SAMA INSIDER

April 2017

International conference on social determinants of health tackles huge inequities in SA

The constitutional dispensation for health and healthcare: Is it working?

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

SOUTH AFRICAN MEDICAL ASSOCIATION

PARTNER WITH A PRO.

Nothing quite matches the satisfying thrill of driving a MINI. The comforting luxury of the interior and the knowledge that under your control is a precision-engineered machine meticulously designed to give you ultimate driving pleasure. As a corporate partner of SAMA, we take pleasure in extending the following exclusive offer to all SAMA employees.

This includes:
- Ride and Drive events where you will drive the latest models
- Invitations to product launches
- While you wait servicing (on request)
- Servicing from 07:00 –17:00
- Competitive pricing on lifestyle items and accessories
- Motorplan of up to 5 years or 100 000 km

***Preferential deal break down:**

Excluding newly launched vehicles or vehicles in limited supply (Separately Negotiated) Preferential service bookings. A minimum of 8% discount on all new MINI models.

For more on Northcliff Auto MINI or our solution for SAMA employees, please feel free to contact:

Corporate Sales Manager
Nicci Lopes
Cell. 083 200 4555
E-mail. nicci.lopes@bmwdealer.co.za

Northcliff Auto MINI
Tel. 011 392 6263
11 Cresta Lane, Cresta
www.mini-northcliffauto.co.za

EXCLUSIVE OFFER FOR SAMA EMPLOYEES.

CONTENTS

APRIL 2017

Source: Shutterstock - Carroteater

MEDI-ACC
Medical Accounting, Tax & Consulting

At Medi-Acc, we specialise in accounting and tax services for the healthcare industry as we are familiar with the accounting and financial aspects relevant to Medical Practitioners. We differ from other Accountants in that we bring experience working directly with healthcare industry professionals. We offer the convenience of working with one professional services firm, taking care of all your bookkeeping, accounting, tax, payroll, labour and personal financial advice needs.

WHAT WE OFFER

- Taxation services – tax returns, planning and tax saving strategy;
- Assistance with all SARS matters – disputes, appeals, meeting facilitation, etc;
- Monthly Bookkeeping & Accounting;
- Financial Statements;
- Management Accounting;
- Payroll;
- Company Registrations;
- Personal financial advice;
- Trust Registration & Administration; and
- Practice Consulting.

WE COME TO YOU

We offer an initial consultation service, AT NO CHARGE to you as a Medical Professional. This gives you the opportunity to discuss various tax, accounting and financial issues you may need clarity on. Our very affordable monthly packages starting from as little as R2,500 cover all your accounting, tax, payroll and labour needs so you can focus on what you do best – taking care of your patients. Because we understand your busy schedule during the week, we have consultants available on weekends. Please call, sms or e-mail a consultant today to schedule a meeting and we shall come to your premises for your obligation-free consultation.

WHERE TO FIND US

MIDRAND Head Office
Birchwood Court – East Wing
43 Montrose Street
Vorna Valley, Midrand
Tel: 011 100 2592
Cell: 071 092 4660
info@medi-acc.co.za

DURBAN
The Business Centre
2 Ncondo Place
Ridgeside
Umhlanga Ridge
Tel: 031 000 4404
Cell: 071 092 4660
info@medi-acc.co.za

CAPE TOWN
Northgate Island Mall
Unit A15, Block 1
Northgate Estate
Cape Town
Tel: 087 151 0251
Cell: 071 092 4660
info@medi-acc.co.za

NELSPRUIT
Promenade Centre
First Floor
Suite 11 A
Nelspruit
Tel: 013 000 0175
Cell: 071 092 4660
info@medi-acc.co.za

PRETORIA
Oxlynn Centre
323 Lynnwood Road
Menlo Park, Pretoria
Tel: 087 151 0251
Cell: 071 092 4660
info@medi-acc.co.za

BLOEMFONTEIN
62 Keller Street
Westdene
Bloemfontein
Tel: 087 151 0251
Cell: 071 092 4660
info@medi-acc.co.za

PORT ELIZABETH
280 Cape Road
Newton Park
Port Elizabeth
Tel: 031 000 0175
Cell: 071 092 4660
info@medi-acc.co.za

EAST LONDON
24 Pearce & Tecoma
Berea
East London
Tel: 087 151 0251
Cell: 071 092 4660
info@medi-acc.co.za

POLOKWANE
Amy Park, Office No. 2
128 Marshall Street
Polokwane
Tel: 015 000 0001
Cell: 071 092 4660
info@medi-acc.co.za

BELLVILLE
Shop 4 The Bridge
304 Durban Road
Tyger Valley
Tel: 031 000 0175
Cell: 071 092 4660
info@medi-acc.co.za

SOMERSET WEST
170 Main Street
Cnr. Main & Helderberg
Somerset West
Tel: 087 151 0251
Cell: 071 092 4660
info@medi-acc.co.za

Kindly visit our website www.medi-acc.co.za for more information on how we can assist to grow your medical practice.

EDITOR'S NOTE

APRIL 2017

Diane de Kock
Editor: *SAMA INSIDER*

A sad farewell

It is with great sadness that we mark the passing of former SAMA president, Denise White, in this issue of *SAMA Insider*. A good friend, mentor and regular contributor to the magazine, Denise will be sorely missed by the profession and all who knew her.

Her regular monthly columns tackled issues of the day head on, and her beautiful photographs adorned the covers of the September and October 2016 editions of the magazine. Read SAMA board member Mark Sonderup's tribute to a friend and colleague on page 5.

After nearly two years' planning, the first ever international conference on social determinants of health took place in Johannesburg on 23 and 24 February 2017. On pages 6 - 9 of this issue, we publish the first of three articles on this important conference and its outcomes.

Other articles in this issue look at SAMA's stance on the Life Esidimeni deaths (page 11), the recent announcement by the HPCSA that medical aids are to be abolished (page 13), SAMA's mission and vision (page 15) and the recently published WHO list of antibiotic-resistant "priority pathogens" (page 19).

As always, your feedback, articles and letters are welcome.

Correction

In the 2017 branch council elections article printed in the March issue of *SAMA Insider* the following paragraph should have read:

"The system automatically indicates the number of choices allowed per member nominating or voting, and promotes adherence to the historically disadvantaged individuals (HDIs) provisions of SAMA's **memorandum of incorporation** (MOI) and rules."

Our apologies for any misunderstanding that might have occurred.

Editor: Diane de Kock
Chief Operating Officer: Diane Smith
Copyeditor: Kirsten Morreira

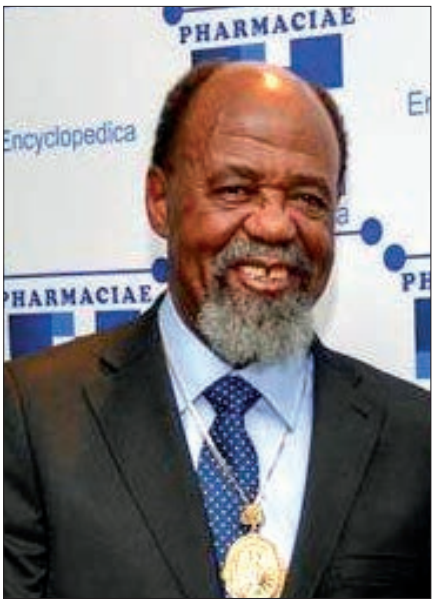
Editorial Enquiries: 083 301 8822
Advertising Enquiries: 012 481 2069
Email: dianes@hmpg.co.za

Design: 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

The constitutional dispensation for health and healthcare: Is it working?



Prof. Dan Ncayiyana, *SAMA president*

We recently witnessed a tragic drama unfolding right before our eyes in Gauteng Province, in which more than 100 psychiatric patients (and counting) died needlessly due to neglect and lack of appropriate healthcare, as a result of administrative incompetence and political arrogance within the provincial government.

When it became public knowledge that an unusual pattern of deaths was occurring among psychiatric patients in Gauteng Province, minister of health Aaron Motsoaledi requested that the ombud for health investigate. The ombud's report was released recently.

Towards the end of 2015, the provincial minister of health (or member of the executive council) for Gauteng Province, Qedani Mahlangu, announced that she was terminating the contract with the long-time private provider, Life Esidimeni (Place of Dignity). The reason given for relocating these patients from a facility that had offered quality inpatient care, including treatment and rehabilitation, for publically funded patients with chronic psychiatric disorders and severe intellectual disability for some years, was that the cost of care had become too high.

It is clear that the decision was taken without consulting the national Department of Health, and was implemented in direct defiance of advisories from the national department.

