_37/index.html

The new WMA President is Prof. Sir Michael Marmot from the British Medical Association. He is a world renowned public health specialist.

The first day of the Assembly involved meetings of the Council and the committees, which are the Finance and Planning Committee, Socio-Medical Committee and the Ethics Committee. SAMA sits in the Council and all the committees except the Finance and Planning Committee.

The work of the committees is to receive new documents sent to the WMA by the National Medical Associations for possible

adoption. The committees may accept or not accept a document for discussion. Once accepted for discussion a document it is then discussed and modified. The committees may also be requested to look at and modify existing WMA policies.

The policies or documents are then dealt with in the following manner:

- Accepted after modification and referred to the Council for approval
- Circulated to the National Medical Associations for further input
- Referred to a working group for further research, discussion and modification. Working groups are formed mainly in instances when the document requires extensive work to be done or if, in the case of an existing policy, it requires a major revision.

Once a document has been referred to Council for approval the council may deal with it in the following manner:

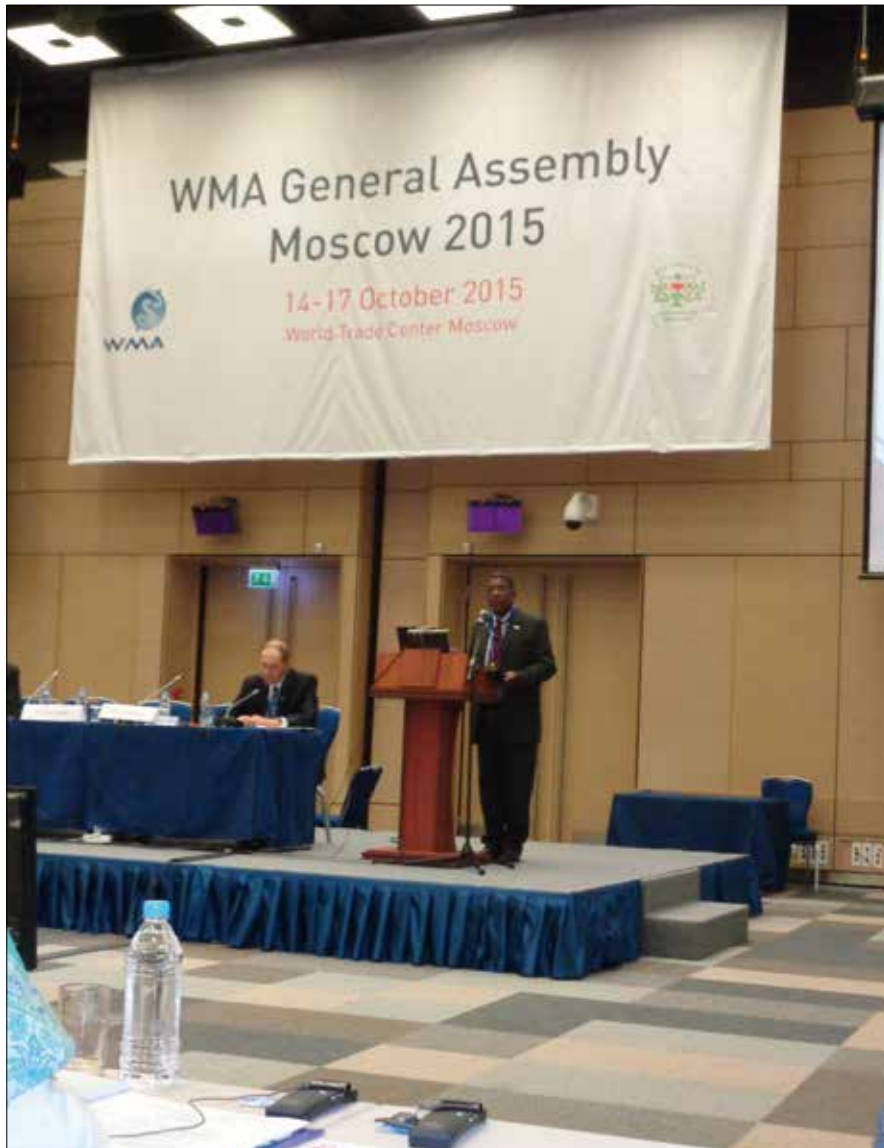
The Council considers the recommendation of the Committee to approve the document.

The Council may:

- amend the document
- send the document back to the Committee for additional work



Dr Mokomo, Prof. Mazwai, Dr Grootboom and Dr Sadiki



Prof. Mazwai delivers his presentation

- approve the document and forward it to the General Assembly with the recommendation that it be adopted.

