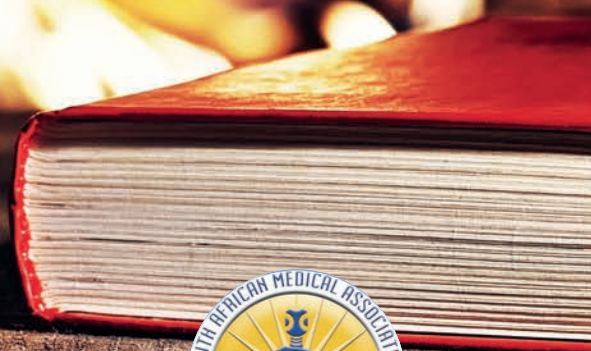


SAMA INSIDER

June 2017

WMA – SAMA to lead major revision

Doctors protest poor health services in KZN



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THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

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Session 1: Obstetrics
Session 2: Gynaecology
Session 3: Medicolegal and Ethics
Session 4: Gynaecologic Oncology
Session 5: Reproductive Medicine

SATURDAY 9 SEPTEMBER 2017

Session 6: Urogynecology
Session 7: Maternal Medicine
Session 8: Fetal Medicine
Session 9: Endoscopy
Session 10: A Look into the Future

Invited International Faculty

Prof Phillip Bennett | United Kingdom
Dr Mark Slack | United Kingdom
Prof Frederic Amant | Belgium

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Diane de Kock
Editor: *SAMA INSIDER*

Ongoing challenges

In this issue we highlight the ongoing challenges of the medical profession both in SA and internationally. Illustrative of the dire situation in SA are the recent protests in KwaZulu-Natal by health professionals to draw attention to a deteriorating level of health services in the province. SAMA has warned of a total collapse of health services in the province if the situation is not rectified soon (page 5).

In his president's message on page 4, Prof. Ncayiyana focuses on the dire need for more medical schools in the country. There is a huge shortage of health professionals, and yet only approximately 1 000 of the 30 000 people who apply to study medicine will be accepted. "SA seldom acknowledges that these shortages are largely self-inflicted," says Prof. Ncayiyana.

The recent international conference on addressing health inequities has also highlighted numerous ongoing challenges in healthcare, not least of which is the increasing evidence of a callous, greedy and uncaring system in SA: "The country appears to be spending sufficient money on several aspects of the system, and yet compassion and respect do not cost a penny" (pages 6 - 8). As pointed out by Ms Marije Versteeg-Mojanaga of the Rural Health Advocacy Project, the right to healthcare is enshrined in our constitution, and the government has the obligation to progressively achieve the full realisation of the right to health.

At the WMA's 206th council session in Zambia in April, it decided to revise the MEC's statement on telemedicine, a process which will be led by SAMA. The MEC will also appoint a working group, including volunteers from SA, to look at the proposed WMA declaration on therapeutic abortion (page 14).

A focus at the recent Ethics Alive week was meaningful transformation – how to adapt to meaningful transformation in the health field and considering the application of ethics in the process of transformation.

We live in challenging times and hopefully in time, as Steve Biko said: "We shall be in a position to bestow on SA the greatest possible gift – a more human face."

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

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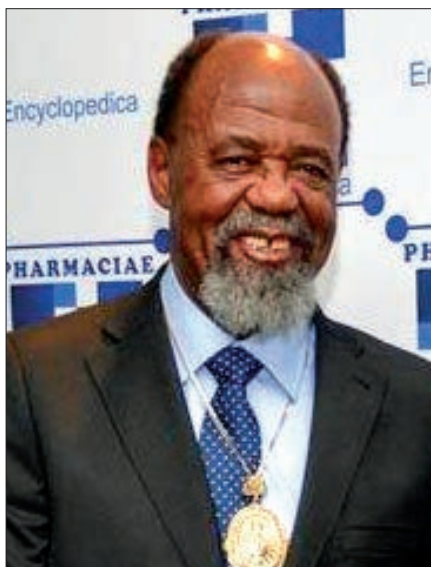
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SA needs more medical schools



Prof. Dan Ncayiyana, SAMA president

I recently read somewhere that 30 000 aspirants will apply to study medicine in SA this year, of whom only about 1 000 will gain admission. Access to medical training remains a special privilege, constrained by limited opportunity, in SA today, despite the crushing national disease burden, rampant HIV/AIDS and TB and the purported resolve to implement a National Health Insurance.

As we all know, SA is faced with an absolute shortage of health professionals, compounded by a maldistribution of health human resources between the public and private sectors, and between rural and urban areas. About 70% of medical practitioners, 40% of nurses, over 90% of dentists and 85% of pharmacists work in the private sector, largely in urban areas. The overall shortage of health professionals in the public sector has been estimated at 80 000. In the public sector, there is just one dentist for every half a million people. In 2011, the public sector nurse shortage was estimated at 46 000.

SA seldom acknowledges that these shortages are largely self-inflicted. My colleagues abroad are astonished when I tell them that the youngest fully functioning medical school in SA was established in 1976, at a time when SA's population was 22 million. Moreover, at that time, five of the seven medical schools were intended to produce doctors for an even smaller white population. The eighth medical school, at Walter Sisulu University, came into being by happenstance. It was established by the Transkei homeland

government some 30 years ago in the face of fierce opposition by the then-SA government, and has since distinguished itself in innovative community and problem-based medical education. A new medical school was approved for the University of Limpopo in 2015, but has experienced significant management setbacks in getting up to speed.

Instead, SA has opted to outsource the training of doctors to Cuba, at a huge monetary cost to the government. The outsourcing extracts an emotional toll of 6 years of social alienation for the students, receiving incongruent medical training in a foreign language and culture. The outsourcing may be justifiable and perhaps necessary as far as it goes, but it can never be a sustainable substitute to "growing our own timber" right here at home.

The collective production of medical practitioners by the existing medical schools during the 23 years since the 1994 democratic dispensation has been a steady 1 200 - 1 500 doctors per annum, even as the population has ballooned to 52 million, to make up for retirements, deaths and emigration and for those others who leave the profession for careers in other fields, as well as to add to the country's doctor pool.

The urban-rural and public-private maldistribution is a global phenomenon, but in SA, it is exacerbated by the overwhelming resource dominance of the private sector, the crisis and chaos within our public health system, as well as how and where we train health professionals. Migration by health professionals to other countries has unduly dominated the discourse on the shortage of doctors in our country. The impact of emigration is real, but has been highly overblown. Trans-border mobility by health professionals has been in this universe since the days of Hippocrates. And we have not done enough to mitigate the "push factors" that fuel the emigration, nor to facilitate the immigration of qualified physicians from elsewhere.

SA has 1.5 medical schools per 10 million people, compared to – say – Brazil and Australia, each with 8.2. Ethiopia has established 13 medical schools in the last few years, and new medical schools are springing up in neighbouring countries such as Namibia and Botswana, each with populations of about 2 million.

SA medical schools have been under pressure from government to increase their

annual intakes, but this can only be a stop-gap intervention. Simply expanding capacity at existing health sciences faculties will not be sufficient all on its own to address the deficit in the number of health professionals. What SA needs is new schools for the health sciences. For this reason, the Nelson Mandela Metropolitan University in Port Elizabeth deserves support in its exploration to establish its own new medical school.

