

SAMA INSIDER

March 2017

Eastern Cape health system collapse: A democratic failure

Council for Medical Schemes
embarks on PMB review process



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

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CONTENTS

MARCH 2017



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- 3 EDITOR'S NOTE**
Some light at the end of the tunnel
Diane de Kock
- 4 FROM THE PRESIDENT'S DESK**
The Eastern Cape health system collapse: "Not an apartheid legacy, but a democratic failure"
Prof. Dan Ncayiyana
- 5 FEATURES**
5 SAMA 2017 branch council elections
Yolande Lemmer
- 6 The rise of Clinical Practice Guidelines**
Shelley-Ann McGee
- 7 SAMA saddened by the death of Dr Margaret Mungherera**
SAMA Communications Department
- 8 CMS embarks on the PMB review process**
Shelley-Ann McGee
- 9 WMA urges Iran to stop denying medical care to prisoners**
World Medical Association
- 9 Migrants must have access to proper healthcare, says WMA**
World Medical Association
- 10 Code of conduct – SAMA members**
SAMA Communications Department
- 11 SAMA core values, the foundation of our behaviour**
Dr Ayodele Aina
- 13 Sexual harassment in the workplace**
Modisane Lelaka
- 14 SAMA meeting rulebook: Ground rules**
SAMA Communications Department
- 16 SAMA attends the HSPCA roadshow**
Medical Protection Society
- 17 Financial advice: Will 2017 be better than expected?**
Gert Viljoen
- 18 GPPPC strategise for 2017**
SAMA Communications Department
- 19 MEDICINE AND THE LAW**
A cannula complication
Medical Protection Society
- 20 BRANCH NEWS**

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Diane de Kock
Editor: SAMA INSIDER

Some light at the end of the tunnel

Joining together to form action groups to press for change has proven to be an effective way of pushing for reform. Read about the Eastern Cape Health Crisis Action Coalition on page 4 where SAMA president, Prof. Ncayiyana, writes about the Eastern Cape healthcare system collapse and appeals to members to support the coalition as “the only hope for light at the end of this tunnel.”

On pages 6 and 8 Shelley-Ann McGee sheds some light on the rise of Clinical Practice Guidelines and the Council for Medical Schemes’ recent announcement that it would review the existing prescribed minimum benefit (PMB) package. “SAMA is gratified to see so much effort and emphasis placed on obtaining the best available clinical evidence on conditions and emergency management,” says Shelley from Knowledge Management and Research Development at SAMA, about Clinical Practice Guidelines. “Given the influence of the PMB package on reimbursement to practitioners and levels of care of patients, this process is an important one for SAMA to be part of.”

This month we also begin a series of articles on the SAMA Code of Conduct, which was adopted at the national council meeting in September last year. In the same vein, Dr Aina, on page 11, reminds members of SAMA’s six core values “which serve as a compass for our actions and guide the organisation in the conduct of its business as it evolves and grows.”

Meetings are part of the profession, and ground rules offer SAMA members a way of making the process more efficient and less time-consuming, and ensuring that the desired outcomes are achieved. Read about the SAMA meeting rulebook on page 15.

“Economists are arguing things should get better,” says Gert Viljoen in his financial advice column on page 17 – another light to look forward to in 2017.

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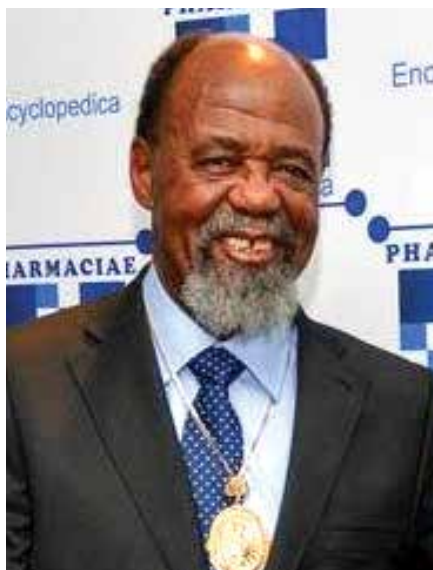
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The Eastern Cape health system collapse: “Not an apartheid legacy, but a democratic failure”



Prof. Dan Ncayiyana, SAMA president

The Eastern Cape's health system has collapsed. It is riddled with corruption. There is no electricity or water, no drugs, too few doctors and nurses, no chance of an ambulance arriving, no dignity and no care," writes Greg Nicolson in the *Daily Maverick* on 24 January 2017. This alarm over the healthcare crisis in the Eastern Cape (EC) is nothing new. I have published editorials, and the news editor has written many horror stories in the *SAMJ* on the parlous state of the health facilities, the gross mismanagement and the shabby treatment of patients in that province since the early 2000s.

The irony is that in the bad old days up until the 1994 democratic dispensation, the system was in pretty good shape, notwithstanding the ever-present deprivations of staff, money and material. There was a time when the EC (particularly Transkei) hospitals were considered among the best-run in the country, when they were under missionary control. Medical students from universities in SA and abroad flocked to these hospitals for their clinical electives. The hospitals were clean and exceptionally well managed, and were particularly known for respectful and compassionate patient care by highly motivated and well-respected missionary doctors and nurses. These hospitals pioneered the idea of satellite clinics in rural communities run by nurse practitioners with

regular doctor visits, and backed by effective referral protocols and functional ambulance services.

The system continued to function effectively after the missionary health facilities were expropriated by the state, and even after the system was taken over by homeland governments. I have some personal experience of this, having worked in the "independent" Transkei health system for a decade.

The recent report by the civil society organisation Section 27, entitled *Death and Dying in the Eastern Cape*, makes for horrifying reading. It contains the personal, first-hand accounts of patients with blood-curdling in-hospital experiences. One young woman was admitted to a level III hospital for intrauterine death at 7 months. She was made to share a bed with another woman in normal labour. There was no electricity and "[w]hen it became dark, the nurses attended to the women and delivered the babies by the light of their cell phones." Her labour was induced, and when the contractions became intense at night, "I stood up and searched in the darkness for a nurse. The nurses ordered me to walk around. I tried to tell them that something was coming out of me. They told me to walk around more. I kept telling them about the pain. By then my dead child had come out feet first and the head was stuck inside me. The baby hung from me as I walked around the ward and tried to plead with the nurses, to beg them for relief from the pain. I was still walking around when I collapsed from the pain."

Toxic mix

The health crisis is largely a result of the toxic mix of corruption and incompetence in governance. The demands of running a complex system involving the acquisition, distribution and maintenance of facilities and supplies, including pharmaceuticals and transport, in an expansive province of six million people, seem to be beyond the aptitude of the governing elite and bureaucracy. Whether this is a result of a shortage of competent people in the province, or of political patronage – jobs for pals irrespective of competence – is anyone's guess.

Writing in the Section 27 report, Dayan Eagar observes that "the Auditor General's

annual audits of the department's financial statements over the last decade revealed that tens of millions of rands are lost each year through a mix of deliberate fraud, improper financial oversight, and poorly managed supply chain systems." He goes on to point out that "[b]roken systems of financial management and accountability have opened the door to endemic fraud and corruption. A Special Investigations Unit investigation into corruption in the provincial department showed that in the 18 months between January 2009 and June 2010, officials and their associates pocketed more than ZAR800 million."

Unfortunately, short of changing the EC provincial government, which seems very unlikely, there isn't much anyone can do about this state of affairs. In terms of schedule 4 of the Constitution, health provision is primarily a provincial responsibility in which the national minister has limited powers to intervene. Therefore, minister Aaron Motsoaledi can do little more than advise and cajole the member of the Executive Council for health. The national government can take over the administration of a service only if the system truly runs into a ditch, but then only for a limited period, as has happened in the EC in the past.