The second day was dedicated to a scientific session of the Assembly. The theme was 'Medical Education'.

The SAMA President gave a talk entitled: 'Transformation of Medical Education in the 21st Century'.

The main activities on 16 October were the inauguration of the new WMA President, Prof. Sir Michael Marmot from the British Medical Association. He is a world renowned public health specialist. He has published extensively and was head of the World Health Organization (WHO) Commission on Social Determinants of Health. The findings of the commission are published in a book entitled:

'Closing the Gap in a Generation'. It can be sourced at: www.who.int/social_determinants

The plenary session of the General Assembly considered and adopted the following policies:

- WMA Statement on Alcohol
- Statement on Mobile Health
- WMA Statement on Ethical Issues Concerning Patients with Mental Illness
- Statement on non-discrimination in Professional membership and activities of doctors /physicians
- WMA Statement on Nuclear Weapons
- WMA Statement on Physicians Well-Being
- WMA Statement on Supporting Health Support to Street Children
- WMA Statement on Riot Control Agents
- WMA Statement on Transgender People
- WMA Statement on Vitamin D Insufficiency

- WMA Guidelines on Promotional Mass Media Appearances by Physicians
- WMA Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools World-Wide
- WMA Declaration of Oslo on Social Determinants of Health.

The following resolutions were adopted:

- Resolution to stop attacks against healthcare workers and facilities in Turkey
- Resolution about the bombing on the hospital of MSF in Kunduz
- WMA resolution on the global refugee crisis.

As part of the agenda, time was allocated for an open session where different Medical Associations shared their experiences with regard to International Trade Agreements that affect health.

The Israeli Medical Association reported on their activities and their engagement with their government with regard to the enactment of a law allowing doctors to force feed detainees and prisoners on hunger strike.

They as a Medical Association have campaigned against the law on the basis of the fact that the act of force feeding is not only a degrading and dehumanising act but is also unethical. They advised the doctors in that country against taking part in such acts and have approached the courts in their country to declare the law unethical and unlawful.

The future meetings of the WMA are as follows:

- Health Database and Biobanks Expert meeting in Seoul, February 2016
- 203rd WMA Council Session in Buenos Aires, 28-30 April 2016. The Council meeting is usually open to all constituent members participating as observers.
- World Health Professionals Regulation Conference 2016 in Geneva, 21-22 May 2016
- Members of Council and guests are advised that the WHO World Health Assembly opens on Monday, 23 May 2016 in Geneva. On the first and second day of the WHA we are traditionally holding receptions for the delegates to the World Health Assembly, the first of which is together with the World Health Professions Alliance (www.whpa.org). Of course the delegates of our constituent members are cordially invited.
- WMA General Assembly, Taipei 2016, 19-22 October 2016 .

Disclosure of confidential information – after the patient's death

Wendy Massingale, SAMA Legal Advisor

There has been an overabundance of confusion, regarding whether a medical practitioner has an obligation to release the deceased patient's medical information. It is an accepted fact that the patient's medical information is to be kept confidential by the medical practitioner. However, there are exceptions to this rule, in particular, where the deceased's estate requires such disclosure.

What is expected from medical practitioners?

With regard to the medical practitioner's duty to release patient information, The National Health Act^[1] stipulates that all patients have a right to confidentiality; this is in line with the right to privacy imparted in the South African Constitution.^[2] Further, section 14 of the Act^[1] outlines the subject of confidentiality as follows:

'(1) All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.

(2) Subject to section 15, no person may disclose any information contemplated in subsection (1) unless -

(a) the user consents to that disclosure in writing;

(b) a court order or any law requires that disclosure; or

(c) non-disclosure of the information represents a serious threat to public health.'

Rule 13 of the Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act^[3] addresses the issue of professional confidentiality. It specifies the following:

'(1) A practitioner shall divulge verbally or in writing information regarding a patient which he or she ought to divulge only - (a) in terms of a statutory provision; (b) at the instruction of a court of law; or (c) where justified in the public interest. (2) Any information other than the information referred to in subrule (1) shall be divulged by a practitioner only - (a) with the express consent of the patient; (b) in the case of a minor under the age of 12 years, with the written consent of his or her parent or guardian; or in

the case of a deceased patient, with the written consent of his or her next-of-kin or the executor of such deceased patient's estate.'

