

SAMA INSIDER

FEBRUARY 2017

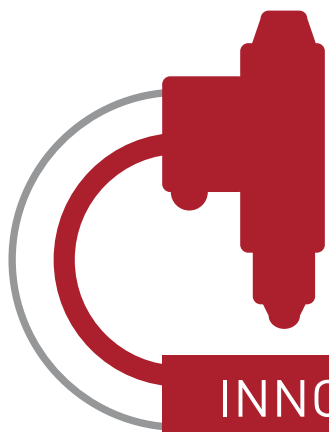
**Welcome from
SAMA chairman,
Dr Mzukisi Grootboom**

**Impact of the new DPSA
directive on RWOPS**



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

**SOUTH AFRICAN
MEDICAL ASSOCIATION**



34TH SOUTH AFRICAN NATIONAL BLOOD TRANSFUSION CONGRESS

28 - 31 AUGUST 2017 - SUN CITY

INNOVATION - LIFELINE TO THE FUTURE

SAVE THE DATE

28-31 August 2017



www.sabloodcongress.org /  South African National Blood / Transfusion Congress /  sabloodcongress / #SANBTC2017

DIAMOND:



PLATINUM:



GOLD:



SILVER:



BRONZE:



Enquiries: Scatterlings Conference & Events, Project Manager: Carolyn Melnick
Tel: 021 422 2402, Email: caro@soafrica.com

CONTENTS

FEBRUARY 2017



Source: Shutterstock - Kochneva Tetyana

- 3 EDITOR'S NOTE**
A new and demanding year
Diane de Kock
- 4 FROM THE PRESIDENT'S DESK**
The medical profession and end-of-life encounters
Prof. Dan Ncayiyana
- 5 FEATURES**
Welcome from SAMA chairman, Dr Mzukisi Grootboom
Dr Mzukisi Grootboom
- 7 An official response to the NHI White Paper**
SAMA Communications Department
- 10 The impact of the new DPSA directive on RWOPS and established RWOPS practices**
Adv. Mpotlana Daniel Madiba
- 11 SAMA welcomes 2017's new intern doctors**
Dr Mzukisi Grootboom
- 14 PPS addresses the state of the SA healthcare system and its future**
Jeanette Snyman
- 14 Teamwork and joint effort can make a difference in the lives of many - SEDASA**
SEDASA National General Council
- 15 Understanding the purpose and goals of the Labour Relations Act (1995): A crowning achievement for organised labour and workers in general**
Adv. Mpotlana Daniel Madiba
- 17 Insights into financial wellness and medical law**
Shivdev Training Academy
- 18 SAMA stakeholders' lunch**
Bokang Motlhaga
- 18 Physicians' New Year hopes about climate change**
World Medical Association
- 19 MEDICINE AND THE LAW**
Concealed sepsis
Medical Protection Society
- 20 BRANCH NEWS**

MEMBER BENEFITS



Alexander Forbes

Herman Steyn

012 452 7121 / 083 519 3631 | steynher@forbes.co.za

Offers SAMA members a 20% discount on motor and household insurance premiums.



Automobile Association of South Africa (AA)

AA Customer Care Centre

0861 000 234 | kdehyzel@aasa.co.za

The AA offers a 12.5% discount to SAMA members on the AA Advantage and AA Advantage Plus Membership packages.



Barloworld

Lebo Matlala (External Accounts Manager: EVC)

011 052 0167

084 803 0435 | LeboM@bwmr.co.za

Barloworld Retail Digital Channels offers competitive pricing on New vehicles; negotiated pricing on demo and pre-owned vehicles; Trade in's; Test Drives and Vehicle Finance.



BMW

Nicci Barry (Corporate Sales Manager)

083 200 4555 | nicolene.barry@bmwdealer.co.za

SAMA members qualify for a minimum of 8% discount on selected BMW & MINI models. All Members also receive competitive pricing on Lifestyle items and accessories as well as a Motorplan that can be extended up to 200 000km's.



FORD/KIA CENTURION

Burger Genis (New Vehicle Sales Manager – Ford Centurion)

012 678 0000 | burger@laz.co.za

Nico Smit (New vehicle Sales Manager – Kia Centurion)

012 678 5220 | nico@kiacenturion.co.za

Lazarus Ford/Kia Centurion, as part of the Lazarus Motor Company group, sells and services the full range of Ford and Kia passenger and commercial vehicles. SAMA Members qualify for agreed minimum discounts on selected Ford and Kia vehicles sourced from Lazarus Ford / Kia Centurion. SAMA members who own a Ford/Kia vehicle also qualify for preferential servicing arrangements. We will structure a transaction to suit your needs.



Hertz Rent a Car

Lorick Barlow

072 308 8516 | lorick@hertz.co.za

Hertz is proud to offer preferential car rental rates to SAMA members. A range of value-add product and service options also available. No cost to register as a Gold Plus Rewards member to enjoy a host of exclusive benefits.



Legacy Lifestyle

Allan Mclellan

0861 925 538 / 011 806 6800 | info@legacylifestyle.co.za

SAMA members qualify for complimentary GOLD Legacy Lifestyle membership. Gold membership entitles you to earn rewards at over 250 retail stores as well as preferred rates and privileges at all Legacy Lifestyle partnered hotels and further rewards back on accommodation and extras.





Diane de Kock
Editor: *SAMA INSIDER*

A new and demanding year

2017 is set to present new and continued challenges for the medical profession. In this issue SAMA chairman, Dr Mzukisi Grootboom, welcomes newly graduated doctors who will enter the public health sector as interns this year (page 11). He wishes them well and assures the young doctors of SAMA's support as they enter the over-stretched environment of public hospitals and their hugely taxing demands.

In his message to SAMA members on page 5, Dr Grootboom highlights the association's concerns, challenges and successes at the beginning of a new and demanding year. He asks members to focus their attention on several key issues and to bring those issues into SAMA structures for debate and resolution. There is power in numbers, and as Dr Grootboom says, "We all have a contribution to make and every idea is most welcome." On a similar note the *Insider* team would like to encourage readers to use this magazine as a platform for communication. In 2017, we look forward to receiving articles and letters that represent the news, concerns, complaints, ideas and queries of **all** SAMA members.

On page 8 we publish the last in a series of articles on SAMA's submission to the minister of health in respect of the White Paper for the NHI, and on page 10 Daniel Madiba looks at the impact of the new Department of Public Service and Administration directive on remunerative work outside the public service (RWOPS) and established RWOPS practices, and encourages members to contact the Industrial Relations Department if they have any questions.

Some of our branches bid farewell to 2016 in style – read about these fun events on page 20.

The *Insider* team wish readers a prosperous and successful 2017.

Editor: Diane de Kock
Chief Operating Officer: Diane Smith
Copyeditors: Kirsten Morreira, Naadia van der Bergh

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

Design: Clinton Griffin, Travis Arendse

Published by the Health and Medical Publishing Group (Pty) Ltd
Block F, Castle Walk Corporate Park, Nossob Street
Erasmuskloof Ext. 3, Pretoria

Email: publishing@hmpg.co.za | www.samainsider.org.za | Tel. 012 481 2069
Printed by Tandym Print (Pty) Ltd

DISCLAIMER

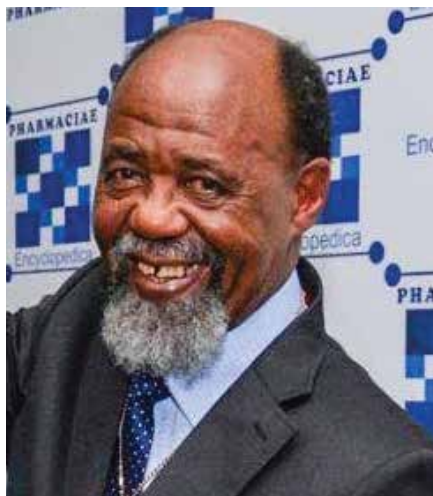
Opinions, statements, of whatever nature, are published in *SAMA Insider* under the authority of the submitting author, and should not be taken to present the official policy of the South African Medical Association (SAMA) unless an express statement accompanies the item in question.

The publication of advertisements promoting materials or services does not imply an endorsement by SAMA, unless such endorsement has been granted. SAMA does not guarantee any claims made for products by its manufacturers. SAMA accepts no responsibility for any advertisement or inserts that are published and inserted into *SAMA Insider*. All advertisements and inserts are published on behalf of and paid for by advertisers.

LEGAL ADVICE

The information contained in *SAMA Insider* is for informational purposes and does not constitute legal advice or give rise to any legal relationship between SAMA or the receiver of the information and should not be acted upon until confirmed by a legal specialist.