The health crisis is largely a result of the toxic mix of corruption and incompetence in governance

On the optimistic side, there are a number of civil society advocacy groups that have joined together to form the Eastern Cape Health Crisis Action Coalition to press for change. The coalition was formed in May 2013, and consists of over a dozen change agents, including the Treatment Action Campaign, Section 27, Rural Doctors Association of South Africa, SAMA and others dedicated to monitoring healthcare delivery failures, proposing solutions and pressing the EC government for reform. The coalition represents the only hope for some light at the end of this tunnel, and deserves everyone's support.

SAMA 2017 branch council elections

Yolande Lemmer, *company secretary, SAMA*

The SAMA online web-based branch council elections commenced on 22 February 2017. These elections are conducted in preparation for an elective SAMA National Council meeting in November 2017.

The online election process is convenient and easily accessible. SAMA members are asked to nominate and vote from any electronic device (computers, laptops, tablets, smart phones) using a fixed line or 3G connection.

Requests to update profiles have been issued, with candidates adding profile pictures and a short CV to assist members in selecting a candidate to vote for.

The system comprises a nomination round of seven days, a two-day pause to finalise the various nominations lists (all 20 branches are voting simultaneously), followed by another seven-day period of voting for the nominees who have accepted their nominations. The system automatically indicates the number of choices allowed per member nominating or voting and promotes adherence to the historically disadvantaged individuals (HDI) provisions of SAMA's memorandum of understanding and rules. The steps to be followed during the process are set out in the online election programme, and members receive SMS and email notifications during the process to encourage participation, as well as procedure reminders.

Election results can be viewed in real time. Although the process is followed simultaneously by all branches, some branches may require second rounds.

Voting authentication and counting is protected by a 2048-Bit SSL certificate with strong encryption and authentication and processes are independently administered, managed and audited. Only full SAMA members

registered on the SAMA website are able to nominate and elect candidates.

On a more technical level, branch members will be allowed to nominate and vote for respectively six, eight, ten or twelve branch council members, depending on the size of their branch membership and in accordance with rule 12.1 of part Q of the company rules. Branches with up to 500 members have 6 branch councillors; those with a membership number from 501 to 1 000 members have 8 branch councillors; those with 1 001 to 1 500 members 10 branch councillors; and those with 1 501 and more members twelve branch councillors.

Please note that only nominees with a "seconded" nomination will be considered duly nominated for the subsequent election process. The system will automatically contact all nominees by means of email to enquire as to whether or not they accept their nominations. The prospective nominee can use either the "accept" or "decline" link provided in the email.

In some instances, e.g. where HDI compliance must be revisited or where nominations received are fewer than the prescribed minimum set out above, the voting process for a specific branch may have to be extended to allow for the additional processes to be followed in this regard, as set out in the company rules – for example, properly motivated exceptions to certain rules may be considered by the SAMA board.

Members that have been elected will automatically be notified via email once the voting process has ended. Branch council chairpersons will be elected in the same manner; however, only elected members of each branch council will be able to nominate and vote. Once elected, chairpersons, together with their predecessors, will attend

the 2017 chairpersons' forum. Given the small delay in this process, the date for this will be communicated by email and newsletter.

One of the reasons for the somewhat later start of the elections was related to an intricate process followed by the interim Employed Doctors Committee (iEDC) to evolve a strategic plan for the participation of employed doctors in SAMA structures from branch level upwards, in accordance with the strategic direction provided by the national council in September 2016. The iEDC's proposal in this regard has been presented to the SAMA board and the board is in support thereof. Their suggested way forward includes, among other ideas, an employed doctor representative from each branch at SAMA National Council level, which will have the effect that branch representation at national council will increase from approximately 40 councillors (as per the current rules) to 65 councillors. The specific detail of this well-constructed plan will be tabled at the chairpersons' forum for consideration by all the branch chairpersons attending on behalf of their various constituencies. It is foreseen that a company rule change to incorporate the necessary changes may follow, whereafter a separate round of elections for the additional employed doctor branch representative will have to be held, increasing all branch council numbers by one.

However, fully canvassing the proposal at the chairpersons' forum can only follow once the chairpersons have been elected, and therefore the priority remains to have the electronic branch council elections, including those of their respective chairpersons, finalised before the end of March 2017.



The rise of Clinical Practice Guidelines

Shelley-Ann McGee, Knowledge Management and Research Development, SAMA

SAMA comments on the HPCSA's Professional Board for Emergency Care (PBEC) Clinical Practice Guidelines (October 2016)



Clinical Practice Guidelines (CPGs), originally defined as “systematically developed statements to assist practitioner and patient decisions about appropriate health care for their specific clinical circumstances,” have become ubiquitously used around the world.

Many of us have learnt from, utilised or even assisted in the development of CPGs in our own environments. Many countries have gained significant experience in the development, appraisal and implementation of CPGs at multiple levels, recognising that they are key tools to improve the quality and appropriateness of health services.

Despite this, there remain problems with the dissemination, acceptability and uptake of CPGs in many environments. The development of evidence-informed CPGs can be intense and time-consuming, and in the last few decades, the processes for developing CPGs have shifted from being written by experts in respective fields, to being written by methodologists. This has resulted in increased emphasis on how the process

for guideline development is managed, to ensure that CPGs have the desired impact in influencing clinical decision-making.

The increasing emphasis on guideline development and standards has spawned multiple instruments and methods for grading both clinical evidence levels and the guideline development process itself, for such factors as independence, stakeholder engagement, underlying evidence, and rigour and clarity of recommendations.

Recently, SAMA was afforded the opportunity to comment on a set of CPGs developed for emergency services personnel, on behalf of the HPCSA. While these are not guidelines applying directly to medical practitioners, the management of patients in emergency care situations before reaching health institutions such as clinics, hospitals and casualty centres can have a significant impact on their outcomes – hence the relevance for the medical profession at large.

The HPCSA and the Professional Board for Emergency Care (PBEC)

The HPCSA regulates the country's health professions in aspects pertaining to registration, education and training, professional conduct and ethical behaviour.

Twelve professional boards operate within the HPCSA structures. These are established for and deal with a specific profession, and include a board for medical and dental professionals, several allied professionals and emergency care.

Emergency care professionals represent a range of different levels of qualifications and expertise, and include basic ambulance assistants, ambulance emergency assistants, operational emergency care orderlies, paramedics, emergency care technicians and emergency care practitioners.

The PBEC was established in terms of regulations promulgated in 2008 under section 15 of the Health Professions Act No. 56 of 1974, and regulates multiple aspects of the training and registration of emergency care practitioners.

During 2015 and 2016 the PBEC, along with the African Federation of Emergency Medicine, the Divisions of Emergency Medicine at the University of Cape Town and Stellenbosch University, the Department of Emergency Medical Sciences at the Cape Peninsula University of Technology, and the Centre for Evidence-based Health Care at Stellenbosch University, worked together to create the first evidence-based CPGs for the emergency care profession in SA.

Instead of producing these CPGs *de novo* (from scratch) – which would have involved significant effort in systematic literature review, data synthesis and guideline formulation of recommendations – the contributors elected to adopt recommendations from multiple existing international evidence-based guidelines. Essentially, the guidelines have borrowed from the best available existing guidance in the rest of the world, and contextualised these recommendations in the SA setting.

The PBEC published the draft CPGs for stakeholder comment in October 2016 and SAMA contributed to the process, through the work of the Knowledge Management and Research Department (KMRD) and the Education, Science and Technology Committee.