The most frequent excuse against the establishment of new medical schools in this country is the purported lack of sufficient staff and facilities to train health professionals. This is premised on the doctrine that a medical school must be anchored in the traditional training model, à la Oxford, in which students are trained exclusively by highly qualified specialists in technically sophisticated academic hospital settings, within constrictive curricula. The prevailing culture is to glorify research over teaching excellence and community outreach. Clearly, standards must be maintained, but as Botswana and Namibia have demonstrated, it is possible to provide quality medical training in settings that specialise in teaching rather than research, and where the many willing international teachers are allowed in.

There is ample evidence from elsewhere in the world, particularly Australia, at the so-called "rural clinical schools", and from Canada, that you can expand the clinical training platform considerably, and accordingly increase the intake of students, by creating clinical training centres in appropriately equipped rural and other community hospitals and clinics, not for short rotations of 8 - 12 weeks a year, but for longitudinal training from 1 to 4 years, with generalists rather than super-specialists doing much of the teaching. Australian experience is that such students perform as well as, and sometimes even better than, those that have been trained exclusively at metropolitan academic centres, in their final examinations.

The objectives in respect of human resources for health in SA are crisply summed up in an editorial by Susan Burch. She writes: "The facts speak for themselves – we need to train more healthcare professionals, improve the retention of healthcare personnel in SA, improve doctor-to-population ratios in public healthcare facilities, and distribute doctors better, so as to address the healthcare needs of marginalised communities."

SAMA doctors protest poor health services in KZN

SAMA Communications Department

Around 1 000 doctors, nurses and other health professionals marched through the streets of Durban on Friday 2 May, to protest what they say is the deteriorating level of health services in KwaZulu-Natal.

The march was co-ordinated, and led, by SAMA KZN Coastal Branch members, and their chairperson, Dr Mvuyisi Mzukwa. The doctors handed a memorandum outlining their concerns to the head of the KZN Department of Health, Dr Sifiso Mtshali.

Among the concerns raised by the branch are staff shortages, a lack of medicines and supplies (including soaps, gloves and needles), inadequate and dated equipment and a lack of “proper institutional leadership”.

According to Dr Mzukwa, there are many unfunded, frozen and abolished medical posts in the province. He said many posts have also been removed from service points.

“Registrar posts, which were abolished, have not been replaced with commensurate service medical officer posts. There is also no attempt at aspiring to human resource norms for the provision of health in the province,” he said.

Association warns of “total collapse” of health services in province if situation not rectified soon

Apart from this, he said, the provincial Department of Health is failing to provide conditions of service which will retain staff.

“A good example of this is where the contracts of committed long-term sessional doctors have unilaterally been converted to month-to-month contracts, despite a motivation from heads of clinical units, and service delivery needs, against this move,” Dr Mzukwa commented.

A major area of concern for the SAMA KZN Coastal Branch is the commuted overtime policy, which they say has not been agreed to by SAMA. Dr Mzukwa contends that this policy cannot be negotiated without a review of the basic salaries of public sector doctors.

“The policy seeks to decrease the remuneration of doctors performing certain services. This will result in an exodus of staff, and compound existing staff shortages. Forcing doctors to perform overtime (compulsory overtime) is also against the spirit of the Basic Conditions of Employment Act. It must also be considered that no other category of employee is expected to work a 60-hour working week, every week, while employed,” he said.

He added that commuted overtime does not aim to achieve an increase in staff, which would ultimately alleviate the need for overtime on a permanent basis.

Dr Mzukwa said that in addition to a lack of doctors, the shortage of support services and nursing care in the province has increased hospital stays of patients, and has an adverse impact on outcomes such as in-hospital mortality and rehabilitation.

“Essentially, the staff shortages are causing burnout and high levels of stress, all of which are leading to poor patient care, and, sadly, litigation,” he said.

Apart from this, Dr Mzukwa said that the KZN public was owed an explanation of what had happened to funds allocated to the failed process of outsourcing medical equipment procurement for the province. He also said that the public has a right to know which institutions are facing critical equipment shortages, as this is hampering service delivery.

“As for hospital systems, this is a big problem. Asset managers in hospitals don’t have a universal record to track assets in a specific hospital, and they have no idea what went for repairs a year ago, and what has or has not been returned. There is a failure on their part to maintain, repair or replace high-tech equipment such as radiology and oncology machines,” he lamented.

Dr Mzukwa pointed to the fact that there is “poor institutional leadership” within the KZN Department of Health, and at hospital management level.

He said hospital managers don’t undertake proper situational analysis, and, because of this, don’t report back on critical matters to the Department of Health. He said there is a failure of hospital management to identify,

and advocate for, the needs of the institutions they serve, or the patients cared for in these institutions.

“There is a lack of quality management with regards to human resources, equipment, medical processes and patient outcomes, and a recycling of poorly performing managers. Ultimately, we believe, there is a lack of accountability and ‘consequence management’ for poor performance,” he noted.

Other areas raised in the memorandum include poor and unsafe working conditions of health workers, poor ambulance services, the poor maintenance of hospitals in general and rising litigation against doctors and the Department of Health.

The memorandum called on the provincial Department of Health to:

- Fill vacant posts and create more positions to account for population growth, and the increasing burden of disease, to reduce unsafe long working hours.
- Recognise that the efficient primary healthcare-based health system should be backed by adequate resources in terms of district, regional, and tertiary care. Therefore, the country should continue training, recruiting, and retaining specialists.
- Finalise and implement healthcare worker staffing norms.
- Improve the working conditions in the workplace by developing and implementing comprehensive occupational health services (which should include risk assessment and mitigation) for healthcare professionals.
- Provide a safe and secure environment for patients and staff.
- Improve supply chain management of essential equipment, consumables and medicines.
- Rescind the proposed Commuted Overtime Policy.
- Revise the remunerative packages for staff.
- Improve infrastructure of health institutions throughout the province.
- Ensure there is sufficient professional development.

The provincial Department of Health has agreed to meet SAMA members, and unions, to address the issues they have outlined.

International public health conference: Addressing health inequities – whose responsibility?

Bernard Mutsago, Selaelo Mametja, Shelley-Ann McGee, Jolene Hattingh, *Knowledge Management and Research Development, SAMA*

This is the last of three articles covering the conference on social determinants of health, which was held at the University of the Witwatersrand (Wits) on 23 and 24 February 2017. Presentations are available on the SAMA website: <https://www.samedical.org/links/social-determinants-of-health>.

Theme 4: Social determinants of the burden of disease

The four presenters on this theme shared vital epidemiological statistics, and expressed support for ongoing commitment and action on mental health, communicable diseases, occupational diseases and preventable mortality in SA.

One of the three overarching recommendations of the WHO Commission on Social Determinants of Health is to “measure and understand the problem”. The collection of national statistics related to equity is part of the process of measurement and monitoring. The presentation by Dr Kefiloe Masiteng, the deputy director general of population and social statistics at Statistics SA, was entitled “What mortality data tells us about social determinants of health”. The statistics demonstrated that the poorer socioeconomic population groups and provinces are more susceptible to disease and related mortality. In 2014, there were 453 360 deaths nationally, the top 10 causes of death being (in descending order): TB; cardiovascular diseases; diabetes; influenza and pneumonia; HIV; other forms of heart disease; hypertensive diseases; intestinal infectious diseases; other viral diseases; and chronic lower respiratory diseases.