The medical profession and end-of-life encounters



Prof. Dan Ncayiyana, SAMA president

"I learnt a lot of things in medical school, but mortality wasn't one of them. Although I was given a dry, leathery corpse to dissect in my first term, that was solely a way to learn human anatomy. Our textbooks had almost nothing about ageing, frailty or dying. How the process unfolds, how people experience the end of their lives, and how it affects those around them seemed beside the point. The way we saw it, and the way our professors saw it, the purpose of medical schooling was to teach how to save lives, not how to tend to their demise."

This is the opening paragraph of a remarkable book entitled *Being Mortal* (published in the UK by Profile Books in association with the Wellcome Collection, 2014) that every doctor, and certainly every medical student, would do well to read. The writer, Atul Gawande, is a surgeon and an accomplished author. Born of immigrant parents, both medical doctors from India, Atul was raised in Athens, Ohio in the USA and studied medicine at Harvard. A blurb on the jacket describes the book as being "about the modern experience of mortality – about what it's like to get old and die, how medicine has changed this and how it hasn't, where our ideas about death have gone wrong". In a story that crosses the globe, Atul Gawande examines his experiences as a surgeon and those of his parents and family, and learns to accept the limits of what he can do.

He writes that it doesn't take too much effort to see how medicine often fails the elderly or those with terminal illnesses by

offering "treatments that addle (their) brains and sap (their) bodies for a sliver's chance of benefit". He relates a case that has haunted him since the days of his internship. It is the story of a man he calls Joseph Lazaroff who, in his sixties, was afflicted with a widely metastatic prostate cancer. His abdomen, scrotum and legs were filled with fluid, and he had lost movement of his right leg and control of his bowels. The cancer had spread to his thoracic spine, causing it to collapse and compress his spinal cord. The neurosurgeon offered Mr Lazaroff two options: comfort care or surgery to remove the growing tumour mass from his spine. The patient chose surgery, and it fell to the author to explain the operation and obtain informed consent.

The author's point of the story is that although Lazaroff's operation might arrest the progression of the spinal cord damage, the doctors knew "it wouldn't cure him, or reverse his paralysis or get him back to the life he had led. No matter what we did, he had at most a few months to live ... The operation posed a threat of both worsening and shortening his life." Despite these grave risks, the patient had been emphatic that he wanted the operation. The surgical procedure, which took more than 8.5 hours, was technically successful. But in the intensive care unit, Lazaroff developed respiratory failure, a systemic infection, blood clots from his immobility and haemorrhage from anticoagulant therapy. He was on life-support, and on the 14th day his son instructed the doctors to stop.

Should the surgical option have been offered in the first place? This is an American story that perhaps reflects the cultural proclivities of medical practice in that country. I have a strong sense that such a choice would not likely have been contemplated in the SA setting. What strikes the author most is not how bad the patient's decision was, but "how much we all avoided talking honestly about the choice before him". His large healthcare team included oncologists, radiation therapists, surgeons and other doctors who saw him through months of treatment who all knew his problem could not be cured, but "we could not bring ourselves to discuss the larger truth about his condition or the ultimate limits of our capabilities, never mind what might matter most to him as he neared the end of his life. If he was pursuing a delusion, so were we". He continues, "We

offered no acknowledgement or comfort or guidance. We just had another treatment he could undergo. Maybe something very good would result." That brings to mind the passing of my own wife a little more than a decade ago. She had disseminated cancer of unknown origin, and endured months of chemotherapy against my better judgement, along with its side-effects of nausea, mouth sores and other discomforts. I was deeply sceptical of the efficacy and appropriateness of chemo in her particular circumstances, but if she was pursuing a delusion, so was I. The oncologist was a lovely man who could engage her in cheerful small talk, but was as ill-equipped as I was in talking about the realities of her circumstances and fate. One day she asked the chemotherapist directly: "Am I going to die?" and his best answer, as he was quickly getting ready to escape was, "Well my dear, we are all going to die."

Counselling for a terminal patient and their family is a skill that ought to be taught in medical school, and is hopefully beginning to be incorporated in the medical curricula of some medical schools in disciplines such as family medicine and medical bioethics. There certainly is a body of knowledge in the literature on this subject, as the concept of hospice and palliative care has emerged and taken root. For example, an article by Sullivan *et al.* from the Dana-Farber Cancer Institute in Boston reports on a study conducted at US academic medical centres: "*in the clinical arena, students are systematically protected from, or deprived of, opportunities to learn from caring for dying patients. When they do participate in this care, they lack role models with expertise to learn from, as well as feedback and support that facilitate clinical growth. Although faculty profess that end-of-life care is an important learning domain for trainees, students and residents perceive a much lower level of faculty support for learning about care of the dying. Although students and residents regularly break bad news to patients and talk with them about their wishes and values about end-of-life care, (many) feel ill-prepared to address patients' fears about dying, about half feel poorly prepared to address cultural and spiritual issues, and almost half feel ill-equipped to manage their own feelings about their patients' deaths. While preparation is likely to improve with clinical experience, these levels of preparation are unacceptably low and not likely to improve without focused teaching.*"

Welcome from SAMA chairman, Dr Mzukisi Grootboom



On behalf of the Board of SAMA I would like to wish all our members a prosperous and successful 2017. SAMA is and will remain the representative association for all medical doctors in SA. We are appreciative and honoured at the opportunity to represent and serve the nation's doctors.

As we usher in 2017 it is time for us to reflect on the past year. 2016 has been a challenging year for all at SAMA and to the profession at large. The year ahead in medicine, tumultuous as it promises to be, holds several key issues on which doctors as a whole should focus their attention.

The medical profession in this country is unique in that it is often its own worst enemy in not realising how effective it is as a united profession. This characteristic has had the effect of preventing SAMA as the national professional association from fully realising its main objective of "uniting the profession for the health of the nation". That said, SAMA remains the voice of the doctor in this country. For instance, I am often asked how we allowed ourselves to be part of the current HPCSA. My answer to this question is that doctors are part of society and some of the decisions taken may have been influenced by the developments in our country since the advent of democracy.

Organisations and individuals want to be politically correct, and in the process forget the purpose of their very existence as a professional organisation and their mission in society. Professional organisations exist to defend and promote the livelihood of their membership, to promote and advance the science of medicine, and to pursue the betterment of health. Of paramount importance in the medical field is self-regulation, as it is not only an ethical requirement but is part of good patient care. It is my view that had the profession been united in defending their position and not succumbed to political and other tendencies, we would not have found ourselves under the control of the legal and other professions as is the case today. What makes things even worse is that despite the recommendations of the recent ministerial task team, the Medical and Dental Board has not moved on the recommendations but is seemingly complicit in its silence on the matter. This is one issue that we as the medical profession, irrespective of our differences, need to prioritise in 2017. SAMA appeals to all doctors for their support in demanding an independent medical and dental board.

**The year ahead
in medicine,
tumultuous as it
promises to be,
holds several key
issues on which
doctors as a whole
should focus their
attention**

What are the other issues likely to affect us as a Profession in 2017? There are various changes and reforms in the pipeline. Most critically: the proposed National Health Insurance (NHI) system; a change in the Commuted Overtime Policy and Remunerative Work Outside the Public Service (RWOPS) policy;

a Safe Working Hours Policy; progression of the new registration requirements for specialists; amendments to the Medical Schemes Act (MSA); a revision of the PMB regime; the appointment of the new CEO of the Council for Medical Schemes (CMS); the introduction of new reimbursement models; the proliferation of benefit plans by various medical aid funds; high medical litigation costs; and the conclusion and announcement of the findings and recommendations of the Health Market Inquiry. The list is nowhere near exhaustive. The issues are vast and varied and, for example, we have been informed that the National Health Council (NHC) finalised the new RWOPS policy following input from various stakeholders, including the National Committee of Medical Deans.

SAMA would like to thank all those who have contributed to our comments on the White Paper and we would like to confirm that your comments were included in the comprehensive SAMA submission. My thanks go to the SAMA secretariat and in particular the Knowledge Management and Research Department for managing and overseeing the NHI project. The document is available on our website and you are welcome to read and continue to comment.

An issue that we have been grappling with recently is the new Commuted Overtime Policy. SAMA would like to place on record that following the consultation process with members and having taken all contributions into consideration, a SAMA submission was made to the national DoH (NDoH). Following this process, there were various related activities at the NDoH and the NHC aimed at finalising the policy. Despite approaches made (by SAMA) to highlight problematic areas in the document, these inputs were not considered. This happened despite an acknowledgement (on the part of the NDoH and the NHC) of merits of the SAMA submissions. To date the implementation of the new policy has been placed on hold following an agreement between the SAMA leadership and the national director general. Negotiations on the policy will commence in January 2017. Following a meeting of the Interim Employed Doctors Committee (IEDC) and SAMA branch representatives in late December 2016 a communication has been sent to the branch

chairpersons to engage the membership in the finalisation of all outstanding issues.

