SAMA INSIDER

NOVEMBER 2016

Prof. Dan Ncayiyana elected President for 2016

Armbands shine spotlight on doctors' working hours

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EDITOR'S NOTE NOVEMBER 2016

Diane de Kock
Editor: *SAMA INSIDER*

Celebrating outstanding achievement

In this issue SAMA celebrates achievement among peers. On page 6 we welcome Prof. Dan Ncayiyana as President of SAMA for 2017 – an accolade and fitting recognition of a career dedicated to the medical profession in SA. "The only true achievement in one's career is recognition by one's peers," commented Prof. Ncayiyana in his acceptance speech where he looked at the history of the medical association since 1927. "SAMA has done very well, and survived many a crisis since its founding on 28 May 1998, thanks in no small measure to the leadership . . . of a succession of leaders . . . who helped launch the ship . . ."

On page 8, we congratulate ten local heroes who received SAMA awards at the recent SAMA conference. Recipients were nominated by their peers and then selected to receive recognition. Their contributions to their fields have been varied. All have had a huge impact on communities and in some cases nationally and internationally.

The new SA armband campaign has received a positive response from the medical profession and the public – a visible reminder that SA should employ more doctors to manage the workload (see page 15).

Gauteng North branch held an award ceremony for life members to acknowledge the important role these members have played at the branch and the positive impact the example they have set has had on many young doctors. Branch chairperson Dr Angelique Coetzee said: "Their knowledge and experience contributes in a very positive way and can definably contribute even further to the lives and careers of younger doctors."

As Sir Arthur Conan Doyle so succinctly put it: "Mediocrity knows nothing higher than itself; but talent instantly recognises genius."

Editor: Diane de Kock
Chief Operating Officer: Diane Smith
Copyeditor: Anne Hahn

Editorial Enquiries: 083 301 8822
Advertising Enquiries: 012 481 2069
Email: dianed@hmpg.co.za

Design: Clinton Griffin

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Are medical malpractice claims in SA getting out of hand?

Prof. Dan Ncayiyana, *SAMA President*

In an editorial for the *SAMJ* of May 2004, I observed how "South Africa has experienced a surge in both the number of [medical malpractice] suits and the quantum of compensatory awards in recent years". I then continued to assert that, as a matter of principle, "it is only right that patients who sustain preventable [and unnecessary] medical injury are entitled to appropriate compensation, both as a matter of social justice and as an incentive for prudent and conscientious care on the part of the practitioner". In previous years, particularly during the apartheid era, a patient sustaining a disabling injury as a result of medical incompetence had little chance of success in a claim for compensation in the courts. That began to change with the advent of our democratic dispensation in 1994.

However, medical malpractice suits and premiums have skyrocketed in recent years, especially in the fields of obstetrics and gynaecology, spinal neurosurgery, neonatology and orthopaedics. I have some personal experience with this sort of crisis from my 15-year stint as an obstetrician-gynaecologist in the USA, a country with perhaps the most pernicious profile of medical malpractice litigation in the world. More recently, I was chair for some years of the Medical Protection Society South Africa Advisory Committee. As in so many other ways, SA seems to be mimicking the American example in this regard.

At least two factors appear to be driving the malpractice litigation epidemic. Citizens have become more aware of their rights and ways to exercise them. But more importantly, the epidemic is also being driven by the glut of lawyers looking to make a living, particularly after the opportunities for a lucrative legal career were decimated with the changes in the way the Road Accident Fund is administered.

Medical malpractice suits and premiums have skyrocketed in recent years

So what can medical practitioners do to protect themselves and to mitigate this scourge? First, establish a relationship of trust and mutual respect with your patient – every patient. Some doctors are prone to be abrupt and technology-focused, and rarely engage with the patient on a basic human level. Patients rarely sue a doctor they genuinely like and with whom they have a personal relationship. Patients understand that risk is inherent in any medical procedure even in the hands of a most competent and conscientious practitioner, and are loth to blame the doctor when things don't go right.

The medical profession, through SAMA, must lobby Parliament for the adoption of the so-called "no fault insurance"

Second, do not undertake procedures for which you are ill qualified, or employ technology with which you have little or no experience. Third, be upfront with your patient when something goes wrong and do this immediately.

Ultimately, the medical profession, through SAMA, must lobby Parliament for the adoption of the so-called "no fault insurance", which dispenses with the adversarial tort mechanism with its hugely expensive requirement to prove and defend negligence in a court of law. In this system, already adopted in New Zealand and Scandinavia, an alternative, much simpler mechanism mediated by a panel of medical experts is put in place to redress a patient who sustains injury, whatever the cause, and send lawyers to the poor house.

Letters to the Editor

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
- must be on subjects 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.

An official response on the NHI White Paper

SAMA Communications Department

This is the fourth 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 sixth and seventh chapters of the submission:

Chapter 6: Universal health coverage for mental health

Chapter 6 singles out mental health to emphasise and lobby for prioritisation of this field of medicine's inclusion in universal coverage, since mental health disorders have been neglected in the health system, despite having a high burden, and in spite of the available robust national Mental Health Policy Framework.

The NDoH in its NHI pilot districts must implement the mental health package as envisioned in the national Mental Health Policy Framework

SAMA appreciates the White Paper statements (albeit broad) on mental health in paragraphs 96, 131, 169, 199 and 341 of the White Paper. This chapter uses evidence to strengthen the case for allocation of more focus and resources towards these disorders, which have an annual prevalence of about 17% in SA and are exacerbated by the effects of HIV/AIDS.

Lifetime prevalence of common mental health disorders was in the region of 33% in 2009. The chapter highlights the enormous stigma and discrimination suffered by those with the disorders at the hands of the health system and society, and pinpoints that mental disorders are a risk factor for communicable and non-communicable diseases. The chapter reports that the challenge is not confined to the state sector, but also plagues the private sector, for example, prescribed minimum benefits (PMBs) only cover two chronic mental conditions, are hospital centric, and often demand out-of-pocket co-payment.

As mental disorders are associated with certain socioeconomic environments that many South Africans are exposed to (poverty, violence, drug abuse, family discord, workplace stress, etc.), SAMA commends the national Departments of Health (NDoH) and Education for implementing the Integrated School Health Programme in the needy quintile 1 and 2 schools. Early interventions at critical childhood developmental stages are likely to have positive impacts and have been appropriately prioritised.

The chapter describes critical issues, namely barriers to accessing mental health services, poor financial prioritisation of mental health, as well as requisite human resources for the discipline. The recommendations in this section make a case for integration of comprehensive mental health into primary healthcare, deinstitutionalisation of mental health, effective antidiscriminatory strategies, the use of mental health co-ordinators and specialist mental health professionals at primary level, improved access to medicine through patent law reforms and other interventions, and strengthening monitoring and evaluation. In order to redress the inequities experienced by mental health patients, the NDoH in its NHI pilot districts must implement the mental health package as envisioned in the national Mental Health Policy Framework.

Chapter 7: Monopsony and labour markets

Monopsony is an example of imperfect competition whereby one buyer of healthcare services exists among many suppliers of services. Monopsony is often referred to as a buyer's monopoly. This chapter uses available literature to analyse the pros and cons of the monopsony model envisioned for the NHI, whereby the NHI Fund will leverage its monopsony purchasing powers as a single purchaser of health services supplied by multiple providers.

