

SAMA INSIDER

FEBRUARY 2016

**Social media:
Should we, can we,
must we?**

**GP IMBIZO: The
practitioners have
spoken**



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

**SOUTH AFRICAN
MEDICAL ASSOCIATION**

Invitation to participate on the Government Employees Medical Scheme (GEMS) Advisory Panels of Experts for:

1. Orthopaedic and Spinal Surgery
2. Psychiatry
3. Oncology and Biologics*



The Government Employees Medical Scheme (GEMS) Registration Number 1598, was registered in terms of the Medical Schemes Act 131 of 1998 with effect from 1 January 2005. The Scheme reports to the Registrar of the Council of Medical Schemes and is defined as a body corporate that undertakes liability related to its members' healthcare benefits in exchange for receiving contributions.

Objective

A GEMS expert advisory panel is formed with the following objectives:

- Informing the Scheme's approach to funding benefit entitlements where claims are for healthcare interventions where clinical care is not standard;
- Suggesting enhancements to the Scheme's clinical and funding protocols based on evidence that describes effective best practice;
- The examination of current evidence-based data and guidelines;
- Invitation of peers for review if necessary; and
- Assisting the Scheme's Ex-Gratia Committee in its decision-making process.

Panels required

GEMS seeks to establish the following Expert Advisory Panels:

- Orthopaedic and Spinal Surgery Expert Advisory Panel
- Psychiatry Expert Advisory Panel
- Oncology and Biologics Expert Advisory Panel*

Panel composition and structure

Each expert advisory panel will consist of three members.

Panels will exist and execute their duties independently from each other.

Each panel will meet at least once every quarter in a year, but may meet more frequently if required.

Qualification requirements and remuneration

Applications are called for from suitable candidates who have the requisite qualifications, research and clinical practice experience in the relevant field.

Qualification requirements are:

- Appropriate academic training, qualifications and relevant clinical experience;
- Proven career-related achievements in one or more of the above mentioned fields; and/or
- International and/or local experience and/or recognition.

GEMS will pay a competitive fee to members of the panels for participation. Travel-related subsistence costs will also be covered. The quantum of payment will comply with GEMS policies.

To apply, please send your CV and covering letter to leticia@gems.gov.za. Please note that where an application is made for more than one panel, separate submissions are required.

The closing date for applications is **18 March 2016**. Should you not hear from us by **31 March 2016**, please consider your application unsuccessful.

GEMS adheres to principles of integrity and ethics in assessing responses to such invitations.

**Kindly note that the Oncology and Biologics Expert Advisory Panel is already established and GEMS only seeks one candidate for this panel.*

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ROAD ACCIDENT BENEFIT SCHEME

A NEW DAWN BECKONS

The present:

The relationship between the Road Accident Fund (RAF), injured road crash victims and the private health care industry has for decades been dissatisfactory, largely as a result of the common-law, fault-based, compensation scheme administered by the RAF, and the consequent impact it has on the payment of claims.

Under the RAF dispensation, a service provider who provides treatment to a road crash victim is faced with a number of risks, foremost of which are: complex claim procedures; the risk of the claim payment being rejected because the patient was solely at fault; the risk of the claim being reduced because of the patient's contributory negligence; the risk of the claim becoming litigated because the patient's negligence is in dispute; and, the lengthy time it takes for the RAF to assess the claim, before payment is made.

Except for instances where the injured road crash victim is a member of a medical scheme, it is rare for the private health care industry to provide services to road crash victims.

A step towards the future:

In order to improve road crash victims' access to timely and appropriate health care services, the Road Accident Fund Act, 1996, is being amended. The amended Act will provide - among other things - for an initial no-fault claim period and for a single, clear, market-related, medical tariff.

In terms of the amendments, claims for medical treatment provided to injured road crash victims, during the period of 30 days immediately following the road crash, will not be rejected or reduced because of fault.

This amendment significantly reduces the risks currently faced by service providers. When coupled with faster claims payments by the RAF, due to expedited claim assessment as a result of the removal of the fault requirement, and taking into account the new clear, market-related, single medical tariff, it is anticipated that the role played by the private health care industry in servicing road crash victims will increase substantially.



A new dawn:

The Road Accident Benefit Scheme (RABS) is the new social security scheme that will replace the RAF, thereby bringing to an end the artificial adversarial relationship created in statute, which has over decades stood in the way of closer collaboration with the health care industry.

Under RABS the fault requirement is removed entirely; medical treatment and rehabilitation of the injured road crash victim is prioritized; and, claim procedures are simplified. Even more significant is RABS' ability to establish a national network of contracted public- and private health care service providers, to provide health care and associated services to road crash victims, in terms of a contracted rate. Meanwhile, services provided by non-contracted health care service providers will be compensated in terms of a prescribed, clear, market-related, single medical tariff and treatment protocols.

RABS is the future of road accident assistance provided to the victims of road crashes and creates exciting new opportunities for collaboration.

EDITOR'S NOTE

FEBRUARY 2016



Diane de Kock
Editor: SAMA INSIDER

The challenge of 2016

As we move into a new year I would like to wish readers all the best for 2016, a year which promises to present many challenges for healthcare in South Africa, some of which are particularly highlighted by our new President, Prof. Denise White on page 4 and our chairman, Dr Mzukisi Grootboom on pages 5 and 6.

SAMA branches around the country have made presentations to new intern doctors to inform them about SAMA and all it offers new doctors in terms of support and facilities at their disposal. This *SAMA Insider* includes a welcome to interns from both Dr Grootboom on page 8 and SAMATU on page 16.

One of the aims of this publication is to promote dialogue between members and become a vehicle where members feel comfortable to air their views. We are therefore happy to publish a letter from Dr Peter Desmarais on page 13, which again addresses professional ethics, a subject which is obviously very close to the hearts of many doctors.

Another theme in this issue is climate change – something, I am sure, we can all relate to while dealing with the extreme temperatures and water shortages in many parts of the country. There are very real health threats involved with climate change, some of which are highlighted in Prof. White's message on page 4, the article on the Paris climate agreement on page 15 and the World Medical Association article on page 18, which deals with how doctors around the world are tackling climate change and fossil fuels. This is a subject which will be highlighted in future issues of *SAMA Insider*.

Ending the year in style was the order of the day when Gauteng North branch celebrated the end of a successful 2015 in Pretoria. Some members were acknowledged for outstanding work in various fields and five members received lifetime achievement certificates. Please keep us posted on what is happening at your branch for future articles in this magazine.

Articles, information or letters should be emailed to the editor: Diane de Kock at dianed@hmpg.co.za. We look forward to hearing from you.

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Prominent challenges in the year ahead



Prof. Denise White, SAMA President

At the start of the New Year I wish you all good health and prosperity in the year ahead. Sentiments we fervently wish for our beloved country in 2016, albeit in the face of challenges that undoubtedly threaten the prosperity and health of our citizenry.

Since I assumed office as President of SAMA major headline-grabbing events have occurred nationally and internationally: events that are currently having, and will continue to have, an impact on the health and livelihoods of many of South Africa's people and those beyond our borders.

Drought has wrought havoc in many provinces, turning vast tracts of the country into barren wasteland. Harrowing scenes displayed on our news screens portray heart-rending visuals of extreme human and animal suffering, scenes that drive home the reality of climate change.

Most of us are only too aware of the devastating effects of water shortage. Countrywide, certain communities have run out of water, while others are being forced to make drastic cutbacks on water usage.

As a profession we can no longer afford to ignore this mounting issue while simply carrying on business as usual.

As a participating member of the World Medical Association (WMA), SAMA has been proactive in highlighting the health risks of climate change in South Africa, and has urged its members, collectively and individually, to commit to the core principles of the 2015 WMA statement to the Paris Conference of Parties (COP21) held in November 2015.

In recognising that climate change poses an urgent and potentially irreversible global threat, the unanimous agreement

on resolutions adopted at the recent COP21 is encouraging, yet precariously balanced should the 'buy-in' required by the international community be compromised.

The effort to reduce carbon emissions so as to maintain change in global temperature below 2°C (preferably to 1.5) is a common concern and an imperative for the survival of the planet.

Although data are limited, the effects of climate change already contribute to the global burden of disease and to premature death. These are projected to increase, with an expected additional 250 000 deaths per annum by 2030 from natural disasters, malaria, malnutrition, diarrhoeal diseases, heat stress and cardio-respiratory disorders.

Developing countries, such as ours, are least likely to cope.

As a profession we need to "green" our offices and facilities to ensure we play our part in reducing carbon emissions. SAMA has recommended the website www.mygreendoctor.org as a free and user-friendly resource for practising "green medicine" and for creating a healthier office and a healthier community. The setting up of dedicated "office green teams" is suggested as an effective way to address and implement greening. The website sets out numerous actions and measures to make changes:

- in the conserving of energy and water
- in the use of renewable energy
- for recycling and solid waste disposal
- in the provision of educational material for patients.

An innovative example of a public sector hospital's commitment to "greening" is the initiative taken by the Lentegour Psychiatric Hospital in Mitchells Plain, Western Cape.

It is a registered Foundation that is using innovative approaches to capture the vision of Lentegour Hospital as a leading, sustainable mental health centre at the heart of its community. Translated, the word Lentegour means: "the aroma of spring" and the Foundation aims to reform the look, the feel and the activities of a psychiatric hospital by bringing alive the metaphor of spring as the "re-birth of hope". This is being done through a hospital greening project involving the reduction of carbon and water footprints, a radical transformation of the hospital's landscape into a place of beauty, and the development of a range of psychosocial rehabilitation and outreach programmes

that aim to re-establish a sense of hope and recovery through a reconnection, not only to the natural world but also to community, to identity and to heritage.