SAMA appeals to all doctors for their support in demanding an independent medical and dental board

The safe working hours policy has been agreed to by the NDoH, the profession and the regulator. We would like to appeal to all colleagues involved to make SAMA aware of any deviations and would also encourage our senior colleagues to assist in its implementation. In the event there are challenges through poor staffing, these must urgently be brought to the attention of the SAMA Industrial Relations Department.

The new specialist registration regulations were implemented in 2016, much to some consternation in many quarters, and various challenges were brought to our attention by the South African Registrars Association (SARA). A delegation of SAMA leadership met with the national deputy director-general (DDG), the president of the HPCSA and his delegation in late October 2016. The meeting decided that there was a need for a summit of all the stakeholders, including the profession, the HPCSA, the Colleges of Medicines SA, the Committee of Deans and the NDoH to address all the issues related to the new registration requirements, including the challenges that have been identified. The meeting/summit is expected to take place in 2017.

We would like to appeal to the NDoH to not shirk its responsibilities and the stewardship role it has over the provincial health departments

The issue of a lack of effective leadership in many of our public healthcare facilities has become a very serious concern to SAMA, particularly when the problem affects healthcare delivery adversely in many instances. What is even more bothersome is the complete lack of consequences and accountability. We would like to appeal to the NDoH to not shirk its responsibilities and the stewardship role it has over the provincial health departments.

Amendments to the MSA are in the offing and, more importantly, there is a process underway to modify the current PMB regime. SAMA would like to appeal to all our members in the private sector to make their contribution and comments known to the relevant private practice committees. SAMA is preparing a submission on behalf of its members.

SA has been lauded in many quarters around the world for having "independent regulatory bodies". What is of concern, however, is the consistent appointment of compliant and perhaps not so independent leaders in these institutions. Recent CMS appointments have raised concerns within SAMA but despite our reservations, for now we have decided to keep an open mind. We know for a fact that the new incumbent has been in the forefront of a fight in our courts to scrap Regulation 8 of the MSA. This is despite his full knowledge of the fact that the said regulation is there to protect medical scheme members from financial ruin. This is also secondary to the built-in protections that the MSA has afforded the schemes to mitigate the potential financial risks associated with the current PMB regime. There are moves afoot to introduce new reimbursement models by the major medical scheme administrators. The reasons given are that they want to curtail the high healthcare costs that are currently prevalent in the private sector. As a profession we have expressed our concern with high healthcare costs, have identified the main cost drivers, and appealed to the regulators to reign them in, to no avail. There are allegations made that doctors and specialists in particular are responsible for the problem and therefore the fee for service must be abandoned in favour of these models. The other concern is that costs due to non-healthcare factors, i.e. the hospital groups and allied health practitioners, are ignored. What is even more concerning is that this happens without consultation or communication of data to support the assertions made. Worse still, this happens in an environment where

there is weak regulatory control on the part of the CMS, which is supposed to protect the interests of medical scheme members. I would strongly advise all members in private practice not to sign any contract without proper advice from the SAMA legal team.

As a profession we have expressed our concern with high healthcare costs, have identified the main cost drivers, and appealed to the regulators to reign them in, to no avail

The administrative **and** regulatory burden placed on our doctors in private practice is likely to continue unabated in 2017. Doctors in this country spend too much of their time on administrative tasks rather than patient care. Colleagues have to navigate a minefield of different medical funds that are in existence in this country. There are 86 registered schemes, each with an average of 6 - 8 benefit plans. There are currently about 322 of these benefit plans registered with the CMS, each with its own rules. There is enough evidence available to indicate that this kind of risk pool fragmentation is not sustainable and against sound financial principles. For any healthcare financing to be sustainable, the following are applicable:

- There must be pooling of financial and health risks.
- The size of the risk pools must be large enough to allow for adequate and meaningful cross-subsidisation between the rich and the poor, and between the sick and healthy.

Contrary to the provisions of the MSA, the CMS has allowed this practice to continue. Besides the financial implications for the scheme members, the profession is unknowingly exposed to an ethical dilemma of having to discriminate between those patients on high-benefit options and those on low option plans. The question that has to be asked is who benefits from this situation. The answer

is that the administrators have a lot to gain in this iniquitous situation. I dare say that the regulator and the trustees of medical schemes should share some of the blame for shirking their oversight role, which is clearly defined in the MSA.

Doctors in this country spend too much of their time on administrative tasks rather than patient care

The issue of the high medical litigation costs is a priority that we all have to address this year, and recent announcements on law reform are welcome. Briefly, there are currently other proposals that involve alternatives to litigation and are related to alternative dispute resolution. The national minister of health has taken a leadership role in addressing this problem and has setup a ministerial task team wherein SAMA is a participant. The Medical Protection Society has also looked at the current proposals and have circulated their

own proposals and comments on how to address the problem.

The Competition Commission market inquiry on healthcare is still underway and we believe it is in the process of developing recommendations, which we anticipate will have a positive impact on the industry as a whole. SAMA was a participant in the process, and to that end we have made both written and verbal submissions. While we are in support of the process, as we believe it will once and for all give us an indication of the real cost drivers in the private health sector, we have great concerns that it might just be a smoke screen for a predetermined outcome. We are waiting, with keen interest, for the release of the final report.

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

We are renewing our commitment to excellence through our strategic focus. I assure you of our commitment and dedication to you as our members and encourage you to get involved and become part of the decision-making processes. Please continue

to make suggestions that will make SAMA a continually better representative body. With each idea, each innovation, each initiative, together we are improving our working conditions, practices and the health outcomes of our patients.

The issue of the high medical litigation costs is a priority that we all have to address this year

We will continue to build unity and serve the profession with dignity. I would like to thank all of you for the privilege of serving you. I would also like to appeal to those of you who believe that the issues that face us as an organisation should and can be dealt with successfully outside of the organised formations of your organisation, to rather bring those issues into the SAMA structures for debate and resolution. We all have a contribution to make and every idea is most welcome.

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

SAMA, in compiling an official response on the NHI White Paper, consulted members in various categories. In addition to a member survey undertaken in December 2015, the various structures of SAMA were consulted on a continuous basis. The following is a brief summary of chapters 10 and 11 of the submission.

Chapter 10: Legal perspective on the White Paper

This chapter gives a comprehensive overview of the predominant legislative and regulatory aspects relating to the implementation of the NHI, providing legal guidance and highlighting potential legal pitfalls that must be avoided in any foreseeable changes to legislation necessitated by its implementation. The chapter identifies over a dozen directly health-related Acts and regulations, as well as a flurry of non-health statutes (e.g. the Income Tax Act and Patents Act). These must be carefully considered, reviewed and aligned in the course of NHI implementation, and this chapter underscores the fact that strict adherence to the principles entrenched in the rule of law, and reinforced by the South African Constitution, will be essential for the success of the NHI. The National Department of Health (NDoH) and the NHI system will be expected to comply with all this legislation.

Some examples of legal precedent included in this chapter highlight a number of critical issues that could arise under the NHI, for example:

- limitations imposed on the state's constitutional obligation to provide healthcare services as a result of budget constraints
- the risk of health regulators acting outside their statutory mandate in contravention of the Promotion of Administrative Justice Act
- the need for an appropriate balance between the interests of the public in having access to affordable healthcare, and

the interests of suppliers or providers and their viable livelihoods.

With regard to the Office of Health Standards Compliance (OHSC), a 3-year-old statutory body, SAMA regrets the absence of final norms and standards regulations to give the entity full powers, especially against the background of evidence (following inspections) of serious non-compliance by health facilities. SAMA supports the principle that both the OHSC and the ombudsman should remain totally independent from undue influence by the state.

SAMA supports the principle that both the OHSC and the ombudsman should remain totally independent from undue influence by the state

In relation to the Medical Schemes Act (MSA), this chapter interrogates section 8.10 of the White Paper ("The future role of medical schemes") and raises two major issues:

- The White Paper is disconcertingly vague on specifics in relation to the NHI v. the future of medical insurance and medical schemes. With specific reference to "Demarcation Regulations" drafted in terms of the Long-Term Insurance Act of 1998, SAMA submits that medical schemes (regulated by the MSA) and insurance products (regulated by the Short- and Long-term Insurance Acts) for a variety of health services should still find regulated application under the NHI until such time as a proper public sector health service system can carry the weight of adequate health services without the need for these additional insurance products.

