

SAMA INSIDER

SEPTEMBER 2016

**National Institute for
Clinical Excellence to
be established in SA**

**Celebrating women
leaders in SAMA**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
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EDITOR'S NOTE

SEPTEMBER 2016



Diane de Kock
Editor: *SAMA INSIDER*

Leadership – a vital role

August was women's month in South Africa – an opportunity to acknowledge the role women play in our communities and organisations. In this issue of *SAMA Insider* we celebrate the women who lead with skill and balance.

On page 9 we focus on the women in SAMA who hold leadership positions, as chairpersons of committees and branches. We asked them to reflect on the challenge of working within SAMA as women, their interests and passions, and what advice they have for other women.

SAMA president, Prof. Denise White, writes about the GP in private practice who is "not only under-acknowledged but a seriously endangered species" and emphasises how important it is for doctors to take a leadership role.

Dr Shadrack Mazaza, who teaches Personal Transformation and Leadership at the University of Cape Town, has written an article on page 6 about the importance of understanding power and leadership: "Power and leadership go together and you cannot exercise one without the other".

One woman who is making waves both internationally and at home is branch national council member Dr Nirvadh Singh. Read about her new book *You: The Journey Begins* and how to unlock potential to make your dreams a reality on page 12. In healthcare the power of the mind is paramount.

Another theme of this issue is community involvement, both at head office and the branches. See pages 16 and 19 to read about staff volunteering on Mandela Day, donating to the President Kruger Children's Home in Pretoria and supporting foster children in Goldfields.

The importance of good leadership and role models in our communities and organisations is vital.

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Doctors – followers or leaders?

"Leaders think and talk about the solutions. Followers think and talk about the problems" Brian Tracy



Prof. Denise White, SAMA President

A joint Indaba of SAMA's General Private Practice Committee (GPPC) and Specialist Private Practitioners' Committee (SPPC) was held in Pretoria in July.

The highly successful event was well attended, particularly by GPs. The programme was broad-based with speakers giving substance to issues relevant and of interest to doctors in the private sector.

The essence of the issue is that practitioners in the private sector have lost authority and leadership within their profession on multiple fronts

With characteristic messianic fervour, health minister Motsoaledi spoke about the status of government's bold but as yet unfulfilled ambition to establish a universal, equitable

and accessible health system for all South Africans – the so-called NHI – a health scheme that is fully supported by SAMA.

In his introductory speech to the conference delegates, Dr Jacob Mphatswe, chairman of the GPPC, sounded a note of serious concern in highlighting the threats to the viability of GPs in the country. The essence of the issue is that practitioners in the private sector have lost authority and leadership within their profession on multiple fronts.

Powerful stakeholders and controllers of the purse strings of private healthcare are draining the lifeblood from the profession. In a fiercely competitive market medical aid schemes prioritise specialists and hospitals in their budget allocations while GPs are financially squeezed. A meagre 24% of the current year's medical schemes' budget was allocated to GP funding, which in real terms is a 6% decrease.

Furthermore, GPs are faced with multiple competitors in the private healthcare industry: nurse practitioners, pharmacists, traditional healers and a plethora of self-styled alternative healers.

GPs are incensed that pharmacists can now obtain a postgraduate qualification allowing them to diagnose and treat private patients at primary healthcare level.

GPs are also at reputational and financial risk from punitive and exploitative processes employed by medical schemes' forensic investigators, who target GPs as the chief culprits in cases of suspected medical aid fraud.

While media attention is often focused on the plight of the public sector doctor, it is apparent that the GP in private practice is not only under-acknowledged but a seriously endangered species. This does not bode well for the implementation of a universal healthcare system in our communities.

Minister Motsoaledi has affirmed the GP as the "heartbeat" of the primary healthcare system. But, as Mphatswe indicated, while GPs support and welcome the pivotal role of the GP in the proposed primary

healthcare model of the NHI, there are challenges.

GPs are running out of time and cannot hold out indefinitely against long delays in implementation.

The health system is poised on the edge of what undoubtedly will be a painful abyss of change for many of its hitherto pivotal role-players and stakeholders

Furthermore, the NHI proposes "a nurse-run and doctor-led model" at primary healthcare level. GPs believe there is an imbalance in the proposed staffing model and that GPs should be both – the leaders and the providers of clinical services.

In addressing delegates' concerns, Motsoaledi opened a door of opportunity for doctors to exercise leadership by encouraging the profession to present innovative ideas and solutions to the NHI fabric of services, via SAMA and/or independent practice associations (IPAs).

He also proposed that a 1-day workshop be held for SAMA and the Department of Health to thrash out difficulties and plan the way forward.

The health system is poised on the edge of what undoubtedly will be a painful abyss of change for many of its hitherto pivotal role-players and stakeholders.

In the maze of complex challenges that lie ahead, balanced and assertive leadership from the profession is critical for the NHI principles to succeed and become the hoped-for lifeline for our GP constituency.

An official response on the NHI White Paper

SAMA Communications Department

This is the second of a series of articles on SAMA's submission to the minister of health in respect of the White Paper for NHI.

SAMA, in compiling an official response on the NHI White Paper, consulted members in their various categories. In addition to a member survey that was undertaken in December 2015, the various structures of SAMA were consulted on a continual basis. The following is a brief summary of the second and third chapters of the submission:

Chapter 2: Quality of care

Chapter 2 provides an examination of the quality of care gaps and opportunities in the SA healthcare system and scrutinises quality-related proposals (and omissions) in the White Paper. The poor quality of care, particularly in the public sector, is highlighted with facts, making a case for urgent redress by Government.

The less-publicised quality deficiencies in the private health sector are also unveiled. The chapter notes the enormous damage, and loss (i.e. poor population health outcomes, high mortality, etc.), to citizens brought about by poor quality of care practices across all system layers, sectors and facets (e.g. poor quality in services, training, staff, clinical processes of care, data collection and dissemination, primary to quaternary levels of care, etc.). Michael Porter's concept of "value-based care" is emphasised.

Using the basis of the Donabedian framework that evaluates quality at three levels, namely Structure, Processes, and Outcomes, the chapter identifies the heavy lean of government initiatives (including the mandate of the Office of Health Standards and Compliance - OHSC) on **structural** improvements/performance of facilities to the (almost) exclusion of processes of care and outcomes measurement. The independence of the OHSC is also in question.

The key recommendations made in the chapter are: desperate attempts to boost personnel numbers (e.g. mid-level workers) should not compromise quality; there must be standardised quality metrics in both sectors, with comprehensive and monitored reporting; and the OHSC must

be **truly** independent and must monitor **all** three Donabedian dimensions. **Process** indicators of care in particular are easier/faster (mortality data, for example) to measure, and must be prioritised for priority health conditions; there must be enforcement of quality measurement in both health sectors. Quality of Cuban-trained graduates must be scrutinised. Government must influence shift of competition in the market towards competing on **outcomes** rather than on patient volumes and facility outlook; critical functions must not be decentralised to grassroots levels.

Chapter 3: Human resources for health

SAMA is a doctor representative organisation and, as such, issues of "human resources" are of broad interest to the body. SAMA acknowledges and appreciates the efforts of the health minister to consult the medical profession on the NHI.

"Health workforce", as one of the WHO-identified key building blocks of any health system, is indispensable in NHI. Chapter 3 articulates the collective voice of the various SAMA doctor categories (junior doctors, public sector doctors, general practitioners, specialists, etc.) on key issues in the White Paper, with a bearing on the medical profession and health workers in general.

Chapter 3 uses data and statistics to highlight the serious human resource gap in the country, attributing the problem to, inter alia, **misdistribution** between public and private health sectors. The continual "bleeding" of professionals is lamented.

Five migration patterns of SA doctors are noted, namely: (i) public to private; (ii) rural to urban; (iii) SA to overseas; (iv) from the medical profession to other professions; and (v) from overseas back to SA. Caution is expressed about government's "additive" approaches to enhance the number of health professionals (e.g. Cuban training programme, more undergraduate training in Bachelor of Medicine and Surgery intake), without addressing absorptive capacity of the system and effective retention interventions. This

will perpetuate "brain drain" while quality of medical output service delivery becomes compromised.