It is clear that the duty to maintain patient confidentiality persists after a patient's death. As indicated above, the degree to which the patient's medical information may be divulged after their death will largely depend on the circumstances. The requirements set out in rule 13^[3] above have to be adhered to. Not only is there an obligation to keep patient information confidential, there is a corresponding duty to ensure that the information is kept properly, to prevent unauthorised persons from gaining access to it. Section 15 of the National Health Act^[1] deals with access to health records, while section 17 is concerned with the protection of health records. 'A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person ... for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user.'^[4] In addition to safe-guarding who may have access to the information, 'the person in charge of a health establishment in possession of a user's health records must set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept.'^[5]

PAIA – how does it fit in?

The above should be looked at against the backdrop of the Promotion of Access to Information Act,^[6] which affords everyone the right of 'access to any information that is held by another person and that is required for the exercise or protection of any rights.'^[6] This includes access to medical information held by a public or private body. Section 61 of the Act^[4] deals specifically with the access to health records. In terms of section 61 of the Act, the patient or the person requesting access to the information on the patient's behalf, must be granted such access, unless access 'might cause serious

harm to his or her physical or mental health, or well-being'.^[6]

A practical example of when the medical practitioner may be requested to disclose information to an executor would be: Depending on the value of the deceased estate, an executor will be appointed by the Master of the High Court. This is usually the person named in the will as an executor, or if the deceased died intestate (without a will), it will be the person nominated by the heirs of the deceased to act as such. It is the executor's duty to administer the deceased estate in terms of either the will, or if there is no will, the Intestate Succession Act. There are various reasons as to why an executor may request the deceased's medical information. For instance, if the will is being contested due to lack of capacity by the deceased, based on their medical condition prior to their death, or the signing of the will. Another reason would be to determine the deceased's medical condition prior to their death, in the event of suspected foul-play by an heir. This information may determine how the deceased estate is to be administered, and thus, disclosure of same would be of paramount importance.

Conclusion

It is my opinion that a medical practitioner has a duty to convey the deceased patient's information, upon receiving written consent from the deceased's next-of kin, or the Executor of the deceased estate. The doctor is still bound by the principles of doctor-patient confidentiality. Confidentiality is not only an ethical obligation, but a legal one as well. The relevance of the information to be divulged will vary from case to case. However, in all cases, should the medical practitioner decide to disclose confidential information, they must be prepared to justify their decisions.

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E-cigarettes: More evidence required on their health benefits and harms

SAMA Knowledge Management and Research Department

The growing awareness of the enormous burden of disease and mortality accredited to tobacco smoking, and the accompanying anti-tobacco drive internationally, has led to individual determinations to quit smoking, resulting in a spike in use of alternative nicotine products, such as electronic nicotine delivery systems (ENDS), of which electronic cigarettes (ECs) are the most common type. (Other nicotine-replacement therapies include gums, lozenges and patches, inhalers, and nasal sprays.) The use of ECs (referred to as 'vaping') has become the subject of public health debate. Despite the popularity of ECs as a smoking cessation aid or for recreation, evidence for their overall benefits and harms at both individual and population levels is still lacking; there are concerns over ECs' efficacy, safety, quality, age-unrestricted access, addictive properties and lack of regulation. Doctors need to know how to advise patients and the population in relation to these devices. The stances of key international bodies such as the World Medical Association (WMA), World Health Organisation (WHO), Centre for Disease Control, World Lung Federation, and the Food and Drug Administration, among others, have to date shaped the response of the health and medical community to EC use, which has largely been unenthusiastic.

Although no standard definition currently exists, ECs are 'electronic devices that heat a liquid - usually comprising propylene glycol and glycerol, with or without nicotine and flavours, stored in disposable or refillable cartridges or a reservoir - into an aerosol for inhalation. Different flavours are commonly added, such as fruit, tobacco, candy, mint, chocolate, and so forth.

The EC market has flourished, fanned by aggressive marketing, especially among youths. Today one finds a staggering 4 600 widely varying brands and 7 700 different flavours, a situation that reflects lack of standardisation and quality control complications.

The appeal of ECs over traditional cigarettes is that ECs do not involve tobacco combustion, thus sparing EC users (commonly known as 'vapers') from exposure to the 7 000 chemicals found in tobacco smoke, most of which are toxic and over 70 of which are carcinogenic. According to the WHO, about 6 million people die each year because of tobacco smoking.



More than 5 million of those deaths are the result of direct tobacco use while over 600 000 are the result of non-smokers being exposed to second-hand smoke.