It is also clear that the decision was taken without consultation with the families of the affected patients, who were deeply anxious about the move but were utterly powerless to exert influence on their government. One desperate family member was quoted as saying: "We cried to government, we pleaded with them not to close because they told us that they are closing in March." The decision was also opposed by some officials within the provincial administration, as well as by external professionals and other stakeholders.

With the deadline of 31 March 2016 fast approaching, the province hastily and clumsily implemented what it called the Gauteng Mental Health Marathon Project, whereby the patients were transferred from the Life Esidimeni hospital facility to 27 newly contracted NGO facilities scattered in various, sometimes remote, locations. The transfer was rushed and chaotic. To quote from the ombud's report, "Some patients were transferred directly from sick bays, others with comorbid medical conditions that required highly specialised care into NGOs where such care was not available. Moreover, frail, disabled and incapacitated patients were transported in inappropriate and inhumane modes of transport, some without wheelchairs, bound and carried with bedsheets, and some were transported in open bakkies."

The Gauteng crisis is not an isolated incident. It is symptomatic of a corrupt and crumbling public health system nationwide.

What is crystal clear is that at the time the decision was made to withdraw the patients from this well-established facility, no suitable alternative arrangements were in place for their continued care. It turns out as well that none of these NGO facilities was licensed, and most of them were hopelessly ill-prepared to receive and provide appropriate care to the incoming patients, many of whom were severely disabled. The NGOs were not fit for purpose. The accommodation was often cramped. There were no medications, no qualified staff and not enough food. In short, there was utter chaos, and people died.

In a sense, the callousness, the condescension and the cruelty with which these patients were treated by the Gauteng provincial government represents the zenith of human rights abuse in the health sector. It resembles a throwback to the horrors of the apartheid era, so vividly described in the late 1990s seminal book *An Ambulance of the Wrong Colour*, by Laurel Baldwin-Ragaven, Leslie London and Jeanelle de Gruchy (Juta, 1999).

Human rights abuses

Mental healthcare users are among the most vulnerable, invisible and forgotten groups of people in our society. However, there is no shortage of constitutional provision, legislative framework or policy directives in our country aimed at protecting the human rights of the mental healthcare user. The problem lies in the all-too-common culture of indifference and, one might add, blatant disdain for people who are both sick and poor, by privileged people in positions of political power.

SA is a signatory to numerous international human rights conventions, including the Mental Health Declaration of Human Rights, which asserts that mental healthcare users have the right to:

- fully equipped medical facilities and appropriately trained medical staff in hospitals, so that competent physical, clinical examinations can be performed
- hygienic conditions and non-overcrowded facilities, and to sufficient, undisturbed leisure and rest.

The Mental Health Act (Act 17 of 2002) specifically seeks to protect the wellbeing of the mental health patient. Section 11 directs that every person or health establishment providing care, treatment and rehabilitation services to a mental healthcare user must

take steps to ensure that users are protected from exploitation, abuse and any degrading treatment.

Our Constitution contains a Bill of Rights that protects every South African, including mental illness sufferers. In this regard, it is apropos to quote once again from the ombud's report, which states:

"The execution and implementation of the project showed a total disregard for the rights of the patients and their families, including but not limited to: the right to human dignity; the right to life; the right to freedom and security of person; the right to privacy; the right to protection from an environment that is harmful to their health or wellbeing, the right of access to quality healthcare services, sufficient food and water and the right to an administrative action that is lawful, reasonable and procedurally fair."

The Life Esidimeni fiasco demonstrates once again that that laws and policies cannot, in and of themselves, protect the lives and dignity of persons with disabilities. The people and the system providing the care must themselves be fully transformed and true to their calling.

The Gauteng crisis is not an isolated incident. It is symptomatic of a corrupt and crumbling public health system nationwide. The tale of mismanagement and human rights abuses of patients who are both sick and poor echoes across the country as provincial health departments seem to be mired in corruption and incompetence.

Stories of this kind are not limited to Gauteng. In my previous column, I commented on the recent report by the civil society organisation Section 27 entitled *Death and Dying in the Eastern Cape*, which makes for horrifying reading. The systemic collapse is also occurring in Limpopo, Mpumalanga and elsewhere in other provinces. Section 27 has quite perceptively summed up the situation – that we are no longer dealing with the legacy of apartheid. We are dealing with the failures of democracy.

This brings us to the nub of the problem: Who is accountable?

In terms of the Constitution, health is a dual responsibility (or is a concurrent competence) of both the national and provincial governments. The national government is responsible for overall national policy and funding, but the provinces are responsible for managing the provincial health system autonomously. Minister Aaron Motsoaledi has limited power to intervene. The question therefore arises: Who is ultimately accountable? Where does the buck stop? Who is to blame?

Hamba kahle qabane, Denise

Mark Sonderup, *SAMA Board of Directors*

It is with profound sadness that we report the untimely passing of our recent SAMA past-president, and much-respected colleague, Prof. Denise White. She died peacefully in the Royal Trinity Hospice in London, surrounded by her family, on 9 March. True to her nature, Denise demonstrated extraordinary courage in the last few months, after a diagnosis of metastatic carcinoma in October 2016, very shortly after completing her term of office as SAMA president.

Denise was born in New Zealand and moved to SA at a young age. She completed her under- and postgraduate medical training at UCT and Groote Schuur. Her professional and academic life as a psychiatrist was dedicated to the public sector, having worked at both Groote Schuur and Lentegeur Hospitals.

Prof. Dan Stein, head of psychiatry at UCT, notes that her seminal academic contribution included work on the link between catatonia and neuroleptic malignant syndrome in describing and hypothesisng a causal link between the two conditions. The work she was part of had very important treatment implications, given that patients often responded to neuroleptic discontinuation and benzodiazepine introduction, rather than other therapies.

She mentored many students and registrars and was a shoulder to lean on and sounding board to many of her colleagues when they had issues of concern. Her calm demeanour and her positive feedback, as well as her offer of ongoing support, will be missed by many.

Professionally, Denise played a massive role in representing doctors and professional matters on a local, national and international level. Her role and contribution to the medical association is unsurpassed. She chaired the Academic Doctors Association of SA and later the Public Sector Doctors Committee of SAMA. During this tenure she led the public sector into its affiliation with COSATU – a relationship that lasts till today. She eventually became the vice-chairperson of SAMA and served a year as chairperson, notably within the period of the first ever national doctors' strike in SA. Her commitment to local matters was always present and she served doctors' issues within Groote Schuur and beyond, while remaining a steadfast member of the local branch of SAMA. Denise's approach was simple; she was never loud or populist, and her approach reflected the very essence of who she was: humble, principled, quiet, yet determined and unshakeable in her beliefs and views. She always did what was right – not what was expedient.

She was honoured by the national council of SAMA and elected to serve as SAMA president for 2015/16. Her tenure as president was very capably completed, fully understanding the titular role of the position and always offering wise counsel. Her timing, as usual, was perfect, given her availability as a sounding board for advice and expertise for the public sector structures of SAMA.

Denise served the profession, her colleagues, doctors and patient interests with equal zest. She did so with dedication and commitment. She was a true example of what it really means to serve. SAMA honoured her with the 2016 Gold Medal Award of the year for her loyal dedication in service to the profession and SAMA – an award she was worthy of receiving.