SAMA is gratified to see so much effort and emphasis placed on obtaining the best available clinical evidence on conditions and emergency management

The CPGs address a wide range of emergency situations, from management of pregnant patients and childbirth, to trauma and

environmental and toxicological exposures. The PBEC confirmed in requesting comment that these CPGs are not intended as a bedside handbook, but rather as a training and education tool for those institutions training emergency medical personnel. The PBEC also acknowledged that some areas, such as the emergency management of mentally ill patients, have not been adequately addressed through this version of the CPGs, and will be addressed in specific processes in future.

SAMA is gratified to see so much effort and emphasis placed on obtaining the best available clinical evidence on conditions and emergency management. The decision not to follow a *de novo* approach did result in the relatively fast publication of a set of draft guidelines, which could well have taken years to produce, had such an approach been followed.

SAMA's overall assessment of the guidelines was positive – the CPG recommendations

draw from multiple sources citing the best evidence available in the often difficult-to-investigate world of emergency medicine.

Remaining challenges are that in multiple areas, the new HPCSA guidelines do not concur with other existing local guidelines

Remaining challenges are that in multiple areas, the new HPCSA guidelines do not concur with other existing local guidelines, for example the Standard Treatment Guidelines and Essential Medicines List, or condition-

specific clinical practice guidelines published by local societies that address emergency situations. Some of the medicines suggested for administration by emergency medical service staff on the basis of international guidelines do not fall within their scope of practice in SA, or are not even registered in the country. Noting these challenges and inconsistencies is part of placing these CPGs into the local SA context, and SAMA is pleased to have been able to contribute to the process of the development of evidence-based clinical practice guidelines in this critical area.

SAMA encourages any members who have not had the opportunity to peruse these guidelines but who may be impacted by them to view them on the HPCSA website: <http://www.hpcs.co.za/PBEmergencyCare/Guidelines>

References are available from the author on request.

SAMA saddened by the death of Dr Margaret Mungherera

SAMA Communications Department



Dr Margaret Mungherera

SAMA is greatly saddened by the untimely death of Dr Margaret Mungherera – she was 60 years old.

Dr Mungherera was a senior consultant psychiatrist and medical administrator in Uganda. She served as the president of the World Medical Association in 2013/2014. She also served as president of the Uganda Medical Association from 1995 to 2005 and 2010 to 2015.

Dr Mungherera was a psychiatrist by education, a public health activist by nature, and a determined advocate for the people of Africa by conviction. She was also a physician leader on the global stage. For those involved in healthcare, Dr Mungherera was more than just a colleague; she was a friend, teacher and confidante.

"Margaret was diagnosed with colon cancer in 2014 and bravely managed her

disease until her untimely death while in India for treatment, on 4 February 2017. She continued to actively participate in many meetings in Africa and globally, and she will be greatly missed," said Dr Mzukisi Grootboom, chairperson of SAMA.

Dr Grootboom said that the medical community had lost a gallant soldier who fought tirelessly for the realisation of health equity, human rights and ethics, not only in Africa (where she was based) but also globally.

"We have lost a true sister of South Africa and Africa, and the global health community joins us in mourning her passing. We are all poorer for it," said Dr Grootboom.

SAMA expresses its condolences to her husband, her family, and all her colleagues in the Uganda Medical Association, the recently formed African Medical Coalition, and the World Medical Association.

CMS embarks on the PMB review process

Shelley-Ann McGee, Knowledge Management and Research Development, SAMA

In a circular issued in December 2016 (Circular 83 of 2016), the Council for Medical Schemes (CMS) announced it would review the existing prescribed minimum benefit (PMB) package, explained the background and guiding principles and presented proposals for construct, process and timelines for the review.

The Medical Schemes Act 131 of 1998 requires that PMBs are reviewed every 2 years, specifically to address: *"inconsistencies or flaws in the current regulations; the cost-effectiveness of health technologies or interventions; consistency with developments in health policy; and the impact on medical scheme viability and its affordability to members, to address issues relating to flaws in the existing regulations, and the cost-effectiveness of technologies."*

Although a consultative review process was undertaken in 2008 and 2009, and submissions for proposed changes were made by the CMS to the National Department of Health, the reviewed benefits were never approved by the minister of health. The Department of Health has cited various reasons for this non-approval.

As a result, the existing PMBs as defined in the Act are now effectively more than 15 years old and in dire need of review. SAMA fully supports the review process and has committed its support to the CMS.

The CMS's circular and discussion document on the review propose a significant overhaul of the existing PMB structure. The CMS has indicated that these proposals serve to set out a possible process for engagement and information submission from stakeholders to determine terms of reference for engagement going forward. The CMS is, depending on the input from the various stakeholders, to contribute substantially towards informing the identification of current problems, processes of engagement going forward and inclusion and exclusion of services into the PMB package.

Given the influence of the PMB package on reimbursement to practitioners and levels of care of patients, this process is an important one for SAMA to be part of.

The CMS's intentions, as clearly stated, include aligning the PMB package more with the current health needs of the country, as

well as supporting instruments such as the Sustainable Development Goals. In addition, the CMS intends for there to be significant emphasis on the cost-effectiveness of interventions, and on a situation where the PMB package remains affordable to medical schemes and their members.

This is a tall order, and will likely only be achieved through multiple stakeholder participation and through a detailed process of deliberation.

SAMA is engaging with the CMS as well as various professional SAMA committees to ensure that medical doctors, best clinical evidence and best clinical practice can be represented at all times as the review process progresses.

There is little doubt that the current PMB situation is problematic – the majority of complaints handled by the CMS relate to non-payment or short payment of PMBs. The disease-specific approach means that many patients are without cover simply because their diagnosis doesn't fit into a PMB condition, and multiple new technologies have been introduced in the years since the PMBs were introduced that have not been fully evaluated for their clinical and economic merits.

Also importantly, the original PMB construct deliberately excluded primary healthcare, on the basis that this was best provided by tax-funded health services. The PMBs sought largely to address catastrophic illness, but neglected to include some elements of important basic health cover. This seems to be an aspect of the original design, which this review seeks to address.

A second circular (Circular 1 of 2017) sought to further clarify the CMS's intentions. SAMA has subsequently engaged with the CMS and understands that the review process is intended to be a highly transparent and robust process involving all affected stakeholders, with significant time for analysis and evidence-informed decision-making. As a representative body for both general and specialist practitioners in the country, the CMS agrees that SAMA's contributions are extremely valuable.

Several technical clinical advisory committees have been proposed, to address specific areas of benefit package inclusion and

exclusion, and a costing committee is also proposed to work closely with the clinical committees to ensure that the principles of affordability and sustainability are maintained.

With assistance from the Knowledge Management and Private Practice Departments, and Specialist and General Private Practice Committees, SAMA is making a full submission in response to the proposals, along with the submission of CVs of representative members and staff as requested by the CMS. At this stage the amount of time and resources that will need to be dedicated to the engagement process is not clear, but SAMA intends to ensure that the medical practitioner community is well -represented at all stages of the review process.

PMB definitions project continues

- In addition to the ongoing PMB review process, the council is also in the process of developing definitions for gastrointestinal (GIT) diagnostic treatment pair PMBs. These include appendicitis, hepatocellular carcinoma, hernia with obstruction and/or gangrene, and gastric and intestinal ulcers with haemorrhage or perforation.
- The PMB definition project at the CMS has been running since 2010, and aims to better clarify PMB level of care for the 270 DT-PMB conditions covered by the PMB legislation. Since 2010, benefit definitions have been published for solid organ transplants, ischaemic heart disease and breast and prostate cancers. These have been met with mixed responses by medical practitioner groups and medical schemes.
- SAMA has made substantive clinical submissions in response to the call for definitions for the GIT conditions and is participating in the clinical advisory committees involved in drawing up the definitions. We hope that we can play a role in ensuring solid evidence-based and clinically appropriate definitions for these conditions.