The potential health benefits of ECs are debatable. ECs are claimed to contain zero to very low levels of the harmful chemicals found in smoked tobacco. A Cochrane review published in 2014, found that e-cigarettes can reduce rates of smoking; however this was based on low quality randomised control trials. E-cigarettes were also not found to be inferior to the nicotine patch. In addition, ECs provide an effective mimic of the behavioural and sensory aspects of smoking that appeal to smokers, while presenting a lower risk of harmful second hand smoke for bystanders. Many also use the ECs to escape the smoke-free laws.

However, ECs are not free from risk. Contrary to many beliefs, the puff from an EC is not just a 'harmless vapour'. ECs carry the danger of nicotine toxicity, nicotine addiction, inhalation of other potentially harmful and addictive chemicals (e.g. marijuana oil and other prohibitive substances), and indoor pollution. In overseas countries such as the USA, there have been more and frequent calls to poison centres due to e-liquid exposures especially among young children. Studies such as by Leventhal *et al* and Bunnell *et al* demonstrate an association between vaping and risk of initiating use of combustible tobacco products, especially among youngsters, although causality is not confirmed. Health experts argue that ECs will appear to normalise smoking, thereby deterring smokers from completely stopping smoking. In the absence of affordable nicotine, there is a risk of encouraged tobacco use.

The legal status of ECs is blurred in many countries. In South Africa, tobacco products are controlled under Tobacco Products Control Act and nicotine is regulated through

the Medicines and Related Substances Act, where it is categorised as Schedule 1 (gum) or Schedule 2 (patch) depending on the delivery mode. As a schedule 1 or 2 substance, nicotine can therefore only be sold by pharmacists. ECs including refills are freely available in the market and online shops in South Africa. Internationally, 32 WHO member countries have legislation regulating ENDS as either a therapeutic product or as a tobacco product; 25 countries have legislation banning their sale; 17 countries include them in national legislation on smoke-free environments; 9 countries include them in national legislation on health warnings on packages; and 13 countries include them in national legislation on advertising, promotion and sponsorship.

As argued by key health and medical bodies, the absence of definitive scientific evidence on the safety and effectiveness of ECs makes it impossible to predict any long-term health effects. Physicians, including SAMA doctors, should exercise caution in giving advice around use of ECs. Non-smokers should be advised of nicotine addiction and a possible risk of using tobacco in the absence of affordable nicotine. The WMA statement on ECs and other electronic nicotine delivery systems, adopted in October 2012, calls for the inclusion of ECs in smoke-free laws and emphasises that any use of ECs as a smoking cessation method should be based on evidence. The WMA Statement also recommends national regulation of the manufacture, sale and marketing of ECs and urges physicians to 'inform their patients of the risks of using e-cigarettes even if regulatory authorities have not taken a position on the efficacy and safety of these products'.

For a list of the references used in this article please email Bernard Mutsago at SAMA: bernardm@samedical.org

SAMA reviews HPCSA pronouncement

Julian Botha, Strategic Accounts Manager: SAMA Private Practice Department



The HPCSA has made a pronouncement under the title 'Rates Discrepancies are Unethical' which is available on their website. SAMA has reviewed the contents of this document and questions the basis and accuracy of the statements contained.

The legislative provisions that are quoted in the statement do not make any reference whatsoever to the issue of discounted cash settlements of account. There appears to be a *non sequitur* here. There is no connection with the contents of these statutory provisions and the conclusions drawn by the author of the HPCSA statement regarding unethical conduct. In their release, the HPCSA referred to three statutory provisions.

- Section 53(2) of the Health Professions Act states that: 'Any practitioner who in respect of any professional services rendered by him or her claims payment from any person (in this section referred to as the patient) shall, subject to the provisions of the Medical Schemes Act, furnish the patient with a detailed account within a reasonable period'.
- Section 59(1) of the Medical Schemes Act states as follows: 'A supplier of a service who has rendered any service to a member or to a dependant of such a member in terms of which an account has been rendered shall, notwithstanding the provisions of any other law, furnish to the member concerned

an account or statement reflecting such particulars as may be prescribed'.

- Section 59(2) of the Medical Schemes Act states that, 'a medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit'.

As can be seen from the above sections, there is no mention whatsoever of the 'discounting' of fees, nor is there any reference to the prohibition of charging different rates to patients who elect to pay cash for services and those who elect to claim from their medical schemes for payment for such services.

The HPCSA is at pains to point out that it is the right of the patient/medical scheme member to choose how they pay for or be funded for the health services they receive. This is absolutely correct and cannot be argued against. However, the practitioner also has the right to determine what fees they charge for the services they render. If the practitioner were to grant a discount, for example for early settlement of the account or for cash payment, he or she is entitled to do so.

It is difficult to discern upon which basis the HPCSA makes their pronouncement that discounting practices described are 'unethical'.