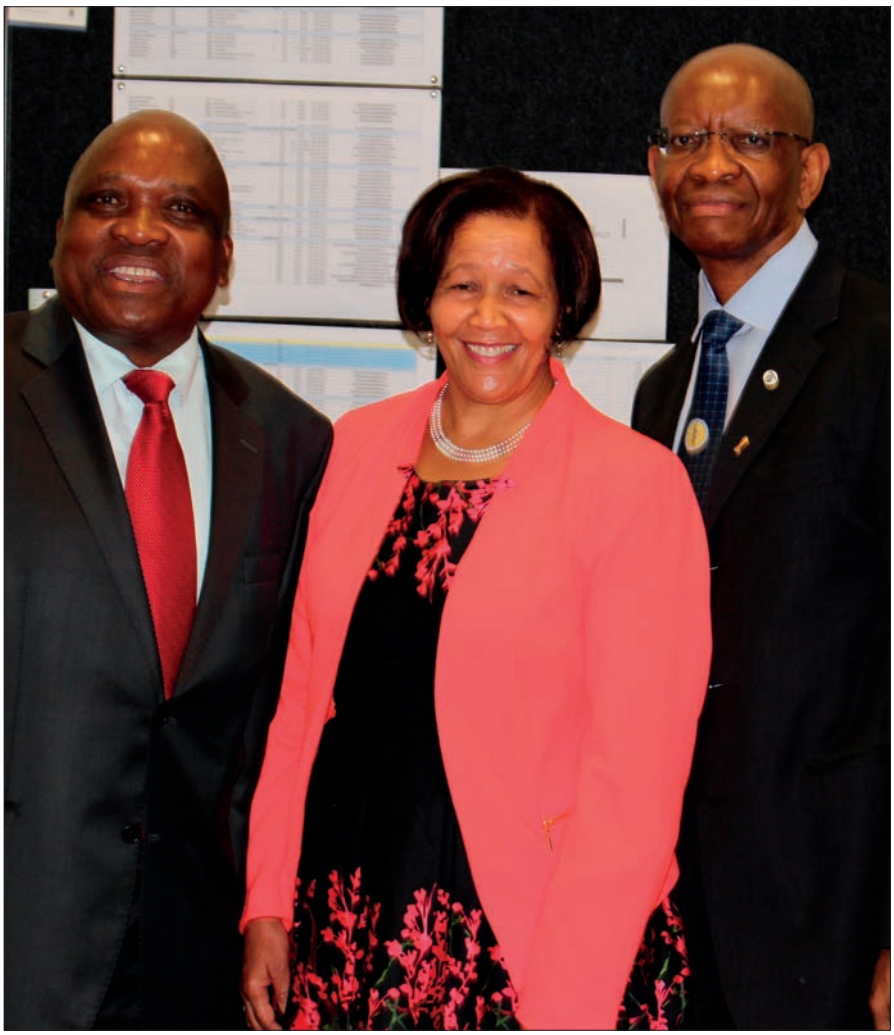
Denise (72) was a much-admired and loved colleague who was held in high affection by her friends and family. She leaves behind two daughters, a son and three grandchildren.

Hamba kahle qabane, Denise!
Lala ngoxolo.

International conference on social determinants of health tackles huge inequities in SA

Bernard Mutsago and Selaelo Mametja, *Knowledge Management and Research Development, SAMA*

This is the first in a series of articles on the Social Determinants of Health (SDH) conference titled Addressing Health Inequities: Whose Responsibility?



From left to right: Dr J Phaahla, deputy minister of health, Prof. L Rispel, National Research Foundation research chair, and Dr M Grootboom, chairperson of SAMA

On 23 and 24 February 2017, at the University of the Witwatersrand (Wits) in Johannesburg, the first ever international conference on social determinants of health (SDHs) to be organised in the SA health space took place under the fitting theme, "Addressing health inequalities: Whose responsibility?" Following nearly 2-year-long preparations, the eventual success of the conference was a well-merited payoff, with more than 120 delegates attending.

The event was a joint initiative of SAMA, the WMA and the School of Public Health (SPH) at Wits. Prof. Sir Michael Marmot of the Institute of Health Equity, University College London, a world-renowned expert on health inequalities and SDHs, and also the president of the WMA, was the keynote speaker. The SA deputy minister of health, Dr Joe Phaahla, delivered the opening address.

The Wits SPH helped fund part of the conference expenses from the Sheiham Family Wits Programme on Social Determinants of Health and Health Inequality, while SAMA funded the remaining portion of the cost, reflecting a recognition of the role of the medical profession in tackling health inequities in SA.

About the Aubrey Sheiham Fund

Aubrey Sheiham, 12 September 1936 - 24 November 2015, was an SA-born British academic, dental epidemiologist and emeritus professor of dental public health at the School of Life and Medical Sciences, University College London. He studied dentistry at Wits before moving to London. A few days before passing on, he and his wife, Dr Helena Sheiham, donated R8.8 million to Wits to fund research on the SDHs and health inequalities. He is survived by his wife, who is co-director at the Centre for Philosophy of Natural and Social Science, London School of Economics.

In a country marked by gross inequalities and a widening Gini coefficient, this conference met a long-felt need for serious dialogue on SDHs

Conference proceedings

The conference attracted a diverse range of delegates from various institutions around SA and beyond: the WHO, the Public Health Association of SA, SAMA, medical societies, Wits and other tertiary institutions, the HPCSA, the Council for Medical Schemes, government departments, government parastatals and hospitals. SAMA also capitalised on this event to invite fellow medical associations within the African region to the conference for a dialogue around the conference theme, seizing the opportunity to build regional relationships among medical bodies in addressing health inequities. During the parallel

session, medical association delegates from Nigeria, Lesotho and Zambia gave presentations on a range of topics, such as prospects for regional networking on health equity, and specific country experiences on social determinants of health. Delegates from the medical associations of Kenya, Uganda, Zimbabwe and Malawi unfortunately cancelled their trips at the last minute due to unforeseen circumstances.

The 1.5-day conference discussed and debated the strategies needed to eradicate health inequalities within and among countries in Africa, protect health rights, address the social determinants of health and move towards universal health coverage. At the outset, Prof. Laetitia Rispel of Wits underscored the fact that the conference should focus on identifying solutions and actions to addressing SDHs and health inequities, instead of ending as hypothetical discussions.

The conference would not have been possible without the tireless work of the organising team, comprised of SAMA and Wits staff, the presence and expertise of Prof. Sir Michael Marmot, the representation of various key sectors, and the attendance of several distinguished guests from abroad and from SA.

The programme was divided into seven broad themes, namely:

- health inequities and SDHs
- social determinants of the burden of disease
- appropriate workforce training and education
- constitutional obligations and human rights
- addressing upstream factors
- the health system as an SDH
- SDHs and the role of civil society.

Health equity should not focus on the rich v. the poor but on all the people in between; there is a need to address the gradient

There were 21 invited presentations, 6 discussion slots, several panel discussions, 2 parallel sessions, question and answer sessions, and the official launch of the Sheiham annual lecture, this year by Prof. Sir Michael Marmot, on the first evening. The parallel sessions on day one had two streams, namely:

- **Group 1:** The role of medical associations in addressing health inequities through the SDHs
- **Group 2:** The role of the public health community in addressing health inequities through the SDHs.

Prof. Sir Michael Marmot, the keynote speaker at the conference

In a country marked by gross inequalities and a widening Gini coefficient, this conference met a long-felt need for serious dialogue on SDHs. The conference came at a critical point when five independently momentous developments happened around the same period in SA, events that served to underscore the negative socioeconomic, political, nutritional and institutional circumstances that society finds itself in, and that impacted on the country's goal of good health for all, especially the disadvantaged.

First was the Life Esidimeni debacle in the previous few weeks, in which over 100 mental health patients – many of whom develop mental disorders in the first instance owing to unfavorable socioeconomic and other circumstances – lost their lives in the care of non-governmental organisations around Gauteng, the host province of the conference.

Secondly, on day two of the conference, the province was rattled as local communities marched against immigrants, with threats of violence against some of the world's most vulnerable people, including women and children. The reasons for the resentment towards the immigrant community are telling: competition for jobs and access to economic opportunities, and alleged criminal activities, including drug peddling and prostitution. These "reasons", all symptoms of a fractured society, are linked to a miscellany of health-damaging exposures. Both the targeted immigrants and the concerned local residents are at the bottom of the socioeconomic ladder, and therefore at higher risk of poor health. For example, wrangles between locals and immigrant individuals over occupation of the state subsidy low-cost homes or "RDP houses" are common.

The third development was government's recently announced commitment to proceeding with implementing a new tax, i.e. a tax on sugar-sweetened beverages, in a bid to curb non-communicable diseases such

Dr Mzukisi Grootboom setting the scene for the in-depth analysis of health inequities and social determinants of health

as diabetes. In many countries, including SA, diet quality and associated health outcomes follow a social gradient. In SA, studies attest that active outdoor advertising and branding of fizzy drinks are driving up consumption among school-going children, especially in black townships, contributing to the huge epidemic of obesity seen in these communities and the country at large. The conference's deliberations would include identifying actions for addressing the social determinants of inequities in healthy eating and diet-related diseases in our society. To give a practical angle to the relevance of the tax, and to uphold the wish of the late Aubrey Sheiham on his bequest to Wits, the conference organisers consciously excluded fizzy drinks from the conference's meals.

The responsibility for addressing social determinants of health in SA rests squarely on all of us

Fourth were the "fees must fall" protests, which highlighted the inequitable distribution of poverty and access to university education, with race being a key factor. Evidence shows that higher educational attainment can lead to improved health through a number of related pathways, such as understanding of health and advanced employment opportunities.