Rural retention is specially emphasised. Evidence of the enormous retention potential of non-financial incentives as a complement to financial incentives is used to urge government to implement such incentives as: good working conditions, rural infrastructure development, rural CPD activities, and rural rotation of specialists, among others. The outcome of government's GP **contracting-in** experiment (only about 300 doctors contracted) is symptomatic of a major problem, and government needs to properly engage health professionals and commit to ironing out any sticking points.

We specifically note that **contracting out** is the preferred model for the majority of independent doctors, yet the model has not been piloted. Also, irrespective of NHI, the current inadequate remuneration (basic salary and overtime) for doctors is a major sticking point and an automatic push factor, which will affect available human resources for NHI.

The chapter's key recommendations are that:

- retention be strengthened, especially in rural areas
- NHI must be doctor led
- multisectorial collaboration is needed to create retentive conditions ("pull factors") for health professionals
- it is cheaper, and appropriate, to import trainers and train locally rather than training doctors in Cuba
- government must stop freezing posts in the public sector
- medical school intake should reflect national demographics
- voluntary accreditation of private practitioners should be considered
- the scope of practice for clinical associates must be finalised.

The full submission is available on the SAMA website:

<https://www.samedical.org/links/nhi-exec-summary>

<https://www.samedical.org/links/nhi-white-paper>

Understanding power and leadership

Dr Shadrick Mazaza, Chairperson of the Specialist Private Practice Committee, member of the Exco and Board of SAMA

Let me begin this discussion with an engagement I had with a management practice and leadership class at a business school. I said to them, "Leadership is difficult and that is why most people are afraid to take up leadership positions." Upon hearing this, several students burst out laughing, to my surprise, and when I asked them what was funny, they said that there is no one who doesn't want to be a leader, and that all of them wanted to be leaders. These students were confusing wanting to take on the task of leadership and wanting the trappings of leadership. They of course wanted the prestige and rewards of leadership – the fruits of leadership – but not the act of planting the tree of leadership. Who wouldn't want to live the lifestyle of Jacob Zuma? Do they have what it takes to lead a volatile, uncertain, complex and ambiguous post-apartheid South Africa?

Most people would claim to know what leadership is all about, and may even claim to be good leaders themselves, but do they? And are they? There are as many definitions of leadership as there are stars in the sky, but all of them point to one thing: making decisions and implementing those decisions on behalf of many. For a country, it means doing this on behalf of all the people in the country, and for an organisation like SAMA, on behalf of all its members. Herein lies one of the major challenges of leadership. All leaders bring to the situation their own unique individual perspective (I call it their own unique "world") and they also come from a particular group, tribe, race, culture, political party, branch and organisation. Effective leadership demands that they should transcend but include all of these – a daunting task, requiring an ability to manage paradox, and the reason why leadership has been described as a transcendent activity.

Embracing and being comfortable with paradox is crucial, not only in leadership, but in all human endeavour. This is because the universe itself is one huge paradox where everything always has its polar opposite. It is one massive factory of "coins" – you will never get a one-sided coin. The world's big minds, such as Freud, Jung and Hegel, and ancient Chinese and Egyptian hermetic philosophies have all alluded to this. This dynamic play

of polar complementary opposites is what maintains balance and order throughout the universe. This is why, in human experience, it is impossible to get only positives without any negatives: bullies at work get bullied at home by their spouses; a child who gets every support at home gets bullied by friends at school. We will always experience support and challenge, pleasure and pain, positive and negative emotions, peace and war, and sympathetic and parasympathetic effects. What does all this mean in leadership? We will always encounter polar opposites of opinions, perspectives, priorities and desires.

Power and leadership go together and you cannot exercise one without the other

F Scott Fitzgerald wrote about the need for a mindset that holds two opposing thoughts at the same time. The law of eristic escalation dictates that we will always be faced with polar and complementary opposites in every situation. For every individual who values something, another devalues the very same thing. As John Demartini puts it, there are pro-lifers and pro-aborters, conservatives and liberals, industrialists and conservationists, and many other possible sets of complementary opposites. Therefore, if you are leading a tripartite alliance political party, you are faced with a multitude of these polar opposites and whatever decision you make on their behalf, you are bound to be supported and opposed in equal measure. The same challenge applies to non-profit membership organisations representing a multitude of societies, branches, races, tribes, personalities and economic interests. Leadership of such organisations has to deal with the challenge of suspending the voices of their little groups while deliberating on issues affecting the whole. Leaders need to manage paradoxes and that requires a degree of transcendence and acting "for the greater good".

Exploration of leadership has been described as a metaphysical journey that is required to meet the challenges of today's complex organisations. Working through the four Ps (personalities, private agendas, politics and power play) requires it. The desirable attributes of leadership, such as authenticity, congruence, courage, integrity and wisdom, demand a transcendent mindset for clarity of purpose and stakeholder management to run an efficient and effective organisation or a country.

For organisations and society at large, ensuring that you put in position the required leadership is the main challenge. Most people who occupy leadership positions are not leaders. They are there to represent a demographic, special-interest group and for political historical reasons. Now, here's the rub: the leadership you put in place has to be given the space to listen to all pairs of opposing views and opinions, and then do the one thing followers tend to dislike, that is, make decisions on behalf of followers, decisions that may not be palatable to some sections of the organisations or society. This is one right of leaders that flies in the face of the so-called democratic participatory leadership. Faced with this paradox themselves, followers may attempt to micromanage their leaders with threats of withdrawing their allegiance to the organisation if their private agendas are not met. There is a temptation to disempower your leaders in this way, but power and leadership go together and you cannot exercise one without the other. John Kenneth Galbraith put it this way:

"The exercise of power, the submission of some to the will of others, is inevitable in modern society; nothing whatever is accomplished without it ... Power can be socially maligned; it is also socially essential. The essential role of power in social organization is linked to inevitable conflicts of interest. Because of our ability to affirm preferences and make choices accordingly, conflicts of interest will appear in any human community, and power is the means by which these are resolved."

Therefore, besides managing paradoxes with a transcendent mindset, leaders must have and manage power. It requires wisdom to appropriately exercise coercive, compensatory and conditioned power available to them.

National Institute for Clinical Excellence to be established in SA

Dr Stephen Grobler, *Vice-Chairman, SAMA Specialist Private Practice Committee (SPPC)*

Since 1999, the UK's National Institute for Health and Care Excellence (NICE) has provided the National Health Service (NHS) and those who rely on it for care with national guidance and an increasing range of advice on effective, good-value healthcare. NICE's role is to improve outcomes for people using the NHS and other public health and social-care services.

NICE guidance takes several forms:

- **producing** evidence-based guidance and advice for health, public health and social-care practitioners, including evidence-based recommendations on a wide range of topics, **technology appraisal** of clinical procedures and cost-effectiveness of health technologies, and **interventional procedures guidance**
- **developing** quality standards and performance metrics for those providing and commissioning health, public health and social-care services
- **providing** a range of informational services for commissioners, practitioners and managers across the spectrum of health and social care, e.g. NICE Evidence online search engine, access to information content purchased for the NHS, a range of bibliographic databases such as MEDLINE and professional journals, British National Formulary publications (including recently through the use of smartphone apps), medicines prescribing support (e.g. new pharmaceutical products, use of products outside the scope of their licensed indications, practice guidelines to support best practice in medicines management, practical advice on developing and maintaining local medicines formularies)
- Fellows and scholars programmes to foster a network of health- and social-care professionals committed to improving the quality of patient care within their local health and professional communities, as well as supporting the core values that underpin NICE's work
- NICE International to help to raise standards of healthcare around the world by providing advice, support, shared learning and international meetings to

encourage the use of clinically and cost-effective treatments.

Efficiency, equity and NICE clinical guidelines

The stated purpose of clinical guidelines from NICE is to "help healthcare professionals and patients make the right decisions about healthcare in specific clinical circumstances." However, what constitutes "the right decisions" depends on your point of view. For individual patients the right decision is that which maximises their wellbeing and this is properly the concern of the clinician. Yet in resource-constrained healthcare systems this will not always coincide with the right decisions for patients in general or society as a whole. Cost-effectiveness analysis allows decision-makers to improve efficiency by spending the limited healthcare budget on activities that generate the greatest health benefits for the monies spent.