In fact, allowing medical schemes to determine the levels at which doctors may charge fees would seriously impact on the autonomy of medical practitioners. If one were to illustrate by means of an example:

A patient who is experiencing financial difficulty comes to consult the doctor. The patient is not on a medical scheme and consults his family practitioner. The patient, having previously been retrenched is no longer on a medical scheme. The doctor wants to assist his patient and, in order not to embarrass that patient offers to charge a drastically reduced fee for the consultation, which the patient is willing and able to pay in cash.

In terms of the HPCSA pronouncement, the doctor, in acting this way, would be acting unethically. Surely the HPCSA is not protecting this member of the public, by compelling the doctor to charge this unfortunate patient the

full rate that would be charged to a patient on a medical scheme.

The only scenario, in terms of the quoted provisions, is that it would be impermissible where the patient settles an account in cash, receives the discounted rate and is furnished with a receipt/invoice (for submission to their medical scheme) which reflects the 'undiscounted' amount – in other words, the medical scheme would be expected to reimburse the full, and not the discounted, amount to the patient. This would constitute fraud.

In our review of the Ethical Rules as well as the Health Professions Act no mention, let alone prohibition, of offering discounted rates can be found.

It is imperative for the practitioner to provide accurate statements and/or invoices to their patients under all circumstances

It is imperative for the practitioner to provide accurate statements and/or invoices to their patients under all circumstances (both cash and medical scheme claims). This will ensure compliance with the legislative provisions. Practitioners should never receive cash payment from patients and then submit a claim to medical schemes, resulting in the receipt of a second payment for the same service – this would be criminal conduct.

In addition, practitioners should not unduly increase their rates for those patients who wish to submit claims to medical schemes (as opposed to paying cash) in order to induce those patients to rather pay cash. The 'discount' should be an actual and not a manufactured discount.

In order to avoid any confusion doctors are advised to reflect all amounts charged, and any discounted amounts (with the reasons for such discount explained) on accounts submitted to their patients and/or medical schemes.

SEDASA National General Council 'one more time'

Dr Ayodele Aina, SEDASA National Chairperson

The National General Council (NGC) of the Senior Employed Doctors Association (SEDASA) held a contact meeting on 6 November 2015 in line with its 2015 theme 'moving into action'.

This meeting took place a week after the SAMA National Council meeting where SEDASA was officially represented by five National Councillors.

The NGC was honoured to be addressed by Dr C Sewlal, a veteran SEDASA leader and health activist, on the benefits of cost-effective medicine.

Team-building facilitators entertained the NGC with an indoor activity session that improved communication and teamwork, promoted relationships and created respect for different personalities and cultures. This team-building exercise was the first of its kind in SEDASA history and ensured the NGC's renewed vigour following a stressful year.

The mission and vision of SEDASA are:

- To ensure proper representation of its members
- To negotiate on behalf of its members
- To promote better communication between its members, the South African Medical Association (SAMA), the health authorities and other stakeholders.

**'Let's do it together.
We've heard what
we have to do. We've
seen what we need to
do. Now is the time to
do it, and, together,
we can do it.'**

The SEDASA NGC also resolved to call on all its members to adhere to a proper code of conduct, to show respect and to demonstrate a high level of ethical behaviour and professionalism in all their dealings and communications, in the interests of upholding the integrity of our beloved organisation (SAMA). Members are also requested to follow appropriate channels of communication when expressing their workplace concerns –



At the SEDASA NGC, from left to right: Dr A Hussain, Dr A Aina (SEDASA chairperson), Dr C Sewlal (DoH KZN), Dr R Adams



The National General Council of SEDASA: (Left back) Dr D Sithole, Dr C Mojapelo, Dr D Hagemeister, Dr A Hussain, Dr R Green-Thompson, Dr M Kolosa, Dr B Malumane, Dr J Ngundu; (front left) Dr A Aina (SEDASA Chair), Ms G Moseki (SAMA Coordinator), Dr P Songo, Dr T Smit, Dr R Adams

i.e. directing these communications to their SAMA Trade Union leadership structures or the industrial relations department at SAMA, and not to their employers directly. The SEDASA NGC noted individual occurrences of such inappropriate communication and strongly condemned such actions.

I want to extend a special thank you to Ms Girly Moseki, the SEDASA committee coordinator, for her unrelenting efforts and hard work for SEDASA during 2015. She made a huge difference in an otherwise challenging year.

My personal message to all SEDASA members is:

'Let's do it together. We've heard what we have to do. We've seen what we need to do. Now is the time to do it, and, together, we can do it.'