Dr Mvuyiso Talatala also presented on the social determinants of mental health. He is a psychiatrist at the Dr S K Matseke Memorial Hospital in Soweto, and also an honorary lecturer in the Department of Psychiatry at Wits. In his presentation, he lamented the challenges in interpretation as well as poor implementation of the key national policies on mental health, namely the Mental Health Act, the Mental Health Policy Framework, and the Strategic Plan. He noted that, despite

the framework envisaging intersectoral collaboration between mental-health and non-health sectors – the departments of police, housing, education, agriculture, social development, labour, as well as non-profit and for-profit entities – these collaborations have not been fully exploited, leading to tragedies such as Life Esidimeni (and other less high-profile mental-health failures), where patients were “wrongly” deinstitutionalised in spite of dissension from patient advocacy groups.

Deinstitutionalisation is common, he observed, and has been used for other diseases such as TB; the heartache comes from its failure in the mental-health discipline.

Dr Talatala was also concerned about the imbalance of “nature v. nurture” in mental-health practice. He regretted that not all psychiatrists are cognisant of the social causation of mental health. Instead, disparate focuses are placed on the development of more effective mental health biomedical drugs, which is in itself, nevertheless, commendable. He underscored the need for embracing the “no health without mental health” and the “mental health in all policies” philosophies, as well as employment of a public-health approach to mental health. One thing is clear: Policies and awareness are not enough to turn the tide on mental health. Action is needed!

The presentation on the burden of social determinants of occupational diseases was made by Dr Sophia Kisting, executive director

of the National Institute for Occupational Health in SA. She highlighted the huge global and national burden of occupational diseases and injuries, as well as the social drivers behind them. Sadly, occupational diseases are underreported in SA.

Dr Kisting explained that, globally, according to the International Labor Organization, 6 300 people die daily as a result of occupational accidents or work-related diseases – more than 2.3 million deaths annually. In SA, according to the Department of Health, there were 41 810 cases of TB in SA mines in 2014 (8% of total cases and 1% of the population). There is a wide range of occupational risk factors for occupational diseases, falling under the broad categories of behavioural, metabolic and environmental risk factors. She highlighted the relationship between silica-dust exposure and the development of TB, stressing the imperative to lower silica-dust levels in the mining and construction industries in the interest of TB prevention.

One of the three overarching recommendations of the WHO Commission on Social Determinants of Health, namely, “improve daily living conditions”, includes “creating fair employment and decent work”. Dr Kisting noted that work and the workplace are in themselves recognised as social determinants of health. She highlighted the following as social drivers of occupational diseases in SA: working in the informal economy, low education/skills, decent-work deficit,



Left to right: Dr Sophia Kisting, Dr Kefiloe Masiteng, Prof. Lucy Blumberg and Dr Mvuyiso Talatala



Prof. Mvuyo Tom

high unemployment and extreme wealth inequalities, among others.

Dr Kisting aptly noted that these occupational diseases are preventable through workplace programmes, as well as skilling workers and empowering them to refuse dangerous work. The world of work can also be better utilised to prevent occupational and environmental exposures.

Prof. Lucy Blumberg, on behalf of Prof. Shabir Madhi of the National Institute for Communicable Diseases, presented on the social determinants of communicable diseases. She noted that low-resource settings remain vulnerable to major communicable disease outbreaks, citing as an example the African continent, where infectious diseases remain the dominant cause of death, despite non-communicable diseases being the major killers at a global level. She explained that the recent assault by Ebola on already fragile African health systems underscored global inequalities in the distribution of healthcare resources. Likewise, immunisation coverage levels are lower in under-resourced world regions, underlining the need to focus immunisation efforts on reaching out to the poorest quintile, who are also disadvantaged by a lack of access to curative health services. Prof. Blumberg also shared recent (2015) international scientific literature showing higher infant mortality rates in rural than urban areas in the majority of 90 countries worldwide. During the discussion section, Prof. Sharon Fonn of Wits argued that while vaccines are good, they are not a silver bullet, and more investment should be made towards intersectoral preventive interventions such as clean water supply.

Theme 5: Appropriate workforce training and education

Is higher education a social determinant of health? This was the simmering discussion point of Prof. Mvuyo Tom, who is the vice-chancellor at the University of Fort Hare. He highlighted the indisputable association between educational attainment and health. Using data, he explained that the economic and social benefits of post-secondary education are well demonstrated in the literature, and suggested that the ongoing struggle for transformation of higher education in SA is a struggle for the transformation of a very important social determinant of health. The big question, however, is whether higher education can be isolated from the continuum of education as a social determinant of health?

It appeared Prof. Tom had placed a greater-than-expected premium on higher education, judging from the ensuing debate during the question-and-answer session, where some delegates argued intensely that higher education, while significant, must not transcend the importance of basic education and early childhood development, including preschool programmes. Early childhood development has been neglected over the past years in SA, and must be reprioritised in view of the WHO Commission on Social Determinants of Health's recognition of early childhood development and education as "powerful equalisers". The panel session argued that SA has sufficient resources to make necessary improvements in all education – basic and higher.

Dr Tladi Ledibane of Sefako Makgatho Health Sciences University addressed the topic of "Inequitable distribution of healthcare training resources and access: Has the platform levelled in medical training?". He highlighted the historical racial disparities that still persist in the health sector. For example, the Dr George Mukhari and Chris Hani Baragwanath academic hospitals, built many decades ago, are typical "township hospitals" that were made for the black masses. These and other historical training institutions still exist, and face training limitations due to old equipment and equipment shortages, among other challenges. The institutions are buckling under the heavy pressure from rapid peri-urbanisation and the spawning informal settlements.

Dr Tladi also bemoaned the badly fragmented health system that is riddled with fiscal federalism. He offered some key recommendations: increase resources in areas of greatest need; increase resources in high-priority health programmes; fast-track NHI; and monitor policy implementation and the effects thereof. During the discussion, Dr Lindi Shange motivated for the expansion of the use of GPs as trainers of medical students, as is already happening at the Medical University of SA.

Turning to the nursing profession, Dr Sharon Vasuthevan spoke on "decolonising nursing education". She is the group nursing executive of the Life Healthcare Group and also chairperson of the Nursing Education Association.

She noted that while there has been much transformation in the nursing profession in SA, many of the ideologies remain embedded in Eurocentric thinking and philosophies. She explained that nursing education policies, regulations and programmes were developed from models based in the UK. This calls for a paradigm shift and the development of our own locally relevant nursing theories and practices, rather than blindly adopting international practices. There is also need to integrate indigenous knowledge, healthcare beliefs and practices and the caring philosophy into nursing education systems – a missing factor in the current system.

Dr Vasuthevan drew attention to the country's nursing education system, which is undergoing significant policy and legislative changes which present both opportunities and threats for the sustainability of nurse training in SA. All nursing training and qualifications will now be under the ambit of the Department of Higher Education and Training (DHET), the registered professional nurse will have a Bachelor's degree and all specialist qualifications will be at postgraduate level. These developments warrant a joint approach among the nursing regulator, the DHET, tertiary institutions, employers and students, to avert challenges such as variable standards, possible discrimination from the employers and readiness of nursing colleges to meet the new requirements under the DHET.