The WMA declaration on climate change is addressed in full at the links below. I would encourage you to spend a few moments to read through the contents: <http://www.cop21paris.org/about/cop21> http://www.wma.net/en/30publications/10policies/c5/http://www.wma.net/en/40news/20archives/2015/2015_41/index.html.

A devastating incident that sent shock waves throughout the financial world, locally and abroad, was the "Black Swan" event of President Jacob Zuma's sacking of the finance minister Nene in December, followed by the political fiasco of having three finance ministers within one week. The situation was eased somewhat with the appointment of the experienced and trusted previous Minister of Finance, Pravin Gordhan. However, the country remains in a state of financial uncertainty after the catastrophic loss of billions of rands from its financial markets. Some analysts have likened the impact on our economy to that of the Lehman Brothers bank shutdown in the USA in 2008.

So what is the likely impact on the health sector in the context of our seriously cash-strapped national treasury? What consequences will there be for the implementation of the long-anticipated NHI? Currently there are far more questions than answers to these perennial issues.

The long overdue White Paper on the NHI was published in December 2015 and is currently open for stakeholder and general public comment. It is essential that SAMA, as the recognised body representing the profession, is fully apprised and actively engaged in discussions on the NHI. Media reports suggest that insurmountable problems exist in the merging of the private and public health sectors. The NHI's intention is noble but how the 'marriage' of two disparate systems will happen is not clear in the paper. Morally there can be no argument against a fair and equitable health system. Having spent most of my working life in public sector facilities and more recently in the private sector, I fear that the chasm between these two sectors is vast and appears to be growing.

In my opinion these are some of the prominent challenges that we face in the year ahead and my hope is that as a profession we have the collective wisdom to meet them.

Message from SAMA chairman, Dr Mzukisi Grootboom



On behalf of SAMA I would like to wish all our members a prosperous and successful 2016. SAMA is and will remain the representative association for all medical doctors in South Africa (SA). We are very grateful for and honoured by the opportunity to represent and serve our nation's doctors.

2015, you will all agree, was very challenging for the profession in all sectors, both private and fulltime employed members.

For our colleagues in the public sector we have seen an increasing deterioration of working conditions including lack of equipment, drug stock-outs and lack of theatre time. While we are aware that SA has a quadruple burden of disease and that there are pockets of excellence within the system, a lot needs to be done to improve the situation in our public hospitals. The situation has been made even more difficult when those who run our public hospitals fail to acknowledge and address the problems. There has been a tendency recently for those in authority to make very demeaning statements in the media about our doctors and even suspending them without due process, knowing full well the challenges that exist and worse still without establishing the facts before making such statements and taking such actions. These issues have not only raised concerns but ethical challenges as well on how we as professionals should

deal with such issues, not only in the public sector but in every area we as a profession serve our patients.

SAMA's position is very clear

- A doctor's professional service should be considered distinct from commercial goods and services not least because a doctor is bound by specific ethical duties, which include the dedication to provide competent medical care.
- Any judgement of a doctor's professional conduct or performance must incorporate evaluation by the doctor's own professional peers, who, by their training and experience, understand the complexity of the medical issues involved.
- Any procedure for considering complaints from patients or the Department of Health (DoH) which fails to be based on good faith evaluation of the doctor's actions or omissions by that doctor's peers is unacceptable. Such procedure or even utterance would undermine the overall quality of medical care provided to all patients.

The private sector has had its own challenges; chief among them has been persistent inadequate remuneration of our members particularly those in GP practices. This has unfortunately been coupled by an increasing administrative burden which is not compensated for in the current payment regime. SAMA is on record to have advised its members not to sell themselves short in the provision of medical services to the general public. The important principle is that doctors, like all citizens in this country, have a right to earn a decent living. SAMA is by law precluded from setting any tariffs but we are of the view that no doctor can be expected to provide a service without taking the following into consideration, at the very least:

- The costs of running the service
- The years of study involved in obtaining the qualification
- His or her level of skill and experience
- The complexity and the risks of the service
- The costs of the indemnity insurance

The NHI White Paper is now out for public comment. We as SAMA will make our views to the DoH known at the appropriate time.

We encourage all our members to view the document on the SAMA website. We have also provided a comment channel for you to make your comments. We will collate all your views and incorporate same in our final document which we shall send to the DoH.

We have no doubt that South Africans deserve a high-quality, accessible and affordable healthcare system. Our support should be conditional on the commitment on the part of the government, at the very least, to address all of the elements of the Ten Point Plan of which the NHI is but one. We would like to emphasise the importance of the human resources for health, particularly our doctors who are a very critical and important resource.

It is quite disappointing to note that the Certificate of Need (CON) is still with us. While we agree that the intervention has to be made to improve access to healthcare in our underserved areas, we are of the view that the CON is one of many instruments that can be used to address the problem. In fact we maintain that under the current circumstances it is not only inappropriate but also unconstitutional.

While we have been encouraged by the announcement of the findings of the Mayosi commission on the state of affairs, we are extremely perturbed by the deafening silence of the new Health Professions Council of SA and, in particular, the Medical and Dental Board on the issue. SAMA has long been calling for an independent and stand-alone Medical and Dental Council. We would hope that you, the members, will give us your full support in realising that dream.

The competition commission market inquiry on healthcare is still underway. SAMA is participant in the process and to that end we have made a submission. We have recently been told that the public hearings have been scheduled for February 2016. Your Board has indicated to the panel that we will also be willing to make an oral submission. While we are in support of the process, as we believe it will once and for all give us an indication of the real cost drivers in the private health sector, we have great concerns that it might just be a smoke screen for a predetermined outcome. We will, however, continue to participate.

The turn of a new year does not necessarily bring an end to pain and the

difficulties we have faced as a profession. It also does not diminish uncertainty and change. It does, however always bring with it a sense of new hope, an opportunity to reflect on the year which was and the will to do things differently, better and sometimes bigger.

We are renewing our commitment to excellence through our strategic focus. I assure you of our commitment and dedication to you as our members and encourage you to get involved and become part of the decision-making process. Continue to make suggestions that will make SAMA a better

representative body. With each idea, each innovation, each initiative, together we are improving our working conditions, creating thriving practices and improving the health outcomes of our patients

We will continue to build unity and serve the profession with dignity.

Social media: Should we, can we, must we?

Marli Smit, Senior Legal Advisor



Many practitioners have been put in the unfortunate position where a patient sends them a message via cellphone, email or even social media such as Facebook, requesting medical advice or assistance.

In moving with the times, the technology which creates a continuous growth and sustainability in the modern world has had a prodigious impact on the way in which medicine is not only viewed by patients, but also practised by medical practitioners.

Social media, the demand for current information and the constant and continuous probe for knowledge and transparency on medical content and information by patients, has placed an unfair encumbrance on medical practitioners.

Should we?

I am continually asked by medical practitioners whether they have a legal obligation to respond

to patients who contact them through means other than visiting the practice and asking for medical advice or assistance.

Section 27A of the Health Professions Act^[1] clearly indicates what the expectation is from medical practitioners in terms of their duty to patients and the medical profession conglomeration.

The duties which every medical practitioner has in this regard place a much higher burden on them to abide by the requirements as set out in the Act.

In situations where medical practitioners are approached through e.g. social media for advice and assistance, the burden on them becomes even more cumbersome, as they are put in a high risk situation with a potentially precarious outcome.

The best way to answer the question on whether a medical practitioner should provide advice and assistance to a patient through either social media, email or via phone, is to be guided by the Act and the ethical guidelines as provided by the HPCSA.^[2]

One should also remember that the risk to the patient is incredibly high, as the limitation on fallacious diagnosis through proper physical examination, which includes obtaining a full and detailed medical history from the patient, is removed and a vast space created where pictures, incorrect explanations of symptoms etc. hinder a medical practitioner from being able to correctly diagnose, treat and/or refer a patient to the relevant specialist.

Main responsibilities of health practitioners

Section 27A. A practitioner shall at all times:

- Act in the best interests of his or her patients

- Respect patient confidentiality, privacy, choices and dignity
- Maintain the highest standards of personal conduct and integrity
- Provide adequate information about the patient's diagnosis, treatment options and alternatives, costs associated with each such alternative and any other pertinent information to enable the patient to exercise a choice in terms of treatment and informed decision-making pertaining to his or her health and that of others
- Keep his or her professional knowledge and skills up to date
- Maintain proper and effective communication with his or her patients and other professionals
- Except in an emergency, obtain informed consent from a patient or, in the event that the patient is unable to provide consent for treatment himself, or herself, from his or her next of kin
- Keep accurate patient records.

Can we?

Despite there not being a specific section in the Act preventing medical practitioners from interacting with their patients on forums such as social media, email, WhatsApp etc., the ethical guidelines of the HPCSA^[3] provide an outline as to what a doctor is ethically bound to do and how to approach ethical dilemmas.^[4]

In light of this guidance, and understanding the sometimes almost insurmountable ethical burden placed on medical practitioners in how they practise medicine, the appropriate conduct would be to not engage a patient who has not been through a physical

¹ Health Professions Act 56 of 1974 (as amended).

² Health Professions Council of South Africa.

³ HPCSA. 2008. Guidelines for Good Practice in the Health Care Professions. Booklet 2.