'Is life so dear or peace so sweet as to be purchased at the price of chains and slavery? Forbid it, Almighty God! I know not what course others may take but as for me give me liberty or give me death.'

May the Spirit of SEDASA live long!
AMANDLA!

SAMA journal club guidelines for CPD accreditation 2015

SAMA Communications Department

Aims of a journal club:

- Continuing professional development
- Keeping up-to-date with the literature
- Disseminating information on and building up debate about good practice
- Ensuring that professional practice is evidence based
- Learning and practising critical appraisal skills.

Setting up a journal club:

- Roles and responsibilities should be clearly defined and accreditation obtained by the SA Medical Association: cpd@samedical.org
- Meetings should have a chair or facilitator
- One person should be responsible for coordinating the meetings
- All members should be encouraged to contribute their views
- Each member should commit to reading the article beforehand

- A training needs assessment for the group should be carried out
- The format for the meetings should be decided in response to the needs of the members
- Training should be provided as needed (critical appraisal, presentation skills, etc)
- Important to have an environment of shared learning
- Clear boundaries: start and finish times, timetable for the year all made clear well in advance.

Content of the meetings:

- This can be topic based (this is more work, though), or you can look at an article of interest
- One person to present and discuss a paper or topic, or you can discuss the article as a group
- If one person is presenting, you can use this as an opportunity to practise and give feedback on presentation skills

- Critical appraisal journal clubs: choose an article on a topic of interest/recently published paper and appraise it using a checklist
- Evidence-based journal clubs: start with a real clinical question (end of a meeting); search the literature; select and read the most relevant paper (before the next meeting); appraise it at the next session; decide whether/how to put it into practice.

TIP: Avoid pulling the paper to bits in critical appraisal – the point is to objectively weigh the paper's strengths against its weaknesses. For further information on CPD accreditation please contact: Lisa Reid on 012 481 2082 or cpd@samedical.org

Minutes of the meeting must be sent through every six months to your accreditor for auditing purposes.

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Letters to the Editor

Our thanks to Dr Lingham for submitting the first letter for publication. The **Letters to the Editor** page aims to give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare which you feel should be shared with your colleagues and fellow readers.

Please note that letters:

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

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



Professional ethics – have we lost it?

The Editor,
I wish to refer readers to the September issue of the *SAMA Insider* and Professor Mazwai's article titled *Medico-legal litigation: Do we have the solution?*

Professor succinctly captures salient points that need attention and correction in the way in which we practise medicine; however, I wish to add another spin to his article with particular reference to the Ethics and staff attitude.

Two critical factors:

Professional Ethics: In the seventies and eighties when general practitioners referred cases to specialists – a specialist would review the case and advise the referring general practitioner on his findings and his proposed management plan, the specialist would further indicate a treatment plan in generic terms. It was the responsibility of the general practitioner to institute and to continue follow up as may be required. Similarly, for patients admitted to hospital and if the specialist required an opinion from a second specialist, the referring general practitioner was to be advised and the specialist would also

request of the general practitioner whether the second suggested specialist is acceptable or whether the general practitioner wishes to propose another specialist.

Today professionalism has changed drastically.

Patients referred to specialists are often times sent on a round-robin circuit of specialists, no report back letters to the referring general practitioner and all subsequent follow-ups are done by the specialist – in essence the patient is lost to the specialist until medical aid source funding is depleted.

The point I am making is that professionalism, professional ethics, compassion, care and empathy have been lost in the equation – the drive for monetary gain is paramount. Once medical insurance funding is exhausted the patient then lands at the general practitioner's door.

May I ask why is there such a reluctance, particularly with the more recently qualified specialists, not to commit their findings and management plans to writing by way of a simple report back letter to the general practitioner, is this a lack of

professionalism or fear of revealing their incompetence?

A **second point**, if a patient is admitted to hospital under a specialist, and as a general practitioner you visit the patient, what is the ethical norm in inspecting the test results and various investigations – do you inform the specialist of your intention and/or request of the specialist permission or is requesting of the sister in charge permission sufficient? What about the PAIA (Promotion of Access to Information Act)?

Lastly, a patient under specialist care in a private facility falls out of bed and sustains a head injury – cot sides not raised by the nursing staff (clearly a nurse omission). The patient is medically assessed and a CT scan is ordered. For whose account will the CT scan be? What about follow-up management costs for any injury or complication sustained in the fall?

I invite comment from colleagues and healthcare funders.