Theme 6: Constitutional obligations and human rights

Prof. Dan Ncayiyana, president of SAMA, addressed the topic "Constitutional dis-



Dr Lindi Shange (chairperson of the SAMA Health Policy Committee) posing a question during a Q&A session

pensation for health and the healthcare system: Is it working?”. On the whole, his conclusion was “no”. Highlighting the plight of the victims of the Life Esidimeni tragedy, Prof. Ncayiyana examined how these patients’ rights had been totally disregarded in an attempt to reduce costs in Gauteng Province. This fiasco demonstrates that laws and policies cannot protect the lives and dignity of people and patients. Gauteng was not an isolated incident – these kinds of things happen nationwide, and the Gauteng tragedy is a symptom of a bigger problem.

Prof. Ncayiyana questioned whether the country is facing a systemic collapse of the health system, and whether the underlying problem is lack of accountability for poor service delivery or associated poor outcomes. The authorities know that they can get away with murder and nothing will happen to them.

As the provinces are responsible for managing the running of provincial health departments, the health minister has relatively little constitutional authority over provincial operations. Nevertheless, he bears responsibility as the highest level of authority. Corruption and incompetence in the provinces are responsible for problems at a local level.

The question becomes whether or not this is a structural issue? The country appears to be spending sufficient money on several aspects of the system, and yet compassion and respect do not cost a penny. There is evidence that the system remains callous, greedy and uncaring.

Prof. Ncayiyana finished his presentation with a range of questions: who is ultimately accountable? Where does the buck stop? Who is to blame? Is the existing constitutional arrangement working, or is it a structural issue?

Or was society so brutalised by apartheid that we have become callous, uncaring, selfish and greedy? These are the issues which have to be addressed.

Prof. Relebohile Moletsane of the University of KwaZulu-Natal then took an in-depth look at gender and race as social determinants of health in Uthukela District in KwaZulu-Natal, where she has done much of her work in communities. She shared her experiences on conducting research from the perspective of participants, and highlighted ethical dilemmas around the issues. Participation in research can expose people to violence.

Girls in SA continue to be faced with harmful traditional practices – The Bill of Rights and the Constitution have not addressed these. Negative outcomes include early school-leaving, teenage pregnancy and continued poverty. Ideas still persist that girls are responsible for sexual violence against them, and power imbalances within the community render girls completely unable to negotiate what happens to their own bodies. Trying to stand up for themselves often exposes them to more violence. Prof. Moletsane recommended three levels of action:

- Transforming the institutions
- Changing the social norms
- Targeting the individuals.

Ms Marije Versteeg-Mojanaga of the Rural Health Advocacy Project tackled issues of health activism and access to care. She advanced that the right to healthcare is enshrined in our Constitution and the government has the obligation to progressively achieve the full realisation of the right to health.

Cost-containment measures affect recruitment of healthcare workers to the most vulnerable communities in particular. Not enough noise is made about staffing figures as they are not widely available. The number of posts in the health sector in the North West province are being decreased year on year, and this is not unique to this province. Ms Versteeg-Mojanaga put forward four propositions:

- The current priority setting process is flawed and deepens inequities.
- Health budget cuts affect the most vulnerable disproportionately.
- The argument of “unavailable resources” does not hold.
- Multi-stakeholder activism is needed more than ever.

She referred to the WHO Guidance for Priority-setting in health as only looking at cost efficiencies. It does not address the health needs and ends up disadvantaging the already disadvantaged populations. She particularly brought to the spotlight that resource allocation based on utilization perpetuates the inequities.

Closure of services currently is being done without a longterm view, this results in inefficiencies, poor health outcomes and increased expenditure due to increased morbidity and legal costs. She gave an example of the closure of Calvinia hospital; the only available obstetric unit was 400 km away, and this resulted in an increased rate of birth defects with resultant longterm dependency on government in terms of healthcare, disability grants and legal costs and loss of future income earning. This leads to other costs downstream.

We desperately need consensus about the points and taking up the cause, as well as additional research into issues like frozen posts and failure to invest. She said that priority setting should be guided by three principles: maximising health outcomes, reducing inequities, and minimising inefficiencies. She argued that prioritisation should further take into consideration the burden of disease, the groups of people likely to be impacted by availability or lack of services, and criteria related to protection against financial catastrophe.

Prof. Laurel Baldwin-Ragaven of the University of the Witwatersrand and Dr Mark Sonderup of the University of Cape Town gave brief reflections as discussants. They called for inter-sectoral collaboration and noted that rights are not given to us – they should be fought for. Rights on paper can easily be overturned by an executive order.

Credit rating for medical schemes

Dr Solly Motuba, SAMA Private Practice Department

S A's recent credit ratings downgrade to below investment grade (junk) by Standard and Poor and Fitch has generated a lot of interest around the workings of credit agencies. It has also increased the level of awareness of the immediate, short-term and long-term implications of ratings notched by our country, and of the economic outlook.

The truth is, credit ratings are not the preserve of governments. Their ambit of operations includes, but is not limited to:

- Financial institutions: banks and non-bank financial institutions
- Insurance: short-term insurance, life insurance, reinsurance and healthcare (medical schemes)
- Corporate and public sector debt: corporates and industrial borrowers, property funds, parastatals, utilities, state governments and local authorities
- Structured finance and securitisation.

Medical schemes are no exception, and are credit-rated on an annual basis. The credit rating of medical schemes goes back to the days of Republic Rating and Duff and Phelps in the late 1990s, who were at the forefront of rating medical schemes. Global Credit Rating (GCR) is the present-day premier rating agency for medical schemes.

What goes to the heart of credit-rating agencies is the need to address the problem associated with asymmetry of information between issuers and lenders regarding the creditworthiness of the borrower, and closer

Rating	Description
AA +	Very high claims-paying ability.
AA	Protection factors are strong.
AA -	Risk is modest, but may vary slightly over time due to economic and/or underwriting conditions.
A +	High claims-paying ability.
A	Protection factors are above average, although there is an expectation of variability in risk over time due to economic and/or underwriting conditions..
A -	
BBB +	Adequate claims-paying ability.
BBB	Protection factors are considered adequate for the present, but there is considerable variability in risk over time due to economic and/or underwriting conditions.
BBB -	

Source: GCR

to home, between medical schemes and members (both incumbent and prospective). The ratings also serve as a warning signal or an assurance medium for providers of care on the claims-paying ability of rated schemes.

It is common knowledge that the biggest nightmare for any scheme member or provider of care is that of a medical scheme going belly-up on the eve of or following a major medical procedure. This is in view of the inherent risks associated with having to queue for the disbursement of payments or settlement of benefits from a scheme under liquidation. Rating agencies therefore play a vital role in keeping the public apprised of information that is otherwise not readily available, and also help to keep index entities on their toes.

GCR is an independent company that rates the claims-paying ability of medical schemes over a 12 - 18-month period. The following factors are taken into account in the rating process:

- How quickly the scheme's investments can be realised, to pay claims
- The number of months' claims that a scheme can pay from its cash reserves
- The scheme's balance sheet
- The number of months' claims a scheme can pay from its overall reserves
- The size and profile of a scheme's membership base
- The scheme's solvency ratio
- Governance.

A rating of AA+ is regarded as the highest rating, and BBB- the lowest.