⁴ HPCSA. 2008. Guidelines for Good Practice in the Health Care Professions. Booklet 3.

examination by the medical practitioner making the diagnosis.

In answering the question, yes we can, but we shouldn't.

Must we?

A medical practitioner must always act in the best interests or well-being of his/her patient. The core ethical values and standards required of healthcare practitioners^[5] give perspicuous indication on what a medical practitioner must do.

Core ethical values and standards required of healthcare practitioners

- Respect for persons
- Best interest or well-being: Non-maleficence
- Best interest or well-being: Beneficence
- Human rights
- Autonomy
- Integrity
- Truthfulness
- Confidentiality
- Compassion
- Tolerance
- Professional competence and self-improvement
- Community

Taking the above into account, no doctor "must" respond to a patient who makes contact

through social media or any forum which does not allow for a doctor to physically examine the patient in order to make the necessary diagnosis.

Guidelines on using social media

The popularity of social media has grown rapidly in recent years. There is widespread use of sites such as Facebook and Twitter among medical students and doctors and there are a growing number of well-established blogs and internet forums that are aimed specifically at medical professionals.^[6]

It is imperative that we remind ourselves that the ethical and legal duty to protect patient confidentiality applies equally on the internet as to other media.^[7]

The predominant factor, besides the risk for fallacious diagnosis, is ultimately that patient confidentiality can't be guaranteed. It is imperative that medical practitioners ensure the privacy and confidentiality of their patients. This is part of the core ethical values of the medical profession.

Conclusion

In reminding ourselves of the duties each medical practitioner has to his/her patient,^[8] it is imperative that medical practitioners understand the risks involved in allowing patients to approach them through social media and/or other similar forums.



Patient confidentiality must always be a pivotal factor when making decisions on whether to engage with patients on social media or through e-mail, WhatsApp, etc.

The risk involved in giving advice or making a diagnosis via email, WhatsApp, Facebook etc., is too high for any medical practitioner to take.

The Best Practice will always remain the approved method whereby a patient visits his/her doctor at their medical practice where all the relevant tests, examinations and referrals can be made after proper face-to-face consultation and diagnosis. This is essential not only for the safety and confidentiality of the patient, but also for the protection of the medical practitioners' practice.

We should engage with our patients to keep them informed of progress in medical technology and innovation which will add value to their lives and health.

We must always act in the best interest of our patients.

We can engage with patients through social media, emails, WhatsApp, etc. but we must not diagnose or give medical advice relating to questions posed about medical issues when doing so.

A visit to the doctor's practice remains the best place to ask a doctor for his/her advice on any medical issue or ailment.



⁵ HPCSA. 2008. *Guidelines for Good Practice in the Health Care Professions. Booklet 1.*

⁶ SAMA. 2015. *Using Social Media: Practical and Ethical Guidance for Doctors and Medical Students.*

⁷ SAMA. 2015. *Using Social Media: Practical and Ethical Guidance for Doctors and Medical Students.*

⁸ Health Professions Act 56 of 1974, Section 27A.

SAMA welcomes 2016's new intern doctors

Dr Mzukizi Grootboom, SAMA Chairman

SAMA would like to welcome all the new interns who have joined the ranks of our noble profession. You all are very privileged to be part of a profession whose goal is to improve the health of our fellow human beings and to prevent illness and death.

Most of you would have taken the Hippocratic Oath or the Declaration of Geneva in your different universities and we hope you will adhere to it and treat human life with the utmost respect. It is also important to note that our noble profession is not only a calling but the ultimate gift by humanity to the profession to allow us to learn from them, not only when they are alive but even from their dead bodies. You will be seeing patients and not clients or cases. Your commitment must and should be to the best interests of your patients. You will be held in high esteem by society but it is important to always maintain your humility and always have time to talk to your patients and their relatives. Your advice and recommendations must be done with them and the decisions taken about any intervention should always be with their consent and full understanding.

The respect of the public for the medical profession is arguably unsurpassed by any other profession and that privilege depends on respect and mutual trust. Always remember to treasure that trust and your professional life will be most rewarding and you will experience immeasurable satisfaction.

You will be held in high esteem by society but it is important to always maintain your humility and always have time to talk to your patients and their relatives

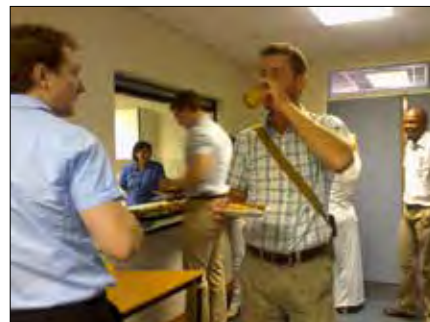
Being a doctor in South Africa (SA) has its own challenges as there are not many of us. Some of you may work long hours and under challenging conditions because of SA's high



Dr Michael van Niekerk presenting to interns at the New Somerset Hospital in Cape Town



June du Toit and Dr N Mofolo at the SAMA Free State branch presentations to interns



Intern doctors take a break during the presentations by the SAMA Free State branch

burden of disease. You will find satisfaction in knowing that your senior colleagues will always be available for advice and to offer a helping hand. You will also find that in facing adversity you will experience the proudest moments of your career. Please remember internship is your first opportunity to learn medicine hands on. There is no substitute for experience in medicine. Therefore, make sure you make full use of the opportunities you get and never stop asking questions and even challenging the dogma that you may find in some of your senior colleagues. You now have an opportunity to decide what kind of doctor you want to be and whether you will want to make a difference to the lives of your patients.

As interns you may find some challenges that you may regard as not compatible with good working conditions and maybe some unfairness. Remember your Medical Association is there to look after your interests. You may find your local representative in the

hospital you work, the closest SAMA branch or a senior colleague who is a SAMA member. If all fails please do not hesitate to contact the SAMA head office at 012 481 2000.

We sincerely hope you will continue to play an active role in the affairs of your profession by taking part in the activities SAMA is involved in. You are joining the profession at a time when SA is undergoing a series of healthcare reforms, the National Health Insurance (NHI) being the most important. The National Department of Health has recently published a White Paper for public comment and SAMA is studying same and will comment on behalf of the profession. A copy of the White Paper is available on the SAMA website. Please do familiarise yourselves with it.

SAMA wishes you the best of luck with your internships, in the hope that you will become the kind of tough, disciplined, compassionate and ethical doctors that our country requires you to be.

Improving communication between state hospitals and SAMA members in Gauteng North

Diane de Kock

In the middle of 2015, SAMA Gauteng North branch began an initiative, led by branch chairperson Dr Angelique Coetzee, to improve communication between the State hospitals in the area and SAMA members. To date, there has been a lack of understanding between doctors and the state hospitals about their requirements, particularly in the referral process when doctors refer patients to hospitals, clinics and outpatient departments.

Judy Mills, secretary at the Gauteng North branch, compiled a questionnaire which was sent to all SAMA members and the CEOs of all the State hospitals in the area, asking for comment on the relationship between SAMA doctors and the hospitals. It was established that there was a lack of communication which needed to be improved to enhance patient health and provide better care to patients.

Yes, all public health regions and SAMA branches should be encouraged to follow this initiative

Dr Andre van der Walt (Director Clinical Services at Steve Biko Academic Hospital) was asked to provide details on how the hospitals function and which hospitals provide which facilities. SAMA doctors were asked to improve their referral letters to the State hospitals and the branch is in the process of compiling a booklet for members which will detail contact details and timetables of all the hospitals in the area so that doctors can refer patients to the right place at the right time. The booklet will also provide details about how each state facility functions and which facilities they offer. SAMA doctors can now refer directly to a specific doctor and facility which speeds up the referral process and provides better care to patients.



Judy Mills, secretary SAMA Gauteng North branch

One outcome of this initiative has been that Dr Ngcobo, of the Human Resource management division at Steve Biko has invited all SAMA doctors to attend the hospital cluster meetings in their area which will potentially improve communication between them. This will hugely benefit patients and cement the relationship between the doctors and the hospitals.

SAMA Insider spoke to Dr van der Walt about the impact this initiative has had on the level of care provided by the doctors and hospitals in the area.

What has this initiative meant for the area and how has it improved the relationship between the doctors and the hospitals?

The meeting between representatives of SAMA Northern Gauteng and Hospital Management of Steve Biko Academic Hospital is a very welcome step in the right direction. As most doctors in the public sector are familiar with the health service environment in the private sector, private practitioners in general are not familiar with the intricacies and challenges of the public health care system. A better understanding in this regard would already go a long way in improving the relationship between the doctors of the two sectors. Proper communication between doctors on an individual basis is also key and is an aspect that both parties need to seriously work on. This is especially important when arranging patient referrals to ensure good continuous



Dr Angelique Coetzee, chairperson of the branch

patient care. The ultimate aim is to streamline the co-operation and working relationship between the doctors of the public and private healthcare sectors

Would you recommend that other provinces look at a similar system?

Yes, all public health regions and SAMA Branches should be encouraged to follow this initiative.

Has this initiative improved the relationship between the hospitals and SAMA doctors? If so, how?

As the mentioned meeting was held only in September 2015, I feel that the questions are somewhat premature to already expect marked changes in attitudes and co-operation between the private and public sector doctors. And even if it has improved, an honest answer to the questions would require a survey among our doctors after a further period of some months (and the same should be done among the local private doctors).

Please comment on doctors attending cluster meetings and how this has enhanced patient care in the area?

SAMA Northern Gauteng has also not yet nominated a representative(s) to attend the SBAH cluster meetings; so we cannot comment on that. We do, however, expect SAMA Northern Gauteng to have their internal arrangements in this regard finalised by the date of the first SBAH cluster meeting of the year scheduled for 25 February.