Yours sincerely
Dr P Lingham

A case of renal failure

Medical Protection Society

Mrs B was a 44-year-old teacher with two children. She smoked ten cigarettes a day and was overweight. She saw her GP, Dr T, about knee pain and he prescribed ibuprofen and advised her to lose weight. The ibuprofen helped so she continued to take it long-term.

Later that year she saw Dr T again, complaining of itching. Dr T thought the likely issue was a change in washing powder so prescribed antihistamines and suggested she switched brands. He also requested some blood tests including renal function. Her creatinine was slightly raised at 138 and her eGFR (estimated glomerular filtration rate) was 38 (indicative of chronic kidney disease stage 3b). Dr T had documented 'blood tests OK, repeat in three months'.

Mrs B forgot to have her repeat blood tests but saw the nurse and different GPs several times over the next few years with minor ailments. The issue was not raised again by any of the health professionals. A nurse had documented her BP as 125/80 when she had attended for travel vaccinations.

Three years later, she consulted Dr R, another GP at the practice, complaining of breast tenderness. His notes remarked on a diagnosis of CKD stage 3 but Mrs B was not informed of the diagnosis and no investigation or further follow-up was made.

Another year later, Mrs B made an appointment with Dr R because she was struggling with anxiety and was concerned about palpitations. She was stressed at work and was waiting for some cosmetic surgery that she was nervous about. Dr R checked her BP and found it greatly elevated at 216/107.

He prescribed her diazepam and propranolol and arranged an ECG on the same day, which showed ventricular hypertrophy. Dr R arranged blood tests the following day and rechecked her blood pressure. Her eGFR was 21, indicative of CKD stage 4. Her creatinine was 226 and urea 10.6. Mrs B was informed about a problem with her kidney function and was referred and seen the same day by a nephrologist, Dr W.

Dr W started treatment with amlodipine, bisoprolol, alphacalcidol, simvastatin, ranitidine and aspirin. He informed Mrs B that she had

renal failure and accelerated hypertension. Mrs B underwent detailed investigation with blood tests, urinalysis and ultrasound.

In Dr W's opinion, her chronic renal failure was caused by a combination of smoking, a bad family history of vascular disease (and possibly renal disease), and hypercholesterolaemia, which, combined with the adverse effects of NSAIDs, produced an ischaemic interstitial disease that became rapidly worse with the sudden development of severe uncontrolled hypertension.

Mrs B was told that progression to end-stage renal failure was almost certain and that she would require dialysis or transplantation within five to ten years. She was told that her life expectancy with dialysis could be 10–15 years and 15–20 years with transplantation. She would need a complex drug regimen, dietary restrictions and indefinite outpatient follow-up.

Mrs B was devastated and felt that the diagnosis and treatment of her renal failure had been delayed. She was struggling with fatigue and was unable to cope at work. She made a claim against both GPs.

Expert GP opinion acknowledged that there had been a big shift in clinical practice since the case took place. Guidance has changed regarding the recognition and labelling of chronic kidney disease. Expert opinion considered that at the time, few GPs would have recognised that the slightly elevated creatinine and the eGFR of 38 were likely to represent significant renal disease.

Dr T's actions in arranging to repeat the test in three months were found to be very reasonable, but expert opinion would have been critical if this had not been communicated to the patient. Dr T was criticised for failing to notice that Mrs B's renal function had not been rechecked, as repeat testing could have led to an inquiry about potentially nephrotoxic drugs such as NSAIDs, and a timely referral to the nephrologists.

Dr R was criticised for failing to identify the low eGFR and raised serum creatinine and that the plan to repeat the renal function tests had not been implemented. Repeat testing and non-urgent referral should have taken place. Renal physician opinion was also sought, which found that an urgent repeat/confirmatory test should have been ordered. Mrs B should

have been examined for potential causes and complications of renal disease.

The GP should have sent urine for culture and ACR (albumin:creatinine ratio) estimation and carried out dipstick testing for blood. Blood tests should have been arranged to exclude diabetes, anaemia and nephrotic syndrome.

Expert opinion also suggested that an urgent referral within a week should have been made if the hypertension was marked and the rise in creatinine rapid. In the absence of a rising creatinine and in the presence of a normal blood pressure, the patient would normally have been seen within two months. Had this been done, the severe episode of hypertension could have been avoided and renal function preserved.

The timely withdrawal of NSAIDs would have been of some benefit. As a result of missed opportunities for referral and intervention, progression to end-stage renal failure was almost certain and dialysis or transplantation would be required. The claim was settled for a substantial sum.