Fifth was the emphasis on radical economic transformation and inclusive growth in the 2017 budget speech on 22 February, in view of the current high inequities in SA. For example, despite progressive labour policies in the country, the plague of "the working poor" is a persistent menace, especially in the mining and construction industries, as evidenced by the Marikana massacre that happened in the course of failed wage negotiations. The budget sought to attain the constitutional imperative of equitably shared wealth and economic opportunities in conjunction with rights to access housing, medical care, social security and basic services. The following national statistics from the budget speech highlight the wide gap between the "haves" and the "have nots" in SA:

- Uneven income growth: the bottom 20% have benefited from social grants and better access to services, while the top 20% have benefited from the rising demand for skills and pay increases. Those in the middle have been left behind.
- Wealth remains highly concentrated – 95% of wealth is in the hands of 10% of the population.
- Thirty-five percent of the labour force are unemployed or have given up hope of finding work.
- Despite progress in education, over half of all children in grade 5 cannot yet read adequately in any language.
- More than half of all school-leavers each year enter the labour market without a senior certificate pass, and 75% of these will still be unemployed 5 years later.
- Our towns and cities remain divided, and poverty is concentrated in townships, informal settlements and rural areas.
- Our growth has been too slow – just 1% a year in real per capita terms over the past 25 years, well below that of countries such as Brazil, Turkey, Indonesia, India or China.

The WHO defines the SDHs as the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources. The priorities highlighted in minister Pravin Gordhan's budget speech reflects government's correct diagnosis of the root causes of health inequities in this country, as well as comprehension of the multifactorial, cross-sectoral nature of determinants of health. The redistributive thrust of the 2017 budget is hailed by many: it addresses several determinants of health through transformative interventions in various sectors as well as the health sector, as health is inherent in almost any sector. These interventions include: economic growth and inclusive economic participation; access to decent and well paid jobs; significant

Prof. Dan Nacayiyana, SAMA president, welcomes Dr Adamu Al-Hassan Umar from Nigeria

allocations for education, health, social grants and developmental programmes; and housing provisions and hikes on sin taxes, which may discourage unhealthy habits.

The very first Aubrey Sheiham public lecture took place on the evening of the first day of the conference, delivered by Prof. Sir Marmot, with about 100 people in attendance. Prof. Sir Marmot recognised an "epidemic of disempowerment", seen in countries such as the USA, as possibly applicable to SA. Disempowered people are prone to poor health through psychosocial mediation. He also shared other stark insights: social injustice is killing on a grand scale. Health equity should not focus on the rich v. the poor but on all the people in between; there is a need to address the gradient. The health equity movement must take off in SA.

At the end of the conference, had the answer to the conference theme question been found? That is, "Addressing health inequalities: Whose responsibility?" The 1.5-day deliberations made it plain that the responsibility for addressing social determinants of health in SA rests squarely on all of us – government, business, individual members of communities, professional bodies, academics, civil society and individual practitioners, to name a few. However, the state is the most fundamental agency to ensure improvement on SDHs. Multisectoral action is needed, and there must be action at all levels at the same time.

"Rekindle the spirit of social justice that got us into studying medicine in the first place"

In his plea for action on health equity, Prof. Sir Michael Marmot challenged medical doctors to "rekindle the spirit of social justice that got us into studying medicine in the first place". At the close of the conference he concluded that "We know what to do – the challenge is to figure out how to do it."

In conclusion, the conference was an enormous success, not least because of the venue in which the dialogue was conducted – a country with the greatest inequality in the world. The work is cut out for all of SA. In the words of Prof. Sir Marmot at the conference: "We need to do something. Do more. Do better."

More details of the conference proceedings and outcomes will be published in future editions of *SAMA Insider*.

Attendees at the conference

Code of conduct – SAMA members

SAMA Communications Department

This is the second article in a series on the SAMA code of conduct. The code expresses SAMA's commitment to consolidating the institutional image of the association as an example of integrity, accountability and professional ethical standards.

This section deals with disciplinary procedures at branch level, and the appeal procedure between the branch and the board.

Disciplinary procedure: Branch

- A branch disciplinary committee (BDC) will be responsible for ensuring that members abide by the code of conduct.
- The BDC, which will be appointed for a particular case only, will comprise three branch council members appointed by the particular branch council.
- The BDC will have, apart from any other powers the branch council may determine by ordinary resolution, the following powers:
  - To investigate any alleged or suspected breach of the code of conduct by a member, or any other conduct warranting the appointment of a BDC; to call upon any member who is suspected of having breached the code of conduct and for witnesses, where applicable, to furnish the BDC with such information as it may deem necessary to properly consider the alleged breach
  - To hand down a verdict as to whether the breach of the said code of conduct was committed by the member concerned or not
  - To order the suspension of the member in question for such period as it may, in its sole discretion, deem fit, once it has determined that the member has breached the code of conduct and that his/her conduct warrants suspension
  - To recommend to the board to order, over and above the suspension imposed by the BDC, the expulsion of the member once it has determined that the member has breached the code of conduct and that such breach warrants expulsion.
- All the proceedings of the BDC will be conducted in a summary manner, on the basis that it will not be necessary to observe or carry out the strict rules of evidence applied in legal proceedings. The procedure to be followed will be set out by the BDC, provided that such procedure is based on accepted principles of fairness and equity.
- The BDC will be entitled to consult any person it may deem necessary to reach a just and equitable conclusion, and the member concerned will have no right to be present during such consultations or to be made aware thereof, provided that the member will be given an opportunity to rebut any evidence against him/her compiled in such consultation.
- The BDC will not be bound to follow strict principles of law, but may decide on the matter according to what it considers just and equitable in the circumstances.
- Save for the appeal provisions hereunder, the BDC's decision on matters dealt with in this clause will be final and binding upon the member concerned, unless full expulsion is recommended, in which case the BDC's decision must be either ratified or set aside by the board.
- The BDC will, from the date of its appointment, complete its investigations and deliver its verdict within a period of 4 ordinary weeks.

The code expresses … the institutional image of the association as an example of integrity, accountability and professional ethical standards

- The member whose conduct was investigated by the BDC will be informed by the branch council of the relevant branch of the BDC's decision and reasons therefor within 7 ordinary days of such a decision being taken.
- In the event that the BDC decides to recommend to the board to order the expulsion of the member, over and above any suspension that may already be in place as ordered by the branch council, the branch council will send such recommendation to the board, addressed to the chairperson or vice-chairperson, within 7 ordinary days of being informed of the BDC's decision.
- The board will confirm or set aside the recommendation of expulsion so received within 14 ordinary days from receipt thereof, and will inform the branch council and the member concerned of its decision within 7 ordinary days of having reached it, in writing, stating its reasons for its decision. The board's decision will be final and binding.
- In the event that a particular branch council cannot agree on the composition of a BDC, and/or is incapable of doing so as a result of a non-functional branch council, the disciplinary process described above will be conducted by the SAMA board in terms of clauses 8.1 and 8.2 of this code of conduct.

Appeal procedure: Branch to board

- A member may appeal to the board with regard to his/her suspension and/or any matter concerning his/her membership as a result of disciplinary action taken against him/her by his/her branch as set out above.
- Such an appeal must be lodged, in writing, to the chairperson or vice-chairperson of the association, by no later than 7 ordinary days after the member is informed in writing by the branch council of the BDC's decision, stating the member's reasons for his/her appeal.
- The board will have 14 ordinary days from the date of receipt of the written appeal by the chairperson or vice-chairperson to consider the appeal and apply its mind to the decision reached by the BDC in relation to the written appeal, and must inform the member and the branch council of its final decision within 7 ordinary days after having reached the decision, in writing, stating the reasons therefor. The board's decision will be final and binding.

Life Esidimeni deaths a national tragedy – SAMA

SAMA Communications Department

Family members of psychiatric patients who died earlier this year hold an Esidimeni vigil

Recently, the health ombudsman, Prof. Malegapuru Makgoba, released details on the deaths of psychiatric patients in Gauteng last year. At the time, he noted that around 94 patients had died, but this figure has subsequently been amended to more than 100. It is unclear at this stage exactly how many people have died. Investigations are continuing.

When releasing the findings of his investigation, Prof. Makgoba described the deaths as extremely concerning and disturbing. Shortly before he released his findings on 1 February, the then Gauteng Health MEC Qedani Mahlangu announced her resignation. This move was welcomed by SAMA, although it noted in a press statement that despite this, she should still be held accountable for the deaths.

Prof. Makgoba found that the patients died as result of them being transferred from the Life Esidimeni facility in Randburg to other facilities in the province. The Gauteng Health Department made the decision to move the patients to cut costs.

"The disgraceful, unprofessional and inhumane way the MEC dealt with this situation warranted nothing less than her removal. However, we believe, now that the ombudsman's report is out, further investigations are needed to not only finally deal with the actions of the former MEC but also those of other officials associated with the transfers. Former MEC Mahlangu cannot simply resign and walk away from this. She, and other officials in the department, has to be held accountable," said Dr Mzukisi Grootboom, chairperson of SAMA.