Medical associations and vitamin D insufficiency

Bernard Mutsago, SAMA Health Policy Researcher and Analyst

Besides macronutrients (carbohydrates, proteins, fat), micronutrients (vitamins and minerals) in sufficient amounts are essential for good health and well-being. Literature shows that, in South Africa (SA), many children and adults are prone to micronutrient deficiencies, including vitamin D. With about 30% of the world estimated to have a lower serum concentration of vitamin D, deficiency and/or insufficiency of this 'sunshine vitamin' is a rising global public health problem and the World Medical Association (WMA) in 2015 issued a *Statement on Vitamin D Insufficiency* affirming that "it is desirable to focus attention on adequate preventive action in populations at risk". Population-wide screening for low vitamin D is not endorsed by the majority of medical associations globally; only screening for vulnerable groups is recommended.

Vitamin D (also known as calciferol) is a fat-soluble vitamin that exists in two forms: vitamin D2 (ergocalciferol, found in plants) and vitamin D3 (cholecalciferol, synthesised in the human body). Vitamin D2 and vitamin D3 are inactive forms that are hydroxylated in the liver and kidney, forming the active forms 25-hydroxyvitamin D and 1,25 hydroxyvitamin D. The latter is the biologically active form which regulates calcium and phosphorus metabolism in the bone and the intestine. Studies show that 25-hydroxyvitamin D is the best bio indicator for vitamin D status. Supplements of both vitamin D2 and D3 are available in local pharmacies such as Clicks and DisChem.

There is a difference between vitamin D deficiency and insufficiency. The WMA defines vitamin D deficiency as a 25 hydroxy-vitamin D serum concentration of <50 nmol/L (20 ng/mL), insufficiency as 50 - 75 nmol/L (20-30 ng/mL), and sufficiency as

75 - 100 nmol/L (30 - 40 ng/mL). There is, however, considerable variation in these specifications among various scientific experts and health authorities, primarily due to two factors:

- Recent research showing the influence of vitamin D not only on bone health but also on a range of chronic conditions
- The unclear relative contributions to vitamin D status of dietary and sunshine sources.

Sources of vitamin D

Very few foods naturally contain vitamin D, such as oily fish (salmon, mackerel, herring), cod liver oil, beef liver, egg yolk, and cheese. Supplements and fortified foods are the other dietary sources (for example, fortified milk, margarine, breakfast cereals and bread in SA). The major source of vitamin D for humans is sunlight ultraviolet B (UVB), [wavelength 290 - 320 nm]. UVB is essential for cutaneous vitamin D synthesis. All other factors held constant, a healthy individual should be able to obtain significant proportion of the vitamin D recommended dietary allowance (RDA) from cutaneous synthesis of vitamin D. During spring, summer and autumn, 10 - 15 minutes of sun exposure between 10h00 and 15h00 are sufficient for adequate vitamin D synthesis in light-skinned individuals. Factors that moderate the amount of cutaneous vitamin D synthesis include: skin pigmentation, season, latitude, time of day, obesity, use of sunscreens, amount of time spent indoors, and clothing. Excessive sunlight exposure does not lead to vitamin D toxicity as the excess vitamin D is destroyed by the sunlight. While essential, UVB has harmful effects, mainly skin cancer, cataracts, and erythema (sunburn). In Australia – known as the skin-cancer capital of the world – sun exposure is responsible for about 99% of non-melanoma skin cancers and 95% of melanomas.

Non-skeletal health benefits of vitamin D

It has long been recognised that vitamin D is responsible for bone health. Its deficiency therefore causes rickets in children and will precipitate and exacerbate osteopenia, osteoporosis, and fractures in adults. However, as confirmed in the aforementioned WMA Statement on vitamin D and other published literature, there are emerging scientific claims

of the sunshine vitamin's widespread non-skeletal benefits; although evidence is variable and further research is recommended. Because vitamin D receptors are broadly distributed in tissues, beneficial associations have been demonstrated between vitamin D deficiency and autoimmune diseases such as diabetes, cardiovascular diseases, infectious diseases such as tuberculosis, as well as neurologic and psychiatric disorders.

At-risk populations

Depending on the balance of a number of moderating factors affecting sunshine exposure, anyone is susceptible to vitamin D deficiency. Contrary to popular belief, vitamin D deficiency can occur in places with plenty of sunshine like SA because of multiple factors. For example, latitude and seasonality make residents in certain places in sub-Saharan Africa, specifically Cape Town, get less vitamin D from sunshine.

Other high-risk individuals for vitamin D deficiency or insufficiency include:

- Breastfed infants exposed to insufficient sunlight
- Adults older than 50 years and especially the elderly
- Institutionalised/indoor individuals
- Dark-skinned people
- Pregnant women
- Premature infants
- Malnourished children
- People living at higher altitudes
- Children on glucocorticoid treatment
- People using medications such as anticonvulsants and ARVs
- As vitamin D is fat-soluble, individuals with fat-malabsorption (e.g. suffering from pancreatic enzyme deficiency, Crohn's disease, cystic fibrosis, celiac disease, or had gastric bypass operations).

In the USA and Europe for example, >40% of the adult population aged 50 years and above is vitamin D-deficient. In SA, insufficiency levels of 19% were reported among 10-year-olds in a recent (2015) publication in the *South African Medical Journal*.

WMA recommendations

In its statement revised and adopted in October 2015, titled *WMA Statement on Vitamin D Insufficiency* – whose revision



SAMA took part in – the WMA makes four recommendations to national medical associations (NMAs), namely:

- Support continued research in vitamin D and its metabolites
- Educate physicians about the evolving science of vitamin D and its impact on health
- Encourage physicians to consider measuring the serum concentrations of 25-hydroxyvitamin D in patients at risk of vitamin D deficiency
- Monitor development of dietary recommendations for vitamin D.

SAMA values all the above recommendations and encourages its doctors to embrace the *preventative* approach highlighted in the WMA statement. The ambiguity and debate about the necessary dosage of vitamin D is recognised and should be clarified by scientific research. Supplementation is perhaps the best vehicle for prevention and extending the reach of a critical micronutrient to many vulnerable groups; and as the WMA Statement asserts, "supplementation is a simple treatment method".

While SAMA, in line with international best practice, does not support universal screening for vitamin D, it supports the recommendation for doctors to test at-risk patients in SA for vitamin D deficiency. Given the current dearth of convincing evidence for non-bone benefits of vitamin D and the need for a larger clinical trial, doctors should show practical commitment to advancing knowledge on the benefits of vitamin D through research.

References available on request

Will doctors ever listen and take action to liberate themselves?

Dr Mahlane Phalane, General Secretary of SA Medical Trade Union

The medical profession the world over is made up of highly intelligent and hard-working people. A doctor's work environment is characterised by diseases, disabilities and deaths. Despite their high level of education, sharp intellect and commendable culture of hard work, it boggles the mind whether doctors will ever listen and take action to liberate themselves.

It has become an accepted situation that most doctors are unhappy, unfulfilled, unsatisfied with their jobs, hard working, and poor or financially struggling and some have lost hope. Doctors ought to lead in their occupation and society, business, academia and all spheres of life. But we remain followers and price-takers. In his book *Think and Grow Rich* Napoleon Hill states that "broadly speaking, there are two types of people in the world, leaders and followers. Decide at the outset whether you intend to become a leader in your chosen calling or remain a follower. The difference in compensation is vast. The follower cannot reasonably expect the compensation to which a leader is entitled, although many followers make the mistake of expecting such pay". As doctors we are terrible at making the mistake of behaving like followers while dreaming of compensation only leaders are entitled to.

This state of confusion of behaving like followers while demanding compensation only leaders are entitled to is complicated by our poverty or inability to lead, and

equally our poverty and unwillingness to follow. We are few in numbers but yet we have many organisations purporting to be the rightful voice for doctors in South Africa (SA). We are eagles that behave like chickens. We are ignorant of the biblical truth that a living dog is better than a dead lion. When we are divided, we will remain like chickens whose future and safety remain in constant danger. However, if we were to be united and behave like eagles we would soar above all the challenges we are facing; a public health sector that is severely strained, and a private sector that is impoverishing doctors, especially general practitioners.

Doctors should wake up from a long and deep slumber of oblivion and apathy to reclaim their rightful position as leaders in health and society. In a quest to find solutions to our problems, we should study and practise Napoleon Hill's philosophy on leadership:

- *Unwavering courage – no follower wishes to be dominated by a leader who lacks self-confidence and courage.* As doctors we lack the courage of conviction to stand up for what we believe in and deserve. Pilots know and understand their roles and responsibilities, no pilot will take off an aeroplane if he or she thinks there is a technical fault of some sort, but how many doctors would gamble with patients' lives using faulty facilities or equipment?
- *Self control – people who cannot control themselves cannot control others.* As doctors



Dr Mahlane Phalane

we fail dismally to control ourselves; drawing a mere call roster starts a World War III, the endless fight as to which specialty of medicine is superior is both pointless and endless. We cannot even lead or follow. We have lost control of the Health Professions Council, why did we accept to be engulfed by this structure? It is diagnostic of a severe lack of self control. For years we remain under the control of people who are not doctors or lack any health qualifications, the same way we gave away a working system of nursing matrons and medical superintendents running healthcare, but subjugated that pivotal role to incompetent comrades who displaced healthcare with tendercare.