GCR applies an industry risk ceiling of AA for SA medical schemes

The table left shows medical scheme ratings for 2013 and 2016 (Source: GCR reports).

Given the above, there is a compelling business case for the introduction of a patient-provider index that will afford a grading and rating to medical schemes on the basis of the patients' and healthcare providers' overall experience with medical schemes.

After all, they are the ones that are best placed to judge medical schemes' overall performance. The current medical schemes' ratings, as we have them, are very much in keeping with the proverbial "crystal ball".

Medical Scheme	Rating 2013	Rating 2016	Outlook
Bankmed	AA+	AA+	Stable
Bonitas	AA-	A+	Stable
CAMAF	AA-	AA-	Stable
Compicare	A	A-	Withdrawn
Discovery	AA+	AA+	Stable
Fedhealth	AA-	AA-	Stable
Hosmed	A-	A-	Stable
Medihelp	AA-	AA-	Stable
Medshield	AA-	AA-	Stable
Momentum	AA-	AA-	Stable
Resolution Health	BBB-	BBB-	Withdrawn
Sizwe	Unavailable	A+	Stable
Transmed	BB+	BB+	Stable

SAGE and clinical practice guideline adaptation in SA

Shelley-Ann McGee, Knowledge Management and Research Department



In the March issue of *SAMA Insider*, we reflected on the “The rise of clinical practice guidelines” and how these are becoming increasingly relevant to medical practitioners for clinical practice, reimbursement purposes and even in litigation situations.

In April 2017, SAMA Knowledge Management participated in a panel discussion hosted by the SA Guidelines Excellence Project (SAGE) at the SA MRC. The panel discussion revolved around “Shifting the way we do it: Clinical Practice guidelines adaptation”, and looked at several examples of local clinical practice guideline development and application.

SAMA encourages all its members to take the time to consider the contents and quality of clinical guidelines

This panel discussion used examples from four separate local SA guideline adaptation and adoption experiences to showcase, compare and contrast some methodologies that are currently being used to develop local guidelines from existing guidelines and available evidence, as well as ensuring local guidelines are appropriate for SA’s context.

About Project SAGE

Project SAGE is a partnership which aims to enhance the quality of primary healthcare by engaging in a stakeholder-driven process to improve the standards of local clinical guideline development, adaptation, contextualisation and, ultimately, implementation. Funded by a grant from the MRC, the SA Cochrane Centre has partnered with the Health Systems Research Unit (HSRU) at the MRC, the Centre for Evidence-Based Healthcare (CEBHC) at Stellenbosch University and the International Centre for Allied Health Evidence, University of South Australia since 2013, to examine the current situation in the development of guidelines in SA, and to find ways to improve capacity for the adaptation and development of evidence-based clinical practice guidelines in SA.

The project has been led and coordinated by Dr Tamara Kredo, senior specialist scientist and deputy director at Cochrane SA, and has produced several publications examining the processes and quality of existing clinical practice guidelines in SA, as well as potential methodologies for improvement, as well as active inputs into the improvement of guideline development processes locally.

The SAGE programme also held a summit in February 2016 to facilitate dialogue between stakeholders involved in guideline activities, including development, implementation and use, and research in SA, and to explore future guideline initiatives, and ran a training session in GRADE methodology (The Grading of Recommendations Assessment, Development and Evaluation), which has been successfully employed in the evaluation of quality of clinical evidence to inform clinical practice guidelines in several other countries in the world. We encourage SAMA readers to have a look at the GRADE working group website – <http://www.gradeworkinggroup.org/>.

Focusing on the development of local guidelines – de novo, adopt, adapt or “adolop”?

Believe it or not, “adolopment” is a formal process in the development of guidelines, according to the recently published “GRADE evidence-to-decision frameworks for adoption, adaptation, and de novo development of trustworthy recommendations”. These

recommendations address prevention of duplication of expensive and time-consuming work for clinical practice guidelines development from scratch, by instead adapting recommendations from existing clinical guidelines, through a process of quality evaluation and contextualisation to the local situation.

The April GRADE workshop highlighted four separate and different processes which were undertaken locally to do this work for a variety of practice guidelines. These ranged from national projects such as the national Health Promotion Tool and Guidelines Development (due to be published in September 2017), and the HPC’s prehospital Emergency Care Clinical Practice Guidelines (discussed in an article in the March issue of *SAMA Insider*), through to more locally based guidelines like those for the Management of Chronic Musculoskeletal pain in the Western Cape Province and the hospital-based Guidelines for the Management of Severe Mental Disorders with Comorbid Substance Abuse.

The process employed for all of these local guidelines was really one of “adolopment” – with multiple global recommendations evaluated, adopted and adapted to the SA context.

The success of implementation and adoption of the guidelines has largely yet to be measured, but the experiences of the panel speakers held many lessons for those looking at similar projects in their own settings. Challenges came generally in the form of very tight timelines and the fact that finding, evaluating and grading evidence and recommendations takes a significant amount of time and specialised skills. Stakeholder engagement was also highlighted as a challenge by the developers of guidelines – both from an administrative and process point of view. The fact that many existing guidelines and evidence-bases are centred in Europe and the US also warrants mention – this can make local contextualisation of the recommendations difficult.

However, many lessons were learned and shared through these local guideline “adolopment” processes, which hopefully can be taken up as the country moves forward with plans for universal health cover and the re-engineering of the primary healthcare system. In a resource-limited setting such as SA,

ensuring best use of effective and cost-effective primary care diagnostics and treatments is key to reducing waste, improving access and thereby improving quality of care.

Relevance of Project SAGE to medical practice in SA

The importance of the development of well-researched and evidence-based clinical practice guidelines for SA cannot be overemphasised. The SAGE research thus far has identified several shortcomings in existing structures and processes of guideline development in the country v. international best practice (see the Project SAGE website: <http://www.mrc.ac.za/cochrane/sage.htm>.)

Best practice and real-world experience-sharing serve to bolster the potential for

improvement of the processes and inputs into clinical practice guidelines in the country. SAMA encourages all its members to take the time to consider the contents and quality of clinical guidelines which we may be currently following, and identify any challenges and areas for improvement that these pose in your own practice.

As the NHI work packages, such as benefit package determinations, progress and mature, strong evidence-based inputs into specific clinical and systems issues will become imperative for ensuring appropriate patient treatment and fair resource allocation. SAMA hopes to involve increasingly higher numbers of clinicians in the movement and the development of best practice for the country.

Ideally, even decisions for the necessity for guideline development to address particular illnesses, systems and challenges should be prioritised, as guideline development itself is costly and time-consuming. Participants at the April SAGE panel discussion largely agreed that SA needs a central body to oversee guideline development and set out "guidelines for guidelines", to prioritise topics and issues and to oversee the complex processes and stakeholder inputs necessary to ensure that final guidelines are acceptable to those in clinical practice who are expected to follow them.

References mentioned in this article are available on request from the Knowledge Management and Research Department (KMRD) at SAMA.

Ethics Alive week addresses transformation

Jeanette Snyman, senior marketing officer, SAMA

The University of the Witwatersrand's Faculty of Health Sciences and the Steve Biko Centre for Bioethics hosted the 10th annual Ethics Alive week from 13 to 17 March.