Gauteng Premier David Makhura appointed former deputy health minister, and former Gauteng member of the executive council (MEC) for health, Dr Gwen Ramokgoba, as the new health MEC in the province. While Premier Makhura distanced himself from the tragedy, many have since called on him to also resign. Despite his continued insistence that he was unaware of what was happening, there have been calls from various sectors that he did know and should step down.

Dr Grootboom noted that what had happened with the patients amounts to a national tragedy.

"What happened with these patients is a national tragedy on a massive scale and everything must be done to prevent something similar from happening again," he said.

According to the ombudsman's report, officials acted negligently in moving the patients. SAMA said it welcomed the premier's statement that he views the improper and negligent actions of officials in a very serious light that "must lead to serious consequences and accountability."

"Our thoughts now must be with the families of those who died. This must be an extremely difficult time for them. To prolong, or delay, any action against the MEC and other officials involved in this disaster, will, quite frankly, only make their suffering worse. The premier needs to ensure that this action is swift, and meaningful, not only for the sake of those involved, but for the thousands of other mentally ill patients throughout the country," noted Dr Grootboom.

"What happened with these patients is a national tragedy on a massive scale and everything must be done to prevent something similar from happening again"

SAMA has also welcomed the decision by the premier to move all patients currently placed in NGOs back into public healthcare. This process is ongoing, in consultation with the families of the patients.

"This is an important step by the premier because it sends the dual message that is important to care properly for mentally ill patients, and that the province is willing to fund their continued proper treatment. This, in our opinion, should have been the thinking from the start instead of looking at moving mentally ill patients to save money," Dr Grootboom concluded.

MEMBER BENEFITS

Alexander Forbes

Herman Steyn
012 452 7121 / 083 519 3631 | steynher@aforbes.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 | kdeyzel@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.

HPCSA intends to abolish medical aids to pave way for NHI

Dr Norman Mabasa, *chairman, Society for General/Family Practitioners*

The recent pronouncement by the president of the HPCSA and the chairman of the Medical and Dental Board (MDB) of the HPCSA that medical aids are to be abolished is not only deplorable and despicable, but worthy of condemnation by the medical profession and the private sector in general.

While we do not sing the praises of the private sector, we defend the right of citizens to decide whether to access healthcare from the public or private sector.

The pronouncements made are reckless and border on a Trump-like ban on the private sector. What compounds this dilemma is that we do not know whether the statements were issued by the MDB or HPCSA, as the spokesperson chairs both portfolios. Who holds him accountable for his errors if one has to report him to himself?

The very problems that were intended to be solved by the HPCSA now manifest in enormous proportions.

The HPCSA and the Department of Health (DoH) need to quickly clarify this "official position" so that we can decide which posture to adopt under such an attack by the HPCSA.

The HPCSA cannot ethically adopt positions that run against the stream (their funders).

We call on the HPCSA to urgently engage with SAMA and any interested parties to solve this conundrum.

We further call on the DoH to do the following:

- Speed up the unbundling of the organisation and create a separate Medical and Dental Council
- While that is being pursued, separate the portfolios of president and chairman of any board so that we avoid obvious conflict of interest
- Censure the incumbent to avoid the unethical conduct of pronouncing on non-decisions
- Fill acting positions with full-time positions.

The profession vehemently opposes this statement and we reserve our rights if this is official.

We emphasise that we support the concept of a well-planned and inclusive NHI, but also point out that the private-sector model and the NHI proposal are not mutually exclusive, as there is room for interdependence and co-existence.

We cannot be swayed by individual statements being peddled unchecked.

Lightning and the GP

Dr Ryan Blumenthal, *senior specialist, Department of Forensic Medicine, University of Pretoria*

There are up to 100 lightning-related fatalities annually in SA, and it is probable that there are at least four to five times as many survivors of lightning strike presenting for clinical treatment.

With climate change, one can expect changes in weather. The South African Weather Service calculated the average number of thunderstorm days a year over Pretoria to be in the range of between 65 and 67. This is based on an average for the 10-year period from 2006 to 2015. The GP may encounter lightning strike victims in his/her practice from time to time.

The purpose of this article is to sensitise GPs on what to look out for, and how to approach such patients.

Lightning may be classified as a non-kinetic injury phenomenon. Lightning is a multiphysics phenomenon with four main components that may cause injury, namely: light, heat, electricity and barotrauma.

The light component

Lightning may injure the eye. Ocular lightning-induced injuries have caused uveitis, cystic macular oedema, macular holes, optic neuropathy, eyelid lesions, corneal lesions, thermal papillitis, retinal folds, retinal vein occlusion and rhegmatogenous retinal detachment.

Bilateral iridocyclitis has also been reported due to lightning. The most common ocular injury from lightning is a cataract with posterior subcapsular damage. Cataracts may develop several months after the acute lightning strike.

The heat component

First-degree burns may follow the skin creases. These marks may be centimetres long and generally follow the long axis of the body towards the ground. There is often a


Photo: Dr Neale du Plooy

smell of singeing or burning about the body and clothing. The hair may be scorched or singed.

There is also the element of fire hazard. Before it can catch fire, inflammable material must be heated to its ignition temperature. The likelihood of a lightning flash starting a fire when it strikes inflammable material depends on various factors, such as the intensity of the lightning current, and, to a lesser extent, the rate of increase of the current with time.

The electrical component

Lightning injury may cause abrupt cerebral salt-wasting syndrome. Lightning injury may even cause delayed-onset psychiatric and cognitive symptoms.

Recently, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed) criteria for the diagnosis of post-lightning shock syndrome have been proposed. These criteria, if adopted, may help to more firmly establish the diagnosis of a syndrome occurring following a lightning injury.

The barotrauma component

The primary targets for blast overpressure damage are the hollow organs, ear, lungs and gastrointestinal tract. Oftentimes, blast overpressure may have biochemical and molecular mechanisms of injury. Free-radical-mediated oxidative stress may occur and contribute to blast overpressure injury. Understanding the aetiology of these changes may shed new light on the molecular mechanism(s) of injury, and can potentially offer new strategies for treatment.

Cases are also on record where lightning has exploded concrete pavements, causing fragments of exploded concrete to become embedded within the skin of the victim.

The clothing of a lightning victim may be torn off and this can sometimes raise the suspicion of foul play if the lightning aspect is obscure.

There are many references with regard to lightning damage of the human ear. Lightning-induced pneumomediastinum has also recently been described in the literature.

Treatment

The best treatment for lightning injuries is prevention. "When Thunder Roars – Go Indoors!"

Lightning may kill a person instantaneously, or they may die later due to complications.

We need to alert people to the dangers of lightning. For example, we need to educate athletic trainers and others about the dangers of lightning, provide lightning-safety guidelines, define safe structures and locations, and advocate prehospital care for lightning-strike victims.

Patients may present with minor, moderate or severe lightning injury. This is almost tantamount to the "dose" of lightning they were exposed to. Patients may present with immediate and transient symptoms, immediate and prolonged, or permanent symptoms, possible delayed neurological syndromes or lightning-linked secondary trauma from falls or blast.

There may be cardiac, pulmonary or neurological injuries (central nervous system), peripheral nerve injury, autonomic nervous system injury, even post-traumatic headaches. Burns may be present. Blunt force, concussive and explosive (blast) injuries may be present. Look out for eye injuries and ear injuries.

The fetus of a pregnant woman struck by lightning has an unpredictable prognosis. Pregnant victims require specialist management, as fetal viability should be assessed.

There may be haematological abnormalities and endocrine and sexual dysfunction. Look out for psychological and neurocognitive dysfunction in lightning strike survivors. There may be memory disturbances, concentration disturbances (adult attention deficit disorder), cognitive dysfunction and problems with higher executive functioning.Try to predict behavioural issues, such as emotional lability and aggression, sleep disturbance, phobic behaviour, depression and any other type of behavioural issues.

First, recognise and treat acute lightning injuries. Proper diagnosis is essential. CPR saves lives. Automatic cardiac defibrillators also save lives. Initiate first aid and triage victims as per standard operating guidelines. Take a good history and do a good physical examination.

Do baseline laboratory tests and radiographical examination. As a treatment, use fluid therapy and/or analgesia and anti-oxidants. Focus on cardiovascular therapy, central nervous system therapy, burn wound therapy, eye therapy and ear therapy, and consult specialists in these fields where necessary.

Lightning strike survivors require long-term care, pain control and psychological support. Many may suffer cognitive deficits. Victims may benefit from referral to support groups and other information sources.