- *A keen sense of justice – without a keen sense of justice no leader can command and retain justice.* Distributive justice is one of the principles of medical ethics; we often throw this fundamental principle through the window for myopic and selfish gains or reasons. There is no wonder that we cannot

lead, command nor retain respect among ourselves and within the general society at large.

- *Definiteness of decisions – people who waver on decisions show that they are not sure of themselves.* Which kind of healthcare system do SA doctors want? How much is a doctor in the public and/or private sector worth? Who should be the main and legitimate voice for doctors in SA? How long should it take to train a doctor or specialist in SA? What national clinical guidelines should be followed across the board based on the available clinical evidence? What do SA doctors really want?
- *Definiteness of plans – the successful leader must plan the work, and work the plan.* Please anyone from anywhere help us with definite plans doctors have resolved on, and while at it please tell us of any collective work that doctors are doing for their own liberation. It is sad that as highly educated professionals we have never come up with definite plans about our profession, our own finances, improving the quality of healthcare services and mechanisms to deal with the plethora of problems we are facing. We seem to be ignorant of the fact that failure to plan is a plan to fail. Asked differently, in 20 years time from now, how are we going to improve our financial situation, our appalling working conditions, and the ailing healthcare system and curb threats such as medico-legal litigations?
- The habit of doing more than paid for – this is perhaps the only principle we excel in either by default or design. SA doctors work very hard, and are often not compensated for nor acknowledged for such work. Ours is a thankless job.
- *A pleasing personality – no slovenly, careless person can become a successful leader.* The manner in which some of us treat poor and sick patients is shocking, we treat each other with disdain and disrespect (trying to consult or transfer a patient is a nightmare), we are as repelling and divided as oil and water because of our unpleasing personality to each other. Most stakeholders and society see and experience us as arrogant, impatient, undermining and unpleasant.
- *Sympathy and understanding – successful leadership must be in sympathy with their followers.* There is little or no sympathy among doctors, leaders and followers alike. Leaders are often irritable and intolerant

of alternative view points; followers are quick to start their own organisation at the slightest provocation. The weird phenomenon of planning and celebrating the downfall of doctors is rampant in medicine. It is often a doctor who instigates a medical lawsuit against a colleague. Receiving and referring doctors are always engaged in often pointless and endless egoistic fights.

- *Mastery of detail – successful leadership calls for mastery of details of the leader's position.* Doctors in SA know a lot about their clinical work and very little about the health system they enrich so much. No doctor's organisation knows the exact number and location of doctors practising medicine in SA. No organisation of doctors knows the quantity of drugs consumed how or why medical fees are designed, even clinical information between doctors and health facilities are scarce and scattered as rain in the desert.
- *Willingness to assume full responsibility – successful leaders must be willing to assume responsibility for mistakes and shortcomings of their followers.* Doctors are suffering today because of the lack of this principle; medical litigation is threatening the future and profitability of medicine because no one wants to take responsibility; doctors are abused by medical aids if they have committed mistakes because no one is taking responsibility; a paediatric surgeon was humiliated and found guilty by the HPCSA "because he failed to greet not the patient, but the patient's mother"; this is allowed to happen because no one is willing and capable of taking responsibility. The Occupation Specific Dispensation for doctors remains haphazard, posts for specialists and super-specialists are ignored and undermined, doctors do not get danger allowance while nurses working in the same areas do, anyone else is allowed to make money out of the sweat of doctors while doctors have to do three or four jobs to survive. All this because we fail to take individual and collective responsibility as leaders and followers. Napoleon Hill makes a harsher conclusion on this principle "if followers make mistakes and become incompetent, it is the leader who has failed. If medical students and registrars fail so much, truth be told it is those who are charged with the responsibility to teach them and manage the training programmes who are failing this nation. If clinical standards

and professionalism is going down, it is the senior doctors and managers who have failed. If the "GP" practice is becoming unprofitable and extinct, is the senior general practitioners who have failed to protect and promote this pivotal part of primary healthcare in SA. If medical aid schemes no longer aid but to a greater degree ail the medical profession, it is leadership that has failed. Why should doctors keep quiet when medical aid schemes refuse to cover contraceptives but cover abortion or delivery by teenage mothers?

- *Cooperation – leadership calls for power, and power calls for cooperation.* The time is now that we adapt or die, cooperate or perish as a profession. All doctors and their various associations, societies, concerned groups and any formation of doctors should come together, unite and cooperate or face irrelevance and extinction. Doctors need to speak in one voice derived from different and differing ideas, act in unison and unity of purpose but not in a homogeneous, regional or sector bias manner. We have no choice but to cooperate with all stakeholders within and outside health; this we should do unconditionally without compromising our principles or selling out our souls. Napoleon Hill succinctly sums up this principle by stating that "no individual has sufficient experience, education, natural ability and knowledge to ensure great successes without the cooperation of other people".

As doctors in SA we have no choice but to be united, cooperate, and provide visionary leadership and equally to mobilise an active and vibrant body of followers. We absolutely need the above principles if we want to achieve metamorphosis of the National Health Insurance to meet the national and professional needs. We have to listen to the realities of our times; that we are struggling to afford basic necessities of life such as decent houses, quality education for our children, safe motor vehicles and to accumulate wealth. Above all we desperately need this to improve our job satisfaction and quality of our lives. We live in the illusion of overstressing our bodies and minds to compensate, this indeed scores us temporary gains at a huge personal and family cost; poor quality of life. We should, at the next available opportunity, discuss Napoleon Hill's *10 Major Causes of Failure in Leadership*.

SAMA welcomes new marketing manager

SAMA Communications Department



Dr Simonia Magardie was recently appointed SAMA Marketing and Communications Manager, based in Pretoria. *SAMA Insider* caught up with her to find out a little about the lady behind the title.

Please tell us about yourself, your work history and background?

I was born and raised in Pretoria as one of three children. I had a very happy childhood within the precincts of a stable family. In spite of your normal childhood issues and challenges, I thoroughly enjoyed my schooling years.

I like being organised but I don't follow a routine. Even as a young girl, I never felt entitled to anything, because my parents had inculcated in me and my siblings the value of hard work, as well as to take pride in anything one has to do. I think that this mindset had considerably contributed to me being ambitious, enthusiastic and self motivated in terms of performance and work ethic. I thus have a deep-rooted sense of where I come from, where I currently find myself

and where I am going. I can also state in humility that I possess a sincere love for my fellow being, and nothing gives me greater joy than seeing a friend, or a colleague, or an acquaintance achieving success and progress.

I have always been a very creative individual, with a great passion for the communication sciences. My mentor always used to say that communication is "as wide as God's grace". I am fascinated with the fact that words have such a major impact on every aspect of our lives: how we interact with each other and with our environment, how we learn and acquire knowledge, how we teach and transfer knowledge and skills, how we buy and sell commodities, how we go about in healing and caring for the sick, how we care for the destitute and the vulnerable members of society, how we draft legislation to regulate our orderly co-existence, and even how we dream and envisage. To state it in the primitive of terms: *everything under the sun starts with a word*. It is therefore not surprising that I began my tertiary studies with a National Diploma in Language Practice, after which I went on to obtain a bachelor degree in Education, a masters in Education and a doctorate in Language Practice, the latter which I passed *cum laude*.

I have eighteen years experience in higher education, both in academia and corporate communication. In this regard I held positions at Telkom, Tshwane University of Technology, the

SABC, and the Council on Higher Education. I was also academic director of The Open Window School of Visual Arts in Centurion. I still lecture in the fields of communication, education and gender studies on an ad hoc basis.

The best advice I had ever received was from my father who often said: "If ever you are tempted to compromise – as no doubt you will be – then always place honour, a sense of duty and moral values above all else. If you do that, you would never fail yourself, your family, your colleagues, or your organisation." This is a principle I truly hold dear.

Furthermore, I simply enjoy life and I endeavour to do my best every new day. Conversely, I have learnt not to take life too seriously and to laugh at myself from time to time.

How do you envisage your role as marketing manager?

I am extremely excited about this position. I am indeed privileged to work in a magnificent organisation with a great team, each a specialist in their own right. I think we have already built a great rapport and we look forward to achieving great things.

How do you wind down after a busy day?

I like to take long walks, cook interesting food and retire with a good book. I usually also spend time praying and meditating, it keeps me grounded, humble and appreciative.

GP IMBIZO: The practitioners have spoken

Dr Solly Motuba, HOD SAMA Private Practice Department

SAMA staged the first ever GP IMBIZO on 28 November 2015, at the CSIR in Pretoria. The IMBIZO was in response to the groundswell of complaints regarding the grossly unfair treatment of general practitioners (GPs), by the healthcare funders, medical schemes, administrators and managed care organisations.

According to the 2014 Council for Medical Schemes Annual report (released in 2015), GPs received a paltry 6.6% of the total medical schemes expenditure in 2014. This is in stark contrast to the 37% received by private hospitals, during the corresponding period. This again underlined the hospicentricity of the South African (SA) healthcare delivery machinery and continues to undermine the gatekeeping function of the GP.

For the record:

- Practitioners are of the view that general practice is a dying profession and is in the doldrums.
- GPs are now required to do more (largely admin work) for less remuneration – the law of diminishing returns.
- GPs are often subjected to unilateral network agreements with top down remuneration models that are at best a thumb-suck and dictatorial. Most of these contracts are bent on doing away with balance billing without proffering what constitutes a properly researched and scientific basis of arriving at a fair remuneration model. Their message to the GP is adapt or die.