- The White Paper's suggestion that, on full implementation of the NHI, the only cover to be provided by medical schemes will be complementary and not duplication, is too drastic, and should be reconsidered in the absence of assurances that the NHI services will be available and of acceptable quality.

The Medicines and Related Substances Amendment Act (2015) created the SA Health Products Regulatory Authority (SAHPRA), which SAMA hopes will manage to accelerate the medicine registration process to such an extent that quality-approved generics can rapidly enter the health system, while maintaining quality standards. SAMA supports efficient and effective regulatory control of the very large complementary medicine industry, to be incorporated, or cross-referred to, in the eventual NHI Act, based on a risk-based approach under the auspices of SAHPRA.

With regard to PMBs, the minister of health's intention to change regulation 8 alongside the NHI implementation is noted, but SAMA has to caution that any capping of the current "payment in full" obligation of medical schemes without effective alternatives firmly in place will be detrimental to patients who cannot afford co-payments, and who will have only the current public sector facilities to rely on, with, for example, frequent stock-outs of life-saving antiretroviral medication. Any foreseen regulatory changes in this regard will have to be approached with the utmost caution. The ministry must remain careful that in their efforts to improve healthcare they do not deliberately reduce the health status of medical aid beneficiaries in order to achieve their equalisation with the rest of the population.

A number of paragraphs in the White Paper allude to access to and affordability of health services and goods, including medicine. SAMA supports the right afforded to government to regulate the price of medicines – in both the public and private sectors – provided that such regulation is effected within practical and reasonable parameters, and in an open and transparent manner, with due regard to economic viability.

This chapter also highlights and recommends initiatives (such as SAHPRA's membership of the International Consortium of Medicines Regulatory Authorities) that enhance the international harmonisation of medicine laws. SAMA fully supports all such essential interventions that ensure the availability and provision of essential and other medicines to South Africans. SAMA, regrettably noting that patents are not properly scrutinised in the SA system, and that the patent system undermines access to medicines, recommends drastic review of the Patent Act and the removal of patent protection from the Trade-Related Aspects of Intellectual Property Rights (TRIPS).

The government's proposed use of external reference pricing (ERP) benchmarking against countries such as Australia, Canada and New Zealand is noted. It is SAMA's contention that for the NDoH to effectively implement ERP as part of medicine price regulation in SA, it would require data on true negotiated prices rather than shadow prices, and that its legislation framework for the use of ERP will have to be sound, including the criteria of choice for reference countries.

In respect of price regulation, it is noted that although individual item price regulation may produce savings to health systems, it is not guaranteed that the overall cost of rendering health services will be reduced by price regulation, without considering health outcomes, the availability of services and the utilisation and costs of resources in other parts of the social security system.

On VAT as a revenue stream for the NHI, it is SAMA's recommendation that VAT on essential medicines be scrapped to broaden access to these medicines, as was done in Ukraine. It is recommended that the components used for the manufacture of medicine locally be exempted from import duties.

Product liability legislation is investigated with reference to the Consumer Protection Act and its influence on SAHPRA, and it is pointed out that regulatory development supporting the NHI will have to keep track with pharmaceutical and other healthcare innovations.

The possible influence of the soon-to-be-promulgated Protection of Personal Information Act on the National e-Health Strategy and the normative standards for e-health is cautioned against.

The White Paper gives scope for the contracting of private healthcare providers for the NHI. SAMA notes the limited number of GPs who have, to date, signed the contracts, due to the unreasonable contracting model ("contracting in") and contracting rates offered. SAMA strongly contends that any capitation model in terms of a regulatory price regime set by the NHI (also with reference to paragraph 335, where the White Paper expressly states that the minister and the NHI Fund will determine their own pricing and reimbursement systems) will have to be economically viable for GPs to be enticed to enter into contracts based on such a regime.

The chapter concludes that it will be essential for the NHI to be harmonised with the necessary legal changes that must give effect to the successful implementation thereof. Gradual changes will provide stability and the effective provision of the resources needed to enable effective transitional arrangements until the system is fully operational. Legal changes should be phased in by providing different operation dates for various sections of new or amended legislation, allowing sufficient time to plan for the additional responsibilities, functions and resources needed to give effect to the legislation.

Chapter 11: Governance perspective on the White Paper

Good governance is imperative for a successful NHI in SA. Governance within the NHI health system ought to mirror generally accepted global governance principles. SAMA lauds the White Paper's acknowledgment of the important role of good governance in the achievement of its goals, in view of the fact that Thailand's success with universal healthcare is inter alia attributed to the good governance achieved through its development of institutional capacity.

Beginning with providing a comprehensive WHO definition of "governance," encompassing six aspects, this chapter elucidates the role of governance in the NHI, and highlights specific governance issues and challenges prevalent in SA.

The White Paper provides envisaged commitments on governance structures, and promises the improvement of the management and governance of health facilities at primary healthcare and hospital levels, by strengthening these "in terms of structure, powers, delegation, financial management and accountability".

Regrettably, the NHI is being implemented in an environment riddled with serious governance challenges, especially in the public sector, namely: corruption; poor management at various levels (aggravated by a lack of accountability); a notable lack of implementation of existing policies, regulations and guidelines; and a lack of proper evaluation and monitoring. SAMA is concerned about the NHI's capacity to meet these challenges.

If the success of the NHI depends on decentralisation, the barriers to it must be addressed urgently

SAMA highlights the fact that certain NHI-related entities, which are supposed to have autonomous decision-making powers, must be protected by legislation. These include the OHSC, the NHI fund, and the National Health Commission. SAMA is also concerned that decentralisation to district level was first proposed in the 1997 White Paper on the transformation of the health services. Almost 20 years after this proposal, decentralisation to district level has not been implemented. It is very important that the NDoH reviews why the decentralisation to district level has not yet happened. If the success of the NHI depends on decentralisation, the barriers to it must be addressed urgently.

SAMA also strongly supports the establishment of an independent Medical Practitioner Council, especially in light of the acute deficiencies identified in respect of the HPCSA.

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>

The impact of the new DPSA directive on RWOPS and established RWOPS practices

Adv. Mpotlana Daniel Madiba, SAMA Organising and Bargaining Unit

The minister of public service and administration in the Department of Public Service and Administration (DPSA) has approved the new public service regulations that took effect on 1 August 2016. Some of the regulations deal with the issue of remunerative work outside the public service (RWOPS), and provide more detail on the application process and the general management of RWOPS. This article focuses on these, which took effect on 1 November 2016.

The Public Service Act, 1994

The laws regulating the conduct of public service employees allow public servants to engage in work outside their normal employment. Through the Public Service Act (the Act), the government recognises the need to allow certain categories of public service employee to undertake other remunerative work outside the public service. Section 30 of the Act provides that "(1) no employee shall perform or engage himself or herself to perform remunerative work outside his or her employment in the relevant department, except with written permission of the executive authority of the department".

The laws ... allow public servants to engage in work outside their normal employment

In deciding whether or not to grant permission, the executing authority shall take into account whether or not the outside work could reasonably be expected to interfere with or impede the effective or efficient performance of the employee's functions in the department, or would constitute a contravention of the code of conduct of the public service. This legal provision allows employees to apply for and be considered for

remunerative work outside the public service, while having regard for the considerations that the executing authority may take into account in deciding whether or not to grant permission.

An application for RWOPS prior to commencing the work outside the public service is compulsory

Therefore an application for RWOPS prior to commencing the work outside the public service is compulsory. However, should the executing authority fail to make a decision within a 30-day period, it is assumed that permission was given to the employee to perform RWOPS for a period of 12 months. In this regard, failure by management to respond within the prescribed timeframe cannot be to the detriment of the employees. This provision is sensible as it demands accountable, effective and efficient public service management and administration.

The RWOPS directive – further details

The directive, which was passed by the DPSA minister, took effect on 1 November 2016 and applies to all government departments. The directive introduces the office of an ethics officer appointed by the executing authority of each government department, in terms of regulation 23(1) of the 2016 regulations. The ethics officer has the overall duty of ensuring the smooth management of the RWOPS process.

It is stated that the purpose of the directive is to promote ethical behaviour among public service employees, reduce possible perceived and potential conflict of interest and set out the application process for performing other remunerative work, among other things.

Application process

- The directive provides a prescribed form to be completed in application for RWOPS.
- The directive provides that the request and the approval may not be for a period exceeding 12 months.
- The 30 days in which the department has to respond to the request/application for RWOPS begin on the date on which a duly completed form is submitted to the ethics officer.
- The ethics officer has three days to submit the form to the supervisor of the applicant for recommendations as to whether or not to support it. The supervisor then has 5 days to make a decision.
- The ethics officer receives the returned form and further considers the recommendation, analysing all the information supplied. He or she must pass the application over to the executing authority within 7 days.
- The executing authority or delegated authority must receive and decide on the application (and adhere to the 30-day period).
- On approval, a signed certificate of approval must be issued to the applicant.