An extensive list of references used for this article is available on request. For more information contact Dr Blumenthal on ryan.blumenthal@up.ac.za

Dr Ryan Blumenthal

Dr Blumenthal (MB ChB, MMed (Med Forens), FC Path, Dip Med, PhD) is the senior specialist forensic pathologist at the University of Pretoria's Department of Forensic Medicine. His chief field of interest is the pathology of trauma of lightning (keraunopathology). He has been involved in the publication of numerous articles and textbooks on lightning and electrothermal injuries, and has helped generate international standard operating procedures and guidelines for lightning strike fatality and electrocution victims. He has also published widely in the fields of suicide and other areas involving the pathology of trauma. His chief mission in life is to help advance forensic pathology services both nationally and internationally.

SAMA mission and vision statements

Dr Ayodele Aina, *SEDASA national chairperson*

Members of every organisation that makes a significant impact believe in and act according to the mission and vision statements of their organisation. Smart organisations use these statements to remind their teams why the organisation exists, because they are what makes it successful.

The mission statement serves as a "North Star" that keeps everyone clear on the direction of the organisation. And as Andy Stanley says, "It's your direction, not your intention, that determines your destination." The mission statement tells us what we are doing today that will take us to where we want to be in the future.

The vision statement is a picture of a preferable future. Where will you be in 1 year? 3 years? 5 years?

It's critical that all categories of members and employees in an organisation are constantly reminded of what the organisation does and where it is going. The mission and vision statements form the basis of aligning the entire team in the organisation. The team will all be on the same page when it comes to what to do and why, which leads to better effectiveness and efficiency.

SAMA was formally constituted on 21 May 1998 as a unification of a variety of doctors' groups that had represented a diversity of interests, and today it 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 company registered in terms of the Labour Relations Act. SAMA, a voluntary membership association, exists to serve the best interests and needs of its members in any and all healthcare-related matters.

The mission statement tells us what we are doing today that will take us to where we want to be in the future

SAMA has a responsibility, in accordance with its vision, to be the representative association for the SA medical profession, and according to its mission statement, to empower doctors to bring health to the nation. However, our attitude as members and employees shouldn't be like that of a spectator who watches things happen, or of the ignorant (the overwhelming crowd) who don't even know what is happening. We shouldn't just sit on the fence observing and complaining about the problems within the organisation and enjoying our membership or staff benefits, but rather we must seek out ways to serve, solve problems, and be doggedly committed to the mission and vision of SAMA. Throughout history, we have been conditioned to look out for ourselves, since no one else will. But if we are consumed with pursuing only our selfish interests, what are we? And more importantly, what legacy are we going to leave?

The key to our collective success is attitude rather than aptitude. In other words, it's not ability, it's mentality. Our attitude is a choice, and we are responsible for changing it. Our attitude not only directs our future but also affects who we are today. The former Israeli prime minister, Golda Meir, asserted this truth in one of her interviews. She said, "All my country has is spirit. We don't have petroleum dollars, we don't have mines of great wealth in the ground, and we don't have the support of a worldwide public opinion that looks favourably on us. All Israel has is the spirit of its people. And if the people lose their spirit, even the United States of America cannot save us." There is absolutely nothing that can be done to help a people with the wrong attitude.

Members and employees of SAMA must live and breathe SAMA's corporate mission and vision. We must possess the attitude of teamwork without concern for who gets the credit. We must move from our personal goals to serving the needs of the common good. A team spirit makes the difference between our selfish ambition and the corporate vision. Ambition is a private thing for our individual benefit, while the corporate vision is a big picture that involves benefiting others. The attitude of a team player is one of a humble spirit who recognises that he has both strengths and weaknesses, and needs the strength of others to support where he is weak. We must embrace and encourage the unique gifts, abilities, differences and values that any team member brings to the whole.

Where are we on the measure of teamwork? Are we on the positive side, with conviction and integrity, or on the negative side, with duplicity and moral compromise? Our answer will require some introspection, including an examination of our personal motives.

The key to our collective success is attitude rather than aptitude

All SAMA members and employees must possess the spirit of teamwork and know that, as Ken Blanchard says, "None of us is as smart as all of us." No one can be best at everything, but when we combine our unique abilities, we can be best at virtually anything.

For further information, see:

http://www.glennsmithcoaching.com/7-reasons-your-company-needs-clear-written-mission-statement/

https://www.americanexpress.com/us/small-business/openforum/articles/want-legacy/

Clive and Marié Landman, the driving force behind SA's largest private medical practice

SAMA Communications Department

Drs Clive and Marié Landman in the dispensary at their practice Medipark 24, the biggest private medical practice in SA

It's easy to underestimate Marié Landman. It's easy, but it would be a mistake. Speaking to this tiny doctor from Pretoria, one quickly realises that there is nothing she can't do; nothing stands in her way. Combined with the exuberance and warm personality of her husband Clive, it's no mystery how this couple have grown their private medical practice into the biggest in SA.

"We had big dreams and worked hard for many years. We have been blessed with a growing practice, great colleagues and grateful patients," explains Clive.

Medipark 24 in Rooihuiskraal, Centurion, currently employs more than 120 staff, 55 of whom are doctors on a rotational roster. The practice is open 24 hours a day, 7 days a week – a fact that Clive and Marié say is extremely important.

"There are not many practices open 24 hours a day, but for us it is crucial to our success. Patients can't schedule when there's going to be an emergency; we take being open all the time very seriously, it's an absolute commitment of ours," says Marié.

So committed, in fact, that Clive and Marié live above the practice. They say that when they started the practice in 1988, it was always their intention to be close to their patients. This they achieve with a family home that allows them immediate access to the practice, and a direct line to the community they serve. It is also here where they raised their four children, who literally grew up in the business.

"It's about so much more than just the numbers of people through the door; it's about how they feel when they walk out"

"Marié started the practice down the road in a small space of around 60 m^2. We planned and built the Medipark Medical Centre and moved here in 1995. More colleagues joined, and in 1997 we began offering a 24-hour service. Living on top of our practice allowed us to be close to our children and our patients. It's been great for us, and our children, and we wouldn't want it any other way," says Clive.

Key to their success is the fact that the Medipark model benefits both patients and doctors. For patients, Medipark provides a one-stop service 24/7, emergency care, a dispensary and an ambulance service.

"We believe our size also works for the doctors as we understand the business of medicine and medical aids very well. Tobie Lerm, the dedicated practice manager, runs this operation smoothly. He is supported by a competent team of experts. This allows the doctors to focus on caring for their patients. We think this model works well for everyone," notes Marié.

But it's the practice of medicine that is most important to Clive and Marié, who met while studying medicine at the University of the Free State, from where they graduated in

1985. Apart from heading the practice, the Landmans still see patients full time. They lead by example. The management structure of the practice is flat, allowing doctors clinical freedom to treat their patients.

"There are not many practices open 24 hours a day, but for us it is crucial to our success"

"Patients are drawn to our practice because of our caring doctors, friendly staff and wide scope of services. The 24-hour service is extremely convenient for patients."

Outside of the practice, the Landmans are active members of the community, and to them giving back is hugely important. One of their ongoing projects is to provide school bags to grade 1s at nearby primary schools.

"It's a project we've been involved in for decades, and it has been greatly appreciated by many," says Clive.

This represents the type of people they are: professional and business minded, but at the same time caring and involved. For them, though, it's not just about giving money; they also give of their time, and their facilities at the practice and at home. At the time of the interview, for instance, a local church was holding a *potjiekos* competition in the Landmans' backyard, because the previous venue had become waterlogged.

This, it seems, is how the Landmans are seen in this community – the go-to couple for almost everything. And they wouldn't want it any other way.

"We're very happy here. The practice grows daily, but it's about so much more than just the numbers of people through the door; it's about how they feel when they walk out," concludes Marié.

For more information visit www.medipark24.co.za

Medipark 24

Medipark 24 is the biggest private medical practice in SA. It is situated in Rooihuiskraal in Centurion in Pretoria. Many of the patients at the practice take to social media to thank the staff there for their dedication. Below is a sample of some of the comments from the practice's Facebook page.