In a resource-limited setting such as SA . . . ensuring the best use of effective and cost-effective diagnostics and treatments is crucial to reducing waste, improving access and hence improving quality of care

Clinical guideline development by NICE is via teams from several national collaborating centres that are largely

based at the Royal Colleges. These groups produce evidence reviews for production of guidelines. Guideline development groups consist substantially of senior clinicians with special interest in the disease area. For cost-effectiveness to underpin NICE guidelines in these circumstances is particularly challenging. Robust health economic evidence is often sparse in established clinical areas and, where it does exist, is of variable quality. Clinical experts may suffer conflicted feelings of responsibility to patients and fellow professionals within this disease area versus the efficient and equitable use of scarce NHS resources.

A solution to these struggles is to delineate clearly the individual viewpoints of patients and society and allocate expertise to tasks that are appropriate in the light of this distinction. In this scenario, collaborating centres would be commissioned to produce wholly clinical guidelines, at arm's length from subsequent cost-effectiveness assessment undertaken by specialist academic units. Cost-based judgements should be made by a broad range of clinical and public health specialties, health economists, statisticians and representatives of government and funding organisations. Such an approach would promote consistency between the appraisal and guidelines functions of NICE.

IDEAL framework for new procedures

Evaluation of new surgical procedures is a complex process challenged by evolution of technique, operator learning curves, the possibility of variable procedural quality and strong treatment preferences among patients and clinicians. The IDEAL (Idea, Development, Exploration, Assessment and Long-term follow-up) framework and recommendations have been proposed to provide an integrated step-by-step practical guide for evaluating new surgical interventions, e.g. in earlier phases before a randomised trial, along with the ethical and scientific rationale for specific

recommendations supporting surgical innovation.

South African Guidelines Excellence (SAGE)

SA remains one of the most unequal societies in the world. Addressing the various challenges we face requires multidisciplinary, multipronged approaches, including consideration of strategies for improving the delivery of healthcare. SA's call for primary healthcare re-engineering suggests an acute awareness of local challenges. The planned restructuring, including the NHI initiative, is a means for reducing inequality in the provision of healthcare, which will require new approaches to healthcare delivery, with greater emphasis on health promotion and preventive activities. These changes necessitate a collaborative approach for achieving improvements in key health processes and outcomes, as well as changes in clinician and patient behaviours, all underpinned by innovative interventions.

In the changing healthcare system, healthcare providers need clear, trustworthy guidance on how best to care for their patients so that all can reasonably reach the ideals of quality in healthcare. High-quality, evidence-informed **clinical practice guidelines (CPGs)** are tools for healthcare providers to bridge the gap between policy, best practice, local contexts and patient choice.

SA remains one of the most unequal societies in the world

Internationally, over the past decade there has been a growing volume of research evidence around CPGs, including the processes of guideline development, adaptation, contextualisation, implementation and evaluation. SA has been a contributor to CPG development and implementation for several decades. Guideline development occurs at national, provincial and hospital levels. In addition, professional societies have played an important role, developing guidance based on their areas of expertise. Despite these innovative SA research activities into CPG development and

implementation, there is still limited knowledge of the overall context and processes of guideline development, adherence by clinicians to clinical guidelines and factors that could improve accessibility and use of guidelines in the local healthcare context.

In a resource-limited setting such as SA, where access to resources for health is limited, ensuring the best use of effective and cost-effective diagnostics and treatments is crucial to reducing waste, improving access and hence improving quality of care. CPGs should be seen to transparently and systematically consider best research evidence to produce believable recommendations, which can then be credible vehicles for knowledge translation.

The doctors' dilemma – when funding guidelines interfere with clinical independence

Private practitioners have to navigate a myriad of funding decisions and an assortment of clinical guidelines when dealing with patient care. This is compounded by 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 may have to double up as a range of surgeons, psychiatrists, cardiologists and physicians, all on the same day, as gatekeepers of 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.

Their stance is largely aimed towards containing costs and not so much on the best clinical outcomes. A case in point is the decision by many schemes to resist funding psychotropic or proton pump inhibitor acid-reducing drugs, or laparoscopic and endovascular procedures.

The further ignominy heaped upon the GP and 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 to deal with the full range of medical insurance houses. The process has become expensive, time-consuming and frustrating to specialists and their clients.

Schemes, managed-care organisations and administrators seldom collaborate with representative specialist groups on funding guidelines. We do not have free access to these guidelines and treatment protocols. 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.

A NICE for SA

In the past SAMA hosted the Centre for Quality of Care (CQC). Many clinical guidelines were developed under the auspices of SAMA and special interest groups.

SAMA and others have mooted the re-establishment of a dedicated unit to serve as a research and development repository of evidence-based, best practice, cost-effective healthcare guidelines:

- An independent statutory governance body should define quality of care, develop outcome measurements and benchmarks, and act as custodian of all clinical protocols and guidelines.
- Guidelines should be standardised, not be medical scheme specific and encompass both the public and private sectors.
- The development of these benchmarks is considered particularly important at a time when capitation and global fees are becoming more commonly used. In models such as these, a financial incentive is created for providers to under-serve patients. A system that will ensure the quality of healthcare is therefore necessary to ensure the long-term sustainability of these arrangements.
- Strategies should be identified that improve access, encourage appropriate use and reduce unnecessary or irresponsible consumption of healthcare resources.
- A platform should be provided for independent, quality research towards developing cross-industry solutions to the complex challenges of quality healthcare delivery in SA.

In most instances, international guidelines should suffice and be reviewed for latest information and adaptations for local SA circumstances. SA has a plethora of country-specific communicable and non-communicable diseases that require local research and SA guidelines. Management of strategic issues such as co-ordination of care, chronic disease management, antibiotic governance and treatment outcomes should be targeted.

Celebrating women leaders in SAMA

SAMA Communications Department

It is evident that South Africa (SA) has eventually begun to shift the imbalances of the past pertaining to men and women acquiring senior positions in various organisations. Although this shift is happening slowly, we've seen women nationwide acquiring more leadership roles. SAMA prides itself in employing women at all levels and this month we have chosen to acknowledge women in leadership positions. They have achieved tremendous professional success, nurture the nation's wellbeing and embody various traits of great and extraordinary leadership.

Prof. Ames Dhai



Human Rights, Law and Ethics Committee chairperson; SAMA board member

Prof. Ames Dhai serves on several policymaking bodies in the country, as well as being a past president of SAMA. A consultant/expert advisor for the WHO, she is on the WHO's African Advisory Committee for Health Research, and serves on the WMedical A's Working Group on Health Databases and Biobanks. An ethicist of international standing who can be credited with entrenching bioethics as an integral aspect of health sciences in SA, Prof. Dhai began her career as a medical doctor, and then went on to graduate with a Masters in Law and Ethics, followed by a PhD in Bioethics and Health Law. Currently Prof. Dhai is director of the Steve Biko Centre for Bioethics, and head of the Discipline of Bioethics, Faculty of Health Sciences, University of the Witwatersrand.

"SAMA is always full of challenges," says Prof. Dhai, "and more so now in terms of medical politics. Leadership at SAMA confronts disputes and dilemmas on a regular basis. I don't see these as challenges to me because I am a woman. The

current challenges are reflective of our context and the times we live in today in SA. I can comfortably say that within SAMA, I have not encountered challenges, felt uncomfortable or felt the need to throw down the gauntlet just because I am a woman."

When asked about her particular interests and passions within SAMA and personally, Prof. Dhai responded with a definitive "SAMA's vision of empowering doctors to improve the health of the nation! In this way SAMA's laudable underpinnings and contributions towards achieving access and equity for all in our country must be highlighted."

"My personal passion is my family – as a wife and a mother, being sure that I am there when needed. Harmony and happiness in our personal space is pivotal to wholesome living. My interests are varied but I love cooking and spending time with my family in our country's treasured pearls like the Drakensberg and Sabie." She is married to Dr Faruk Mahomed and has two children, Safia and Zain.