Prof. Dan Ncayiyana, president of SAMA, was one of the keynote speakers at the symposium, which was the highlight of the week, and was hosted at the Women's Goal, Constitution Hill, Braamfontein. Prof. Ncayiyana presented on the topic "Transformation: Is it a bitter pill to swallow?" Other keynote speakers were Dr Freda Lewis-Hall and Mr Nkosinathi Biko, who also gave insights on meaningful transformation.

Dr Graham Howarth, MPS's head of medical services in Africa, delivered presentations during the course of the week on the topic of "Keeping out of trouble when trouble comes a-calling" at the Wits Donald Gordon Medical Centre, Chris Hani Baragwanath Academic Hospital, Helen Joseph Hospital, Len Miller Lecture Theatre, Sterkfontein Hospital and Charlotte Maxeke Academic Hospital.

Ethical conduct in the healthcare fraternity is an issue of continuous discussion, and cannot be overlooked. Overall, the basis of this symposium was two significant issues: adapting to transformation in the health field, and considering the application of ethics in the process of transformation.



From left to right: Prof. Ames Dhai, Prof. Dan Ncayiyana and Dr Liz Gwyther



Attendees listen to Dr Howarth's presentation at Helen Joseph Hospital

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MEMBER BENEFITS



Socio-medical affairs at WMA conference

SAMA Communications Department

The socio-medical affairs committee of the World Medical Association (WMA) recently met during the WMA's annual conference in Zambia, held from 20 - 22 April.

Monitoring report (oral)

Ms Clarisse Delorme reported on the recent work of the secretariat regarding the World Health Organization's (WHO's) Role of the health sector in the strategic approach to international chemicals management towards the 2020 goal and beyond.

A draft roadmap outlining concrete actions to enhance health-sector engagement was developed by the WHO, and the WMA was invited to comment on it. Based on its policy, the WMA insisted on the need to focus on concrete hazard reduction, and to aim at continuously improving the safety of chemicals.

The role of health professionals was also highlighted. It is expected that the draft roadmap will be adopted by the next World Health Assembly in May 2017. Ms Delorme invited those committee members having expertise in this area to work with the secretariat in monitoring the implementation of the roadmap.

Dr Julia Tainijoki referred to the coming WHO 4th global forum on human resources for health, to be held in Dublin, Ireland from 13 - 17 November. The WMA is involved in the preparation of the event. A call for abstracts will be issued, and the WMA will submit a proposal. Dr Tainijoki invited interested members to get involved in this process.

Among the other issues discussed by the committee were:

Health and environment

Prof. Vivienne Nathanson paid tribute to Dr Dong-Chun Shin, co-chair of the caucus, who resigned from his position. She then reported on the meeting of the environment caucus, which met the day before. Caucus members received an updated report on the climate change negotiations from Dr Lujain Alqodmani (Kuwait Medical Association) who participated in the last climate change summit in Marrakesh (November 2016) as one of WMA representatives.

The caucus explored ways to involve ministers of health in the negotiations to

raise the profile of health impacts of climate change, such as changing disease patterns and food security issues.

Participants also considered that medical journals could be a good opportunity to increase the visibility of this issue within the health community. *The World Medical Journal* could dedicate a special issue to this topic.

Role of physicians in adoption practices

The committee considered the proposal for a WMA statement on the role of physicians in preventing exploitation in adoption practices (SMAC 206/Trafficking with Minors REV2/Apr2017). It was recommended this proposal be circulated among members for comments.

Armed conflicts

The committee considered the proposal for a WMA statement on armed conflict, and comments (SMAC 206/Armed Conflicts COM REV2/Apr2017). It was recommended that this proposal, as amended, be approved by the council and forwarded to the general assembly for adoption.

Boxing

The committee considered the proposed revision of the WMA statement on boxing, and comments (SMAC 206/Boxing COM REV4/Apr2017). Two potential versions were debated, and the committee selected the Version 2 "Proposed Statement Supporting Complete Ban with Safety Considerations". It was recommended that this version be approved by the council and forwarded to the general assembly for adoption.

Medical tourism

The committee considered the proposal for a WMA statement on medical tourism, and comments (SMAC 206/Medical Tourism COM REV3/Apr2017). It was recommended that this WMA statement be sent back to the rapporteur, Israel Medical Association, for further work.

Medical cannabis

The committee considered the proposal for a WMA statement on medical cannabis, and comments (SMAC 206/Medical Cannabis COM REV2/Apr2017). It was recommended that this proposal be approved by the council

and forwarded to the general assembly for adoption.

Medical assistance in air travel

The committee considered the proposed revision of the WMA resolution on medical assistance in air travel, and comments (SMAC 206/Air Travel REV/Apr2017). It was recommended that the proposed revision be approved by the council and forwarded to the general assembly for adoption.

Tuberculosis

The committee considered the proposed revision of the WMA resolution on tuberculosis, and comments (SMAC 206/Tuberculosis COM REV/Apr2017). An additional amendment (new paragraph 14) from the Norwegian Medical Association, which was not included in the working document, was also considered by the committee. It was recommended that the proposed revision be recirculated among constituent members for comments.

Access to healthcare

The committee considered the proposed revision of the WMA statement on access to healthcare, and comments (SMAC 206/Access to Health Care COM REV/Apr2017). It was recommended that the proposed revision, as amended, be approved by the council and forwarded to the general assembly for adoption.

Professional autonomy of physicians

The committee considered the proposed revision of the WMA declarations of Seoul and Madrid, and comments (SMAC 206/Professional Autonomy COM REV/Apr2017). It was recommended that the proposed revisions, amended, be approved by the council and forwarded to the general assembly for adoption.

Medical education

The committee considered the proposed revision of the WMA statement on medical education, and comments (SMAC 206/Medical Education COM REV/Apr2017). It was recommended that the proposed revision, as amended, be approved by the council and forwarded to the general assembly for adoption.

Review of WMA general policy on alcohol

The committee considered the proposed revision of the WMA declaration on alcohol and comments (SMAC 206/Revision Alcohol Declaration COM REV/Apr2017). It was recommended that the proposed revision, as amended, be approved by the council and forwarded to the general assembly for adoption.

Water and health

The committee considered the proposed WMA statement on water and health, and comments (SMAC 206/Water and Health COM REV/Apr2017). It was recommended that the proposed statement be approved by the council and forwarded to the general assembly for adoption.

Cooperation of national medical associations

The committee considered that the proposed WMA statement on the co-operation of national medical associations during or in the aftermath of conflicts, and comments (SMAC 206/Cooperation of NMAs COM REV/Apr2017). It was proposed that the statement, as amended, be approved by the Council and forwarded to the General Assembly for adoption.

Epidemics

The committee considered the proposed WMA statement on epidemics/pandemics,

and comments (SMAC 206/Epidemics COM REV/Apr2017). It was recommended that the statement, as amended, be approved by the council and forwarded to the general assembly for adoption.

Health and climate change

The committee considered the proposed WMA declaration on health and climate change, and comments (SMAC 206/Climate Change COM REV/Apr2017). It was recommended that the proposed declaration be revised by the rapporteur, based on the comments exchanged during the session. The revised version will then be circulated among constituent members for comments.

Smallpox

The committee considered the proposed WMA statement on the destruction of smallpox virus stockpiles, and comments (SMAC 206/Smallpox Destruction COM REV/Apr2017). The proposed statement was withdrawn by the associate members, the originators of the proposal.