- GPs that refuse to enter into these totalitarian arrangements are then summarily removed from the network of the index scheme. This cannot be in that they interfere with relationships that most GPs build with patients and their families, often spanning generations. The umbilical cord cannot and should not be cut at the stroke of a pen. Schemes should allow for a situation where patients are allowed to co-pay if they think they are getting value for money or to go to a practitioner that does not balance the bill if they are vehemently opposed to balance billing.
- Managed care organisations are now subjecting GPs to draconian if not unscrupulous rules, regulations, protocols and funding decisions. This is done without having to consult with

GPs and often on a "take it or leave it" basis. Their approach is predicated on the "he who pays the piper calls the tune" doctrine.

- Peer reviews are conducted by funders, in cahoots with a carefully selected group of people. The criteria for the determination of the peer review committees and their basis of adjudication is very questionable with a veil of secrecy surrounding how these committee members are remunerated. The clinical independence and appropriateness of these committees' decisions are a source for concern.
- Peer review committees should have a constitution and terms of reference, indicating the size of the committee, duration of office, frequency of meetings, elections and/or appointment criteria as well as scope and powers. In the spirit of good corporate governance, there should be an electoral system that ensures that people do not become permanent monuments in these structures and that they should have the necessary competency to conduct the tasks at hand.
- Most GPs lament the lack of transparency around peer review and related matters. This needs to be addressed and corrected.
- The general feeling of the attendees was that disease management programmes should be the preserve of practitioners

(GPs and specialists) and not managed care organisations in their present forms. This applied equally to the need to have dispensing practitioners as custodians of the dispensing of chronic medication instead of mail order pharmacies. This will help increase compliance and reduce the number of chronic patients that default while on treatment, with a concomitant reduction in the frequency of hospitalisation.

Given the above concerns, the IMBIZO resolved as follows:

- The GP Imbizo encourages all members to exercise their right to withdraw from all contentious and unacceptable network and/or preferred provider contracts.
- SAMA is instructed to develop and finalise a standardised template for network and/or preferred provider contracts.
- Peer review and other assessment mechanisms must be objective, factually based, fair and must be done by GPs at local SAMA branch councils. SAMA should develop peer review standards.
- Members should exercise their right to opt for a fee-for-service model wherein patients are required to settle their accounts in cash and subsequently claim from their own medical schemes.

- SAMA should lobby to have GP consultations and primary healthcare declared as a prescribed minimum benefit (PMB).
- Short-term strategy:
 - The GP should be entitled to balance the bill, and all reference to a prohibition of balance billing should be removed from all network contracts.
 - GPs should be allowed to dispense chronic medicines.
- Long-term strategy: Lobby for legislative changes to address:
 - Competition law issues
 - Multidisciplinary practices
 - A basic minimum rate payable to GPs.

SAMA Private Practice Department was then mandated to ensure that these resolutions are delivered on before the INDABA, with a progress report being made available as developments unfold. The next steps will involve going to various SAMA branches to articulate the IMBIZO resolutions as well engaging the funders on the issues raised.

The IMBIZO was a roaring success, save for the general apathy displayed by those that did not attend. Apathy remains the biggest threat to the viability of the GP as a profession.

Paris climate agreement a turning point for health

SAMA Communications Department

SAMA is encouraged by the outcomes of the recently ended 21st Conference of the Parties (COP21) to the United Nations Framework Convention on Climate Change (UNFCCC), held in Paris on 30 November to 12 December 2015. The meeting and the resultant international accord was a turning point in the history of global climate negotiations and unquestionably a definitive step for sustainable healthcare. For the first time in history, 195 countries – including South Africa (SA) – agreed on a strong, equitable, transparent, and legally binding international framework to reduce greenhouse gas emissions.

Of critical significance to the health sector, the ambitious agreement expresses commitment to the "right to health" and sets a framework for creating climate resilient health systems, promoting low carbon healthcare, and fostering healthcare leadership for a greener planet and healthier human generations. Health co-benefits of cutting greenhouse gas emissions are recognised in the accord, while strong mitigation and adaptation actions by the health sectors

are framed. The health community has lauded the agreement as "the greatest public health accomplishment of our time". The voice and force of the health sector at the COP21 – vigorously expressed by a joint community of healthcare organisations, health leaders, as well as thousands of doctors, nurses, and other healthcare professionals – did not go unnoticed this time. SAMA warmly appreciates such boldness and activism by these healthcare representatives.

At the same time as SA is enduring a relentless wave of climatic catastrophes such as drought, floods, fires and unseasonal snow, the nation is in some measure demonstrating leadership in climate change responsive actions. Two SA cities, Cape Town and Johannesburg, lifted SA's flag high by receiving international awards for climate action at the COP21. The two cities were Africa's only winners. Johannesburg was honoured for its Green Bond initiative, while City of Cape Town was presented with the C40 Cities Award for "Adaptation Implementation", recognising the City's Water Conservation and Demand Management (WCWDM) programme.

While we celebrate the compelling international blueprint, the greater challenge of transforming the agreement into tangible action lies ahead. Successfully transitioning from carbon-intensive economies and practices will depend on how various governments will interpret and implement the agreement. SAMA is encouraged by the recent launch by the SA Department of Health, of the National Climate Change and Health Adaptation Plan 2014 - 2019, and the presence of a SAMA representative to the National Climate Change and Health Steering Committee. SAMA has its own task team on climate change and health and is willing to mobilise its available medical expertise towards establishing sustainable healthcare and green medicine in SA. Harmonious with its mother body the World Medical Association, SAMA takes climate change seriously and urges its doctors to support action on climate change and to exert necessary pressure on the government, especially since SA is the largest greenhouse gas emitter on the African continent.

SAMATU supports 2016 interns

SAMA Trade Union

Attention all new doctors and interns! The following is an important notice on remuneration and associated issues from the South African Medical Association Trade Union (SAMATU).

SAMATU would like to welcome our interns throughout the country and congratulate all those who will be new appointees. Some of you have completed community service and some have finished their terms as registrars, while others are specialists and medical officers new to the field of public health. You are about to enter one of the most exciting stages of your career, during which you will experience a baptism of fire, as it were, that will teach you what it really means to be a doctor.

The following information has been compiled by SAMA as a service to all newly appointed doctors, including those transferred from one province to another and from one institution to another. Please note that it has been our common experience that doctors don't get paid correctly or at all during their first month of employment.

Therefore SAMATU is advising all members to make sure they have the following documentation on hand in order to counter the excuses that public hospitals' Human Resources managers always have when you confront them.

Critical checklist

- Valid, current registration with HPCSA.
- Completed forms obtained in your HR office, signed and stamped by your bank on your first day.
- Qualification certificates (interns should provide an oath-taking letter if they have not yet graduated).
- A valid ID document (passport and working permit for non-citizens).
- SARS registration documents.
- An updated curriculum vitae.
- Commuted overtime forms, recommended by your clinical manager and approved by the hospital CEO, should be filled in before mid January 2015 before Persal closes.
- A rural allowance must be captured – where applicable early January 2015.

- Keep your job offer and acceptance letters handy and make sure your clinical manager submits your assumption of duty letter to the HRM.
- Ensure that you keep all copies of submitted documents.

Important advice

In order for you to be paid your salary with all the benefits that are due to you, make sure you visit your HRM or salary department during January 2016. If you don't appear in their system you won't be paid your salary. Please contact us on (012) 481 2000/ 90/ 92 so that we can intervene urgently.

It is very important that you ensure that these matters are attended to as soon as possible, or else your internship might end up being plagued by labour issues, as has happened far too often in the last few years. For further information and/or assistance with regard to remuneration and other employment issues, kindly contact the SAMA Trade Union on (012) 481 2090/2092 or labour@samedical.org

MPS and legal reform

Medical Protection Society

MPS believes that legal reform could help address some of the issues contributing to the rising cost of clinical negligence.

MPS data indicate that between 2009 and 2015, there has been an escalation in the likely value of claims being brought against doctors, with claim sizes increasing by over 14% on average, each year, during that period. The average likely increase of claim size for dentists per year during this period was similar at just under 14%.

As part of its 'Challenging the Cost of Clinical Negligence: The Case for Reform' policy paper, MPS proposes:

- The development of an efficient, patient-centred complaints process that addresses patient concerns before they become claims
- Procedural changes to the legal system to make it quicker and more cost effective for patients and healthcare professionals to resolve clinical negligence claims

- A Certificate of Merit to be introduced to discourage unmeritorious claims
- Limiting general and special damages awards to control costs.

Dr Graham Howarth, Head of Medical Services, Africa at MPS said: "There is growing recognition of the need for legal reform in South Africa, and from his comments at a medicolegal summit earlier this year, we know that the Minister for Health is concerned about the cost of clinical negligence. These are undoubtedly challenging times for healthcare professionals and I am keen that MPS plays its part in the debate about reform needed to tackle the escalation of costs associated with clinical negligence.

"There are potentially a number of complex factors contributing to the current claims environment, while some are positive, some are not and need to be addressed. In publishing our proposals today, we recognise

that we are only one voice, and our proposals are not exhaustive. We hope that our paper will be one contribution among many to this important and increasingly relevant debate.

"As the leading provider of professional protection to more than 30 000 health professionals in South Africa, we will also continue to support our members and promote safe practice in medicine and dentistry by helping to avert problems in the first place."