Transitional measures

In terms of the regulations, the following transitional period is introduced to manage existing approvals:

All approved applications granted prior to the coming into effect of the directive on 1 November 2016 will terminate within 6 months from the commencement of the directive, at the end of May 2017. Those employees who wish to continue with RWOPS will need to submit new applications in line with the new regulations.

Internal and external transfer and new appointments

Applications for RWOPS will be reviewed should an employee be transferred or reassigned within the department. Therefore, employees transferred or reassigned within the department are required to inform the ethics officer within 5 days of this happening, in order for the review to be conducted.

Members are encouraged to contact the Industrial Relations Unit with any issues of clarity or questions regarding these developments.

SAMA welcomes 2017's new intern doctors

Dr Mzukisi Grootboom, SAMA chairman

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

Most of you would have either taken the Hippocratic oath or made the Declaration of Geneva in your different universities, and we hope you will adhere to these and treat human life with the utmost respect. It is also important to note that our profession is not only a calling, but also represents the ultimate gift by humanity to the profession – allowing us to learn from people, not only when they are alive but even from their dead bodies, too. Humanity, in turn, expects nothing less than your full commitment to the best interests of your patients in all your decisions in the practice of your profession. You will be held in high esteem by society, but it is important to always maintain your humility, and always to have time to talk to your patients and their relatives. Your advice and recommendations must be made together with them, and decisions taken about any intervention should always be with their consent and full understanding. You must remember that particularly in the environment in which we are currently practising, with such high levels of litigation, communication is not only an ethical obligation but also your best defence.

Public respect for the medical profession is extremely high, and that privilege rests on mutual trust. Always remember to treasure that trust; your professional life will be most rewarding and you will experience immeasurable satisfaction.

Being a doctor in SA has its own challenges, as there are not many of us. Some of you may work long hours, despite the recent negotiated changes, and experience challenging conditions as a result of SA's high burden of disease. You will find satisfaction in knowing that your senior colleagues will always be available for advice and to offer a helping hand. You will also find that in facing adversity you will experience the proudest moments of your career.

Please remember that internship is your first opportunity to learn medicine hands-on. There is no substitute for experience in



Intern orientation at Kalafong Provincial Hospital



Ms Keletso Makwe (SAMA industrial relations advisor) delivering the SAMA presentation at Tembisa Hospital

Medical Practice Consulting

Inge Erasmus

0861 111 335 | werner@mpconsulting.co.za



MPC offers SAMA members FREE access to the MPC Online Medical Education platform. SAMA members further have access to Medical Scholarships through MPC for online CPD, CME and Short Courses as well as the attendance of international conferences. For more information, please visit www.mpconsulting.co.za

Mercedes-Benz South Africa (MBSA)

Refilwe Makete

012 673-6608

refilwe.makete@daimler.com



Mercedes-Benz

Mercedes-Benz offers SAMA members a special benefit through their participating dealer network in South Africa. The offer includes a minimum recommended discount of 3%. In addition SAMA members qualify for preferential service bookings and other after market benefits.

SAMA eMDCM

Zandile Dube

012 481 2057 | coding@samedical.org



SAMA eMDCM™

67% discount on the first copy of the electronic Medical Doctors Coding Manual (previously known as the electronic Doctor's Billing Manual).

SAMA CCSA

Zandile Dube

012 481 2057 | leoniem@samedical.org



CCSA: 50% discount of the first copy of the Complete CPT® for South Africa book.

Tempest Car Hire

Corinne Grobler

083 463 0882 | cgrobler@tempestcarhire.co.za



SAMA members can enjoy discounted car hire rates with Tempest Car Hire.

V Professional Services

Gert Viljoen

012 348 3567 | gert@vprof.co.za

10% discount on medical practice bureau service through V Professional Services.



Xpedient

Andre Pronk

+27 83 555 2885

Sales – 086 1973 343 | andre@xpedient.co.za



Xpedient's goal is to enable Medical Specialists to focus on their core competencies and allow us to assist them in making their business a success.

As a SAMA member you qualify for a complimentary preliminary business assessment specific to your practice to the value of R 5000

16/01/2017

MEMBER BENEFITS





Intern orientation at Helen Joseph Hospital

medicine. Therefore, make sure you make full use of the opportunities you are given, and never stop asking questions or even challenging the dogma that you may hear from some of your senior colleagues. You now have an opportunity to decide what kind of doctor you want to be, and whether you want to make a difference to the lives of your patients. You must also remember to regard your internship as another step in lifelong learning. You will, without a doubt, find more growth and fulfilment the more you make use of the opportunities that are presented to you.

As interns you may encounter challenges that seem incompatible with good working conditions, and possibly some unfairness as well. Remember that your medical association is there to look after your interests – never hesitate to call and discuss your issues. You may find your local representative in the hospital in which you work, at the closest SAMA branch, or in a senior colleague who is a SAMA member. If all else fails, please do not hesitate to contact the SAMA head office on 012 481 2000.

Medicine is well known for the collegiality that exists among members of the profession.

You must take advantage of that, as you are likely to develop and nurture some of the best relationships of your life. You must never shy away from discussing with colleagues the challenges that you may come across, whether they are of a professional or personal nature.

We sincerely hope that you will continue to play an active role in the affairs of your profession by taking part in SAMA activities. As a junior doctor you will also find a home in the Junior Doctors Association of South Africa (a special interest group of SAMA), if you are not a member already. You are joining the profession at a time when SA is undergoing a series of healthcare reforms, some of which will have positive impacts, while some may have the opposite effect. By being part of your professional association, you have a unique opportunity to influence the outcome of some those policy decisions. Remember also that not only will you be able to advocate for your profession, but you will also be in a position to advocate for your patients and the community at large.

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



Chris Hani Baragwanath Academic Hospital's intern orientation



Prof. Chauke delivering the SAMA presentation to Dr George Mukhari Hospital's interns



Dr Kim Harper (chairman of the Border Coastal Branch) presenting to the Frere Hospital interns

PPS addresses the state of the SA healthcare system and its future

Jeanette Snyman, Senior Marketing Officer, SAMA Head Office

On 24 November 2016, the Professional Provident Society of South Africa (PPS) conducted a panel discussion to address the current state of the SA healthcare system and its future, to which Dr Mzukisi Grootboom, chairperson of SAMA, was invited. The panel discussion was held at the society's head office.

PPS has taken note that most healthcare professionals are concerned about the future of the SA healthcare system. These concerns are not limited to the potential implementation of the National Health Insurance (NHI) but also involve current issues relating to access to affordable healthcare.

The keynote speakers were Prof. Alex van den Heever, chairperson of Social Security at the University of the Witwatersrand School of Governance, and Dr Brian Ruff, chief executive officer at Professional Provider Organisation Services.

Prof. van den Heever addressed the attendees on the current state of the healthcare system and the possible future, while Dr Ruff's presentation emphasised accountable care as the solution to numerous challenges encountered within the healthcare field.



Gerhard Joubert, head of marketing at PPS, leading the panel discussion

Teamwork and joint effort can make a difference in the lives of many – SEDASA

SEDASA National General Council

The Senior Employed Doctors Association of South Africa (SEDASA), a SAMA interest group that constitutes the majority of SAMA membership in the public sector, in collaboration with the South African Cancer Association (CANSAs) and EQURA Health, has embarked on a project to support CANSAs oncology care centres in Bloemfontein by contributing and raising R80 000 towards replacing old beds for oncology patients, and for other needs identified at the care centres.

CANSAs oncology care centres in Bloemfontein serve almost 50% of the geographical land area of SA. They provide treatment to patients from the Free State, Northern Cape, North West, part of the Eastern Cape and Lesotho. The patients rely on CANSAs oncology care centres such as House Olea and House Katleho for accommodation while undergoing treatment.

Teamwork plays a fundamental role in patient care, in the workplace and in the community. SEDASA has demonstrated this by making a substantial difference to the lives of the oncology patients being

treated at the care centres in Bloemfontein, by promoting general wellbeing and the awareness of prostate cancer, and by donating 13 new mattresses and base sets.

The new mattresses and base sets and the additional funds raised were handed over to CANSAs at a fitness and prostate awareness event on 25 November 2016 at the Nelson Mandela Drive oncology centre in Bloemfontein. The event, supported by SEDASA leadership, was honoured by the presence of the Cheetahs rugby team, Kovsie Karate Club, several sports stars and renowned specialists in prostate cancer and sport medicine.