Sustainable development

The committee received the report of Dr Mari Michinaga (Japan Medical Association), chair of the working group. The working group met the day before and discussed a preliminary draft statement on health and sustainable development. A draft will be submitted to the

council in Chicago. The working group also discussed the opportunity to publish articles on this issue in medical journals.

Avian and pandemic influenza

Secretary general Otmar Kloiber reported to the committee that the secretariat will submit a revised version of the WMA statement on avian and pandemic influenza at the next council in Chicago. The secretariat will also look at potential overlaps with the proposed WMA statement on epidemics and pandemics (SMAC 206/Epidemics COM REV/Apr2017).

In addition, the Social Mobilisation Action Consortium (SMAC) considered new business matters at the conference. Several proposals relating to women in medicine, fair medical trade, and plastic bags and ecological issues were raised. It was recommended that proposals on each of these topics be circulated to constituent members for comments.

At the closing, the committee considered the recommendations received on a number of SMAC documents. Among these was a recommendation that the resolution on health and human rights abuses in Zimbabwe be reaffirmed.

For links to the documents and further information please contact SAMA head office: 012 481 2164.

SAMA to lead major revision on WMA MEC statement on telemedicine

SAMA Communications Department

The World Medical Association (WMA) recently held its 206th council session in Zambia. Among the committees which met during the conference, held from 20 to 22 April, was the Medical Ethics Committee (MEC).

One of the key outcomes of the conference was a decision to revise the MEC's statement on telemedicine. Among the MEC's duties is to review policies which were adopted, or last revised, 10 years ago, and the MEC's statement on telemedicine falls into this category.

It was decided at the conference that this statement requires a major revision, a process which will be led by SAMA.

In addition, SA featured in two other decisions taken by the MEC during the conference:

- The proposed WMA declaration on therapeutic abortion (MEC 206/Therapeutic Abortion COM REV/Apr2017) will be referred to a working group. To this end, the chair of the council, Prof. Vivienne Nathanson, will appoint a working group comprised of volunteers from Australia, South Africa, and Canada.
- Looking ahead, the MEC received an oral report from Dr Jón Snædal about the planned three-day WMA Ethics Conference 2018, to be held in conjunction with the WMA general assembly in Reykjavik, Iceland



(the conference is open to the public). The second conference day, which will replace the scientific session of the general assembly, will focus on important topics for the WMA. An informal scientific group will be installed to advise on topics for the conference programme. The following members volunteered to participate: Denmark, Canada, the Netherlands, Turkey, Kuwait, Brazil, CPME, Japan, Spain, South Africa, Belgium and the chair of the MEC committee.

Classification of 2007 policies

The committee reviewed the recommendations received (MEC 206/Policy Review 2007/Apr2017) on the potential revision of the MEC policies for which it has been 10 years since adoption or last revision.

The committee received an oral report from the chair of the workgroup on the Declaration of Geneva, Dr Ramin Parsa-Parsi. He reported on the WMA session on the Declaration of Geneva at the UNESCO Chair in Bioethics 12th World Conference Bioethics, Medical Ethics and Health Law in March 2017.

It was recommended the WMA call for public consultation on the draft version of the Declaration of Geneva presented at the MEC meeting during the general assembly 2016 (MEC 204/Draft revision of Declaration of Geneva/Oct2016), followed by circulation among WMA members for comments.

The committee considered the proposed WMA declaration on quality assurance in medical education, presented by the American Medical Association. It was recommended that this declaration, as amended, be approved by council, with the recommendation that it be forwarded to the general assembly for adoption.

In addition to these, the committee considered a number of other critical, relevant topics. These included:

Medical ethics in the event of disasters

The committee considered the proposed WMA statement on medical ethics in the event of disasters. It was proposed this statement be adopted and forwarded to the general assembly for adoption.

Declaration of Malta on hunger strikers

The committee considered the proposed WMA Declaration of Malta on hunger strikers. This led to intense discussion regarding informed consent and the circumstances under which forced feeding of hunger strikers is acceptable. It was recommended that the revision of the proposed WMA Declaration of Malta on hunger strikers (MEC 206/Hunger Strikers REV2/Apr2017), as amended, be approved by council, with the recommendation that it be forwarded to the general assembly for adoption.

Statement on assisted reproductive technologies

The committee considered the proposed WMA statement on reproductive technologies. It was recommended that the statement, as amended, be approved by council, with the recommendation that it be forwarded to the general assembly for adoption.

Statement on HIV/AIDS and the medical profession

The committee considered the proposed WMA statement on HIV/AIDS and the medical profession (MEC 206/HIV-AIDS COM REV/Apr2017). It was proposed that the statement be approved by council, with the recommendation that it be forwarded to the general assembly for adoption.

Anal examination

The committee considered the proposed WMA resolution on forced anal examinations. It was recommended that the revision of the resolution, with the new title "WMA Resolution on Prohibition of Forced Anal Examinations to Substantiate Same-Sex Sexual Activity", be approved by council, with the recommendation that it be forwarded to the general assembly for adoption.

Bullying and harassment

The committee considered the proposed WMA statement on bullying and harassment (MEC 206/Bullying and Harassment COM REV/Apr2017). It was recommended that the revision of the statement, as amended, be approved by council, with the recommendation that it be forwarded to the general assembly for adoption.

MEC new business

In terms of new business, the MEC considered the following topics:

Person-centred medicine: The committee considered the proposed WMA statement on person-centred medicine, and recommended that the statement be circulated among constituent members for comments.

Child abuse: The committee considered the proposed amendment to the WMA statement on child abuse (MEC 206/Child Abuse/Apr2017). It was recommended that the WMA statement be circulated among constituent members for comments.

Organ and tissue donation: The committee considered the proposed amendment to the

WMA statement on organ and tissue donation (MEC 206/Organ and Tissue Donation/Apr2017), and recommended that the statement be circulated among constituent members for comments.

Classification of 2007 policies – recommendations

The committee reviewed the recommendations received (MEC 206/Policy Review 2007/Apr2017) on the potential revision of the MEC policies for which it has been 10 years since adoption or last revision. It was recommended that:

- the Declaration of Hamburg concerning support for medical doctors refusing to participate in, or to condone, the use of torture or other forms of cruel, inhuman, or degrading treatment be reaffirmed, with a minor revision by the secretariat, and be submitted to the committee and council at the next meeting
- the statement on the ethics of telemedicine undergo a major revision, led by the South African Medical Association (SAMA)
- the statement on the licensing of Physicians fleeing prosecution for serious criminal offences undergo a major revision, led by the French Medical Association (CNOM)
- the proposal for a United Nations rapporteur on the independence and integrity of health professionals be reaffirmed, with a minor revision by the secretariat, and be submitted to the committee and council at the next meeting.

WMA human rights

Clarisse Delorme, WMA advocacy advisor, referred to the council report (Council 206/SecGen Report/Apr2017), and highlighted the fact that the secretariat was involved in the consultation process for the drafting of the report on mental health and human rights by the UN high commissioner for human rights.

The secretariat provided a contribution to the report based on WMA policies, with the support of psychiatrist Dr Miguel Roberto Jorge (Brazilian Medical Association). The report was published recently, and the secretariat will review the new document to ensure that the WMA's concerns are taken into consideration.