About MPS

- MPS has more than 30 000 members in South Africa, and more than 300 000 worldwide
- A full copy of the policy paper is available to read here: <http://www.medicalprotection.org/southafrica/about-mps/our-policy-work>

The specialist dilemma: When funding guidelines interfere with clinical independence

Dr Solly Motuba, HOD SAMA Private Practice Department; Dr Stephen Grobler, Deputy Chairperson for the Specialist Private Practice Committee



Dr Solly Motuba

The present day specialist is constantly having to navigate his way through a myriad of funding decisions and clinical guidelines when dealing with patient care. This is compounded by what constitutes interference with clinical independence by medical schemes and their medical advisors.

Medical advisors are in the unenviable position of having to play judge, jury and executor as pertains to funding decisions and guidelines. The same medical advisors sometimes have to double up as surgeons, orthopaedic surgeons, urologists, psychiatrists, cardiologists and physicians, all on the same day, depending on what they need to authorise at the time. This is because they are the custodians, gatekeepers and determinants as pertains to what gets funded by the medical schemes they represent. This they do with little or no knowledge or qualifications in the aforementioned disciplines. Their fall-back position is predicated on scheme rules and clinical guidelines that are presumably evidence based.

When one looks inside the DNA of a medical advisor, one is confronted with a profile that clearly does not justify the powers that are sometimes bestowed on them. For the record:

- Most of them are medically qualified and registered with the HPCSA.
- A significant number of them are general practitioners with little or no GP experience.
- Those that have specialised tend to cover disciplines outside their speciality in their execution of their roles as medical advisors.
- Medical advisors are highly competent and go on regular refresher courses,

however, they may have deficiencies when confronted with decisions that pit their clinical acumen against those of specialists that are being denied authorisation.

- Their stance is largely aimed at containing costs and not so much on the best clinical outcomes. A case in point is the decision by many schemes to resist funding laparoscopic procedures and innovative changes such as robotic or endovascular surgical procedures; they are under pressure rather to fund ostensibly cheaper but more radical therapies. The same applies to the choice of prosthesis; these are often reference priced on particular brands, thereby making other brands inaccessible to both the surgeons and patients.
- The further ignominy heaped upon the clinical specialist in practice is a bureaucratic quagmire of administrative blockages and lack of direct access to medical advisors. Too many administrators and schemes with their partisan quirks and rules make it even more difficult when having to deal with the full range of medical insurance houses. The process has become expensive, time-consuming and frustrating to specialists and their clients.

The truth is, all these funding decisions have a ripple effect on clinical outcomes, and ultimately on lawsuits that specialists are often having to contend with. The painful thing is that when specialists get sued, medical advisors and schemes are not in any way affected, despite at times having played a pivotal role in the clinical management of the index patient through delayed authorisations, reference priced prosthesis, and disdaining of newer technology, owing to lack of evidence – all in the name of clinical appropriateness and cost effectiveness. Too much time and energy is spent on the administrative funding issues, preventing unfettered interaction with the clients on medically and legally adequate informed consent and counselling.

Schemes do not understand that the small fee offered for consultations and procedures is frittered away by arduous interaction on the preauthorisation processes and attendant short payments of accounts.

Schemes, managed care organisations and administrators alike have wised up to the fact they have different levels of competencies

as pertains to clinical governance and funding guidelines. They now regard that as intellectual property that gets put under lock and key. The result is that there is no standardisation of clinical protocols and guidelines. This results in practitioners having to deal with different funding decisions from different schemes, often for the same condition. This cannot be in that if decisions are evidence based, the evidence used should hold true on all instances and should not be scheme specific. We do not have access to these guidelines and treatment protocols, unless with a fight or having to pay to view them at a legal representative's office.

Schemes and administrators should interrogate the value of all these bureaucratic processes; it is our contention that the doctor is inevitably correct and that the schemes simply waste time and money.

Our view is that:

- There should be an industry body that will be the custodian of all clinical protocols and guidelines.
- The body should have statutory powers.
- These guidelines should be standardised and should not be scheme specific.
- Standardisation should encompass both the public and private sectors.
- The Medical Advisors Group (MAG) should be an integral part of such a body and should help with the updating and the upkeep of the guidelines and funding decisions or serve as an advisory committee.
- There should be inputs and representation of specialists' societies and GP groupings on such a body.

This will help remove perverse incentives, optimise patient care and contain costs without compromising on quality of care.

Until then, our view is that SAMA should look at establishing a dedicated unit to serve as a research and development repository and custodian of evidence-based, best practice, cost-effective healthcare. We will be able to broker with evidence where there is a stalemate between funders and specialists, and assist practitioners seeking authorisations. Again, this intervention should be proffered without any element of bias, should be evidence based and in the interests of patients.

Letters to the Editor

Our thanks to Dr Peter Desmarais for submitting the letter below 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: The importance of referring a patient

The Editor,

I write in response to Dr Linghan's letter: "Professional ethics – have we lost it?" Phew – I cannot decide where to start – this issue is so close to my heart.

I spent about 12 years in general practice before specialising (now almost 30 years in specialist practice) so I think I am well qualified to voice an opinion.

As a GP, referral to a specialist would be accompanied with a note defining the problem and a request for help with diagnosis and management.

It was rare for a patient to be sent to a specialist merely because the patient "wanted a specialist". And the specialists obliged with a comprehensive report and very often a phone call to discuss the problem.

It was MY patient and the specialist assisted me (much like an advocate assisting an attorney). There was no waste of costly medical resources.

One wonders what has happened – patients very often now come to my practice 'unreferred' (and my front office has strict instructions to ask the patient to come with a referral [a letter and any reports of investigations done] and if this was not possible, then to at least to contact their GP and get his or her 'blessing' to see me).

There is so much resistance to this, and one wonders if the time has not come for the funders to insist that they will only reimburse a specialist's fees if the patient was referred.

There is so much resistance to this, and one wonders if the time has not come for the funders to insist that they will only reimburse a specialist's fees if the patient was referred

I do my very best to send a report to the patient's GP (but very often I do not know who the patient's GP is). Sadly though, there can often be a delay between my seeing the patient and doing the report.

Dr Lingham is correct when he says that often young specialists do not do reports – perhaps it is because they were never in general practice.

And yes, the round-robin circuit of specialists sending patients to other specialists should be curtailed except in an emergency. And the patient should remain the GP's patient. It is a win-win situation. The GP keeps his patient, is informed of management and learns how to handle a medical situation that he is not familiar with. The specialist has more control over his practice, does not get bothered with afterhours phone calls that don't relate to his field, (I have patients who have come 'unreferred', regard me as their primary care doctor, and then contact me with just about any symptom or flu-like illness). I frequently suggest to patients that they should consult with a "proper doctor" before seeing me – after all my ENT rooms do not lend themselves to a comprehensive examination (there is no facility to do urine checking, ECG etc. and heck, I seldom even do a BP check!)

Of course the big savings will be seen in the appropriate use of medical resources not to mention the cost savings.

Yours,
Dr Peter Desmarais

Physicians advised to treat tuberculosis as a disease of poverty



Tuberculosis (TB) should be treated as a disease of poverty and inequality, the World Medical Association (WMA) said in December 2015.

Against the background of the global growth of TB, the WMA is updating its training course for physicians to emphasise the relationship between poverty and TB.

The revised interactive training course will provide basic clinical care information for TB including the latest diagnostics, treatment and information about multidrug-resistant TB. It will also provide information on how to ensure patient adherence and infection control and will include many aspects of TB care and management with a global scope so that it can be used across regions. The launch of the course took place at the 46th Union World Conference on Lung Health in Cape Town last year when thousands of physicians

and other health care providers from around the world met to focus on TB.

Sir Michael Marmot, WMA President, said: 'It has become abundantly clear that TB is the result of a lack of basic health services, poor nutrition and inadequate living conditions. Poverty is fuelling the alarming spread of tuberculosis. The World Health Organisation estimates that one third of the world's population is infected with TB.

"We as physicians have to realise that the conditions in which people are born, grow, live, work and age, the social determinants of health as I call them, increase vulnerability to contracting TB. That is why I am delighted that one of the United Nations' new sustainable development goals is to reduce inequality within and among countries.

"It is vital that physicians keep up to date on how to diagnose and treat tuberculosis.

I hope the WMA's updated refresher course, highlighting the social determinants of health, will help us stem the global growth of TB."

Dr Lee B Reichman, Founding Executive Director and Senior Adviser to the New Jersey Medical School Global Tuberculosis Institute, which developed and revised the course with the WMA added: "We are delighted to be able to make these updated materials widely accessible, so that this all too often ignored and neglected disease is correctly diagnosed, treated, and ultimately ended as a global health threat."

The WMA's TB refresher course, funded as a "USAID TB CARE II project", is developed as a preparation course to its MDR-TB course and both courses together offer a complete training module on TB. Both courses are accessible free of charge at the WMA webpage www.wma.net.

Doctors around the globe tackle climate change and fossil fuels



Paris, 4 December 2015. Public health advocates from five continents shared success stories on energy choices that protect health and mitigate climate change and air pollution.

Taking place in Paris during the COP21 climate talks, the event was entitled "Health professionals in action for Healthy Energy and Climate". It was organised by the Health and Environment Alliance (HEAL) in collaboration with the Conseil National de l'Ordre des Médecins (CNOM), the World Medical Association and the International Federation of Medical Students' Associations, which represent millions of doctors worldwide.