WMA urges Iran to stop denying medical care to prisoners

World Medical Association

The WMA, along with other organisations involved in medical ethics and human rights, has urged Iranian authorities to stop using the denial of medical care as a form of punishment against political prisoners being held at Raja'i Shahr Prison.

In a joint letter to Ayatollah Sadegh Larijani, Head of Judiciary in Tehran, WMA president Dr Ketan Desai refers to the "deliberate indifference of prison officials to prisoners' medical needs, their refusal to transfer critically ill prisoners to hospitals outside the prison, long periods of time without hot water for washing and bathing, inadequate space, poor ventilation, unsanitary conditions, insect infestations near kitchen areas, insufficient cleaning supplies and meagre rations of (poor-quality) food. Such conditions are believed to have put inmates at risk of infection and various skin and respiratory diseases."

Dr Desai and other signatories to the letter from the International Federation for Health and Human Rights Organisations, the Standing Committee of European Doctors and the International Rehabilitation Council for Torture Victims also protest the

pattern of guards beating, verbally assaulting and sexually harassing political prisoners, particularly when transferring them to and from hospital and court.

The letter goes on: "We are extremely concerned by this situation that precludes access to adequate medical care, a key human right which under international law and standards must not be adversely affected by imprisonment. Denying medical care amounts to ill-treatment and can constitute a form of torture or other cruel, inhuman or degrading treatment that are unambiguously prohibited under international human rights law."

The signatories remind the Islamic Republic of Iran that it has signed up to international covenants on "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and the commitment that "prisoners should enjoy the same standards of healthcare that are available in the community, and should have access to necessary healthcare services free of charge without discrimination on the grounds of their legal status."



Dr Desai and his colleagues call on the Iranian authorities to stop the denial of medical care, to protect prisoners from torture and other ill-treatment, to ensure that they are treated humanely and to allow monitors to conduct inspection visits.

Finally, they urge Iran to ensure that medical decisions on care outside prison and the necessity of release on medical grounds are taken only by the responsible healthcare professionals and are not overruled or ignored by non-medical authorities.

Migrants must have access to proper healthcare, says WMA

World Medical Association

The world's migrants must have access to appropriate healthcare and protection, the WMA said at the end of last year.

In a statement to mark the annual Global Candlelight Vigil on 18 December 2016, commemorating all those migrants who lost their lives last year, the WMA said that the global community needed to act to care for people currently seeking refuge or asylum.

The United Nations International Migrants Day is held annually to recognise the efforts, contributions, and rights of migrants worldwide.

WMA president Dr Ketan Desai said the authorities had failed to prevent the tragic deaths of thousands of migrants fleeing from war, violence and poverty.

"However, there is much we can all do now to ensure that proper healthcare is provided for those thousands of migrants seeking help at the moment.

"Refusing to provide healthcare ... is not only morally wrong, it poses a serious medical risk from the spread of disease"

"We believe that physicians have a duty to provide appropriate medical care for all migrants and that governments should not deny patients the right to such care. What matters is not who the migrants are or where they come from, but their clinical needs.

"Refusing to provide healthcare for migrants is not only morally wrong, it poses a serious medical risk from the spread of disease. The global community must learn from the mistakes it made this year to ensure the right of all people to receive medical care on the basis of clinical need alone. And doctors have a duty to speak out against legislation and practices that are in opposition to this fundamental right."

Code of conduct – SAMA members

SAMA Communications Department

This is the first in a series on the SAMA code of conduct

This code of conduct expresses SAMA's commitment to consolidating the institutional image of the association as an example of integrity, accountability and professional ethical standards – relating to SAMA members *inter se*, as well as their relationship with the association and the public. It was adopted at the national council meeting in September 2016.

- In terms of Section 25(3 - 5) of the Companies Act No. 71 of 2008, read with Section 4.3.2 of the Memorandum of Incorporation of the SAMA NPC, the SAMA board of directors has the authority to adopt a code of conduct to which all SAMA members must adhere. Non-adherence to this code of conduct will result in the institution of the disciplinary measures set out herein. The board also has the authority to amend this code of conduct from time to time.
- The generally accepted principles of ethical professional conduct, including the specific examples set out in this document, will inform any decisions made by disciplinary committees and the board in respect of an alleged infringement of this code by SAMA members. The principles and possible causes set out herein are not exhaustive, and each matter must be adjudicated on its individual merits.
- Any act or omission by a SAMA member that constitutes a breach of this code of conduct, when brought to the attention of a particular branch council or the SAMA board, will be considered a cause for disciplinary action. Disciplinary measures will also be instituted following any conduct by a SAMA member, individually or in concert with others, that could bring the association into disrepute or be perceived to do so. Dishonest or fraudulent acts, including those that result in a criminal conviction, are also considered a breach of this code of conduct.

Further causes for disciplinary action include, but are not limited to:

- Failure to respond to or co-operate with requests made by any of the SAMA

disciplinary committees or the board in the fulfilment of their duties described in this code of conduct when investigating an alleged infringement thereof, including requests by head office staff so instructed by any of the bodies mentioned.

- False and/or misleading statements made to or about the association, the SAMA board, its branches or any other of its structures, in the media or otherwise.
- Distribution of confidential information not available in the public domain but only available to SAMA members, which may include information of a proprietary nature, information which is legally restricted from circulation, or information which a member has reason to believe SAMA would not wish to be divulged in the best interests of its membership. All information circulated to office bearers/ employees of SAMA should be treated as confidential unless otherwise stated by the person distributing the information.
- Unprofessional communication in written, oral or electronic format issued by a member in respect of the association and/or its members, without appropriate business communication steps being taken to ensure that the communication is appropriate to the circumstances and to its intended audience, and is sufficiently courteous.
- Failure to declare an actual or perceived conflict of interest, and/or performing under an impaired ability to act fairly as a result of a conflict of interest.

SAMA members will at all times and in whatever capacity such members may act:

- Maintain the honour and dignity of SAMA
- Treat others with courtesy and fairness
- Conduct their personal and public lives with care and diligence
- Refrain from using, directly or indirectly, SAMA or anybody controlled or appointed by SAMA, to advance their own political or religious beliefs, or social or economic needs at the expense of SAMA
- Refrain from committing any act that may

conflict with the goals of SAMA or may prejudice the interests and good name of SAMA or other members of SAMA

- Diligently and with due care carry out any obligations the member may have towards SAMA
- Enhance the standing and good name of the medical profession
- Commit to the highest possible standards of professional conduct and competency
- Exercise integrity, honesty, diligence and appropriate behaviour in all professional and personal activities
- Act within the law.

Suspension

- A branch council or a branch disciplinary committee may suspend any member of the branch for the duration of any disciplinary proceedings set out herein.
- The social and ethics committee may suspend any member in respect whereof a grievance is received, as set out below, for the duration of the disciplinary proceedings as set out herein.
- The board or a board-appointed disciplinary committee may suspend any member in any province for the duration of any disciplinary proceedings set out herein, and confirm the expulsion of any member(s) as set out herein.

Other forms of discipline available to all the above-mentioned bodies may include, but are not limited to:

- Obtaining from the member a written undertaking to refrain from continuing or repeating the offensive conduct
- A written undertaking to the member that the consequences of his/her initial actions or any recurrence thereof will lead to stronger disciplinary actions
- A temporary withdrawal of membership benefits, the specific nature of which to be decided by the appropriate disciplinary body described in this code of conduct.