One attractive feature of monopsony is the allure of efficiency (economies of scale) and thus potential reduction of prices or goods and services, leading to broader access to healthcare services. The downside is that the monopsonist buyer (NHI Fund) is poor at negotiating quality. The monopsonist also dictates terms to suppliers (healthcare providers), thus potentially leading to low reimbursement levels for doctors. Under monopsony, salaries are, in theory, determined by Government's willingness to pay, Government's ability to pay, and the size of supply (number of medical employees). Unionisation by doctors would be critically imperative to enhance suppliers' negotiating power for tariffs.

The chapter identifies that review of competition laws is necessary to allow health professionals to negotiate tariffs. To ensure transparent price determination, establishment of a Pricing Commission is recommended, as well as institution of cost studies and evaluation of existing coding systems. Short of competitive salary (reimbursement) levels, and conducive working conditions, brain drain is inevitable.

The full submission is available on the SAMA website: https://www.samedical.org/links/nhi-exec-summary **or** https://www.samedical.org/links/nhi-white-paper

Prof. Dan Ncayiyana elected SAMA President for 2017

Diane de Kock

SAMA held their National Council meeting on 23 September in Johannesburg. At this meeting Prof. Dan Ncayiyana was inaugurated as president.

Dan Ncayiyana is emeritus professor at the University of Cape Town, and was editor of the *South African Medical Journal* for 20 years. He was closely involved in the process of transforming the Medical Association of South Africa (MASA) into SAMA.

He was born and raised in KwaZulu-Natal and obtained his primary medical degree in the Netherlands and postgraduate qualifications at New York University. He has served as consultant to the World Health Organization, United States Agency for International Development, the Ford Foundation and other international agencies in the areas of public health, university governance and community-based medical education. He has served as professor in obstetrics and gynaecology, medical school dean and vice-chancellor at two South African universities. He is an honorary Fellow of the Colleges of Medicine of South Africa, and Member of the Academy of Sciences of South Africa. He was until recently a research associate at the Human Sciences Research Council.

Prof. Ncayiyana has been consultant project leader in the founding of new medical schools in Ghana and, most recently, in Polokwane with the first intake in 2016. Below we publish his acceptance speech:

"This evening represents a very special occasion for me. The only true measure of achievement in one's career is recognition by one's peers. I am therefore both proud and thankful for this recognition by SAMA, and am very honoured indeed to be installed as president.

"I couldn't have wished for a more fitting accolade at this time when my career is winding down.

"SAMA has a long history dating back to 1927, when independent medical societies in the various provinces merged together to form the Medical Association of South Africa, subsequently to be popularly known as MASA.

Prof. Ncayiyana delivering his acceptance speech

"The *South African Medical Journal* is of course much older, having been started in 1884 when South African doctors still belonged to the British Medical Association.

"There were only a handful of black doctors when MASA was first formed in 1927, and it remained a white organisation right up to the unification process that resulted in the formal inauguration of SAMA 71 years later, on the 28 May, 1998.

"Who were these 'handful of black doctors'? William Anderson Soga, born in the village of Tamarha outside of Butterworth in the Transkei, and sponsored by the United Presbyterian Church of Scotland to study medicine in Glasgow, became the first black doctor in South Africa when he graduated from Glasgow in 1883. He also brought back a Scottish wife, which must have intrigued the village folks.

"This was 60 years before the founding of the UCT medical school, and about 100 years before UCT admitted its first black African student.

"Dr Abdullah Abdulrahman of Cape Town became the third black doctor when he graduated, also in Scotland, in 1893. He was a Cape Town city councillor and an outspoken activist for non-racialism. His daughter Cici married a medical doctor, Abdul Hamid Gool. But another daughter, Waradea, also qualified from Glasgow in 1927 to become the first black female doctor in South Africa.

"Altogether, there were 29 black doctors who qualified in either the UK or the USA between 1900 and 1940. In the meantime, medical schools for white people had been established at UCT and Wits, and subsequently at Pretoria and Stellenbosch.

"Now to get back to the MASA story, MASA was hijacked by the Afrikaner Broederbond during the apartheid years, and even though MASA accepted black doctors as members in order to avoid an international backlash, those who did join were conspicuous by their invisibility.

"Alternative black doctor societies emerged, the most prominent being NAMDA, the National Medical and Dental Association. NAMDA was not just a professional society, it gained recognition nationally and across the world as an anti-apartheid movement. It was

non-racial and accepted white doctors who chose to join.

"Among other things, it pushed for the international isolation of South Africa's medical establishment and was instrumental in the boycott of academic co-operation and academic exchange between medical schools in South Africa and elsewhere in the world.

"Up until I became editor of the *SAMJ* in 1993, the *Journal* was a virtual mouthpiece of the MASA management. The editor did as he was told. Editorials were vetted by the secretary general to ensure that there wasn't anything politically offensive to the apartheid government before the *Journal* went to print.

"If you were to do a word search in the *SAMJ* editorials as I have done, you would be hard put to find the word 'apartheid' prior to 1993.

"One story worth sharing is that of the Steve Biko affair. During Steve Biko's incarceration and torture, he was regularly evaluated by at least two medical doctors, one of them a specialist neurologist, who both repeatedly gave him a pass despite the severe and potentially fatal injuries he had sustained, especially to his head. Eventually, even they could no longer contain their conscience and recommended, rather belatedly, that he be admitted to hospital, but they then acquiesced in having him transported in an open pickup truck from Port Elizabeth (PE) to a military hospital in Pretoria. The rest, as the saying goes, is history.

"When Helen Zille, then an investigative journalist, first cracked the Steve Biko story, it caused an uproar around the world, except within MASA. Only a small segment of liberal members of MASA tried to raise their voice. They demanded that the two PE doctors be censured by the Medical Association and be disciplined by the Medical Council. Their representations fell on deaf ears. Eventually, MASA came out with a lame statement absolving the PE doctors. The protesting members, including Stuart Saunders who was later to become the vice-chancellor of UCT, wrote vociferous letters of protest to the editor of the *SAMJ*, but the editor was instructed not to publish them. Many, including Stuart, resigned in anger from MASA.

"The editor instructed his PA to destroy the letters. The PA was Lorraine Griessel, born into an Afrikaans aristocratic family with property in an upmarket neighbourhood on the Cape West Coast. Lorraine was very anti-establishment, and she decided to hide the letters in a secret file rather than shred them.

"Years later, when I was editor of the *SAMJ*, I was challenged – in rather antagonistic terms – by activist colleagues in the New South Africa to publish those Biko letters. Although these colleagues knew me and my politics, I had become part of the MASA machine, and therefore come to be seen as complicit in suppressing the truth about the letters. In truth, I had no idea where those letters were, or what they contained. Fortunately, Lorraine had stayed on as my PA. She shared her secret with me, and retrieved the letters which we then proceeded to publish in a dedicated issue of the *SAMJ*.

SAMA has done very well, and survived many a crisis since its founding on 28 May 1998, thanks in no small measure to the leadership . . . of a succession of leaders . . . who helped launch the ship . . .

"My appointment as *SAMJ* editor was a story all on its own. MASA had never had to deal with a black applicant before, especially for such a senior position. At the official selection interview, a mixture of ambivalence mixed with anxiety was almost palpable. But this was 1993, and the democratic transformation for the country was on the horizon.

"At that time, the *SAMJ* was officially bilingual, also known as the *Suid-Afrikaanse Mediese Tydskrif*. The fact that I didn't speak Afrikaans became a huge issue, or perhaps an excuse since the other two candidates with whom I was shortlisted were Afrikaners. Never mind the fact that Nic Lee whom I was replacing was a Brit who didn't speak a word of Afrikaans, whereas I was at least fluent in Dutch.