Learning points

This case occurred before 2008 and the expert opinion follows practice that was current at the time. Guidelines surrounding the management of CKD have since been updated – see the National Institute for Health and Clinical Excellence guidance: (NICE), Chronic kidney disease – Early identification and management of chronic kidney disease in adults in primary and secondary care.

Good note-keeping is important. This is vital for a good defence. It was useful that Dr T documented that he had advised Mrs B to return for blood tests in three months.

Steps to ensure continuity of care would have made it easier to notice that Mrs B had not returned for the planned follow-up. GPs should review previous notes when seeing patients, to put the consultation into context and continue with existing management plans.

It is important to keep up-to-date and be familiar with guidelines and developments that affect your work.

Award for Frere's Prof. Gerald Boon

The SAMA Border Coastal branch wish to congratulate Gerald Boon, a Frere Hospital professor who was recently hailed a medical hero after being awarded this year's Spirit of Medicine Award by SAMA. Prof. Boon is currently the head of paediatrics at Frere Hospital.

Boon, described as a role model, mentor and an inspiration by his colleagues, was nominated by his colleague Dr Kim Harper. He said the award meant a lot to him: 'I work with a team of tremendous people who all deserve to be recognised for their efforts. To be nominated and be awarded the Spirit of Medicine Award means a lot.'

It was Boon's commitment to bringing justice and equality to all children in the province that inspired Harper to nominate him for the award. 'He has represented the country at many national committees and his input and values are esteemed and rightly sought after,' said Harper.



SAMA Border Coastal congratulate Prof. Gerald Boon who was recently awarded the Spirit of Medicine Award

'He has proudly stood up to the challenges of politics, adversity and obfuscations to say "this child's life counts" and for so many children, he has made their lives valued,' said Harper.

Boon's long list of commitments over the years include serving as the chairman for the Ciskei AIDS advisory committee in the early 1990s and working on a project to feed malnourished children in Potsdam, Ndevana and Mdantsane.

Frere Hospital CEO Rolene Wagner said the award recognised Boon's contributions to paediatric service delivery in the region. 'Health professionals in the public sector share a common value system of servitude to those who need it the most and Prof. Boon exemplifies that commitment to serve,' said Wagner.

Source: Aretha Linden, East London Daily Dispatch

Seven quick tips about business management

The guidelines for business management are an important part of any corporate culture. They should be embedded in the fixed company principles and therefore be used as the basis for decision making on all levels.

The following seven tips will help business managers achieve their annual goals:

Have a department plan

An idea is doomed to failure without a plan behind it. You have to set targets that will ensure that the team achieves their goals. Without a plan and dedication to executing it, they will inevitably drift, gradually losing sight of their potential and value. Hold yourself accountable by evaluating progress weekly and making adjustments as circumstances evolve.

Be an example

Convey confidence and stay composed. Own up to your mistakes, so that your team does the same. Follow your own rules, knowing no job or rule is beneath you and stay positive and approachable at all times. People watch what you do more than they listen to what you say so always walk the talk and recognise the image you project at all times.

Be consistent

As business grows more complex and uncertain, your team should never guess

how you will react. Instead, they should view you as a fixer who will provide a fair hearing and honest feedback. Otherwise, they will invariably tell you what you want to hear rather than what you need to hear, and silence is a far greater threat to any business than honesty.

Be fair

Team members need to know that opportunities for their professional growth and career enhancement are alive and well on a level playing field in which managers are the gatekeepers. As a manager, you should demonstrate your awareness and commitment to your individual team members by conducting regular one on one meetings, checking in throughout the year to ensure the team members are within striking distance of their annual goals and providing solid feedback for multiple performance activity. Avoid favouritism at all cost.

Provide ongoing communication

Your employees' perception of you can be your biggest asset or drawback, so you have to reinforce a good impression by reaching out and maintaining a two-way dialogue and seeking feedback on what's important to them. You are responsible for others, and they need to know you are watching out for their interests.

Open to new ideas

The departmental meetings can be used as a platform for team members to learn about you and your expectations, and for the manager to listen to complaints if they are immediately followed by a new and better suggestion that has the possibility of being implemented. When a team member approaches you with what they think might be a comprehensive solution, acknowledge them for stepping up with an enhanced idea that might be a win/win for all.

Empowerment

Your team can only move forward and be successful if they feel empowered. Empowerment cannot be taught – it is cultivated and nurtured. You must inspire employees to develop and implement techniques that have proven continuously successful and beneficial.

A business cannot survive without management because management is its means of support. In this management conscious age, the significance of management can hardly be over-emphasised, it is said that anything minus management amount is nothing. There is no more important area of human activity than management since its task is that of getting things done by others.



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