SEDASA National General Council, while addressing visibility concerns raised by

SEDASA members during the random provincial support visits, resolved to use this project to maximise SEDASA visibility, promulgate the name of our beloved organisation SAMA and demonstrate that we care for our patients and the community at large.



SEDASA leadership and the Cheetahs rugby team. From left to right: Dr Mathabo Hlahane (SEDASA National Marketing and Communication Leader), Cheetahs mascot, Johan (Aranas) Coetzee, Michael van der Spuy, Dr Ayodele Aina (SEDASA national chairperson), Dr Dirk Hagemester (SEDASA Free State provincial leader), Tian Meyer; and in front: Dr Deon Menge (SEDASA project and campaign coordinator)

Understanding the purpose and goals of the Labour Relations Act (1995): A crowning achievement for organised labour and workers in general

Adv. Mpotlana Daniel Madiba, SAMA Organising and Bargaining Unit



- *collective bargaining at sectoral level*
- *employee participation in decision-making in the workplace*
- *the effective resolution of labour disputes."*

Meaning and importance of the concepts contained in section 1

Social justice

In broad terms, the concept of social justice involves finding an optimum balance between our joint responsibilities as a society and our responsibilities as individuals to contribute to a just society. Furthermore, it is acknowledged that many different ideas exist about where the optimum balance lies. The earliest recorded ideas of social justice applied solely to a particular people or nation, with the intention of redressing the effects of hierarchical inequalities, and particularly inherited inequalities.

In the SA context, the concept of social justice encompasses the broader context of addressing the injustices of the past and the restoration of the lost human dignity of the people populating our country. Given that the purpose of the LRA is to give effect to and regulate the fundamental rights conferred by section 23 of the Constitution of the republic, it is worth understanding the context in which social justice is associated with the broader constitutional aims. In this regard, the preamble of the Constitution states in part that it is adopted as the supreme law of the republic, so as to heal the divisions of the past and establish a society based on democratic values, social justice and fundamental rights.

In addition, the Constitution instructs the courts, tribunals and forums that when interpreting the Bill of Rights (which includes the rights in section 23), they must promote the values enshrined in the Constitution which underlie an open and democratic

society based on human dignity, equality and freedom (in addition to considering international law and, when appropriate, foreign law).

SA, as a member state of the International Labour Organization (ILO), is also expected to adhere to the constitutional imperatives of the ILO, which affirm that "universal and lasting peace can be established only if it is based on social justice", including the following:

- decent work
- social wage
- living wage
- access to family responsibility leave
- the right to take annual leave
- the right to strike
- the prohibition of child labour
- the right to safe working conditions
- access to justice.

Therefore, given the gross injustices of the past suffered under apartheid rule, it is unsurprising that the achievement of social justice is an important pillar of the SA labour relations environment and discourse. The enactment of labour relations, which recognise social justice as one of the goals to be achieved, represents an important element in the achievement of better lives for workers.

Economic development

From a policy perspective, economic development may be defined as any efforts that seek to improve the economic well-being and quality of life of a community by creating and retaining jobs, and supporting or growing incomes and the tax base. Economic development is also represented by the quantitative and qualitative changes in an existing economy. It involves the development of human capital, increasing the literacy ratio, improving important infrastructure, the improvement of health and safety and other areas that aim at increasing the general welfare of the citizens.

Economic development is important because it leads to improvements in

The Labour Relations Act No. 66 of 1995 (LRA), as amended, is generally argued to be the crowning achievement for South African trade unions and workers in general. This is of course in view of the fact that the Act was literally negotiated to an extent that no other legislation before or since has been, with the exception of the Constitution itself. This article surveys the purpose, meaning and importance of the Act and the extent of the achievement of its stated goals and primary objects.

Section 1 of the Act explains the purpose of the Act, and states that this is to advance economic development, social justice, labour peace and the democratisation of the workplace, by fulfilling the primary objects of the Act, which are:

- *"to give effect to and regulate the fundamental rights conferred by section 23 of the Constitution of the Republic of South Africa, 1996*
- *to give effect to the obligations incurred by the Republic as a member state of the International Labour Organization*
- *to provide a framework within which employees and their trade unions, employers and employers' organisations can:*
 - *collectively bargain to determine wages, terms and conditions of employment and other matters of mutual interest*
 - *formulate industrial policy*
- *to promote:*
 - *orderly collective bargaining*

many sectors of a nation, and more particularly, the sectors of health, research, human development and environmental conservation. This equally implies an increase in the per capita income of every citizen. For a country to achieve economic development, the government must strengthen its efforts towards an accelerated transformation that is about capacity and action. Its policies must provide the most enabling conditions for the flourishing of the talents of all its people to harness and develop their productive potential, to ensure that they play a role in the allocation of national resources, and to partake in the country's wealth. It is in this sense that government introduced, among other things, the LRA, which has as a goal the promotion of economic development.

The LRA as amended, is generally argued to be the crowning achievement for South African trade unions and workers in general

Labour peace

The Commission for Conciliation, Mediation and Arbitration (CCMA) as an institution, established to advance the course of the LRA, tells us that: *"the advent of the new Labour Relations Act (LRA) has raised expectations about the fundamental change in the nature of South African labour relations and of effective dispute resolution and collective bargaining in particular. For many observers, the replacement of the Industrial Court by the CCMA signals a shift from a highly adversarial model of relations to one based on promoting greater co-operation, industrial peace and social justice. The apparent shift seems all the more plausible as an unfolding democratisation process intersects with the challenges of a highly competitive globalised economy, new forms of work organisation and participative decision making."*

In addition, the CCMA explains that in SA the mechanisms offered for dispute resolution in the previous LRA, namely the Conciliation Boards and the Industrial Court, lacked credibility with the state's social partners, organised business and organised labour, and resulted in a very low settlement rate of disputes. The explanatory memorandum released with the draft bill of the LRA highlighted the fact that the previous dispute resolution processes resulted in only 20% of disputes being settled. The failure of the statutory structure to resolve those disputes effectively resulted in an excessively high workload for the Industrial Court, and an unnecessarily high incidence of strikes and lockouts. More specifically, the old legislature attempted to provide a basis for relations among its citizens. However, in certain circumstances, the laws themselves impeded the promotion of good relations. Although labour peace has not been without challenges and at times controversy (particularly in the post-Marikana era), it is obviously an important goal of the LRA.

Democracy in the workplace

Section 213 of the LRA, as amended, serves as a definition clause, and defines a workplace as the place or places where the employees of the employer work. At the time of the adoption of the LRA, the base of the emergent trade unions was in the primary sector, on mines, and in the secondary sector, in manufacturing. In those instances, it was obvious where the workplace was, as it would have been the factory or mine whose workforce the trade union had organised. Therefore, democracy in the workplace meant recognising the trade union that the workers had elected to represent them, and recognising the right of workers to elect their own representatives in the workplace.

The LRA goal to advance workplace democracy is probably the most obvious and traceable goal throughout the Act. In terms of chapter II of the Act, the LRA provides for freedom of association and other general protections of that freedom. Freedom of association includes employees' rights to freedom of association, the protection of employees and persons seeking employment, employers' rights to

freedom of association, and the rights of trade unions and employers' organisations, to list a few.

The sum total of all the primary objects of the Act may be achieved if there is collaboration between employers and employees

Chapter 3 of the Act deals with collective bargaining, in which parts A and B are emphatic regarding workplace democracy, providing for organisational rights, which include trade union access to the workplace, representativeness, the disclosure of information and the right to establish thresholds of representativeness. Part B focuses on collective agreements, which include the legal effect of such agreements, the disputes relating to agreements and the idea of agency shops and closed shops. The LRA therefore acknowledges workplace democracy as one of the most important pillars of our labour relations environment, as the involvement of employees and their representatives (trade unions) is detailed throughout the Act.

Conclusion

Therefore, in order to achieve its stated goals as discussed above, the LRA has established forums such as the CCMA, the labour courts and labour appeal courts that aim to ensure labour peace and serve as facilitators to the observation of workplace rules and procedures, and the maintenance of workplace democracy, by adhering to the standards of decision-making and worker involvement in the workplace. In the end, the sum total of all the primary objects of the Act may be achieved if there is collaboration between employers and employees that ensures labour peace and respects workplace democracy, which contributes to economic development and thereby ultimately achieves social justice.

Insights into financial wellness and medical law

Shivdev Training Academy

The Shivdev Training Academy, in collaboration with eminent speakers in the fields of law and financial governance, highlights key aspects of legality governing the medical profession, as well as financial intelligence for the successful conduct of business. These core insights will assist in avoiding any ethical problems from both a legal and financial perspective.