The French medical council, CNOM, recently issued a newsletter on health and climate change to its 280 000 members. Its leaders are concerned about the risks to health from climate change and want to promote the positive effects that reducing emissions – from coal-powered electricity generation, private cars in cities and fossil fuel use in heating and cooking – can have on health from cleaner air. Air quality in France is responsible for 43 000 premature deaths per year. Dr Patrick Bouet, CNOM President says: "Climate change is above all a question of

public health. Doctors are in the front-line in responding to the harm from climate turmoil. We have a privileged position and a moral duty to protect and promote the population's health. An imperative is to appeal to professional medical organizations to call on local politicians to limit emissions in our towns."

The World Medical Association (WMA) has shown consistently strong leadership in promoting the involvement of physicians in climate action since 2009. It supports the recent WHO Call to Action on climate and health, the Paris Platform for Healthy Energy and is an important partner in the "Our Climate, Our Health" campaign.

Dr Xavier Deau, Immediate Past President of the WMA says: "Thanks to the many physicians who are taking up their responsibility as leaders on climate action, health is moving up the agenda. But it is not yet in the central place that must be achieved. Governments should be hearing more from us on the health and humanitarian disaster that is looming and about the policies needed to protect and promote the health of all our patients." The International Federation of Medical Students' Associations

(IFMSA) represents a group of young people who will feel the full impact of climate change. "We are calling for more ambition in the Paris agreement and national actions to address health co-benefits," says Skander Essafi, IFMSA Liaison Officer for Public Health Issues. "The health sector organisations should divest from the fossil fuel industry – just as they did from the tobacco industry in previous years."

Representatives from many powerful international and national medical bodies around the world are taking part in the meeting. Their healthy energy testimonies will be web-streamed and shared via social media. Genon Jensen, Executive Director of HEAL says: "The Health and Environment Alliance calls for the swift decarbonisation of our economies and energy systems to tackle climate change, reduce pollution and boost health. Energy choices are a key driver for better health and for dealing with the challenge of climate change. By sharing the convincing arguments on an equitable transition to cleaner forms of energy – in Paris and with national governments, in their clinics and hospitals when they go home – doctors can bring health closer to the top of the climate agenda."

Gauteng North end the year in style

Simonia Magardie, SAMA Marketing and Communications Manager

On 28 November 2015, the Gauteng North Branch ended the year in true style. The annual SAMA Gauteng North year-end function was held at the Protea Fire and Ice Hotel, Menlyn, Pretoria and took the form of a murder mystery party with the theme Saturday Night Cleaver. Attendees were dressed according to the theme, all ready to solve the murder mystery. It was all from glitz and glam, to guns, knives and other dangerous murder weapons.

About 80 members of the branch attended and one of the surprises of the evening was the arrival of the chairperson of the Board, Dr Mzukizi Grootboom and his wife, Busi. Behind the scenes, Dr Grootboom said that it is always

a pleasure to meet members and to socialise with them.

The chairperson of the branch Dr Angelique Coetzee, welcomed guests. She said that the branch had a very successful year and that she looks forward to taking the branch to new heights.

The event was also combined with the tradition of awarding members for outstanding work done in various fields. Awards went to:

- Dr Flavia Senkubuge – Extraordinary contribution towards Public Health
- Dr Philda de Jager – Extraordinary contribution towards Sports Medicine
- Dr Lorraine du Toit-Prinsloo – Extraordinary contribution towards Forensic Pathology

- Dr Sam Phalafala – Community Leadership

The following members received lifetime achievement certificates:

- Dr Loubie Loubser
- Dr Rous
- Dr Ismail (in absentia)
- Dr Mavrodaris (in absentia)
- Dr Roodt (in absentia).

Dr Coetzee said that it is an honour to head up a branch with dedicated and hardworking people, who are always willing to go the extra mile.

The rest of the evening was packed with good food, good company and ... well, a murder to solve.



Table decor



Dr Kena Kgarume and Mr Thabiso Morobadi



Dr Philda de Jager and Mr Albert du Toit



Dr Loubie Loubser, Mrs Jenetta Loubser and Dr Carlisle Conje



Dr Philda de Jager and Dr Peter Rous



Dr Angelique Coetzee and Prof. Risgenga Chauke



Prof. Risgenga Chauke presents Dr Flavia Senkubuge with her award



Prof. Risgenga Chauke presents Prof. Lorraine du Toit-Prinsloo with her award



Renier Lategan is acknowledged for his contribution



Dr Peter Kgatuke and Dr Lindi Shange



Dr Susan Mabotja



Prof. Lorraine du Toit-Prinsloo



Mr Jacques Barnard, Ms Patricia Lourens, Mr Johann Lourens (Jr.), Dr Angelique Coetzee, Mr Johann Lourens (Sr.) and Mr Retief Lourens



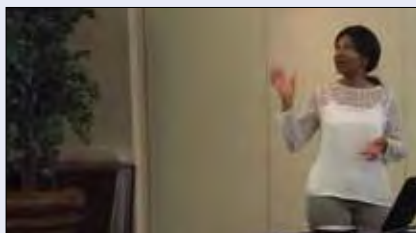
Dr Angelique Coetzee, Dr Chandre Balie and Prof. Risgenga Chauke

Eastern Highveld hold successful CPD meeting

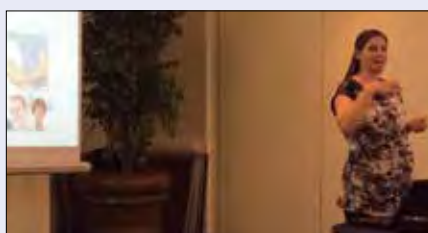
SAMA Eastern Highveld branch held a very successful CPD meeting on 11 November 2015 at the Holiday

Inn Johannesburg International Airport Conference Centre in Boksburg. Various people spoke: from the South African

National Blood Services, a biokineticist, as well as the Private Practice and Trade Union representatives from SAMA.



Dr Pheello Lethola from the South African National Blood Services giving a very informative lecture on 'Appropriate use of blood and blood products' which was well received



Shera Salmon, a biokineticist talking on chronic pain management – a multi disciplinary approach and the role of the biokineticist



Dr Courage Khoza giving his talk on the role of the Trade Union within SAMA



Dr S Motuba, Head of the Private Practice unit at SAMA, delivering his talk entitled '2015 CMS Report, a wake up call or cry in the dark'



The audience paying close attention to the speakers



Welcoming delegates



Dr Bouwer, chairman of the branch paying attention to the lecture

Register now for one of our exciting CEU programmes!

EMERGENCY MEDICINE

SHORT COURSE IN EMERGENCY MEDICINE

Dealing with patients who present in an emergency department or as urgent appointments at a doctor's consulting rooms can provide complex diagnostic challenges. The symptoms may be atypical and yet potentially life threatening. Normal routines are disrupted and the clinician has to cope with many interruptions and distractions. Unfortunately in such settings significant mistakes can be made. This course has been specially developed by experienced emergency medicine experts to equip doctors and nurses to understand the main reasons for diagnostic errors, the types of patients and the kinds of problems that are the main reasons for missing a potentially life threatening diagnosis.

COURSE CONTENT

This course covers the following modules:

- The Emergency Department as an error prone environment (Including equipment);
- Medical mistakes;
- Clinical reasoning;
- High risk presentations;
- High risk patients and
- Safety in triage, disposition and discharge.

ACCREDITATION

Accredited according to the HPCSA CPD Guidelines for Health Professionals -November 2006, for 16 CEUs on level 2.

COURSE FEE, DATES AND VENUE

R 1500 (Inclusive of all VAT and taxes where applicable) This amount includes everything except travel and accommodation.

DATE	VENUE
27 February 2016	KwaZulu Natal
16 April 2016	Northern Cape
14 May 2016	Western Cape
25 June 2016	Gauteng
16 July 2016	Eastern Cape

REGISTRATION

Daniel du Bruyn
Tel: 012 816 9000
Fax: 086 558 9535
Email: danield@foundation.co.za

DIAGNOSTIC ULTRASOUND

SHORT COURSE IN DIAGNOSTIC ULTRASOUND

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

COURSE CONTENT

After completing this course participants will be able to:

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

ACCREDITATION

Accredited according to the HPCSA CPD Guidelines for Health Professionals -November 2006, for 30 CEUs on level 2.

COURSE FEE, DATES AND VENUE

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

DATE	VENUE
20 - 21 February 2016	Gauteng
21 - 22 May 2016	Eastern Cape
23 - 24 July 2016	Limpopo
27 - 28 August 2016	Western Cape

REGISTRATION

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SHORT COURSE IN ICD 10 CODING (DISTANCE)

The implementation of the ICD-10 diagnostic coding in the healthcare environment took effect on 1 January 2005. The National Department of Health and the Council for Medical Schemes support this implementation of ICD-10 in the public and private health sector. The specific regulation pertaining to ICD-10 reads as follows: "(f) The relevant diagnostic and such other item code numbers that relates to such relevant health service". Although the regulations do not specify the ICD-10 diagnostic system, this structure is regarded as the diagnostic standard of choice for South Africa. ICD-10 is a series of international

classifications of diseases, originally introduced by the World Health Organisation in 1948. ICD-10 has become the international standard for the generation of health statistics, allowing relative comparison across countries. ICD-10 operates in conjunction with other procedural and billing coding systems and replaces the "traditional" diagnosis with a code.

COURSE CONTENT

This course will cover the following modules:

- Background to ICD-10 coding;
- Benefits of clinical coding;
- Basic structure and principles of ICD-10 coding;
- Rules and conventions of ICD-10 coding;
- Accuracy in coding and practical applications.

DISTANCE COURSE

COURSE FEE

R 880. This includes all study material and assessment. (Inclusive of all VAT and taxes where applicable)

REGISTRATION

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