Prof. Dan Ncayiyana and outgoing president, Prof. Denise White

"I won't bore you with the details. Suffice it to say that it required two more interviews before I was appointed. The appointment was thanks in part to the support of panellists like Ralph Kirsch and JP van Niekerk, and because Hendrik Hanekom, the secretary general at the time, was determined that I be appointed.

"Hendrik was the right man at the right place at the right time. Ironically, he himself was a product of and activist in the Afrikaner nationalist movement, having been president of the right-wing Afrikaanse Studentebond in his student days. But as secretary general of MASA during the democratic transition, he became a completely transformed man dedicated to the creation of a new democratic and non-racial medical association.

"He was instrumental in the often quite difficult negotiations between MASA, NAMDA and other black doctor societies that resulted in the birth of SAMA. I, and some of you here such as president Denise White, Prof. Mazaza and Prof. Sonderup were significantly involved, directly and indirectly, in that process.

"The South African Medical Association has done very well, and survived many a crisis since its founding on 28 May 1998, thanks in no small measure to the leadership – in those early days – of a succession of leaders such as Zolile Mlisana and Kgosi Letlape, who helped launch the ship on a steady course despite the choppy waters.

"SAMA has lived up to its vision 'To be the representative association for the South African medical profession', and its mission of 'Empowering doctors to bring health to the nation'.

"I am therefore proud to accept the position of president of SAMA."

2016 SAMA awards presented

Diane de Kock

At the SAMA conference in October, the following recipients received awards that recognise medical heroes, in various categories, who have been nominated by their peers. Congratulations to the winners:

Prof. Denise White

SAMA Award of the Year

Nominated by Dr Malikah van der Schyff

"Prof. White is a top psychiatrist and a long-standing member of SAMA who has contributed immensely, particularly within the Bargaining Chamber and in the public sector," says Dr van der Schyff.

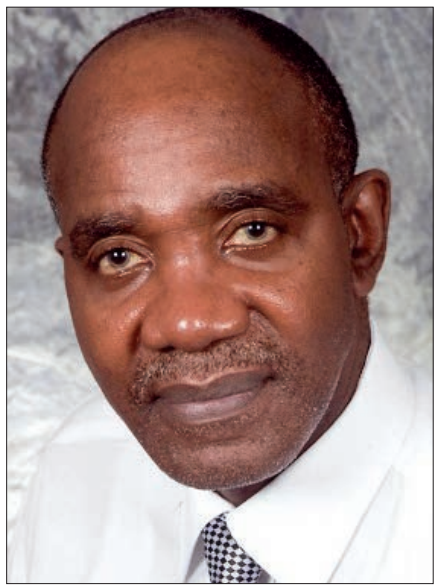
Prof. White has held numerous executive positions in SAMA, including chairperson of the Committee for Public Sector Doctors, member of the Exco Board of Directors, vice-chairman from 2003 to 2008, and in 2009 she was elected interim chairperson of SAMA. In 2015 Prof. White was elected president of SAMA.

Well-known for her negotiating skills, Prof. White is calm and composed in her leadership and well respected by all her colleagues.

She changed an aspect of global psychiatry practice, receiving international recognition early in her career and soon became a highly sought-after speaker at international conferences. Prof. White was described as "an inspirational negotiator, quiet and dedicated leader and clinician of immense skill and intuition," on receiving this year's South African Society of Psychiatrists Distinguished Service Award.

One of Prof. White's focuses is mental health, as mental health disorders comprise five of the ten leading causes of health disability in SA.

Prof. Thandinkosi Madiba



Lifetime Achievement Award

Nominated by Dr Jacob Mphatswe

Prof. Madiba qualified as a medical doctor in 1976 and completed his internship at Edendale Hospital, where he later became a medical officer. He obtained an MB ChB, MMed, LLM (Medical Law) and a PhD from the University of KwaZulu-Natal (UKZN), a Diploma in International Research Ethics from the University of Cape Town (UCT) as well as the Fellowship in Surgery and Colorectal Surgery from the College of Surgeons of South Africa and the American Society of Colon and Rectal Surgeons, respectively. In 1999 he trained as a colorectal surgeon in the UK. In 2000 he started a colorectal practice and in 2005 established the Colorectal Unit at Inkosi Albert Luthuli Central Hospital (IALCH).

He is an international authority on diseases of the colon and is the founder of the SA colorectal and stoma support group, as well as the surgical society. He has played a role in the official structures of the university and the medical school, contributing towards policy and strategy formulation. He championed transformation at the medical school and initiated numerous sessions that have promoted and encouraged the notion of black women surgeons. In 2011 he was awarded the Living Legends award for the outstanding achievement by the Ethekwini Municipality.

Prof. Madiba was rated in the top 30 researchers at the UKZN (2008 - 2010) and the National Research Foundation rates him as a C+ researcher. His achievements include 11 book chapters and over 100 peer-reviewed journal articles; he serves as a reviewer for many international and national journals. He has participated in over 300 international and national congresses, presenting invited lectures and scientific papers.

Now retired, Prof. Madiba has led an exemplary life. He advises his former colleagues to follow their passion and never allow material things to be the motivating factors. That way he believes you will be happy in your job and you will be able to achieve great things, but, if you allow materialism to rule your life, you will never be happy.

Dr Neil Comley

Private Practice Award

Nominated by Dr Kim Harper

Dr Comley is a general surgeon: "He is a rare commodity," says Dr Kim Harper, "a first-class surgeon who has used his superb skills to provide an invaluable service to all inhabitants of the City of East London and the wider surrounds."

Dr Comley completed his surgical registrar programme at Groote Schuur Hospital in Cape Town as well as a diploma in Anaesthetics. In 1995 he commenced private practice in East London.

"His gentle, thoughtful, detailed nature has brought him much admiration and respect. Dr Comley has always been available, with never-ending on-call periods, always willing to step up, come out and assist those in need. His 'bedside manner' is impeccable and his patience legendary.

"He is much loved by his patients. He instills confidence, never appears to be too rushed and takes time to listen. He is deeply humble, approachable and is 100% dedicated to his patients and his profession. He is a true friend and confidante and puts other people's needs before his own."

Dr Comley is a loyal member of SAMA who has supported the Border Coastal Branch throughout his career. "In essence, a truly modern and professional gentleman surgeon," says Dr Harper.

Prof. Linda-Gail Bekker

Fellowship in Art and Science of Medicine Award

Nominated by Dr Mark Sonderup

"Prof. Bekker excelled in the field of HIV medicine with her commitment, service, international footprint, publications and groundbreaking work in HIV," said Dr Sonderup. She is the incumbent president of the International Aids Society (IAS) and is the first woman from Africa to hold this position. She is a physician scientist who has over the last 18 years actively researched the intersection between the two major epidemics of southern Africa, HIV and TB. Her research has included hypothesis-driven health service and clinical research of prevention, treatment and epidemiology of HIV, TB and related infections. Among her many focuses, Prof. Bekker has recognised that individuals were accessing treatment late and this led her to explore community-based models for HIV testing. She designed and implemented the Tutu Testing mobile units, which have explored the feasibility of point-of-care diagnosis and screening. "The model has shown the value of community-based disease screening and most recently, its cost-effectiveness," says Prof. Bekker.

Prof. Bekker is also internationally recognised for her research in the adolescent population, where she has developed key competencies dealing with this population in collaboration with many researchers worldwide, including the HIV Vaccine Ethics Group in KwaZulu-Natal (KZN).

Her research is highly relevant to the public health challenges facing communities in Cape Town, the region and globally.