Prof. Dhai believes knowledge is power, and her advice to other women is: "Being well-informed means being equipped to affirm ourselves and our abilities, and allows for resilience in the face of adversity. While it's not always easy, aim for a healthy and vigorous balance between your professional and personal life. And hold on to the hallmarks that make you the woman you are: compassion, caring and competence."

Dr Marmol Stoltz



Constitutional Matters Committee chairperson, GP Private Practice Committee vice chairperson and member of the SAMA board

"The biggest challenge through the years was to remain principled and focused on a specific

course. Due to the diversity of our members and their needs it is easy to get distracted in an opposite direction. Also as a female leader you have to work twice as hard as your male counterparts to get the same recognition," said Dr Stoltz when asked about working within SAMA as a woman and particularly as a leader.

Dr Stoltz graduated with an MB ChB in 1985 from the University of Pretoria before finishing her internship and being appointed medical officer at Klerksdorp Hospital. Until 1992 she worked as a senior medical officer at both Stellenbosch and Tygerberg hospitals before setting up private practice as a GP. She joined SAMA in 1997 and has worked in various leadership roles since.

As a mother to three children, Dr Stoltz has prioritised raising her children to become successful and happy adults. "This has been my biggest passion as a working mother. They are all three strong-headed individuals and it was such a pleasure to witness them growing into adults. It was important to teach them to enjoy the small things in life such as gardening and cooking together, and enjoying a simple meal together."

"Early in my career as a general/family practitioner I realised that the only way you can affect change in life is to get up and become involved. Therefore I have become involved in medical politics, specifically issues related to GP practice."

Dr Stoltz advises women to take every opportunity that is given to them and if they are not sure that they know how to – find a way and learn how to do it. "Believe in yourself and your own strength. And if life knocks you down, get up and try again."

Dr Lindi Shange



SAMA board member, acting chairperson: SAMA Health Policy Committee (HPC), national councillor: SAMA Gauteng North Branch

Dr Shange is passionate about bringing the concept of community-oriented primary care (COPC) from theory into practice. "I am currently involved in community participatory action research in support of ward-based outreach teams (WBOT) in Atteridgeville and very excited about the National Department of Health's policy of universal health coverage and access to health. I am happy that the HPC participates in shaping national health policies but detail must come from the ground, so we must not ignore the work, the experience and the voice of the foot soldiers."

She will not rest until she sees the GPs regain their rightful position in the health-care system as care co-ordinators and as the backbone of primary healthcare. "The scope of practice of the GP is being eroded systematically from all directions, and we have to stop this scourge."

When asked about her leadership roles with SAMA, Dr Shange said: "I enjoy being part of the SAMA family especially in my current role. To be happy and enjoy your work, in this space, you need to be passionate, hard working, selfless, not judgemental and be willing to serve at all times. When there are challenges facing the organisation (as in all organisations), I believe in being the 'cement' that helps to build it. Challenges are an opportunity for healthy robust debate to strengthen the organisation, not to destroy it; throwing stones does not help."

Dr Shange graduated from MEDUNSA in 1990 and in 1997 became a member of the College of Family Physicians, graduating with an MMed Fam Med in 2007. A Masters degree in Pharmacology followed and she is registered for a PhD. Initially working at the Dr George Mukhari Hospital, she worked in private practice from 1992 to 2012. Currently Dr Shange is manager and principal family physician at Attmed Health Centre in Atteridgeville. Her particular interests include blood conservation and bloodless medicine, community work and education, and professional presentations.

Her advice to other women: "As a doctor, wife, mother, married for 28 years with two adult sons, I don't believe in the concept of a 'superwoman'. Take life one step at a time. Don't bite off more than you can chew. Learn to say no if you have too much on your plate. I live by the motto I received from one of my previous professors, 'You cannot be everything to everybody at all times.' While you are up there, as a woman, work hard to mentor and bring other women up."

Dr Ayodele Adetokunbo Olubukola Aina



Senior Doctors Association of South Africa (SEDASA) national chairperson

Dr Ayodele Aina, a Nigerian by birth, graduated from Ogun State University in Nigeria. She is now a South African citizen and the first female national chairperson of SEDASA. "Ayo", as she is fondly called, completed her education at the Health Science Academy and Stellenbosch University. She has practised for more than 21 years in different health sectors, including the Western Cape Department of Health in the field of HIV/AIDS, and is now employed in Clinical and Programme Management HAST (HIV/AIDS/STI/TB). She is an associate member of the HIV/AIDS Clinician Society of South Africa, Health Science Academy of South Africa and International AIDS Society (IAS).

Dr Aina has been in a SEDASA leadership position since 2014. "When elected the chairperson of SEDASA, I took the bull by the horns. I set out to be a model to fellow female practitioners in my field. Many women are not invited into leadership roles. I've often believed that being a woman is an edge in itself. I believe there are many qualities I possess as a woman, which I can bring to the table as I have a different perception of issues as compared to my male counterparts."

"I believe that in order to maintain (and aid) the ever-growing standard of the organisation in this noble profession, the extra mile is always needed. This also helps me to stand tall despite intimidation among male counterparts and to welcome all critiques as a means to improve my knowledge. So my plan during my tenure is to strive to bridge the gender gap."

Dr Aina feels women are still being sidelined, overlooked and grossly underestimated. "I believe that for this to stop, women have to keep challenging themselves, and never let the gender strife be the hurdle in their race."

When asked about her particular interests and passions, Dr Aina said: "SAMA as the apex medical association should always strive to be at the forefront of the fight to curb the ever-

growing spread of HIV/AIDS and other STIs. Hence I am very passionate about teaching young people, especially young women, who are more susceptible to the spread of the disease. I believe that HIV/AIDS is no longer a death sentence, but rather a wake-up call for change; therefore I am challenged to empower them to lead better lifestyles."

Her advice to other women: "Dream no small dreams, and share your dreams with people who want you to succeed. I have never seen a woman who didn't know what she wanted in life, yet became successful. You can't reach your potential if you don't know in what direction you should be going."

Dr Angelique Coetzee



SAMA Gauteng North Branch chairperson

Dr Angelique Coetzee is a woman who has gained considerable prestige through her work in the health field. Currently a GP in private practice (since 1988), she completed her BMedSci degree in 1981 and her MB ChB degree in 1985 at the University of Pretoria. She furthered her tertiary education by obtaining additional diplomas and certificates, notably the Cambridge Advanced Health Management Course, which she passed *cum laude*.

Dr Coetzee worked as a medical officer at Mamelodi Hospital from 1987 to 1988, after which she entered general practice. From 2002 to 2005 she opted for a change of scenery, doing locum work in Ireland. In 2005 when she returned to private practice in SA she became an active member of SAMA in various positions, including: a committee member of the General Practitioner Private Practice Committee (GPPPC) since 2006; a SAMA board member during the 2013 term; and acting general manager of SAMA from 2013 to 2014. Dr Coetzee has to date served three terms as the branch chairperson of the Gauteng North Branch.

Dr Coetzee is characterised by her insightfulness and passion on health matters, as well as professionalism and empathy. She describes her long-standing affiliation with SAMA as mutually beneficial.

As a woman who has had first-hand experience of the “man’s world” phenomenon, Dr Coetzee advises other women to stand their ground and not be intimidated by others. She believes that if you do what you do best, there’s definitely no need to consider other people’s false perceptions about you.

Dr Kayakazi Pumela Tabata



SAMA Eastern Province Branch chairperson

Based in the Eastern Cape, Dr Kayakazi Pumela Tabata is a GP with more than 20 years of hands-on experience in the medical field. She holds an MB ChB (completed at the University of KwaZulu-Natal in 1991), a Masters in Health and Welfare and an Advanced Diploma in Project Management.

Dr Tabata completed internship at Livingstone Hospital and later went into private practice in the township of Kwazakhele. Her active involvement with medical organisations commenced in 1994 and now, apart from chairing SAMA Eastern Province Branch, she is a member of the GPPPC. Dr Tabata is also a member of the Health Policy Committee (Nelson Mandela Metropolitan University) transforming health science education and equity in health, a project funded by the NSF.