SAMA core values, the foundation of our behaviour

Dr Ayodele Aina, SEDASA National Chairperson



Core values are principles that a person or organisation views as being of central importance. They are standards or ideals that determine people's conduct or policy. They are part of our identity as individuals, guiding our behaviour at home, work or in any other area of our life. They tell us how to behave and not to behave when we're faced with desires or impulses, whether we're alone or with others. They are like a compass that helps us to behave consistently, regardless of the situation.

SAMA embraces six core values, which serve as a compass for our actions and guide the organisation in the conduct of its business as it evolves and grows

For example, when using public transportation, some people give their seat to pregnant women, and others don't. The former believe in the value of courtesy and consideration towards others, whether they are strangers or not. Among those who don't give up their seat, we commonly find children (who haven't yet acquired that value), elderly people who give a greater value to their own need to be seated (correctly so), or people who just attach a greater value to their own comfort.

Therefore, core values are the foundation of our behaviour, and make us feel good about our own decisions.

SAMA was formally constituted on 21 May 1998 as a unification of a variety of doctors' groups that had represented a diversity of interests. Today, SAMA is a non-statutory, professional association for public- and private-sector medical practitioners. SAMA functions as a non-profit company registered in terms of the Companies Act, as well as a public sector registered in terms of the Labour Relations Act. SAMA is a voluntary membership association, existing to serve the best interests and needs of its members in any and all healthcare-related matters.

SAMA embraces six core values, which serve as a compass for our actions and guide the organisation in the conduct of its business as it evolves and grows. Our core values form the acronym LIVUPP, and are fundamental to SAMA's existence.

- L – Leadership:** The capacity to give firm and committed guidance to people
- I – Innovative:** Introducing new ideas, original and creative thinking
- V – Vibrant:** Full of energy and life
- U – Ubuntu:** The quality of being good natured
- P – Professional:** Qualified in a profession
- P – Principled:** Act in accordance with morality, show recognition of right and wrong

Core values determine for us what's good or bad. We should compromise neither our values nor our standards. When we establish

moral parameters for our lives, we must not waiver in our dedication to them. We must not violate them for anyone or anything. We must be predictable to the point that our character speaks for us in our absence. There shouldn't be a "price" that will cause us to compromise our standards, because these values are our life. When we truly believe that a set of behaviours constitutes an essential cornerstone to life, we must be willing to lose money, promotion and other advantages for the sake of these core values.

Core values are the foundation of our behaviour, and make us feel good about our own decisions

Frankly, if we don't have solid convictions, we don't deserve to be leaders. If we keep vacillating in order to please people, if we keep sacrificing our belief system in order to be accepted, we are not leaders – we are compromisers. We must be willing to stand up to the disapproval of our own friends and the public at large for the sake of something that is noble and true.

As medical professionals, leaders and SAMA members, we have a responsibility to live with the utmost integrity. Our convictions must remain intact, no matter how much we may be tempted to compromise our honesty or to give in to our physical appetites. We must remember that people are looking to us for leadership and putting their faith in us. For the sake of our organisation, let us endeavour to live responsible lives based on strong values. We can do this as we identify, believe, receive, live out and share our values, and as we allow them to motivate and regulate our conduct and policies.

Every member of SAMA is bound to these core values and should uphold them in totality. More information on the core values can be found here: <http://www.significanceofvalues.com/wha/index.html>



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16/01/2017

Sexual harassment in the workplace

Modisane Lelaka, *Industrial Relations Advisor*

The objective of this article is to educate SAMA members about sexual harassment, to give guidance when a member finds him- or herself in such situations and to provide examples of real-life cases.

What is sexual harassment?

Sexual harassment is unwanted conduct of a sexual nature. The unwanted nature of sexual harassment distinguishes it from behaviour that is welcome, wanted and mutual.

In the case of *J v M Ltd* (1989) 10 ILJ 755 (IC), De Kock defined sexual harassment as follows: *"In its narrowest form, sexual harassment occurs when a woman (or a man) is expected to engage in sexual activity in order to obtain or keep employment or obtain promotion or other favourable working conditions. In its wider view it is, however, any unwanted sexual behaviour or comment which has a negative effect on the recipient. Conduct which can constitute sexual harassment ranges from innuendo, inappropriate gesture, suggestions or hints or fondling without consent or by force, to its worst form, namely, rape. It is my opinion also not necessary that the conduct must be repeated."*

Sexual harassment may include unwelcome physical, verbal or non-verbal conduct

Although sexual harassment typically consists of persistent behaviour, even a single incident can constitute sexual harassment. Whether or not the recipient makes it clear that the behaviour is considered offensive, the perpetrator ought to know that the behaviour is regarded as unacceptable.

Sexual harassment may include unwelcome physical, verbal or non-verbal conduct. Physical conduct of a sexual nature includes physical contact, touching, sexual assault, rape and strip search by or in front of another person. Verbal conduct includes unwelcome suggestions and hints, sexual advances, comments with a sexual overtone, sex-related jokes, insults or graphic comments about a person's body and inappropriate enquiries about a person's sex life.

Non-verbal forms include unwelcome gestures, indecent exposure and the unwelcome showing of sexually explicit pictures and objects.

Anyone at the workplace can be a perpetrator or a victim. The harasser might be the victim's supervisor, a supervisor in another area, a coworker, or someone who is not an employee of the employer, such as a client or customer.

Real-life scenario

An employee had sexual relations with a colleague from another hospital. Both were employed by the Department of Health. The two had sexual relations on the employer's premises outside working hours. The alleged victim then complained to the employer about the incident. The male was charged firstly for engaging with the female colleague at the premises of the employer, secondly for sexual harassment and lastly for using the property of the employer to commit the sexual act.

The victim had not complained or nor refused any sexual advances before, or on the day of the incident.

The Code of Good Practice on the management of sexual harassment cases stipulates that the act of sexual harassment does not have to be repetitive. The code further provides that a repetitive or persistent sexual harassment or a single incident of serious misconduct can lead to a dismissal. The Code of Good Practice, as contained in schedule 8 of the Labour Relations Act, provides that an employee may be dismissed for serious misconduct or repeated offences.

In disciplining the perpetrator, the employer can either utilise an informal process for minor offences of sexual harassment, or a formal process for severe and repeated offences. Severe cases include sexual assault, rape and strip search.

It is important to always know the forms of sexual harassment. Members are advised to obtain copies of sexual harassment policies from their respective human resources offices. Victims can lodge grievances with their respective employee relations officers.

Code of Good Practice

The objective of this code is to assist in eliminating sexual harassment in the workplace. It provides appropriate procedures to deal with the problem and prevent its recurrence.

Employers are encouraged to develop and implement policies and procedures that will lead to the creation of workplaces that are free of sexual harassment, where employers and workers respect one another's integrity and dignity, their privacy and their right to equity in the workplace.

Application

Although this code is intended to guide employers and workers, the perpetrators and victims of sexual harassment may include:

- owners
- employers
- managers
- supervisors
- employees
- job applicants
- clients
- suppliers
- contractors
- others having dealings with a business.

A non-employee who is a victim of sexual harassment may lodge a grievance with the employer of the harasser, if the harassment has taken place in the workplace or in the course of the harasser's employment.

SAMA meeting rulebook: Ground rules

SAMA Communications Department

Meeting dates for all committees are preset on an annual calendar, distributed at the beginning of the year. These dates cannot be changed randomly. Where real emergencies or unforeseen circumstances exist, the chair of the meeting and the responsible staff members at head office must be contacted immediately. Do not wait until the last minute to offer an apology. When suggesting alternative dates first look at the annual calendar to see whether other meetings are not already arranged on that date. Consider alternatives such as teleconferences when forced to postpone.