Prof. Delawir Kahn

Extraordinary Service to Medicine Award

Nominated by Dr Mark Sonderup

Prof. Kahn is acknowledged for his commitment to the field of surgery, through education and training and publications, which is exemplary, both nationally and internationally. An example is his work in hypertension and liver disease. He co-established the liver transplant programme at Groote Schuur Hospital.

Prof. Kahn studied in the UK, SA and the USA. In 2005 he was appointed head of department of general surgery at UCT and has been a member of the executive committee of the Surgical Research Society of South Africa since 1978, serving as president in 2001. He is a member of the African Association for the Study of Liver disease and in 2000 he was elected president. He is also a member of the South African Transplantation Society, the International Association for the Study of the Liver, International Transplantation Society and the European Society for Organ Transplantation.

His current research is on liver regeneration, liver transplantation and renal transplantation. He has received numerous honours and awards including the Lennox-Gordon prize for postgraduate research in surgery, a Medical Research Council postdoctoral scholarship, and the Davis and Geck Surgical scholarship in 1989, 1994 and 1995. He has written 263 publications in journals, 201 abstracts, 7 book chapters and presented at 79 international congresses.

Internationally he is a clinical associate of the Austin Research Institute in Melbourne, Australia and an honorary lecturer at the PGIMER Institute in India.

Dr Andrew John Ross

Spirit of Medicine Award

Nominated by Dr Mergan Naidoo

Dr Ross has dedicated his life to helping others, not just with his medical skills, where he has worked in various public sector hospitals,

including Mosvold Hospital, a rural hospital situated in Ingwavuma, KZN, but in many other areas. He is known for his ability to step forward and offer a solution when everyone else cannot see any solution.

While at Mosvold Hospital, at the height of their staff shortages, he believed that rural learners from Ingwavuma could succeed in becoming the health professionals the hospital needed, if given a chance and the right support. He single-handedly championed this cause to raise sufficient money to send four local learners to university to study various health science degrees. He convinced the local community to provide support, as well as strangers he met on aeroplanes (some of whom are still supporters). The success of these four learners spurred him on to find more aspirant learners and lobby more people for money based on his "promise" that if given the opportunity these students would succeed. This scheme has grown from the support of four students in 1999, to the current support of over 200 students. The scheme has produced 257 graduates, covering 15 different health science disciplines, 87 of which are doctors. All these graduates are, or have had, a huge impact in addressing the shortages of staff at hospitals in the Umkhanyakude and Zululand districts of KZN.

Although he has moved on from working at Mosvold Hospital, he is still very involved in improving rural medicine. As a lecturer in the Department of Family Medicine at UKZN, he has been involved in the establishment of decentralised family medicine training at Bethesda Hospital, allowing doctors working in rural areas the opportunity to specialise while remaining rural. He serves as a mentor to many of the students the Umthombo Youth Development Foundation (the scheme he started) is supporting at UKZN, and inspires them to achieve more. In his personal capacity he has financially supported this initiative since inception and continues to do so. Dr Ross was awarded the Presidential Baobab Award – Silver in 2015 by the state president for his tremendous contribution to deprived communities in KZN.

"Dr Ross is an example of a doctor who doesn't only see sickness, but sees the whole person and especially their potential, which he so easily draws out. He is a doctor that many should want to emulate," says Dr Mergan Naidoo.

Dr Heike Geduld

Gender Acclaim Award

Nominated by Prof. Roger Dickerson

Dr Geduld is a specialist emergency physician practising in the Western Cape and is the registrar programme director for the combined divisions of emergency medicine at UCT and Stellenbosch University. In this role she supports the training of registrars in emergency medicine – both of SA students and supernumerary students from as far afield as Egypt.

Dr Geduld has a passion for teaching, and has been instrumental in the development of the educational and assessment priorities of the College of Emergency Medicine of SA through her role as the secretary of the college.

Dr Geduld was elected president of the African Federation for Emergency Medicine (AFEM), and is the first female emergency physician to hold this illustrious position. Under her guidance, the Federation has continued to develop the principles and practice of emergency medicine across the continent, and improve the emergency care provided to patients across Africa.

She has fostered close ties between the AFEM and the World Health Organization Directorate on Emergency Care, and has embarked on several projects to empower individuals to provide basic emergency care to all on the African continent.

As an individual, Dr Geduld has worked to develop the postgraduate training in Tanzania, and has spent many months working on site to support her trainees.

Back at home, she has supported her fellow women in the rough-and-tumble world of pre-hospital and in-hospital emergency care. She has developed and hosted several seminars for women in emergency care, and will be hosting the inaugural Women in Emergency Care Conference later this year.

Dr Loganathan Naidoo

Community Service Award

Nominated by Dr Raymond Kammies

Dr Naidoo is a well-known medical doctor in the Uitenhage and Port Elizabeth communities in the Eastern Cape. He is an extremely compassionate and entirely trustworthy colleague, exhibiting a very high level of integrity. Over the years, he has been entrusted with numerous leadership and mentorship roles in many medical organisations, sports, cultural and civic organisations.

Most significant was Dr Naidoo's leadership role in Uitenhage and PE in the care, management and treatment of HIV patients, both in private practice and in the public sector.

During the late 1990s, the GPs and healthcare workers in Uitenhage began to see a massive increase in the number of HIV-related illnesses, opportunistic infections and deaths of young, active people. In 2002, the prevalence of HIV in the Eastern Cape was estimated at approximately 20% (the third-highest in the country). Dr Naidoo took the leading role in the establishment and development of the Udipa Life Centre (ULC), a place to give integrated, comprehensive, all-inclusive management of

HIV and related diseases to the optimum level, to both private and State patients, situated in one convenient location.

By collaborating with the State hospitals, local clinics, schools and community organisations, HIV medication, treatment and counselling is made accessible to everybody affected by HIV in the Uitenhage and PE area. The ULC now has a staff of five part-time medical doctors, including a pathologist, a pharmacist, two nursing sisters and two qualified counsellors. Currently there are more than 2 000 private and State patients being managed by the ULC.

"Dr Naidoo's unique energy, optimism, passion and tireless commitment to the care of HIV patients has contributed tremendously to the development of the Udipa Life Centre into a place of excellence for the management of HIV patients," says Dr Kammies.

Dr Nastassja Koen

Young Leaders Award

Nominated by Prof. Dan Stein

With a record of academic excellence, Dr Koen approached UCT's Department of Psychiatry and Mental Health as a volunteer researcher in 2011. She quickly established herself as key in a number of ongoing clinical studies, and served as project manager of the Brain and Behaviour Initiative (BBI), a university signature theme that enabled cross-faculty, multidisciplinary, collaborative research in the cognitive and affective neurosciences to address locally relevant brain-behaviour issues. Simultaneously, she lectured part-time in psychiatric genetics, and completed her PhD (2011 - 2015) focusing on the intergenerational transmission and genetics of psychological trauma and post-traumatic stress disorder (PTSD) in pregnant women in SA.

Since being awarded her doctorate, Dr Koen has expanded her research: to address questions of the biological pathways of PTSD in an ongoing SA birth cohort study; to access complex data in the Psychiatric Genetics Consortium (PGC); and to collaborate with world-class local and international neuroscientists. She plays a key leadership role in the Broad/Harvard-funded Neuropsychiatric Genetics of African Populations (Neuro-GAP) study, mentoring young psychiatrists in their doctoral studies of clinical and neurogenetics research.

"I have no doubt that her work will contribute to addressing the current gaps in psychiatric research in SA and Africa; and may ultimately enhance the biological, psychological and social understanding of trauma-related disorders in our vulnerable patient populations," says Prof. Stein.