She perceives her affiliation with SAMA as being a reciprocal relationship, one of give and take between her and SAMA. She further describes the relationship as empowering to her. According to Dr Tabata, the philosophical phenomenon “individuals are influenced by the environment surrounding them” subsists, a philosophy she has adopted through contact and observation of other successful colleagues in SAMA.

To most people it might be a cliché, but Dr Tabata believes that a rich nation is a nation that reads; therefore her advice to women and the nation, is “read”. She advises women in leadership roles not to neglect their families but to find a balance between work and home.

Dr Catharina Elizabeth Fourie



SAMA Griqualand West Branch chairperson

Dr Catharina Elizabeth (Elize) Fourie qualified as a doctor during the era when society’s norms dictated that the role of a woman was to bear children and concentrate solely on household duties. She, however, challenged and conquered this norm by qualifying for an MB ChB at the University of Pretoria in 1970. Dr Fourie then commenced an internship with the Far East Rand Hospital in 1971, the same year she became the medical officer there. She later relocated to Bellville to specialise in Radiation Oncology, her husband in Radiology. With her aspiration to assist patients as much as possible, she eventually secured permission to start an Oncology clinic, which soon grew to a massive clinic, seeing approximately 60 - 75 patients a day.

Her journey with MASA (now SAMA) began in 1973. She became actively involved with SAMA after relocating to Kimberly in 1981 when she became secretary, a committee member and a Federal Council nominee for Griqualand West Branch. Dr Fourie’s footprints on SAMA are notable and continue with her work as the chairperson for SAMA Griqualand West Branch.

Dr Fourie is concerned about developing the youth, hence her affiliation with the Kimberly Boys High School as a Rotarian. She is also anxious to preserve nature for future generations. Dr Fourie has raised a daughter, who followed in her parents’ footsteps and became a radiologist, and a son in the financial field.

Although not relevant to her field of expertise, Dr Fourie’s advice to women, and the nation at large, is to start saving for their retirement.

Dr Malikah van der Schyff



SAMA Cape Western Branch chairperson

Dr Malikah van der Schyff has taken up a call to assist other women. She completed her MB ChB at the University of Cape Town in 1996 after which she qualified as an obstetrics and gynaecology specialist in 2004 through the Colleges of Medicine of South Africa.

During her training, she had hands-on experience with various public sector hospitals including Groote Schuur, Somerset, G F Jooste and Mowbray Maternity hospitals.

Dr Van der Schyff’s affiliation with medical organisations started in the early years of her academic career, leaving positively visible marks on the Junior Doctors Association of South Africa (JUDASA), the South African Registrars Association (SARA), the HPC and various other medical organisations.

Enthusiasm, accountability, persistence and social development are the qualities that characterise Dr Van der Schyff; qualities most evident through her work as the chairperson of Mowbray Maternity Health Facilities, chairperson of SAMA Cape Western Branch’s Ethics and Peer Review Committee and, chairperson of SAMA Cape Western Branch.

According to Dr Van der Schyff, healing the nation begins with educating the nation about the illness itself, hence her active involvement in promoting women’s health through local community radio interviews, guest speaking at local community women’s health events, and presenting antenatal lectures for Mediclinic National Antenatal weekend, as well as using other media to communicate with the community on health matters.

Dr Van der Schyff advises other women to actively read and educate themselves about women’s health matters.

Dr Nirvadha Singh reveals unique, practical approach to help others unlock potential

Diane de Kock



Branch National Council member **Dr Nirvadha Singh** (KwaZulu-Natal Coastal) is a member of the elected representative body of SAMA membership, which convenes once a year. It is considered the highest decision-making authority of SAMA. The elected membership of the Council comprises councillors elected by, among others, the respective SAMA branches, SAMA interest groups (e.g. JUDASA, SEHDASA, ADASA and SARA), general practitioner groups and various specialty groups.

Dr Nirvadha Singh is a dynamic personality who believes in transforming dreams into reality. Her unique academic and artistic side envelops her career as a medical doctor, public health specialist, health editor, poet, public speaker, world peace ambassador, and now an author, to add to her accolades. As a humanitarian, Dr Singh has been involved in several campaigns to raise awareness about drug abuse,

HIV, TB, teenage pregnancy, woman and child abuse, violence, cancer, disasters and refugee aid; she has incorporated her unique strategic motivational techniques to enable self-healing within these individuals and communities. "At times, I found that patients wanted to give up on life, and I started counselling them on how to live again and reach their full potential," she says.

You: The Journey Begins (published by BluLotis) provides a unique, practical approach to self-discovery and self-healing. Centred on life-changing experiences, the book provides the solution to self-healing. "My inspiration is from past experiences, life lessons, and the positive energised universe; whereby I turned to the universe to redefine myself to find answers to my challenges," Dr Singh explains.

Providing nourishment for the soul, *You* guides readers to unlock their potential in order to allow them to discover self. It integrates a bio-psycho-spiritual approach whereby the body, mind and soul are all communicating simultaneously.

The book provides the reader with an insight into how to translate a negative mindset into a positive one. "We are always in the cycle of fear, failure and doom and thus cannot move forward until we resolve our perspective of life. The book is from experience and it provides hope to readers that if I can do it against all odds, so can they. Also, it encompasses years of my experience and expertise enabling the reader to create a more positive mindset to solve life's daily challenges," comments Dr Singh.

When asked how she thought the healthcare fraternity would benefit from the book, Singh said she thought the book served as a platform for patients and healthcare practitioners. "It provides guidance to patients on uplifting their mindset to boost the immune system which is a powerful healing factor for the body. After working with many terminally ill patients including those with HIV and TB, I have written this book to assist patients to strengthen their mindset. The book also serves to uplift the

confidence and focus skills of our doctors and nurses in order to develop their concentration skills to make clearer and concise judgments.

"I am living proof that you can dream the impossible dream," Dr Singh says. "If I can do it, so can you."

About the author

Nirvadha Singh graduated with a Bachelor of Science degree with majors in physiology and microbiology from the University of Durban-Westville in 1998. She then went on to attain a Bachelor in Medicine and Surgery from Medunsa in 2002. She completed her studies with two specialist degrees: a Masters in Medicine in Public Health Medicine from the University of KwaZulu-Natal and a Fellowship in Public Health Medicine from the Colleges of Medicine in South Africa in 2010.

"I am living proof that you can dream the impossible dream. If I can do it, so can you."

Dr Singh has held an esteemed portfolio of positions, including medicolegal advisor, executive member of SAMA, member of the KwaZulu-Natal United Music Industry Association and the Cancer Association of South Africa, where she has played a strategic part in the organisation's development. As an international public speaker, she has presented seminars and papers to many known national and international organisations.

The book has received an overwhelming response and is available from Google PlayBook, Amazon, Barnes & Noble, Kobo and Nook.

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MEMBER BENEFITS 2016

The acknowledgement of debt

Julian Botha, *Strategic Accounts Manager: SAMA Private Practice Department*

The conclusion of a settlement meeting with a medical scheme subsequent to a forensic investigation often leads to a situation where a doctor is asked to sign an acknowledgement of debt, commonly referred to as an "AOD". As the entire investigation process is traumatic for the doctor concerned, he/she is often willing to sign this document just to bring the matter to a close. The relief brought by this action is often short-lived as this is an almost irrevocable admission of liability. It is therefore important to understand what an AOD actually entails and the legal significance of signing such a document.

An AOD is a document which contains an unequivocal admission of liability by the debtor. In it the debtor acknowledges that he or she owes a particular sum of money to the creditor and undertakes to repay what is owed.

An AOD requires no more than this in order for it to be legally valid and binding on the signatory. All other terms that may be inserted in the document are incidental but generally they will be designed to protect the interests of the creditor. For instance, the AOD will usually state that if the debtor fails to pay any one instalment of the debt, the whole amount will immediately become payable.

Therefore an AOD is a tool commonly used by creditors when debtors owe them money because chief among its strengths is that it is a "liquid document", one which proves a debt without any extraneous evidence.