Financial wellness

An overview of the South African investment market for 2017

In most financial circles, 2016 is now considered the *annus horribilis*. The All-Share Index ended the year 0.1% lower than the year before (not including dividends and in rand terms). If you consider that inflation was over 6% for the year, all South Africans effectively became 6% poorer in 2016. However, in USD terms, the stock market was up an incredible 16.8% (the 12th best performing market globally), all thanks to the stronger rand. In fact, last year was the first time since 2009 that the rand ended the calendar year in a stronger position than that in which it started. For the record, at the beginning of 2010 our currency was trading at 6.62 to the USD, but it closed 2016 at 13.74, and let's not forget the 16.87/USD we saw on the 18 January 2016. So this is where I remind you that your liability is in the currency you spend.

I recently happened upon an old (2015) Harvard magazine article titled "The Science of Scarcity." The article is a précis and commentary on a study by professor of economics Sendhil Mullainathan, which showed that scarcity lowers mental capacity, whether it occurs as hunger, being time poor, being under financial pressure or being lonely. The researchers used IQ tests as a conclusive measure of mental capacity, which as we all know have been criticised for being culturally biased. However, criticisms aside, the one thing that stuck with me was that Mullainathan and his research team

concluded that financial stress reduces IQ by 14 points – and as they put it, that's the difference between "superior" and "average" intelligence, and a greater erosion of mental capacity than that found in subjects who experienced sleep deprivation.

How doctors need to think about investments

Trying to predict currencies and commodity prices can be a fun exercise (for some), but it tends to be futile in its practicalities – the permutations call for Monte Carlo simulations or binomial tree models, with little to zero certainty of any outcome. In December 2016, the US Federal Reserve System gave us a heads up – US interest rates are going up! What that means for us at the tip of Africa is that with a weak economy and a near-contained inflation rate, the South African Reserve Bank may decide to hold off raising our repo rate in tandem with the USA, resulting in a weaker rand. In addition, as the Organization of the Petroleum Exporting Countries (OPEC) works towards "stabilising" the oil market (read: higher oil prices), combined with the potentially weaker rand, we are likely to see upward pressure on inflation.

Macro drivers aside, there are certainly enough geopolitical risks in 2017 to keep us on our toes. Article 50 looks set to be invoked in the first half of the year, and on 20 January, the Trumps move into the White House. We've also got French, German and Dutch elections this year, with everyone watching to see how firmly rightist politics has taken hold – so let's face it, the euro is looking fragile.

Not everyone aims to invest like George Soros, Warren Buffet or Bill Gross – leave that to the asset managers – but everyone should aim to take full control of their financial situation and work towards financial stability, at least, and financial independence at best. One of the phrases we often use in asset management circles is "sweating your assets". These include your hard-earned cash, which is just one of the asset classes

you can choose to invest in. We also like to focus on the risk/reward spectrum, but until you understand your personal risk, this is yet another meaningless phrase.

Join us on 11 March for our medico-legal seminar on Financial Wellness and Medical Law (see page 21 for more details) as we demystify the stock market and talk you through how to think about your personal risk profile. We realise that doctors sell their time, and there are only 24 hours in a day, so let's look at what you can do to make your money work 24/7.

Medical law

The continuous increase in cases regarding medical negligence and malpractice entering the legal system through specialised attorneys reveals shocking statistics in the medical profession. Many of these cases could be avoided by practitioners becoming aware of the patient's rights (including before and after patient care) and the medical regulations that pose potential risks. Understanding the implications if these are transgressed, and the potential lawsuits that one could encounter if an individual pursues a case against a medical professional, is essential.

The above-mentioned talk on 11 March, "Safety and Sanctions", by Prof. Kapil S Satyapal, explores the causation of medico-legal risks. He discusses high-risk specialties, investigates the nature of adverse outcomes and explores strategies to decrease risk. Examples of legal precedent are also highlighted.

The disciplinary powers of the HPCSA: Medical and Dental Board will also be outlined. These include the functions of the ombudsman, the Preliminary Committee of Inquiry and the Professional Conduct Inquiry. Issues relating to preparation and response by doctors will also be discussed.

In conclusion, the essence of this medico-legal seminar lies in providing pertinent information that will no doubt leave a lasting impression regarding medical finance and risk avoidance.

SAMA stakeholders' lunch

Bokang Motlhaga, SAMA Junior Marketing Officer

SAMA recently hosted their stakeholders at a luncheon held at the Protea Hotel Fire and Ice, Pretoria. The stakeholders' lunch is a means of acknowledging the efforts that various stakeholders have put in to ensure the success of SAMA's initiatives via multiple types of sponsorship.

Gert Steyn, SAMA's general manager, commenced the day's presentations by delivering an eye-opening brief on SAMA history and objectives as well as membership statistics, reassuring the stakeholders of the significant growth that SAMA has undergone.

Dr Jacques Botha, the Private Practice Department (PPD) strategic accounts manager,

presented an overview of the PPD and highlighted the department's plans for 2017, which aim towards improving the working lives of private medical practitioners.

Dr Selaelo Mametja, the Knowledge Management and Research Department (KMRD)'s manager, delivered an informative presentation about KMRD's latest research. This is based on social determinants of health, defined as the economic and social conditions, and their distribution among the population, that influence differences in health status. She also drew attention to the upcoming conference on the subject co-hosted by SAMA and the University of the Witwatersrand School of Public Health.



Dr Jacques Botha, PPD strategic accounts manager



Dr Selaelo Mametja, KMRD manager



Mr Gert Steyn, SAMA general manager

Physicians' New Year hopes about climate change

World Medical Association

The hopes and concerns of physicians around the world for 2017 have been set out in a New Year message from the World Medical Association (WMA).

Among the association's main hopes is one that world leaders will redouble their efforts to combat the effects of climate change.

WMA president, Dr Ketan Desai, said, "One of the most important new policies that the WMA adopted this year was to urge health organisations around the world to transfer their investments from energy companies relying on fossil fuels to those generating

energy from renewable sources. We would hope to see considerable progress on this in 2017.

"We would also hope to see governments strengthen public health systems to improve the capacity of communities to adapt to climate change. Now is the time for the governments to act on their promised commitments to tackle climate change, not to retreat."

A significant concern of the association's is the increasing risk to physicians and healthcare professionals of being targeted in war zones and areas of conflict.

Dr Desai said, "The number of deaths and injuries among physicians and other healthcare professionals over the past year is a tragic reminder of the declining respect for international laws and conventions concerning the protection which should be given to all medical personnel in war zones. The bombing of hospitals and other healthcare facilities has to stop and we would hope in the year ahead to see all governments sign up to new and real efforts to respect health services as one of the core values of international humanitarian law."

Concealed sepsis

The Medical Protection Society shares a case report from their files

Mr D, 53, had suffered with osteoarthritis (OA) in his right knee since turning 50. This had been confirmed with arthroscopy. It rarely bothered him and he continued to work as a physical education teacher. He had experienced a flare-up of knee pain at the start of the autumn term but this settled quickly with analgesia.

He contacted his GP on the first weekend of the Christmas holidays, complaining of 2 days of bilateral knee pain, which was unrelieved by his usual co-dydramol. A home visit was arranged. He was seen by Dr C, who documented a normal right knee on examination, but limited movement in the left knee, with positive meniscal signs and no effusion.

Dr C also noticed that Mr D had a painful swollen left little finger, which he had jammed in a door 2 weeks earlier. Since he was afebrile, Dr C attributed the symptoms to OA and advised that Mr D should also arrange to get an X-ray of his finger to exclude a fracture. She provided him with naproxen analgesia.

The pain continued after the weekend and Mr D had been unable to leave the house to arrange the X-ray. He spoke to Dr V, his GP, and an appointment was arranged for the next morning. The following day, Mr D was

still unable to get to his car and called the GP surgery again. Dr A, who was available at the time, agreed to a home visit.

Dr A recorded an effusion and worsening right knee pain now radiating to the calf and hip. She also mentioned that Mr D had swelling over the dorsum of his injured hand, and identified two erythematous patches on the right elbow and left foot. Mr D had not reported feeling feverish and so vital signs were not recorded.

Dr A prescribed a course of antibiotics to cover for possible infection in the right hand and documented that the knee pain was likely to be a strain. She queried gout as a possible cause and recorded that she was uncertain what the satellite lesions represented. She advised Mr D contact the surgery again the next day.

The next day was 24 December and Dr B was on duty for the day. He visited Mr D at home as requested by Dr A. By now Mr D was feeling better, and the swelling in his hand had reduced, but he was feeling "spaced out" on the codeine analgesia he was now taking. Dr B asked the patient to get out of bed for a full examination, which he was able to do.