In recognition of her work to date, Dr Koen has received numerous awards and in addition, was named as the 2012 - 2014 Research Fellow in the UCLA/South African Trauma Training Research (Phodiso) Scholars Programme, embarking on a 2-year international collaboration with the University of California in Los Angeles (UCLA). She is also a director of Yabonga, a non-profit organisation which supports women, children, youths and families affected by HIV/AIDS, and has recently been placed on the *Mail and Guardian*'s 200 Young South Africans list (2015).

Dr Allan Roy Sekeitto

Young Leaders Award

Nominated by Dr Boipelo Tselapedi

"Dr Allan Roy Sekeitto has shown himself to be a young leader in medicine, not only in the surgical community but in the broader SA healthcare landscape. Dr Sekeitto's contribution to the medical profession at the young age of 30 has earned him the respect and admiration of his peers and colleagues," said Dr Boipelo Tselapedi.

He holds a postgraduate diploma in management from the University of the Witwatersrand (Wits) Business School and is currently a second-year orthopaedic surgery registrar/associate lecturer at Wits University.

Dr Sekeitto is a pioneer in the orthopaedic surgery community. He served as vice president of the South African Society of Surgeons in Training (SASSiT), the first orthopaedics surgery registrar to hold this office. During his tenure he introduced the Orthopaedics Surgery Intermediate Refresher to the existing curriculum, which led to the first national training for orthopaedics at an intermediate level in SA. This was no mean feat as he concurrently maintained the high standards of excellence of the existing SASSiT surgical programmes, which have been pivotal in training numbers of SA surgeons. He also took it upon himself to expand SASSiT's corporate relations, enabling him to secure a sizeable educational grant from Medtronic to be used towards increasing SASSiT's presence.

Beyond the orthopaedic community, Dr Sekeitto is leveraging his clinical and healthcare expertise to improve access to healthcare. He is co-founder and chief medical officer of ConnectMed, an awardwinning social enterprise. This online medical platform is addressing the inaccessibility, cost, scarcity and sensitive nature of healthcare within our country. ConnectMed eliminates geographical limits to healthcare, captures lost doctor time, lowers costs and provides patient confidentiality. Through Dr Sekeitto's work, ConnectMed has received local and international recognition and acclaim.

Dr Sekeitto's work with ConnectMed has made a significant contribution to the healthcare environment and has allowed him to serve as a leader in showcasing SA medical professionals and homegrown medical solutions to the world.

Dr Tselapedi concluded: "In his community, he has led, championed and advanced the surgical trainee plight and, in the national healthcare environment, he has developed technological solutions to challenges faced in SA healthcare."

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Healthcare provider networks – are they parasitic in nature?

SAMA Private Practice Department

Healthcare provider networks are very much alive and well. They are here to stay and are not about to disappear. On the contrary, network agreements are on the increase and have now become the focal point of the healthcare delivery machinery. They are being mooted as the solution to challenges presented by equity, access, availability and affordability of care.

However, if we were to take a closer look at these arrangements, the pattern that emerges is the one that many a practitioner will take a jaundiced view of.

This is in that most healthcare provider network arrangements:

- come at a discount to medical schemes
- come at a discount to patients
- increase the number of lives under administration and therefore help ramp up the revenue for third party administrators (TPAs) and managed care organisations (MCOs).

In addition:

- Practitioners grant the discounts out of already discounted and non-market-related fees.
- The discounted practitioner fee is often not negotiated but is imposed by funders on practitioners – on a take-it-or-leave-it basis.
- As price-takers, practitioners often have no option but to be dragged into bi-specific, if not one-sided, relationships with medical schemes.

That begs the question – are these symbiotic relationships not parasitic in nature? And, if so, who benefits?

It is common knowledge that relationships between patients, providers and funders are symbiotic in nature. However, symbiotic relationships can take many shapes or forms. They can be predicated on the principles of parasitism, commensalism or mutualism, depending on the degree of harm or benefit they bring to the relationship.

Symbiosis – unpacked

Wikipedia defines parasitism as *'a non-mutual symbiotic relationship between species, where one species, the parasite, benefits at the expense of the other, the host.'*

Mutualism on the other hand is defined as *'the way two organisms of different species exist in a relationship in which each individual benefits from the activity of the other.'*

Commensalism is defined as *'a class of relationships between two organisms where one organism benefits from the other without affecting it.'*

While mutualism is preferred and commensalism is acceptable, parasitism is a non-starter and should be shied away from.

Given the material conditions and the undisputed fact that network agreements are the past, present and future of healthcare in SA, we would be remiss not to proffer guidance on what constitutes an ideal health provider network arrangement.

The criteria outlined below are aimed at doing exactly that:

- Not all network agreements should translate into discounted rates, they should be predicated on achieving a balance between cost, value and quality – in keeping with Fig. 1.
- Discounted rates should not be the only driving force behind provider network arrangements – quality of care is equally important and should be the mainstay of such agreements.
- All parties to a provider network arrangement should, where possible, offer a quantifiable discount to the patient – they should embrace the principle of mutualism or where necessary commensalism, and should stay away from any form of parasitism.
- Network agreements should be open to all healthcare providers that subscribe to the value, cost and quality triangle and should not be based on the low-cost high-quantity arrangement – after all, healthcare is a social good not a commodity or a perishable.
- All contracts should be inclusive of every provider that is willing to participate and to adhere to the contractual arrangements and should not be the preserve of those that are prepared to undercut their colleagues in order to have exclusive access to the patient base at the expense of quality and outcomes.
- Network agreements are not employment contracts and should not in any way mirror employment contracts.

In conclusion

It is common knowledge that health provider networks are the mainstay of most quality-focused and cost-effective healthcare delivery models. It therefore goes without saying that they will play a pivotal role in the NHI financing model and delivery machinery.

However, central to the development and implementation of any model is the unequivocal requirement to ensure the balancing act between value, cost and quality as depicted in the Michael Porter model (Fig. 1).

The need to incorporate what constitutes value for money and fair remuneration into health outcomes and patient experience cannot be overemphasised. Value, quality and cost are intertwined and one cannot and should not be present to the detriment of the others.

The balancing act, once achieved and adhered to, will invariably lead to a more desirable symbiotic relationship that subscribes to the principles of mutualism.

Fig. 1. Value in healthcare. Source: Prof. Michael Porter, Harvard Business School

The most common misconduct charge faced by medical officers in the public sector

SAMA Industrial Relations Department

One of the main functions of SAMA's Industrial Relations (IR) Department is to represent members at different dispute forums at the workplace. The emphasis of this article is on disciplinary enquiries. Disciplinary charges entail any conduct that would be found to be unacceptable by the employer, therefore prompting the employer to act with the objective of correcting and addressing the conduct.

Our statistics indicate that one of the prevalent charges that our members face is that of failing or refusing to attend to a patient when called by nursing staff. Five recent cases in which SAMA represented medical officers were all about failing or refusing to see a patient. It is easy for the employer to prove this charge as it would only require witnesses to say and show that the medical officer was indeed called or informed about the patient and did not attend that patient.

The charge in this regard is that of "dereliction of duty" **or** "gross negligence", especially if the patient eventually demised. The definition of dereliction of duty refers to a failure to conform to the rules of one's job, which varies according to the tasks involved. It is a failure or refusal to perform assigned duties. Dereliction of duty is a serious charge which could result in dismissal, even in the first instance.

Not every case of dereliction of duties or case of negligence results in dismissal and every case is judged on its own merits.