Accordingly, an AOD should enable the creditor to obtain a speedy judgment against the debtor without having to endure a lengthy trial in which all the facts relating to the original credit agreement may have to be proved by the creditor. Judgment can simply be taken for the full amount reflected in the AOD because the court is faced with a document in which the debtor has expressly acknowledged that he/she owes the money.

Armed with the judgment, the creditor may then issue a writ of execution against the debtor's property to the value of the judgment debt, and may have the debtor's property attached to satisfy it. All of which arises directly out of the AOD signed by the debtor.

The AOD is therefore a very powerful document which, once signed, is extremely difficult to set aside. An AOD can only be set aside by a competent court on application by the party wishing to have it set aside (or varied). The applicant bears the onus to prove that there is a valid legal reason to void the AOD and provide the court with a satisfactory and persuasive explanation as to why the applicant signed the AOD in the first place.

The AOD is a very powerful legal instrument that should only be entered into after proper legal advice has been obtained

In short, the AOD can be seen as a "confession" of sorts in which the debtor admits that he/she owes a particular sum of money to a creditor.

Legal exceptions

When entering into an AOD, the party acknowledging the debt usually renounces legal exceptions (defences).

Renouncing the following legal exceptions has the following implications:

- **Errore calculi** means that a debtor is prevented from disputing previously agreed amounts (such as those arrived at by the "extrapolation method"), but not unilateral calculations by the creditor, and does not oust the court's jurisdiction to enquire into errors or calculations
- **Non causa debiti** means that the debtor cannot plead that there was no cause of debt.
- **Non numeratae pecuniae** means that the debtor cannot raise the defence that the money was/has not been paid over to him/her.

- **Revision of accounts** means that the debtor cannot raise the defence that the creditor ought to revise its accounts in respect of the debtor's or the principal debtor's indebtedness.

Recommendation on AOD

It has been, and always will remain, our advice to SAMA members not to sign an AOD without first obtaining proper legal advice. We have no authority over members and cannot compel them to adhere to our advice, but we cannot "undo" a member's signature on an AOD.

A medical scheme that employs the "extrapolation method", whereby an estimated amount owing is arrived at, has not actually proved their claim. However, by signing the AOD, the doctor concerned concedes that they have, in fact, proved the claim to the satisfaction of the doctor. It is no longer necessary for the medical scheme to prove the amount owing – the signatory has confirmed that that amount is correct and is owed.

Duress and undue influence

In some instances, members have indicated that they were subjected to duress or undue influence to sign the AOD.

Where the contract has been entered into allegedly as a result of duress or undue influence by the other party, the agreement is nevertheless valid because there is no dissensus. Since the consensus was improperly obtained, however, the contract is voidable at the insistence of the innocent party. The remedy used to set aside a voidable contract is rescission coupled with restitution (known as *restitutio in integrum*), and is available as both an action and a defence.

In order to set aside the AOD, the party alleging the duress or undue influence would bear the onus of proof to show that the duress or undue influence was of such a nature that they were unable to exercise their own volition.

In conclusion, therefore, it must be emphasised that the AOD is a very powerful legal instrument that should only be entered into after proper legal advice has been obtained. Once signed, it is extremely difficult, and expensive, to set aside.

SEDASA closes gaps between knowledge and action

Dr Ayodele Aina, SEDASA National Chairperson

The Senior Employed Doctors Association of South Africa National General Council (SEDASA NGC) held a successful 2-day strategic session in July 2016. Speaking at the session was Dr John Tibane, a human and organisational development consultant and advisor. Dr Tibane is involved in business training and business consulting and is also a graduate of the Medical University of Southern Africa. He completed his medical training in 1989.

Dr Tibane's interaction at the strategic session was a great inspiration. Before speaking, Dr Tibane asked every attendee to say: "I will think positively with my mind, speak positively with my mouth, and act positively with my body. I will think big and grow big. I will think my way to success and prosperity." He firmly believes that everyone has the power to be a leader but emphasised that if the mind is not well managed, failure is inevitable.

The strategic session welcomed the approach of challenging big assumptions in addressing the theme "closing the gaps between knowledge and action". There was an urgent need to define knowledge, gaps and action, to identify the knowledge gaps in relation to SEDASA and SAMA, and what action is relevant to close these gaps.

The presentation of Dr Shailendra Sham, chairperson of the Interim Employed Doctors Committee (IEDC), further supported Dr Tibane's talk, and enriched the strategic session.

Some background

SEDASA is an interest group of SAMA and constitutes the majority of SAMA membership in the public sector, with more than 6 000 members. Any person who is a registered medical practitioner within SA and who is a member of SAMA is eligible for full membership provided he/she has been a registered medical practitioner with the HPCSA for 2 or more years, and is not a registrar or a university-appointed specialist.

SAMA was formally constituted on 21 May 1998 as a unification of a variety of doctors' groups that had represented a diversity of interests. Today, SAMA is a non-statutory, professional association for public and private sector medical practitioners.

It functions as a non-profit company registered in terms of the Companies Act as well as a public-sector-registered organisation in terms of the Labour Relations Act. SAMA is a voluntary membership association,



SEDASA NGC. Front row from left to right: Dr Adams, Dr Hlahane, Dr Ngundu. Back row from left to right: Dr Hussein, Dr Sham, Dr Malumane, Dr Hagemeister, Dr Tibane, Dr Menge, Dr Aina, Dr Sithole, Dr Mojapelo, Ms G Mosek

existing to serve the best interests and needs of its members in any and all healthcare-related matters.

Closing the gaps

The importance of translating the above knowledge into action, and to close gaps, has become necessary for the survival of truly active SAMA membership representation. All these factors compelled the SEDASA NGC to resolve to close the gaps and move into action.

The purpose of the strategic session was achieved when the SEDASA NGC broke down their goal of a "united SAMA" into steps, and backed it up with relevant actions. The SEDASA NGC aligned with the IEDC of SAMA, and renewed their stewardship pledge in a branded uniform.

The SEDASA NGC called on all SAMA members to join hands and sustain the resolution so that the gaps between knowledge and action will be a thing of the past as we bring health to the nation.

"Within our organisation is great magic that we cannot afford to suppress, otherwise we will be ashamed! SEDASA NGC resolved to express the great magic as we stand in unity with amazement!"

Notice of death – new requirements

Marli Smit, Senior Legal Advisor, SAMA

It has been brought to SAMA's attention that the death notification form has been changed. Furthermore, no forms are available on the website of the Department of Home Affairs (DHA) as were previously the case.

Definitions

- **"Informant"** means the family member appearing on the DHA-1663 form.
- **"Designated funeral undertaker"** means a person duly authorised by the informant.

The requirements?

Previously the Notice of Death had to be submitted within the district in which the death occurred; however, this requirement is no longer applicable. Importantly, the Notice of Death may be submitted by the family member or their designated funeral undertaker.

It is also no longer required for both the family member and the funeral undertaker to be present to register the death.

When a funeral undertaker acts on behalf of the bereaved family, a letter of

appointment from a family member must be attached to the new DHA-1663 form to confirm that the funeral undertaker is the duly appointed representative of the bereaved family.

New DHA-1663 form

- From 7 June 2016, no office of the DHA will accept a Notice of Death which is completed on the old form. The new forms can be obtained from local hospitals, and private medical practitioners can arrange

with their nearest DHA office to provide them. In this regard, medical practitioners must provide their HPCSA registration card and a letter on the letterhead of the practice to confirm the physical address.

- Once the letter and HPCSA registration card (a copy of which will be made and kept on file) have been provided, a medical practitioner will be allocated one or two books which contain 20 DHA-1663 forms each – this means the practitioner will only need to return to the DHA once the books are full.
- The DHA confirmed that only registered medical practitioners will be provided with the new form, and no other person will be allowed to obtain forms on behalf of the practitioner.

Contact details

The following people can be contacted to assist in this regard:

Mr Shoki Mphokane

012 402 2248

shoki.Mphokane@dha.gov.za

Ms Kekeletso Rakgotho

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The DHA provided Circular 2 of 2016 (dated 3 June 2016) to inform all medical practitioners and funeral undertakers of the new process to be followed when completing and providing a Notice of Death form.