RSVP

When asked via phone, email or electronic calendar to attend a business meeting, be sure to reply immediately. Meetings are structured – airline tickets, accommodation and meals are secured on the basis of expected attendance. Last-minute bookings and/or cancellations, whether they be of airline tickets, accommodation or car rental, attract additional costs and penalty fees. Head office staff are preparing for meetings and it is unnecessarily time-consuming and costly to phone attendees to ascertain whether they will be attending when meeting invitations are ignored.

Attendance and quorum

Do not cancel at the last minute once you have accepted a meeting invitation, unless it is a real emergency. Meetings cannot continue successfully without a quorum.

Agenda

The agenda and accompanying documentation must be circulated to all participants at least a week in advance. Those who want to add items to the agenda must add such items as soon as possible after receipt of the agenda. It is preferable not to wait until the date of the meeting to add items or address concerns under the agenda item “adoption of the agenda,” although this is allowed for emergencies. The golden rule is that the more that can be done prior to the meeting, the more quality time can be allocated to valuable discussion at the meeting, provided that everyone has at least read through

their documentation and is prepared for the meeting. Agendas must indicate start and ending times and time slots in between where necessary.

Cut-off dates for comments on documents

If in terms of the action lists (described below), action items are allocated to specific persons, those persons must adhere to the timelines indicated on the action list. If a written report is due at the next meeting, this entails that the report should be ready 7 days before the next meeting, to be with the agenda.

Arrive early

If arriving early is not possible, at least arrive promptly at the scheduled time at the latest – but never late. Do not assume that the beginning of a meeting will be delayed until all those planning to attend are present. If you arrive late, you risk missing valuable information and lose the chance to provide your input. Also, you should not expect others to fill you in during or after the meeting; everyone is busy, and those who were conscientious enough to arrive on time should not have to recap the meeting for you. People do not like to be kept waiting and many see it as a sign of contempt and disrespect. Being punctual says a lot about you. It reveals your integrity and shows your humility and discipline, but most importantly, it shows your respect for others and their time.



Start meetings and presentation slots on time

The chairperson of any meeting must start the meeting on time, to enforce the message that SAMA is serious about time and meeting management.

If someone only needs to attend a particular segment of the meeting, he/she must be informed of his/her exact time slot by the meeting organiser. Such a person must be accommodated by the chair at the pre-arranged time slot, even if the agenda is running late, so that the person does not have to wait outside the meeting for an

inordinately long time period that leaves him/her with the impression that SAMA has weak time management and is disrespectful towards invited speakers and their time.

Run and end meetings on time

Stick to the agenda. Each agenda item should have a time limit. If you are going over the set time for a certain item, make one of the following choices:

- Put the item on the “matters standing over” list for the agenda of the next meeting.
- If an agenda item is multifaceted, break it down into one or two key aspects for discussion and table the remaining items on the “matters standing over” list for the agenda of the next meeting.
- The meeting can decide that the item is urgent and needs to be dealt with immediately, and agree that the other items on the agenda will have to be postponed to the next meeting.
- Organise a teleconference prior to the next meeting if required to discuss postponed items.
- Arrive at decisions on postponed matters via a round-robin process prior to the next meeting.

For chairpersons: Chairs are allowed to have, and to implement, discussion ground rules. For example, allow someone to “hold the floor” for a maximum of, say, 2 minutes, and enforce it with a timer or appointed timekeeper for the meeting. Or determine that one speaker may only be allowed the floor twice on a certain topic. Set these rules out clearly at the beginning of the discussion. This will prevent time-wasting and talking the topic to death.

Come prepared

Attendees must come to the meeting with an understanding and knowledge of all meeting topics, derived from the material distributed at least a week prior to the meeting. That is, READ the documents distributed prior to the meeting BEFORE arriving at the meeting. This prevents the asking of questions on information already provided, and contributes to the respect for everyone’s valuable time. It is part of a committee member’s fiduciary duties to be fully prepared for the meeting and be cognisant

of all the content that will be discussed at the meeting.

If you were requested to complete a report for discussion at the next meeting, supply it to the responsible staff members in time for distribution – i.e. at least 7 days before the meeting,

so that it can be circulated with the agenda. At the meeting, you should be prepared to answer questions on your report

from the other participants

who have at that stage read your report.

If you need to do a PowerPoint presentation, have the presentation ready on a USB device.



Abstain from electronics

When you're attending a meeting, you have to be completely present. Meetings are not a mere social gathering; they're held for a reason and their outcomes affect the entire organisation. That's why you need to give them all your attention and put any distractions aside. Although your mobile phone might not be a source of distraction for you, for example, it could be one for others. Your mobile phone should therefore be put on silent mode. Don't watch sports games on your iPad or laptop during a meeting. Don't do other work or do study assignments on your laptop or iPad during a meeting.



Do not interrupt

Hold your comments to the speaker until the chair asks for comments, unless the chair has encouraged open discourse throughout the meeting. Do not interrupt. Conversation during a meeting is disruptive to other attendees and inconsiderate of the speaker. Speak in turn. When asking a question, it is more appropriate to raise your hand than to blurt out your question. The chair needs to acknowledge everyone and you will be provided an opportunity – await your turn.

Be patient and calm. Do not fidget, drum your fingers, tap your pen, flip through or read materials not concerning the meeting, start whispering to the person next to you or otherwise act in a disruptive manner.

Keep your questions brief

When asking questions, be succinct and clear. If your question is detailed, break it into parts or several questions. But be sure to ask only one question at a time; others may have questions as well.

Pay attention

Listen to the issues the speaker addresses, the questions from the attendees, and the answers provided. You do not want to waste meeting time asking a question that has already been answered.

Problem: People don't take meetings seriously – they arrive late, leave early, spend most of their time doodling. **Solution:** Consider meetings as WORK – a shared conviction among participants that meetings are real work and not "downtime".

Stay on topic

Every topic on the agenda must be discussed individually and result in one of the following:

- The topic is noted and finalised, does not need further attention and is removed from the agenda. (This must be minuted.)
- The topic is broken into sections because it is too involved, and certain sections are "parked" and will stand over for a round-robin exercise, teleconference or the next meeting. The "parked" section must appear on the next agenda under "matters standing over" and/or on the action list distributed shortly after the meeting (see below).
- The remainder of the topic where it is broken into sections, or the entire topic if it is not broken into sections, must after discussion lead to a resolution. The resolution describes the action to follow. The chair should summarise the resolution for the benefit of the minute-taker at the end of the discussion of each topic.
- Allocate a responsible person for any topic that needs action in terms of a resolution. Indicate this on the action list (see below) and include a deadline – i.e. when the action must be finalised.

Attend the entire meeting

Leave only when the meeting is adjourned. Leaving before the end of the meeting - unless absolutely necessary and unless you have prior permission – is disruptive to other attendees and inconsiderate. It also affects quorum.

Respond to action items

After the meeting, be sure to complete any tasks assigned to you as expeditiously

as possible; file your meeting notes or the minutes for later review or to prepare for future meetings. Do not leave your notes on the table – it indicates that they were not important to you and staff members cleaning up after you are prone to read them.

Action list

Staff members responsible for the meeting must distribute an action list with timelines within 3 days after the date of the meeting. Action list items must be addressed as set out above.



Minutes

Staff members responsible for meeting minutes must distribute them within seven days from the date of the meeting, unless a number of meetings for which the staff members are responsible occur in the same week – in which case a maximum of two weeks will be allowed, keeping in mind that action lists would have been distributed within three days after the meeting.