In a bid to substantiate their case, the employer will call in witnesses who would most likely be nurses who saw the patient and allegedly called the doctor. Although there may have been different factors that led to the doctor not going to see a patient, justifying the failure or refusal is viewed in a very serious light by the employer. In some instances the employee denies the allegations but concedes that there was a phone call from the nurses, however denying that it was about the patient.

It is therefore advisable to note or record everything, including phone calls, as any interaction among medical personnel about a patient has the potential to become a legal matter. The observation is that nurses record every detail about a patient, including the time they called for the doctor's assistance. It becomes difficult to argue with written evidence when one is trying to deny the incident took place.

The principle of "comply now and complain later" is the best option when a patient involved. Some of the reasons cited by doctors for not going to see patients are:

- they forgot to go and see the patient
- they were busy with other patients
- the history or vitals given by the nurse over the phone did not necessitate their going to physically examine the patient.

There have been cases in which medical officers have submitted that going to see the patient would not have made a difference to the patient's condition. Although there may be some truth in this, the fact that they did not attend the patient puts them in a disadvantageous position in terms of their duty to save lives.

It is also a fact that most chairpersons or commissioners are susceptible to sympathising with the employer in such cases. There is also great sympathy from the community in general when the patient has demised, prompting some presiding officers to make findings based on emotions displayed at the hearing.

In most cases IR gets to know/is informed only after the fact and therefore left only with the option to defend

It is a very difficult problem to overcome when a medical officer has failed to see a patient. It is better to see the patient to assess whether the situation is a serious one or that a patient's life could not be saved despite their intervention rather than wondering what might have happened had they gone to see the patient.

The sad reality however is that in most cases IR gets to know/is informed only after the fact and therefore left only with the option to defend.

Armbands shine spotlight on doctors' working hours

Bokang Motlhaga, *Junior Marketing Officer, SAMA*

For some time now, SAMA, together with its junior doctors, JUDASA, has bemoaned the long working hours of doctors, notably junior doctors. It's a situation that impacts upon both doctors and their patients. To highlight this problem, SAMA is launching a new campaign: doctors will now wear colour-coded armbands to demonstrate how long they have been on shift.

A green armband means the doctor has worked less than 24 consecutive hours. This means the medic is still alert and able to perform optimally. A doctor wearing an orange armband has worked more than 24 hours, while a red armband means the doctor has worked more than 30 consecutive hours. Doctors with red armbands will clearly be exhausted. They must be allowed to rest before being assigned more patients by their employer. If they are compelled to work, they present a danger to themselves and to their patients. The SAMA campaign makes it easier to identify doctors who have worked longer hours. It is also a visible reminder that SA should employ more doctors to manage their workload.

SAMA staff members packaging the armbands and getting them ready for distribution

SAMA condemns transfer of patients, calls for action to prevent more deaths

SAMA Communications Department

Pressure is mounting on the Gauteng Department of Health (DoH) following deaths of 36 psychiatric patients earlier this year. The patients had been transferred from the Life Healthcare Esidimeni facility in Randfontein, Johannesburg, to facilities run by NGOs.

SAMA has called on the Gauteng Health MEC Ms Qedani Mahlangu to do the honourable thing and resign following the death of 36 psychiatric patients. SAMA also condemned – in the strongest possible way – what it called the provincial government's premature relocation of about 2 000 patients to other NGO facilities, without investigating the suitability of facilities at these institutions, and without a viable, co-ordinated strategy for such transfers on a large scale.

On 13 September Ms Mahlangu clearly admitted that the 36 patients had died following the transfers. They were part of a group of 1 300 patients who were moved in June following a decision by the Gauteng DoH to terminate its contract with Life Esidimeni as a cost-saving measure.

SAMA said it condemned the Gauteng DoH for ignoring the expressed concerns by representatives of the medical and psychiatry fraternity, in particular by the South African Society of Psychiatrists (SASOP), as well as concerns of patients' families, and prominent advocacy groups such as the South African Depression and Anxiety Group (SADAG) and the South African Mental Health Federation (SAMHF).

"If their valid concerns and suggestions were considered and taken into account, appropriate action may have prevented the untimely deaths of these patients. We believe that what happened reinforces the perception that Government is not serious in its commitment to care for the most vulnerable members of society and have perpetuated the stigmatisation of mental health, and that 'saving money' is more important than the lives of these most vulnerable individuals," said Dr Mzukisi Grootboom, chairperson of SAMA.

SAMA National Council, its highest authority, unanimously endorsed this view and called for the MEC's resignation or dismissal by Premier David Makhura. Dr Grootboom added that "a health professional MEC is needed who can appreciate the nature of the ethical care of vulnerable patients. Non-health-professionals simply don't understand this imperative".

SASOP has subsequently declared that this case is an illustration of how poorly equipped the country's healthcare system is to handle patients suffering from mental illnesses. It said the NGOs to which the patients were moved might not have had adequate facilities with which to deal with an influx of patients.

Dr Grootboom said SAMA also supports an immediate enquiry by four psychiatric experts appointed by the Health Ombudsman to investigate the matter, as well as an independent judicial inquiry.

"We have been reliably informed by colleagues close to this issue that concerns were repeatedly raised of the level of care at the other facilities and that Gauteng Health was warned that there was a high probability of relapse of these patients if they did not receive the same structured care as at Life Esidimeni. We are talking about the most severe mental health patients. We now also need to establish the condition of the other patients who were moved to ensure their safety is guaranteed, and to prevent more deaths," added Dr Grootboom.

Coding guidelines and interpretations for writing prescriptions

SAMA Private Practice Department: Coding Unit

The Coding Unit understands that some days doctors are faced with uncertain or difficult scenarios regarding coding, such as writing of scripts during consultation and after consultation the previous day.

Initial prescription

The writing of the first prescription forms part of the consultation and is not separately coded, not even on the day after the consultation.

The interpretation of Rule A pertaining to consultation is as follows:

- Visit refers to either a patient visiting the doctor or the doctor visiting a patient to obtain a patient's medical history, perform an appropriate clinical examination and, if indicated, administer treatment, prescribe or assist with advice.
- These services must be face-to-face with the patient and exclude the time spent doing special investigations, which receive additional remuneration.

The interpretation of items 0190 - 0193 mentions that writing of a prescription, repeat prescription or sick note is included in the consultation.

Repeat prescription

Item 0132 may be used for a repeat prescription.

0132 Consulting service, e.g. writing of repeat scripts or requesting routine pre-authorisation without the physical presence of the patient (need not be face-to-face contact) ("Consultation" via SMS or electronic media included)

Item 0132 is used when repeat prescriptions are written or when requesting the pharmacy by telephone to dispense the medication. This request is made by the patient via a telephone call or electronic media, such as an SMS or e-mail and not during a consultation.

This item may also be used if the patient requests the doctor to write a pre-authorisation or call the medical scheme for pre-authorisation, and this service could be provided during a consultation or after the patient has already left the consulting rooms.

Patients are personally responsible for payment of accounts for this item if not covered by their medical scheme benefits; however, the patient needs to be informed of this.

For your coding queries, contact 012 481 2073 or email coding@samedical.org.

Eradicating rabies is a public health necessity

World Health Association

The World Veterinary Association (WVA) and the World Medical Association (WMA) recently joined forces to mark World Rabies Day (28 September) by calling for human rabies contracted from unvaccinated dogs infected with rabies to be totally eradicated by 2030 in collaboration with the End Rabies Now campaign initiated by the Global Alliance for Rabies Control. It has been estimated that rabies kills more than 60 000 people every year, about 40% of whom are children under 15 years old. It is a disease more prevalent in poor communities.