"Took my 2 year old in with a high temperature, our first time at Medipark as we are new in the area. Service was fast, friendly and doctor was great. Would definitely recommend them! Thank you Dr Moenier and Dr Ronel!" – Michelle

"I was really sick when I arrived at the medipark and when I saw Dr Marie Landman it was a sense of relief, have been her patient from the time the medical centre has opened and Doctor bubbly personality goes with her profession and her passion for what she does, thx u for always making me better." – Kamy

"For an overseas person to experience such friendly and helpful service i will recommend this place to all my family and friends." – Alicia

"I always tell people that I got a season ticket at Medipark. Let me explain. We as a family have been patients of Medipark for many years and the work they are doing in the community is not always known and appreciated. They are dedicated doctors which are really 24/7 on duty, ask me. Three occasions come to mind – I showed up once at 11.30, once at 03.45, and the best of all once when my son, on his 16th birthday at 12.16 got stitches. Then the people: Dr Marie, Dr Clive, Dr Anneke can't name all, and Monique, Janie, Nettie and Lizel just to name a few they are always prepared to help. Tobie (Manager) that keeps all this together. People from Centurion we sometime don't know what we've got in our community till you move and have the need for medical attention. And to the people receiving patients you are STARS and please treat them with respect. THANKS FOR BEING MEDIPARK." – Gerhard

You and Budget 2017: Tax increases order of the day

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 his interpretation of the recent national budget.

Budget 2017 is one of the most anticipated for many years, with many questions still needing answers:

- How will the expected tax increases pan out?
- Will the minister of finance and his deputy keep their jobs?
- Will the budget incorporate the "radical eco-nomic transformation" that has become the president's mantra in the past few months?
- How will the ratings agencies view the budget, and do we now face a ratings downgrade?

The tax increases

The minister needs to raise R28 b in additional revenue, which will come from the following:

- Increasing the marginal income tax rate from 41 to 45%. The maximum threshold will be reached when taxable income exceeds R1.5 m. This will affect just over 100 000 taxpayers and is expected to add R4.4 b to tax collections.
- Bracket creep will add R12.1 b to tax revenue. "Bracket creep" means increasing marginal tax bands by less than inflation, thus giving the treasury additional revenue but costing taxpayers more.
- Increasing dividend tax from 15 to 20% – adding R6.8 b tax revenue.
- Increase in "sin taxes" and fuel levies – another R5.1 b.
- A "sugar tax" will be introduced sometime in 2017, depending on when the legislation is passed by Parliament. The proposed sugar tax has been reduced from 20% to ~11%.
- A carbon tax has been on the cards, but looks unlikely to become effective until 2018.

In addition, the Voluntary Disclosure Programme runs to 31 August 2017. So far, almost R4 b in

offshore assets has been disclosed, and this will bring R600 m to the fiscus.

These increases should bring in more than R28 b, but treasury is now nervous about the ability of SARS to continue to deliver increased revenue as it has done for years. In 2016/17 revenue collections are estimated to fall R27 b short of target. Some ascribe this to the ructions in SARS, which have seen the bulk of senior management departing, but it is not possible to indefinitely increase revenue targets, particularly when the news is filled with stories about corruption. At some stage reality kicks in, and that is happening now.

Treasury will now carefully need to rethink tax policy, and taxes like a VAT increase cannot be deferred much longer. Already consideration is being given to adding VAT to the fuel price (it is currently zero rated).

The good news

- Transfer duty will now only apply to property sales of R900 001 or more (previously R750 001). This will give R400 000 back to taxpayers and will hopefully stimulate property sales to first-time and buy-to-let buyers.
- R20 b will be cut from government expenditure. No specifics were given but expenditure targets have generally been met.
- R3.9 b will be allocated to small business.
- The tax free savings allowance has been raised from R30 000 to R33 000.
- The treasury and business have co-operated well so far, which has helped to avert a ratings downgrade. Business plans to offer one million apprenticeships to the youth over the next 3 years. In addition, R1.5 b has been paid into a fund to assist small businesses. This cooperation with business (add to this labour, with the agreement on the minimum wage) does add a new dynamic into the economy. Minister Gordhan often spoke of a new social cohesion to help economic growth and this is evidence that this is beginning to show positive results.
- Inflation will fall from 6.6% now to 5.7%.
- GDP will grow 1.3% this year, v. 0.4% last year.
- The budget deficit will come in at 3.1% of GDP v. 3.2% this year.
- An additional R5 b has been set aside for student fees.

There are still perils out there

The sovereign debt of the country has risen over the past 8 years, and now stands at 50.7% of GDP. If you add in the state entities (Eskom, SAA, Transnet, etc.), this rises to more than 60%. This translates to R169 b in interest being paid by the state – interest is the fastest growing expense in expenditure.

Perhaps more significantly, economic growth has stagnated. As can be seen above, it is becoming more difficult to increase taxes and therefore the way out of a growing budget stalemate is economic growth. Structural reforms are needed to kick-start the economy, but there seems to be little political will to do this.

The downgrade potential

Ratings agencies want to see financial discipline (which Minister Gordhan has again delivered), less political instability and a path to revive economic growth. Time will tell how the country can tackle the latter two problems.

The budget is redistributive

A total of 62% of income tax will be paid by those with taxable incomes greater than R500 000. No one doubts the fairness of the wealthy paying more tax, but the wealthy are being hammered – consider also that dividend and capital gains taxes are also rising. Tax revenues are starting to fall and there is every chance the wealthy will start looking at legitimate ways to reduce future tax liabilities.

"Radical economic transformation"

The minister spoke of transformation more than 50 times. "Radical economic transformation" is the new policy the president has adopted. For this to reflect in the 2017/18 numbers, it requires a complete shift in the way treasury compiles the budget. As it came late in the year, treasury did not have the time to respond to this paradigm shift. Therefore, while the minister spoke of "radical economic transformation," in reality the budget was a continuation of previous budgets.

Nevertheless, he did deliver one or two home truths, such as: "We need to transform in order to grow; we need to grow in order to transform. Without transformation, growth will reinforce inequality; without growth, transformation will be distorted by patronage."

Minister Gordhan has again delivered a credible budget. Clearly, the time has come to take the necessary steps to grow the economy.

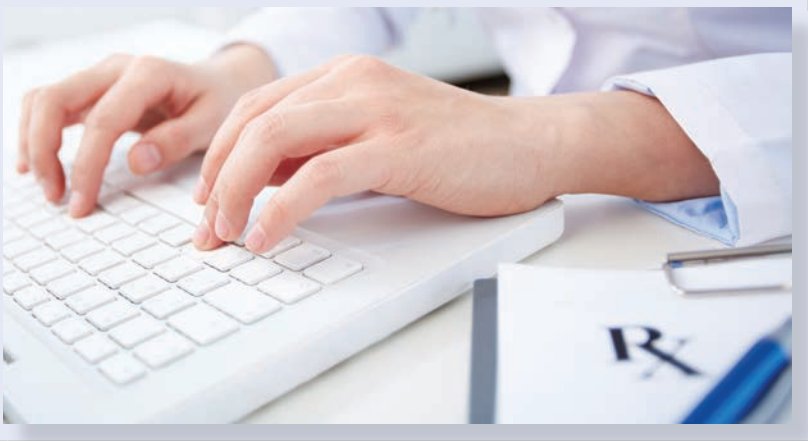
Letters to the Editor

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



New antibiotics urgently needed

World Health Organization

On 27 February the WHO published its first ever list of antibiotic-resistant "priority pathogens" – a catalogue of 12 families of bacteria that pose the greatest threats to human health.

The list was drawn up in a bid to guide and promote research and development (R&D) of new antibiotics, as part of the WHO's efforts to address growing global resistance to antimicrobial medicines.

The list highlights in particular the threat of Gram-negative bacteria that are resistant to multiple antibiotics. These bacteria have built-in abilities to find new ways to resist treatment and can pass along genetic material that allows other bacteria to become drug-resistant as well.

"This list is a new tool to ensure R&D responds to urgent public health needs," says Dr Marie-Paule Kieny, the WHO's assistant director-general for health systems and innovation. "Antibiotic resistance is growing, and we are fast running out of treatment options. If we leave it to market forces alone, the new antibiotics we most urgently need are not going to be developed in time."

The WHO list is divided into three categories according to the urgency of need for new antibiotics: critical, high and medium priority.

The most critical group of all includes multidrug-resistant bacteria that pose a particular threat in hospitals, nursing homes and among patients whose care requires devices such as ventilators and blood catheters. They include *Acinetobacter*, *Pseudomonas* and various Enterobacteriaceae (including *Klebsiella*, *E. coli*, *Serratia* and *Proteus*). They can cause severe and often deadly infections such as bloodstream infections and pneumonia.

These bacteria have become resistant to a large number of antibiotics, including carbapenems and third-generation cephalosporins – the best available antibiotics for treating multidrug-resistant bacteria.

The second and third tiers in the list – the high- and medium-priority categories – contain other increasingly drug-resistant bacteria that cause more common diseases such as gonorrhoea and food poisoning caused by *Salmonella*.