Medical practitioners now have to either obtain the forms directly from the DHA nearest to their practice or at any hospital.

SAMA confirmed with the DHA that medical practitioners must obtain the new Notice of Death form in person; however, one or two books (depending on the arrangement made with the relevant office) will then be provided to avoid unnecessary visits to the DHA offices.

SAMA was also given assurance that medical practitioners will not be required to queue, but will be taken to the relevant department that deals specifically with the Notice of Death forms so that expeditious service can be provided.

Should you have any queries, please contact the Senior Legal Advisor on 012 481 2085 or at marlis@samedical.org

Volunteering 67 minutes to honour Mandela

Bokang Motlhaga, Junior Marketing Officer, SAMA

To honour the 67 minutes of community service to commemorate International Mandela Day, 18 July, SAMA staff members volunteered their services to Sungardens Hospice, Lynnwood. The hospice was established out of a need in the community to take care of terminally ill patients, and serves the greater Tshwane Metropolitan area. SAMA staff members also volunteered at Melgisedek – a perilously old building inhabited by 32 male pensioners without any family care.

Sungardens Hospice caters for patients with diseases that need special care, such as HIV, cancer, advanced emphysema and motor neuron disease. These, according to research, are the types of diseases that escalate on a daily basis and pose a threat to life. The hospice focuses on aspects ranging from bereavement counselling to short-term in-patient medical care. Sungardens Hospice aims to provide and promote a programme of comprehensive palliative care, exclusively for patients with life-threatening illnesses. To generate income, the hospice runs its own second-hand store.

Melgisedek was founded in 2010 and is run by Dr Tshepo Molepo, a qualified medical practitioner who may not currently practice as she suffered a brain tumour. Dr Molepo started the Melgisedek project with her own funds, purchasing necessities for the needy. Melgisedek aims to get sufficient funds to accommodate even more homeless people within the Pretoria CBD. Dr Molepo also aims to secure space to implement skills projects to generate income for the shelter.

It is vital that organisations take action and collaborate towards inspiring change and developing our nation. Dis-Chem generously donated cleaning essentials worth R10 000.

SAMA staff members expressed their goodwill by dedicating more than 67 minutes of their time to assist the two centres in various ways. Among other things, SAMA donated clothes, blankets and food. Gert Steyn, general manager, affirmed that SAMA comprehends the keynote principles of Mandela Day. He and Dr Simonia Magardie, head of public relations and communications at SAMA, emphasised the importance of every South African embarking on a journey of maintaining the Mandela Day ethic. The stakeholders of Sungardens Hospice and Melgisedek were delighted with SAMA and Dis-Chem's work.



SAMA staff and Paul Kirby at Sungardens Hospice



From left: Nalene Paul (clinic supervisor, Dis-Chem), Bernadette Colyn (wellness assistant manager, Dis-Chem) Gert Steyn (SAMA) and Paul Kirby (marketing and fundraising manager, Sungardens Hospice)

2016 Medical Doctors' Coding Manual training workshops

SAMA Private Practice Department

SAMA has identified the need for procedural coding training in the private sector and medical scheme industry. The *Medical Doctors' Coding Manual* (MDCM) training workshops will be held at SAMA Head Office, Pretoria.

It is vital to understand coding when rendering accounts to third-party payers, as well as during the assessment of claims, as incorrect coding has great financial impact on doctors in the private sector.

The workshops will start off with 'Coding 101', which provides basic training in the use and interpretations of the Rules and Modifiers applicable to the coding structure. Time will also be allocated to informal discussions of

general problems experienced by coders. Training will take place over 2 days at the indicated venue. Requests for training in other centres will be considered. If we get a request, there needs to be a minimum of 15 attendees. Included in the registration fee of R2 999 per person (including VAT) are the 2016 MDCM book, training manual, attendance certificate and a light lunch (please indicate dietary requirements).

The target audience for these workshops are:

- doctors' staff
- practice managers
- bureaux
- medical schemes.

The following dates (subject to change) are available for people who wish to attend workshops at SAMA Head Office, Pretoria:

- 31 August - 1 September 2016
- 14 - 15 September 2016
- 5 - 6 October 2016
- 12 - 13 October 2016
- 9 - 10 November 2016.

Payment must be confirmed a week prior to the workshop to secure your booking.

For an invoice, please email us the company details including the VAT number.

Should you have any queries, please contact the SAMA Coding Unit on coding@samedical.org or 012 481 2073.

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Elimination – the theme on World Hepatitis Day 2016

SAMA Communications Department

SAMA has called on government to introduce new measures in the fight against viral hepatitis. The call came before World Hepatitis Day on 28 July under the theme “Elimination”.

According to a recent global disease burden study, hepatitis (B and C) now kills 1.4 million people annually, and has overtaken HIV/AIDS, as well as TB and malaria, as the leading global infectious disease cause of death.

In May 2016, the WHO committed itself to a programme to eliminate viral hepatitis by 2030. The aim of the plan is to reduce new infections by 90% and deaths by 65% by that date.

Viral hepatitis is an inflammatory condition of the liver, caused by a number of viruses – named hepatitis A, B, C, D and E. There are other causes of liver inflammation and disease, including alcohol, fatty liver, drugs, toxins and autoimmune hepatitis.

“The good news is that now treatment for hepatitis C is simple, very effective, has minimal side-effects, and mostly includes tablets taken daily for 12 weeks. Cure rate – that is complete viral eradication – is in excess of 90%. The cost of medications has fallen dramatically in a short space of time and pricing in South Africa is now at an affordable level,” said Dr Mzukisi Grootboom, chairperson of SAMA.

He said, however, that despite this, viral hepatitis is currently not covered under the prescribed minimum benefits of medical schemes.

“But we believe these schemes should consider covering viral hepatitis from risk pools, as treatments are cost-effective and could have a ripple effect on the entire population in preventing viral transmission,” he added.

According to Dr Grootboom, the elimination of viral hepatitis is an achievable goal. He said what is needed are education, awareness, and access to testing and treatment. For this reason, SAMA has aligned itself with the WHO call to eliminate viral hepatitis.

“We know what must be done and we know how to achieve this objective. All that is required is the need to act. We therefore call on government to:

- immediately introduce birth-dose vaccination for hepatitis B – the intervention is safe, cheap and effective
- expand hepatitis B vaccination availability for vulnerable groups and adults
- introduce antenatal hepatitis B screening and scale up a prevention of mother-to-child transmission (PMTCT) programme – piggy-backing this onto the already happening HIV antenatal programme if feasible
- screen for hepatitis C in high-risk groups, as well as those who received blood transfusions before 1992,” Dr Grootboom said.

Background information on hepatitis

Hepatitis A and E are common causes of acute hepatitis with jaundice, acquired through eating infected food or water and occasionally sexually (anal, oral). Most people infected never have a jaundiced illness and immunity acquired is lifelong.

Hepatitis B is the leading cause of liver cancer worldwide

There is an effective and available vaccine for hepatitis A, but the vaccine for hepatitis E is not widely available as yet. While acute hepatitis A uncommonly causes death, the risk of being sick and unable to work for a long time should not be underestimated. For this reason, consideration should be given to vaccination in those at risk, e.g. healthcare workers.

Vaccination for hepatitis A is recommended in those with underlying liver disease, e.g. cirrhosis, as acute hepatitis in such people can be fatal. Hepatitis A vaccination is currently part of childhood vaccination in the private sector in SA – but not, as yet, in the public sector vaccine schedule.

Hepatitis B remains a significant challenge, despite the introduction of the hepatitis B vaccine in SA in 1995. Globally, an estimated

two billion people have evidence of current or previous hepatitis B exposure. Recent literature suggests that 250 – 350 million people worldwide are chronically infected with hepatitis B virus. Hepatitis B is the leading cause of liver cancer worldwide.

A recent *Lancet* publication highlighted the estimated hepatitis B prevalence in SA to be 6.7% of the population, making us a high-intermediate prevalence country. The majority of people with hepatitis B in SA are exposed to the virus in childhood, usually before the age of 5 years.