Dr René Carlson, President of the WVA, states: "Rabies is one of the deadliest diseases we know. Yet rabies is preventable if several measures are followed. Some of these measures include mass vaccination programs of dogs, humane population control of dogs through spay and neuter programs, community education about rabies and dog bite prevention, the importance of dog bite medical treatment, and availability of rabies vaccine therapy after exposure. We currently have the tools to prevent this devastating disease and eliminate the suffering of both dogs and people who contract this essentially fatal disease. Eradicating rabies is not an option. It is a public health necessity."

"Rabies is one of the deadliest diseases we know. Yet rabies is preventable if several measures are followed."

She points out that when a person is bitten by a suspect rabid animal, that person must seek immediate medical care and be evaluated for rabies vaccine therapy. If possible, the animal that bit the person should be examined, quarantined at an appropriate location, or euthanised for rabies virus infection verification by a qualified laboratory. Once symptoms of rabies appear, the disease is nearly always fatal. Canine vaccination and responsible pet ownership are essential measures to avoid this fate.

Sir Michael Marmot, president of the WMA, states: "Many countries and communities have taken the right measures to prevent or eradicate rabies. But unfortunately the disease still kills many children in poor rural communities. Rabies is a disease that is very much dependent on living conditions. So improving living conditions and fostering public health services will save many lives."

Join the WVA and WMA in raising awareness about rabies worldwide and to collaborate with the End Rabies Now campaign to eradicate rabies by 2030.

Human resources for health in SA – a new era is needed

Eric Buch, *School of Health Systems and Public Health, University of Pretoria;* **Gwendoline Malegwale Ramokgopa**, *Policy Implementation Science, Foundation For Professional Development*

Healthcare is a labour-intensive and dependent industry. Globally, roughly two-thirds of health budgets are spent on the health workforce and health system performance is deeply dependent on the successful training, deployment and management of its human resources. Yet, too often, human resources for health (HRH) remain in the shadows as a neglected aspect of health systems development. The Global Health Workforce Alliance and its Kampala Declaration and Agenda for Global Action on HRH seeks to redress this anomaly, as does the Global Strategy on Human Resources for Health: Workforce 2030. The report of the 2016 United Nations High-Level Commission on Health Employment and Economic Growth, co-chaired by the presidents of France and South Africa, has also given prominence to HRH.

To be future ready we need to grow advocacy, strategy, leadership and scholarship in HRH

The 2012 5-year South African HRH Strategy brought some focus nationally, but attention to the entire spectrum of HRH remains patchy. There have been key areas of advance and innovation, but on the whole developments in HRH remain limited. HRH is behind on meeting its seminal contribution to the goal of universal access to quality healthcare for all South Africans and the aspirations of NHI.

If we aim to improve the efficiency of our health system, some of the key HRH questions that need better answers are:

- What is the right mix of professional, mid-level and community health workers? How can we scale up health professional education to meet health needs?
- What are the next steps to meeting the HRH needs in poor and rural areas?
- What will transform HR management in health facilities?
- What innovations and technologies can ensure an enabling environment for a motivated workforce and quality care?
- How do we build the cadre of innovative and inspirational health system leaders our country needs?
- What needs to be done to strengthen regional and global platforms for HRH?

To be future ready we need to grow advocacy, strategy, leadership and scholarship in HRH. There needs to be a shift in the HR paradigm to flexible, strategic HR management, anchored in a trans-disciplinary approach. Transformative changes and innovative practices are needed in workforce planning and development, leadership and management to scale up relevant education, and in staffing, performance and retention. Lessons learned must be shared and new vistas opened. The perspectives of disciplines such as public health, people (HR) management and public administration must be integrated to find new strategies and new ideas for successful implementation.

The question is how to answer this call. It needs more than the eloquent reflections and statements by the minister of health. It needs a strong national multidisciplinary HRH community of practice, comprising HRH managers, health service leaders, strategists and researchers, to shift the discipline and to make the paradigm shift from an HR administration to an HR management and development mind-set and practice. There is also a need to assess the extent to which the HRH strategy responds to primary healthcare which is widely recognised as the most cost-effective strategy for delivering essential health interventions, for example, to reduce maternal and child mortality.

To take this agenda forward, a group of colleagues, under the banner of the Foundation for Professional Development (FDP), will be hosting a conference on 28 - 29 November entitled: "Human Resources for the South African Health System: Creating the people development and management foundation for universal access to healthcare/ the NHI". The programme will include research presentations, invited speakers, panel discussions and debates, all in a vibrant atmosphere tailored to open new vistas in our thinking.

We trust that this conference will spark interest and excitement in this neglected but pivotal building block of any successful health system, including our own. See http://www.nhiconference.co.za/ for more information on the conference.

Eric Buch

Gwendoline Ramokgopa

Cumulative errors

The Medical Protection Society shares a case report from their files

Mrs G, 34, presented to the maternity ward at 12 noon, 38 weeks into her first pregnancy. Her antenatal care had been uneventful apart from measuring slightly "large for dates". She was found to have a longitudinal lie with a cephalic presentation, and was experiencing three contractions every 10 minutes. The midwife examined her and found her to be 2 cm dilated with a fully effaced cervix and "intact membranes".

At 15h00 she was re-examined and found to be 3 cm dilated and was given 100 mg pethidine intramuscularly (IM). At 20h00 she was examined by the midwife again and still found to be 3 cm dilated. The cardiotocograph (CTG), which had been started 1 hour before, was normal, with a baseline of 140 bpm and good variability and good reactivity. Mrs G was now experiencing more painful contractions and an epidural was sited.

At 22h00 she was found to be 3 cm dilated and the "membranes were still intact", despite still having regular contractions, three every 10 minutes. No artificial membrane rupture was carried out; however, Mrs G was started on a Syntocinon (oxytocin) regimen by the midwife. There was no documentation as to whether this was carried out after verbal advice from the doctor or not, but no written prescription could be found on the drug chart, when the notes were reviewed retrospectively.

When things go wrong it is rarely because of a single isolated event

At 12h00 the CTG had become "suspicious", with the baseline 150 bpm and typical variable decelerations, and the contractions were coming five every 10 minutes. Dr A, the obstetrician on call, was notified and he advised "verbally" to stop the Syntocinon infusion, change the position of Mrs G and give her oxygen. The midwife felt the CTG improved after this.

At 03h00 Mrs G was re-examined and her cervix was found to be 6 cm dilated with "bulging membranes". These were artificially ruptured and she was found to have grade II meconium. The CTG baseline had risen to 180 bpm, there were deep late decelerations and the contractions were still strong, coming four every 10 minutes, despite having stopped the Syntocinon. Dr A was informed, but he was "busy" and had still not arrived to review the CTG by 03h35. He was re-contacted and came to assess Mrs G at 04h00. He felt she was now "fully dilated" with the head at the level of the ischial spines. He decided to carry out a ventouse delivery, which was started at 04h15. This was recorded as a "difficult delivery", but no other documentation was made.

Whenever a suspected fetal compromised baby is to be delivered, the paediatric team needs to be alerted

A 3.9 kg baby girl was delivered at 04h35, with an Apgar score of 3 at 1 minute after birth, and 6 at 5 minutes. The cord gases showed severe metabolic acidosis with a pH 6.9 and BE-18 (arterial). The paediatricians were called subsequently and the baby was transferred to neonatal ICU (NICU). Although the baby survived, she had significant hypoxic ischaemic encephalopathy and severe cerebral palsy as a result.