G20 (Group of Twenty) health experts met recently in Berlin. Hermann Gröhe, federal minister of health, Germany, says, "We need effective antibiotics for our health systems. We have to take joint action today for a healthier tomorrow. Therefore, we will discuss and bring the attention of the G20 to the fight against antimicrobial resistance. WHO's first global priority pathogen list is an important new tool to secure and guide research and development related to new antibiotics."

The list is intended to spur governments to put in place policies that incentivise basic science and advanced R&D by both publically funded agencies and the private sector investing in new antibiotic discovery. It will provide guidance to new R&D initiatives such as the WHO/Drugs for Neglected Diseases initiative Global Antibiotic R&D Partnership that is engaging in not-for-profit development of new antibiotics.

Tuberculosis – whose resistance to traditional treatment has been growing in recent years – was not included in the list because it is targeted by other dedicated programmes. Other bacteria that were not included, such as *Streptococcus* A and B and *Chlamydia trachomatis,* have low levels of resistance to existing treatments and do not currently pose a significant public health threat.

The list was developed in collaboration with the Division of Infectious Diseases at the University of Tübingen, Germany, using a multicriteria decision analysis technique vetted by a group of international experts. The criteria for selecting pathogens on the list were: how deadly the infections they cause are; whether their treatment requires long hospital stays; how frequently they are resistant to existing antibiotics when people in communities catch them; how easily they spread between animals, from animals to humans, and from person to person; whether they can be prevented (e.g. through good hygiene and vaccination); how many treatment options remain; and whether new antibiotics to treat them are already in the R&D pipeline.

"New antibiotics targeting this priority list of pathogens will help to reduce deaths due to resistant infections around the world," says Prof. Evelina Tacconelli, head of the Division of Infectious Diseases at the University of Tübingen and a major contributor to the development of the list. "Waiting any longer will cause further public health problems and dramatically impact on patient care."

While more R&D is vital, alone, it cannot solve the problem. To address resistance, there must also be better prevention of infection and appropriate use of existing antibiotics in humans and animals, as well as rational use of any new antibiotics that are developed in future.

WHO priority pathogens list for R&D of new antibiotics

Priority 1: Critical

1 *Acinetobacter baumannii,* carbapenem resistant
2 *Pseudomonas aeruginosa*, carbapenem resistant
3 Enterobacteriaceae, carbapenem resistant, extended spectrum beta-lactamase (ESBL) producing

Priority 2: High

1 *Enterococcus faecium*, vancomycin resistant
2 *Staphylococcus aureus*, methicillin resistant, vancomycin intermediate and resistant
3 *Staphylococcus aureus*, methicillin resistant, vancomycin intermediate and resistant
4 *Helicobacter pylori*, clarithromycin resistant
5 *Campylobacter* spp., fluoroquinolone resistant
6 *Salmonellae*, fluoroquinolone resistant
7 *Neisseria gonorrhoeae*, cephalosporin resistant, fluoroquinolone resistant

Priority 3: Medium

1 *Streptococcus pneumoniae*, penicillin non-susceptible
2 *Haemophilus influenzae*, ampicillin resistant
3 *Shigella* spp., fluoroquinolone resistant

Too much oxygen

The Medical Protection Society shares a case report from their files

A baby was born by caesarean section at 27 weeks' gestation with a birth weight of 980 g. The baby was intubated, ventilated and endotracheal surfactant was administered.

During the first 4 hours of life, the baby's oxygen saturations were recorded as ranging between 90 and 97%. A blood gas taken 5 hours after delivery showed a pH of 7.68 (normal 7.3 - 7.4), a $PaCO_2$ of 1.91 kPa (normal 4.5 - 6.0 kPa), a PaO_2 of 35.84 kPa (normal 5 - 8 kPa) and a bicarbonate level of 24.6 mmol/L (normal 18 - 24 mmol/L). This demonstrated the baby was being overventilated.

The baby was ventilated for 3 days, placed on continuous positive airway pressure, and then placed on 0.5 L nasal cannula oxygen due to recurrent apnoeic spells. Overall, the baby received 204 hours of oxygen, with oxygen saturation levels of 96 - 100% throughout.

The baby was not referred at 4 - 6 weeks of age for retinopathy of prematurity (ROP) screening, and was first seen by an ophthalmologist at the age of 7 months, when a diagnosis of inoperable grade 5 ROP, causing blindness, was made. The baby's parents made a claim against the paediatrician who handled the baby's care.

Expert opinion

The baby had inappropriately high transcutaneous oxygen saturation levels and PaO_2 levels for a period of 204 hours. During oxygen administration to premature infants, very high blood oxygen levels can develop if saturation levels rise above 96%. Weaning of the fraction of inspired oxygen seldom occurred, despite oxygen saturation levels of between 96 and 100%, indicating that the nursing staff had no protocol for weaning of oxygen according to oxygen saturation.

There was no record that an ophthalmological appointment for the screening of ROP was made at the recommended 4 - 6 weeks of age. The baby developed severe ROP and blindness due to excessive oxygen administration. The opportunity to limit the condition and save the infant's vision was missed due to the fact that the child was not referred for screening for ROP.

There was negligence on the part of the paediatrician and nurses in allowing the baby to be exposed to unnecessarily high oxygen levels in his blood over a 4-day period, and for not referring the child at the appropriate time for an eye examination. The case was settled for a substantial sum.

Learning points

- Neonatal units should have written guidelines for oxygen saturation levels during the administration of oxygen to very-low-birth-weight premature infants, and these must be adhered to.
- Attention should be paid to weaning of oxygen when the saturation levels are more than 95%. The recommended safe levels of oxygen saturation in very premature, low-birth-weight infants are between 86 and 92%. Unrestricted and prolonged oxygen exposure in very-low-birth-weight infants is significantly associated with severe grades of ROP.
- ROP is a retinal disease that affects premature infants, and can be limited by adhering to the specific guidelines for oxygen administration and by screening of premature infants at 4 -7 w eeks of age by an ophthalmologist experienced in the identification and treatment of ROP.

SAMA visits Bheki Mlangeni District Hospital

Jeanette Snyman, *SAMA senior marketing officer*

SAMA recently attended a meeting at Bheki Mlangeni District Hospital, Soweto. Dr Emungu, the clinical manager at the hospital, was of the impression that the doctors at the hospital needed a refresher about the necessity of being SAMA members.

Jeanette Snyman, SAMA senior marketing officer, delivered a presentation on the benefits of being a SAMA member, and the procedure that the hospital should follow in applying for CPD accreditation. Simon Buthelezi, SAMA industrial relations advisor, presented on the issues pertaining to commuted overtime and Remunerative Work Outside the Public Service (RWOPS).

This was generally a great opportunity for SAMA to network and listen to what the doctors in the public sector would like SAMA to assist them with.

Front row from left: Simon Buthelezi, SAMA industrial relations advisor; Dr Z Mlisana; Dr B Emungu, clinical manager at Bheki Mlangeni District Hospital. Back row from left: Shelly Warner, Gauteng branch secretary; Sarah Molefe, SAMA junior marketing officer; Jeanette Snyman, SAMA senior marketing officer

MEMBER BENEFITS

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 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

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

Sheer
Driving Pleasure

DRIVEN BY YOUR AMBITION.

EXCLUSIVE OFFER FOR SAMA EMPLOYEES.

Nothing quite matches the satisfying thrill of driving a BMW. The comforting luxury of the interior and the knowledge that under your control is a precision-engineered machine meticulously designed to give you ultimate driving pleasure. Northcliff Auto and Autobahn BMW are proud to be approved BMW dealerships with decades of experience. As a corporate partner of SAMA, we take pleasure in extending the following exclusive offer to all SAMA employees.

This includes:

- Ride and Drive events where you will drive the latest models
- Tours of BMW Plant Rosslyn
- Invitations to product launches
- While you wait servicing (on request)
- Servicing from 07:00 – 17:00
- Competitive pricing on lifestyle items and accessories
- Motorplan of up to 5 year or 100 000 km
- BMW vehicle displays

***Preferential deal break down:**

- A minimum of 8% discount plus BMW assistance on all new BMW models
- Excluding newly launched vehicles or vehicles in limited supply (Separately Negotiated)
- Preferential service bookings

Another major benefit of our motoring solution is that you will have dedicated support staff.

For more on Northcliff Auto and Autobahn or our solution for SAMA employees, please contact:

Corporate Sales Manager
Nicci Lopes: Cell. 083 200 4555
E-mail. nicci.lopes@bmwdealer.co.za

Northcliff Auto
Tel. 011 772 9800
11 Cresta Lane, Cresta
www.bmw-northcliffauto.co.za

Autobahn BMW
Tel. 011 392 6263
Corner Brabazon and Isando Road, Croydon
www.bmw-northcliffauto.co.za

*All other models will be looked at on an individual basis.