Hepatitis B is a vaccine-preventable and eradicable disease. The current immunisation programme vaccinates babies at 6, 10 and 14 weeks for hepatitis B; however, a review of 65 studies by the WHO found significant evidence supporting the effectiveness of birth-dose vaccination for hepatitis B.

In addition, the HIV epidemic in SA has increased mother-to-child transmission risk of hepatitis B, further strengthening the need for a birth dose of vaccine. Birth-dose vaccine in addition to the existing schedule at 6, 10 and 14 weeks will significantly enhance the protection children have against hepatitis B.

A further strategy is a PMTCT programme. This will require that all pregnant women are screened for hepatitis B who, if positive (and HIV negative), will benefit from taking a short course of anti-hepatitis B medication (tenofovir), to reduce the amount of hepatitis B in their blood, and so reduce risk of transmission to their babies at birth.

This strategy, in conjunction with birth-dose vaccination, can potentially eradicate new infections in children. Vaccination of at-risk adults is also needed. This includes vulnerable groups such as people who inject drugs, sex workers and men who have sex with men. Vaccinating partners/spouses of people with chronic hepatitis B is also advised.

Hepatitis C is spread through direct contact with the blood of a person who has the disease, so people at risk include those who received blood transfusions before 1992 or people who inject drugs. Other risk groups include men who have sex with men and sex workers. Once infected, up to 80% develop chronic infection. The true prevalence of hepatitis C in SA is unknown. Left untreated, people over time present with cirrhosis and liver cancer.

The importance of living wills

Medical Protection Society

Patient B, a 70-year-old female, with a history of dementia, stroke and pneumonia, was admitted to the emergency room of a private hospital in a coma. She had advanced lung cancer and was well-known to the physician, Dr Y, who was called to see her.

There was no living will but, in the past, B had informed Dr Y during a consultation that should she become so ill that she could no longer decide on appropriate treatment herself, and if there were no reasonable

prospects of recovery with aggressive treatment, she be allowed to die peacefully with only fluids and pain medication being administered.

This had been documented clearly in Dr Y's clinical records. Dr Y informed the family members of his previous discussions with B. He also informed them that he did not believe that there was a reasonable prospect of meaningful recovery, should he ventilate B and administer aggressive treatment. This opinion was shared by a senior colleague

who had also evaluated the patient at his request.

All the family members disagreed and requested that "everything possible" be done to save/prolong B's life. Dr Y sought legal advice and was advised that he would be acting within his rights if he were to decide not to commence with aggressive therapy and that this should be carefully documented. However, in view of the high likelihood of a complaint by the family, it would be advisable to obtain a court order to protect Dr Y's position.

Helping children in need

SAMA Gauteng North Branch (GNB) recently donated R4 000 to the President Kruger Children's Home in Pretoria as part of its social investment commitments.

"It's important for us to be involved in something like this, even if it is a small donation. Through this sponsorship we hope to bring a little joy to less fortunate children, and make their lives a little easier," said Dr Angelique Coetzee, chairperson of the SAMA GNB.

The President Kruger Children's Home is one of the oldest children's homes in South Africa and cares for 63 children at two locations: 49 children are looked after in Pretoria, and 14 in a home in Reddesburg in the Free State. Most of the children at the homes are court-mandated placements as they are the victims of molestation, family violence, poverty or abandonment by their parents.

The SAMA GNB donation was prompted by the actions of Ms Coni-Lee Human, a concerned member of the public, who became involved in raising funds for the home. She says the cause is very dear to her, and she wants to give something back to children who are less fortunate. Her efforts were seen by Dr Coetzee who decided that SAMA GNB also needed to become involved.

"These children are really grateful for anything extra and with this money we plan to provide them with essential toiletries. For them, having their own shower gel, for instance, is an absolute luxury so



Receiving the cheque from SAMA GNB chairperson Dr Angelique Coetzee (middle) are Ms Coni-Lee Human (left) and Ms Marlene Richardson (right)

this money will certainly be very important in their lives," explains Ms Human.

Ms Marlene Richardson of the President Kruger Children's Home was ecstatic about receiving the donation, saying the lives of the children in the home were greatly improved by the generosity of people and organisations such as SAMA GNB.

Goldfields support local community

Goldfields Branch showed their support of and involvement in the Goldfields community by surprising the 18 foster children of House of Hope Community Life Development and the three housemothers who care for them with brand new duvets on Thursday, 21 July 2016.

From left: Romien Joubert, supervisor of House of Hope; Lynette du Preez, housemother of House of Peace; Dr T P Taute, chairperson of SAMA Goldfields Branch



KZN host SAMA chairman

Vernon Kinnear, *Marketing Officer, SAMA*

SAMA KZN Midlands Branch Council hosted the SAMA chairperson and SAMA KZN Coastal Branch at their meeting on 19 July 2016.

Drs Baldeo, Grootboom and Sham (from KZN Coastal Branch) engaged with the Midlands Branch, the general intention being to develop positive relations between the three branches in KZN, as well as particularly to improve interaction relating to SAMA's labour functions and the resolution of issues affecting employed doctors inside and outside the public service.



From left: Dr Y Baldeo, Dr M Grootboom (SAMA chairperson), Dr M F Bhayat, (acting chairperson, KZN Midlands), Dr S Sirkar, Dr G T T Buthelezi, Dr S Sham

Head Office embody LIVUPP at cook-off competition

Bokang Motlhaga, *Junior Marketing Officer, SAMA*

Head Office employees had a great time during their recent LIVUPP meeting. LIVUPP is an acronym that was coined by the employees themselves in 2013 to depict summative qualities that every SAMA employee should epitomise. The letters in the acronym stand for:

- L – Leadership
- I – Innovative
- V – Vibrant
- U – Ubuntu
- P – Professional
- P – Principled.

The entertainment team organised a cook-off competition in which the internal departments of SAMA had to brainstorm a dish to serve to other employees and then prepare the dish as a team.

The main aim behind the LIVUPP programme is to motivate great work morale as well as best work ethic among employees. The cook-off competition was a hand-in-hand initiative with the LIVUPP programme because at the end of the day team spirit within various departments was reinvigorated and reinforced.

All the teams went full-out to impress, with some delicious looking plates of food, but Marketing and Communications were the winners with Membership/IT/Operations in second place and Private Practice in third place.

Congratulations to the winning teams!



In first place, from left: Jeanette Snyman, Precious Qwabe, Simonia Magardie, Bongani Mashakheni, Bokang Motlhaga, Christiana Naidoo, Vernon Kinnear and Sarah Molefe (Marketing and Communications Department)



Second-place winners: Back row, from left: Dora Tshabalala, Rina Swart, Malebo Mekgwe, Elsie Mbonani, Renier Lategan. Front row: Tumi Maroga, Fundisile Ngcobo, Marilyn Myburg, Colbert Mathonsi and Eddie Katukwana (Membership/IT/Operations Department)



Third-place winners, from left: Solly Motuba, Zandile Dube, Jane Sekgothe, Tebogo Methula and Julian Botha (Private Practice Department)



The jury isn't out any more.



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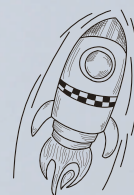


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HOW A LAWYER IS PUSHING THE FRONTIERS OF LAW

Nyambeni Davhana is a man who explores his fascination and curiosity for life through his studies of the law. He understands that it is an integral part of every element of life, helping us to frame all our interactions and enabling society.

His application of this unique perspective through his journey has resulted in winning the annual Kovsies Moot court competition for first-years and representing the University of Pretoria at the Manfred Lachs International Space Law Moot Court Competition. Because as humans reach for the stars, the law will have to travel with us - and through Nyambeni's and his team's efforts, we are well on our way to helping the law go where our imaginations can take us next.

Not only is Nyambeni rising through the ranks of his profession, but he is using his professional thinking and experiences to help coach the next generation of young professional thinkers - especially empowering the black lawyer, through his role as Chairperson of the Black Lawyers Association student chapter.

There are no limits for a self-motivated man. And that's why at PPS we will keep supporting professionals like Nyambeni Davhana to keep exploring beyond the final frontiers of explorations - exactly like we've been doing for the last 75 years.



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