NB: Minutes are sent out for comments and corrections and must be returned to the staff members with such comments and corrections as soon as possible, to avoid a waste of time at the next meeting. Comments on minutes should NOT be held over until the date of the next meeting to be discussed at that meeting – this practice is an unnecessary waste of time.

Uninterested members

Once attempts have been made to elicit a response from a non-attending/uninterested committee member, a committee chairperson will have to recommend to his/her committee to resolve that such a member, showing a lack of interest in committee matters by an intermittent or constant lack of attendance and general unresponsiveness, must be requested to resign from the committee and be replaced by the next candidate on an election list, or alternatively a co-opted member (the latter to serve on the committee until the next elective national council meeting as specified in the company rules). A majority decision by the committee will decide the matter.

SAMA attends the HPCSA roadshow

SAMA attended the HPCSA's roadshow held at Meropa Casino and Conference Centre, Polokwane, on 7 February 2017.

Dr M Kwindu, ombudsman and acting chief operations officer at the HPCSA, delivered presentations on the council's role in guiding practitioners, as well as on ethics and law in the practice of health professions.

The event was well-attended and was a great networking platform for SAMA.



From left: Jeanette Snyman, senior marketing officer at SAMA head office, and Vuyisani Bill, SAMA Limpopo branch secretary



Event attendees



Jeanette Snyman assisting a SAMA membership applicant with filling in the form

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



Financial advice: Will 2017 be better than expected?

Gert Viljoen, managing director, VPROF

V Professional Services (VPROF) is a medical practice administrator, medical bureau and professional accounting firm that is dedicated to supporting the business activities and patient care of independent medical practices around SA. Managing director, Gert Viljoen, gives SAMA members some advice for 2017.

The year 2016 was our annus horribilis, with drought, political uncertainty, low commodity prices, rising inflation and a weak currency.

From such a low base, economists are arguing things should get better.

What will drive the economy in 2017?

Balance of payments

Our economy has been running a substantial trading deficit, which puts pressure on the rand and inflation. As with any economy, it is important that we live within our means. At the end of October, the current deficit was R14 billion, v. R60 billion in 2015. We have an open economy, which means that when exports rise and imports fall, we are creating economic growth. This substantial turnaround in the current account deficit signals that the economy is starting to pick up steam.

Agriculture

We are coming out of one of the worst droughts in living memory. Apart from being a drag on economic growth, the drought has been the largest contributor to rising inflation, with food inflation now above 11%. The 2016/2017 crop, however, is well underway and is expected to be a bumper crop. This will dampen inflation, further improve the balance of payments and could add up to 1% in economic growth.

Commodities

Since the global financial crisis of 2008/2009, the price of commodities has continuously fallen. Iron ore fell from USD140 to just USD20 per tonne. In 2016, it rose to USD80. The same trend can be seen with our other major commodities such as gold and platinum. As commodities make up more than half of our exports, the improvement in prices will also add to economic growth, employment and a further improvement in the balance of payments.



Consumers have been under pressure, and tax increases could add to this

The rand

The rand had a roller coaster ride in 2016 – at one stage it touched R17 to the dollar. Today it is R13.50 to the dollar. If it remains within this range it will give confidence to investors (thus attracting investment which will further strengthen the currency) and will keep inflation in check.

But ... plenty of factors can derail this forecast, such as more political turbulence, particularly around the finance minister, and a ratings downgrade is still a possibility. The global economy still faces a great deal of uncertainty. We also need to remember that consumers have been under pressure, and proposed tax increases in the February budget will add to this pressure.

Nevertheless we should experience positive growth – it could even go above 2%. This growth could be the springboard for a positive growth cycle. Remember that the economy goes in cycles, and we have experienced a low point in 2016 that signals the end of the downward cycle. Our population growth rate is 1.7%, so anything above this means there is real wealth growth for the economically active.

Developing your senior staff: Let them run meetings

One underrated but important aspect of an organisation is its ability to run effective meetings where problems are identified and strategies put in place to chart a successful way into the future. In smaller businesses, invariably the most senior person (the owner or CEO) runs these meetings.

As a business owner or CEO, it is well worth thinking about allowing your senior staff to conduct and lead these meetings.

Everyone benefits

Firstly, one of the key assets in a business is its people. Enabling them to learn an important skill will add to the experience of your staff. It will also give these managers credibility and respect within the organisation, which enhances their commitment to the business.

Secondly, a business is more sustainable and profitable when management and staff act in unison. Getting leadership's vision to filter all the way down the organisation is critical. Upskilling your senior staff will add

to this process and will spread your vision throughout the company.

As a CEO, you are often more effective as a participant in a meeting, as not running it allows you to be more focused. You can ensure the meeting sticks to significant matters by making critical interventions when necessary.

Finally, the fact that you can delegate important tasks fosters teamwork and gets buy-in from your staff.

Letting your managers run meetings is a cost-effective way to improve management skills and to build a more effective company.

Tax ombud now has more powers

The Office of the Tax Ombud (OTO) was created in 2013, and despite initial doubts as to its role, it has carved a niche for itself and gained credibility as a result. Recent legislation has strengthened the OTO.

The OTO was designed as a free service to taxpayers to assist them when there is poor service from SARS, or when taxpayers experience administrative or procedural issues with SARS.

How independent is the ombud?

Initially, the OTO was funded out of SARS' budget and all staff were seconded from SARS. This created the perception that it was not an independent institution.

In January, however, president Zuma approved legislation which permits the OTO to recruit its own staff, and its budget has been moved from SARS to the minister of finance.

This new Act also extends the tenure of the ombud from 3 to 5 years. This will allow the ombud the time to leave his or her mark on the OTO, and thus should improve the calibre of future ombuds.

The effect of ombud findings

These are not binding on either SARS or the taxpayer. The recent legislation requires that the party not accepting the ombud's report has 30 days to explain to the ombud why the findings will not be followed. Apart from providing the OTO with information to help it review how effective its findings are, this explanation requirement will enhance the OTO because SARS and taxpayers will now carefully weigh up whether to reject the ombud's findings.

A concern with the OTO process is the lack of prescribed time periods for the various processes in resolving a complaint, but hopefully this will be addressed in the future.

The power of the ombud has been further strengthened by allowing the OTO to launch investigations (with the permission of the finance minister) of systemic service, administrative or procedural issues. Again, this increases the credibility of the ombud and should be a valuable service to taxpayers.

A Bill of Rights and a Service Charter in the wind?

The ombud has lobbied for an updated Taxpayers' Bill of Rights and a SARS Service Charter, which will provide improved transparency and clarity for both parties. To date this has not yet happened.

The OTO is beginning to provide taxpayers with a useful service. In 2014/2015, 75% of the cases taken on by the ombud resulted in decisions in favour of the taxpayer. By 2015/2016 this had risen to 87%. The ombud is providing a counterweight to the widespread powers that SARS has long enjoyed.

GPPPC strategise for 2017

SAMA Communications Department

The General Practitioner Private Practice Committee (GPPPC) held its meeting on 4 February 2017 at the SAMA head office. In this meeting, the committee explored possible strategies for 2017 and discussed numerous topics affecting the daily professional lives of practising GPs. The committee also strategised for the upcoming year and plans to host provincial indabas across SA, in order to engage with doctors on pertinent and topical matters.



Front row, from left: Dr P Tabata, Dr J Mphatswe; Second row, from left: Dr M Stoltz, Dr B M Choeu, Third row, from left: Dr W Goose, Dr A Coetzee, Dr D Theron

SAMA membership representative committees

SAMA has three membership representative committees: the Committee for Public Sector Doctors, representing the interests of all SAMA members employed in the public sector; the General Practitioners in Private Practice Committee (GPPPC), representing the interests of all SAMA GPs; and the Specialists in Private Practice Committee, representing the interests of all the specialist groupings in private practice among the SAMA membership.