Mrs G made a claim against Dr A and his team for their failure to adequately monitor her baby and recognise signs of fetal distress. This lack of communication between the teams and lack of recognition of the severity of the condition resulted in the infant having severe cerebral palsy, requiring lifelong care. The claim was settled for a substantial sum.

Learning points

- When things go wrong it is rarely because of a single isolated event. Errors and incidents occur within a system and usually there is a sequence of events that occur before an accident happens.
- Although the mother and the baby were "adequately" monitored throughout the whole labour, the expert witnesses felt that there was significant substandard care in the interpretation of this CTG and the communication of the findings with the doctor involved.
- In this case the handover was poor throughout. A recognised handover model is a useful way of ensuring good communication and effective handover between health professionals and teams.
- All verbal advice about the proposed procedures should be carefully documented in the notes, e.g. position of suction cup over the flexion point on the occiput, number of pulls (ideally less than three) and time for completion (less than 15 minutes). In this case there was a 20 minute time period from application to delivery.
- The patient should be reviewed by the doctor before Syntocinon is prescribed. The membranes should be ruptured before this is done because there is the risk of amniotic fluid embolism. The patient should be fully assessed on an individual basis, e.g. signs of fetal distress on the CTG, frequency and strength of the contractions, previous obstetric history, etc.
- If there is any delay in a patient being assessed by one member of a team, seek advice from a higher level to get this expedited (e.g. supervisor of midwives, consultant).
- Whenever a suspected fetal compromised baby is to be delivered, the paediatric team needs to be alerted, so that resuscitation can be instituted as soon as the baby is delivered. In this case the baby had to be transferred directly to NICU before appropriate resuscitation was started.

Gauteng North host high tea and award ceremony for life members

SAMA Gauteng North Branch hosted a high tea and award function for life members at the Willow Manor Lodge in Irene on Thursday 13 October 2016.

Dr Angelique Coetzee, Branch Chairperson, acknowledged the important role these members have played in the Branch and the positive impact they have had on many younger doctors by the example they have set and "their contribution towards the profession and impact on the lives of so many people." She also urged them to continue their involvement with branch activities as "their knowledge and experience contributes in a very positive way and can definably contribute even further to the lives and careers of younger doctors."

During the event Special Life Member Awards were given to Prof. H J C du Plessis and Dr B A Spies for their contribution to the Gauteng North Branch.

Prof. RP Grabe (Oom Buks) with SAMA Gauteng North Branch chairperson, Dr Angelique Coetzee

Dr BA Spies (left), and Prof. H J C du Plessis (right) – Life Members Award recipients with Dr Chandré Balie

Old friends meeting up and enjoying the morning event

The tea was an ideal opportunity for old friends to reconnect, old classmates to meet up again and rekindle past experiences, even bringing together ladies who graduated together in an era when it was quite uncommon for females to graduate as doctors.

The SAMA Gauteng North Branch hopes to make this function an annual event for its Life Members and thereby acknowledge the great contribution and close relationship the branch has with all its members.

Graduated together in 1970. From left to right: Dr Erna Britz, Dr Marcell Groenewald, Dr Dorelle Kirsten

From left to right: Dr Chandré Balie, Gauteng North Branch council member, Dr Simonia Magardie, SAMA Marketing and Communications, Dr Angelique Coetzee, chairperson of the Gauteng North Branch Council and Dr H M Mahomed, SAMA Gauteng North life member

Goldfields CPD meeting on osteoporosis

From left to right: Dr Daan Malherbe (radiologist), Dr Lizzy Tabane (paediatrician), Dr Flip Nieuwoudt (GP), Dr Do-Jo Jordaan (gynaecologist), Dr Cornelius Moalusi (GP)

On 6 September 2016 Goldfields branch held a CPD meeting on osteoporosis presented by guest speaker, Dr Do-Jo Jordaan.

Osteoporosis is a serious disease, which manifests in fragile bones, which are more likely to break or fracture easily. Fragility fractures occur with minimal trauma and lead to pain changes in body shape and disability.

Common fracture sites are the wrist, compressed vertebrae in the spine and the hip. Once a hip fracture occurs, 20% of patients die within a year and 50% are never fully independent again.

The following contribute to risk:

- postmenopausal women
- hormonal imbalances can result in rapid bone loss
- women can lose up to 20% of their bone mass in 5 - 7 years
- amenorrhoea, anorexia and bulimia
- diet low in calcium
- certain medications
- low testosterone in men
- gastric bypass
- inflammatory bowel syndrome
- hyperthyroidism
- excessive exercise, caffeine, protein and salt.

The benefits of treatment of osteoporosis outweigh the risks.

Dr Jordaan emphasised that accurate assessment, prevention and diagnosis are the most effective and safest treatment for osteoporosis.

Gauteng hosts nephrology CPD

A nephrology CPD event was hosted by the SAMA Head Office and SAMA Gauteng Branch on 28 September 2016 at the Sanlam Building in Allice Lane, Sandton. Prof. Anthony Meyers, chairman of the SA Kidney Foundation presented on "A Practical Approach to Kidney Disease and Chronic Renal Failure" and Prof. Ida van Biljon spoke about "Chronic Kidney Disease - Diagnosis, Risk Factors for Progression and Management". Dr Morne Strydom from Synexus gave an interesting presentation on "Ethics in Clinical Research".

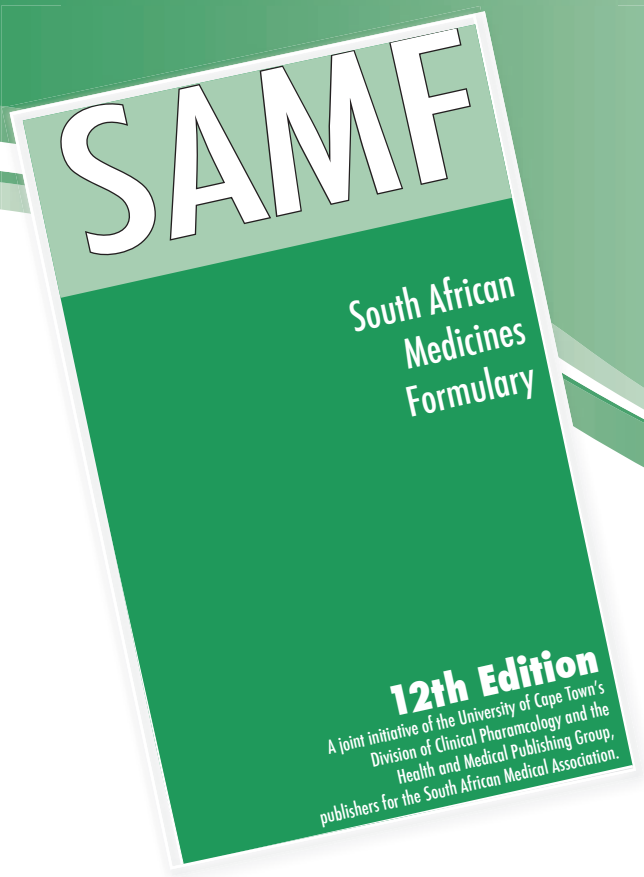
Prof. Ida van Biljon

News from Free State branch

A loyal and long-time member of the Free State branch, Dr E C Wolmarans, a general practitioner in Bethlehem, is retiring. We wish her all the best and many happy hours spending time with her grandchildren.

Branch secretary, June du Toit will be undergoing an operation and is on sick leave until the end of October. Best wishes, June.

Front row, from left to right: Dr H E van Schalkwyk, Dr E C Wolmarans, Dr F C J Bester (president), Prof. N Mofolo, June du Toit. Back row: Dr D Menge, Dr P Menge



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