Mr D's wife recalled the doctor taking her husband's blood pressure and advising he omit his antihypertensive medication. Dr B made no record of this examination. He later recalled that he examined the patient fully, including his temperature, and as he found nothing of concern he did not make a note of this. His advice was to complete the course of antibiotics and increase his fluid intake.

Mrs D recalled that her husband's condition deteriorated towards the end of the day, observing slurred speech and generalised weakness. He made an attempt to go to the toilet with the assistance of his son and it took him 40 minutes. Mrs D awoke the next morning to find her husband had died.

The pathologist who carried out the post-mortem concluded that Mr D had died from complications of septicaemia, but the focus of the infection remained uncertain. He noted splenomegaly but no lymphadenopathy. Experts agreed that the cause of death was perplexing but that the knee was the least likely site of infection, with either the hand or an upper respiratory tract infection being the most likely causes.

Crucially, expert opinion agreed that if intravenous antibiotics and volume replacement had been commenced on 23 or 24 December, the fatal episode of sepsis could have been avoided.

Expert opinion also found that neither Dr A nor Dr B had recorded anything to suggest that their assessments were adequate. In Dr B's case, with no clinical details recorded and no plausible diagnosis, there would be no possible chance that a court would accept that his assessment was reasonable. Similarly, Dr A had not recorded enough to show that her assessment was reasonable on 23 December.

The case was settled for a substantial sum.

Learning points

- Good notekeeping is essential. In this case, recording the vital signs and patient's mobility would have demonstrated that an adequate assessment had been carried out and may have made the actions of the doctors involved easier to defend.
- Clinical presentation can change quickly. Expert opinion was critical of a lack of a plausible diagnosis. It is not clear from the notekeeping how unwell Mr D was when assessed by Dr A. It may have been the case that Mr D appeared so well that Dr A felt it unnecessary to document normality. However, without adequate information or a clear diagnosis to prove that a reasonable assessment was carried out, it is difficult to defend her action given the symptoms of polyarthritis with patches of erythema suggestive of infection.
- Patients should be advised on the signs to look out for and when to seek further help if they continue to feel unwell.

Identifying sepsis early can save lives. The diagnosis may not always be immediately obvious and a high index of suspicion is required to make the diagnosis and prevent fatalities. The Surviving Sepsis Campaign (<http://survivesepsis.org>) is an educational resource to train healthcare professionals in the recognition and immediate management of sepsis.



Gauteng North Branch ends the year in Ancient Greek style

Bokang Motlhaga, *SAMA Junior Marketing Officer*

The Gauteng North branch recently held an annual year-end function at Diep in die Berg, Lynnwood, Pretoria, which embodied an Ancient Greek theme.

Dr Angelique Coetzee, chairperson of the Gauteng North branch, welcomed the attendees and presented an overview of



Dr Coetzee, Dr Martin T Mpe (outstanding work in cardiology awardee) and Prof. Chauke

2016, highlighting the extraordinary activities that the branch initiated or participated in. Dr Coetzee emphasised that members truly deserved a night of unwinding after a long year of great effort focused on delivering excellent healthcare to the nation.

The following members were awarded for their immeasurable efforts towards bettering the healthcare system:

- Dr Marcelle Groenewald – outstanding work in ethical research
- Dr Martin T Mpe – outstanding work in Cardiology
- Dr Mandlakhe Msingapantsi – outstanding work within SARA at Dr George Mukhari Academic Hospital
- Prof. Jan Pretorius – outstanding work in surgery and critical care.

The attendees indulged in Ancient Greek festivities, from the food, the music and the dancing to the smashing of plates while shouting a loud “Opa!”, which is noted as a

common practice at Greek celebrations. In closure, Dr Coetzee encouraged the Gauteng North branch members to continue their great work throughout the year 2017 and beyond.



Gauteng North branch council members. Back row, from left: Dr Coetzee, Prof. Chauke, Dr Marais and Dr D'Alton. Front row, from left: Judy Mills (branch secretary) and Dr Balie

Border Coastal end-of-year social success

Border Coastal Branch held an end-of-year social on 28 November 2016 in the Conference Room at Life St Dominics Hospital, East London.

The hospital kindly gives us the free use of their venue for our monthly Branch Council

Meetings and CPD events. They also provide juice, tea, coffee, sugar, milk, side plates and serviettes for our events.

The tables were beautifully set up and decorated and we are extremely grateful to them.



From right to left: Dr Kim Harper (chairman), Dr Simon Comley (JUDASA Rep) with Dr Bronwyn Gavine and Dr Tinashe Chandauka from the East London Doctors Research Society

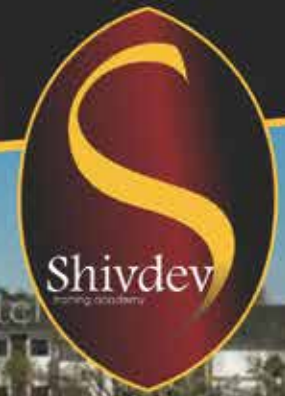


West Rand branch secretary Tracey Gurnell (right) hands over a cash donation to Melanie van Brakel from Cradle of Hope

Donating to the community

West Rand branch held a function in November at the Krugersdorp Town Hall. The purpose was to donate to local charities Bethany House and Cradle of Hope. The evening event was well supported and performances from local artists were well received. All gifts donated were handed out to less-fortunate children from the community for Christmas.

FINANCIAL WELLNESS AND MEDICAL LAW



EARLY BIRD DISCOUNT!

(Before 24 February)

R800 per person

Late Registration (After 24 February)

R1200 per person

Date : 11 March 2017

Time : 01:30pm to 06:30pm

Venue : The Lakes Hotel and Conference Center,
No1 Country lane, Lakefield Benoni, 1501

SAVE THE DATE
11 MARCH 2017

- ✓ Tax, Financial and Ethical Considerations for the Doctor
- ✓ Health Market enquiry regarding competition commission
- ✓ Overcoming Medical negligence and understanding its risk
- ✓ Wealth opportunity.... making money work for you 24/7/365



Prof. K. Satyapal
is a specialist General Practitioner, GP, with an LLM (Medical Law) from the university of Kwa Zulu-Natal



Prof. Dilip Garach
is a chartered accountant (SA) with a masters degree in commerce and is a certified financial planner (CFP).



Ulundi Behrtel
obtained her BLC & LLB degrees at the University of Pretoria. She is a qualified attorney & has extensive experience in law & ethics in the healthcare sector.



Anthea Gardner
obtained an MBA from Wits Business School & has a daily market commentary on Cliff Central, does the Closing Bell market commentary on CNBC Africa & regularly comments for MoneyWeb, Radio 2000 and SAfm.

TIME	TOPICS
1:30pm - 2:00pm	Registration
2:00pm - 2:45pm	Overcoming Medical negligence and understanding its risk...Prof Kapil Satyapal
2:45pm - 3:00pm	Question and answer session
3:00pm - 3:45pm	Tax, Financial and Ethical Considerations for the doctor...Prof Dilip Garach
3:45pm - 4:00pm	Question and answer session
4:00pm - 4:30pm	Tea break and refreshments
4:30pm - 5:15pm	Health Market enquiry regarding competition commission...Ulundi Behrtel
5:15pm - 5:30pm	Question and answer session
5:30pm - 6:15pm	Wealth opportunity.... making money work for you 24/7/365...Anthea Gardner
6:15pm - 6:30pm	Question and answer session
6:30pm - 7:00pm	Refreshments

Sponsored Event



MPS



Payment details
Name: SHIVDEV Training Academy
Bank: Nedbank
Branch: Northmead
Branch Code: 19876500
Account Number: 1948143313

To register please visit www.shivdev.co.za/health.html,
call +27820734746 or visit www.facebook.com/SHIVDEVTrainingAcademy.



info@shivdevedu.org | www.shivdev.co.za



ASSA



SAGES



SASES



VASSA



TRAUMA



SAGINS

SAVE THE DATE



ASSA SAGES 2017

**BOARDWALK CONVENTION CENTRE
PORT ELIZABETH
SOUTH AFRICA
5 - 8 AUGUST 2017**

www.assasages.co.za

Congress Management: Eastern Sun Events

Phone: +27 (0)41 374 5654 | Email: assasages@easternsun.co.za

Conferencing with a view...
...see you in Port Elizabeth 2017!



ENT CONGRESS

28 - 30 October 2017

Boardwalk Convention Centre
Port Elizabeth

EASTERN SUN EVENTS

Tel: +27 41 374 5654

Email: ent@easternsun.co.za

Web: www.entcongress.co.za