The GPPPC committee is tasked with acting in the interests of GPs in healthcare delivery and representing the profession in discussions and consultations with healthcare funders.

A cannula complication

The Medical Protection Society shares a case report from their files

Mrs H, a 28-year-old massage therapist, was admitted to hospital for laparoscopic tubal ligation. Dr T was the anaesthetist for this surgery.

Before the surgery, Dr T placed an intravenous cannula in Mrs H's right wrist and, after surgery, patient-controlled analgesia was commenced through this cannula. According to the nursing records, a cannula was also placed in Mrs H's left hand, although this was not in place following surgery. Mrs H also recalled a cannula site in the left forearm and a further cannula site in the right forearm following surgery, although these were not recorded in the nursing records.

Records show that a day later, slight bloodstaining was present at the cannula site in Mrs H's right wrist. The following day, Mrs H reported the site of the cannula being painful, so it was removed. No further problems were recorded and Mrs H left hospital a day later.

A month later, Mrs H attended her GP in relation to umbilical wound oozing; she also

complained of altered sensation in her left thumb and for this was referred to Dr Q (a specialist neurologist). He noted that Mrs H had had two cannula sites over her left arm where she had developed a haematoma and now had paraesthesia over her distal thumb.

Dr Q noted neurapraxic damage to the dorsal branch of the radial nerve, and advised desensitisation exercises. A month later, improvement was noted and Dr Q noted that the hyperaesthesia had settled. He further noted that there was 40% function in the dorsal branch of the radial nerve and that there was a reasonable chance that this would recover, at least to a degree.

Mrs H made a claim against Dr T for alleged substandard technique during cannulation, also alleging poor record-keeping in his failure to record two cannula insertions on the cannula chart. Mrs H claimed that when the needle was inserted into her vein, poor technique was employed, resulting in the bevel of the needle cutting through nerves and creating neuromas, causing neurological

damage. Mrs H also claimed that the sensory injury had left her disabled, in that she found it extremely difficult to carry out her job.

Expert opinion

MPS obtained an expert report on breach of duty a short time after the letter of claim was received. Prof. I, a consultant in anaesthesia and intensive care, produced the report and was robust in his defence of Dr T. Prof. I stated that he considered Dr T's technique to be entirely appropriate and that he could not see any evidence of substandard care. He considered it likely that the nerve damage did arise from the unsuccessful cannulation but did not in any way reflect bad technique. Prof. I also found Dr T's record-keeping to be appropriate, as he would not expect failed cannulations to be documented.

The MPS legal team was aware that Mrs H's own legal advisers were still to obtain their report on breach of duty, and considered that issuing them with a quick response that was supportive of Dr T would dissuade them from pursuing the matter. MPS served its expert evidence along with the letter of response a short time after the letter of claim was received.

Mrs H withdrew her allegations and the claim was discontinued



Learning points

- Good record-keeping is essential for continuity of care – therefore, the medical records you keep should provide a window on the clinical judgment being exercised at the time.
- When inserting a cannula, consider using the patient's non-dominant hand if possible.
- It is helpful to write a report soon after an adverse event, because of the lengthy time that can sometimes pass before a related complaint or claim arises.

This case is a reminder that not every adverse outcome is negligent. MPS's robust approach meant the case was dropped and the allegation withdrawn very quickly.

Prizes for West Rand intern doctors

On 9 December 2016, SAMA West Rand branch participated in an annual prize giving for intern doctors at the Leratong Hospital. The doctors among themselves, together with the medical officers, vote for the top five doctors they feel deserve an award. SAMA uses the opportunity to market and sign up new members. Each prizewinning doctor received a Woolworths voucher from SAMA.



Intern curator Dr Fiona Rossouw, who runs the programme at Leratong Hospital, presented the prizes



Prize winners, from left: Dr N Snyman, Dr M G Lumata, Dr F P Gabellah, Dr S Nzama, Dr J S Dreyer

New hospital to open in Welkom



The old Ernest Oppenheimer Hospital in Welkom makes way for a new hospital this year

A new hospital will be opening in Welkom – an important development for Goldfields branch, as there are presently only two private hospitals for the whole community. The buildings that housed the closed Ernest Oppenheimer Hospital in Welkom were officially handed over to RH Capital Partners, who have bought the complex in order to open a new hospital in November 2017.

The first phase after opening will mainly focus on maternity, paediatrics and high-care units. In this phase, 141 beds will be made available for patients on medical aid.

Phase 2 is still in planning, but will offer beds to 695 patients and provide medical services to all members of the community.

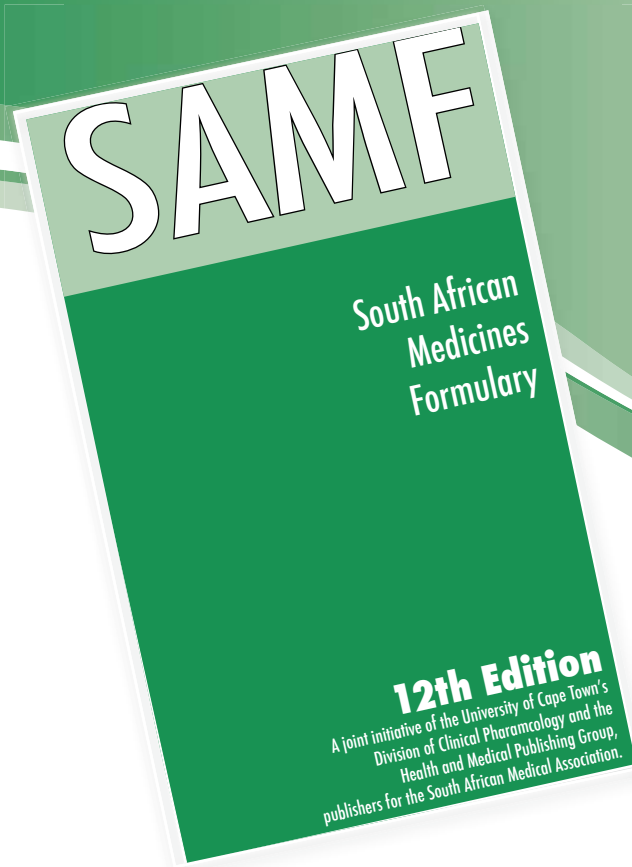
The revamping will take ~8 months to complete, and the company is still awaiting approval from the Department of Health.

Busy month for Eastern Highveld branch

The Eastern Highveld branch will be attending the forthcoming Secretary Conference to be held at head office from 8 to 10 March.

They are also partnering with Shivdev Training Academy, who will be hosting a CPD lecture function at the Lakes Hotel in Benoni on Saturday 11 March from 13h30 to 19h00. The branch has been given a display table, and their banner will be visible. This will give them the opportunity to target any delegates who are not members and convince them to join the association. Hopefully, Shivdev will concentrate on the non-members in our area. Chairman Dr Jess Boucher has been asked to open the proceedings.

In recognition of long service to the association, the branch is inviting life members to a function on 10 March, when Dr Boucher will have the opportunity to present their life member certificates to them.



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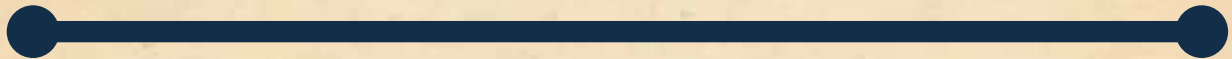
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