For links to the documents and further information, please contact SAMA head office: 012 481 2164.

Living with multiple sclerosis

SAMA Communications Department

Multiple sclerosis (MS) is an inflammatory, immune-mediated primary demyelinating disease, specific to the central nervous system (CNS). It is characterised clinically by episodes of focal disorder of the optic nerves, spinal cord, brainstem and cerebellum, which remit to a varying extent and recur over a period of many years.

The clinical manifestations are varied and are determined by the location, and extent, of the demyelinating foci (plaques). Because plaques can manifest anywhere in the CNS, symptoms vary from patient to patient, and from one relapse to the next in the same patient.

MS is most commonly diagnosed in patients in the 20 - 40 age group, with a ratio of 3:1 between women and men. Genetic factors are implicated, but there is now more evidence of environmental factors such as its more frequent occurrence among people living further from the equator.

MS is the commonest cause of chronic neurological disability among young adults, and most often leads to progressive physical and cognitive disability over time.

Relapsing and remitting MS is the most commonly first-identified form of the disease. This is where relapses occur randomly over a period of the first few years of diagnosis. Here, recovery varies in each remittance and from one patient to the next.

Secondary progressive MS often develops from initially relapsing remitting disease;

primary progressive MS is where the disease progresses gradually, with inexorable decline of neurological function over time.

Primary progressive MS is rare, but secondary progressive MS occurs following a period of relapsing and remitting states. The least severe form is benign MS. Here, patients suffer few relapses, resulting in little or no disability.

Symptoms and signs

MS is often referred to as a mystery disease, as there is no clear or regular first symptom. The first clinical symptoms are often increasing chronic fatigue and general weakness, and optic neuritis with impaired vision in one eye, often with some pain around or behind the eye.

Patients may complain of problems with hand-eye co-ordination and gait and balance disturbances. As the disease progresses, loss of sphincter control, blindness, paralysis and dementia may develop. Other typical symptoms are spasticity and other pyramidal signs, tingling, numbness and lack of sensation in hands, fingers and feet.

Lhermitte's signs, nystagmus, double vision, vertigo and bladder and sexual dysfunction are also progressively noted. Patients may experience pain with multiple sclerosis, although this is often not a prominent feature.

Atypical symptoms for MS include aphasia, hemianopia, extrapyramidal movement disturbances and severe muscle wasting or fasciculation. Over time, cognitive ability

declines markedly and poor short-term memory, impaired judgement and decision-making ability become evident. Social cognitive issues, including poor conversation, lack of concentration, and reduced self-confidence are also sometimes noted.

Chronic MS-related fatigue is a prominent and disabling feature; it differs from normal fatigue in that it generally leaves the patient feeling unable to do anything at all. Patients experience both mental and physical fatigue at the same time. The fatigue is drastically exasperated by heat. MS fatigue makes other symptoms seem much worse.

All of this adds up to drastic depression and mood swings, leading to higher-than-the-norm divorce and suicide rates. MS sufferers are very difficult to live with and care for.

Diagnosis imaging and criteria

In diagnosis, it is critical that all other autoimmune disorders and infectious diseases are ruled out. Exclusion of all other diseases or viruses giving similar clinical symptoms must also be ruled out. The sensitivity of magnetic resonance imaging (MRI) in detecting MS is 84%. MRI outperforms all other tests, including oligoclonal bands, evoked potentials and CT scans.

Patients should be referred to a neurologist upon suspecting the diagnosis. Early treatment has been shown to improve prognosis and outcome.

Imaging findings vary with disease activity, although clinical correlation with specific lesions is generally poor. Most foci identified on standard MRI scans are clinically silent.

Medication

Treatment and management of MS should be targeted toward relieving the symptoms of the disease, treating acute exacerbations, shortening the duration of an acute relapse, reducing the frequency of relapses, and preventing disease progression.

Drugs approved for use in MS which reduce the frequency of exacerbations, or which slow disability progression, are referred to as disease-modifying drugs (DMDs).



Symptoms of MS

These DMDs can be further classified as immunomodulating (or receptor modulating) or as immunosuppressants.

Modern disease-modifying immune treatment is now aiming for a state of NEDA (no evidence of disease activity).

Drugs which treat MS-related symptoms (e.g. acute exacerbations, cognitive dysfunction, fatigue, spasticity, bowel and bladder problems, and pain) but do not modify the course of the disease are referred to as symptom-management medications.

Patient care and rehabilitation

Multiple Sclerosis SA is a non-profit NGO providing support for MS sufferers and their families wherever possible. Branches in Gauteng, the Western Cape and KwaZulu-Natal can assist nationwide.

Get your patient to call the national helpline on 0860 456 772 and their confidential MS SA social workers will assist where possible. Services include counselling, referrals to rehabilitation specialists, support and socialising groups, and home visits where possible.

Patients should also be encouraged to care for themselves. Firstly, a good attitude is essential. MS is not a death sentence. With the right medication and attitude their life can still be rewarding – just different.

Many things can be done to ensure that physical and mental fitness are maintained at an acceptable level. These self-help regimes include joining an MS society and using occupational therapy, physiotherapy and speech therapy.

Wherever possible, physical fitness should be encouraged. Here it is important the body does not overheat. Aqua aerobics, biokinetics, yoga and walking, where possible, work wonders. Mental fitness can be sharpened by doing crossword puzzles, Sudoku and brain/mind training games on computers and smartphones.

MS is tough for those who care for patients, so they also must also look after their mental state. Psychologists and counsellors can assist patients and family. A very positive attitude is essential. Don't let them be shy of psychiatrists, psychologists, therapists, and other social services.

Here, again, MS SA can be an immense help. They have an active Facebook page and website, as well as confidential social workers. The MS national helpline number is

0860 456 772. More information can also be obtained by emailing info@mssainland.org.za.

Websites: Gauteng and inland provinces: www.mssainland.org.za; Western Cape: www.multiplesclerosis.co.za.

MS is a critical disease affecting family life, mortality, disability, unemployment, divorce, suicide, cognitive impairment, and overall quality of life. Cures have not been found but effective and safe medication is available to slow progression and improve outcomes.

Diagnosis is extremely difficult, with MRI being the most reliable method. Prognosis is impossible to predict as the mystery of

the disease leaves everyone in a different situation.

There is high risk of the disease progressing to accumulating disability over time, resulting in increased physical and cognitive impairment. There is no cure, but several medications are available which delay further relapses. Regular monitoring by a medical professional is essential. There is an excellent chance of patients leading a relatively normal life with the correct treatment and a positive attitude.

Information supplied by Prof. Andre Mochan, associate professor, Neurosciences Department, University of the Witwatersrand.

Multiple sclerosis – a patient's story

Brian Eades was diagnosed with MS in 2000, at the age of 42. He endured an extended period of struggling and not being able to pinpoint any specific diagnosis. He led a very active business life as a Marketing Senior general manager in a big multinational, and managed a fair-sized staff and huge budget.

Frequent overseas and domestic business trips affected his fatigue and stress levels.

An active sportsman, his action cricket, squash and golf deteriorated due to declining hand-eye co-ordination. Fatigue in sports also became a big drag. His concentration was affected, as well as general strength and fitness. His foot was dragging and his gait started suffering. Eventually, his hand started slipping off his computer keyboard uncontrollably. At this point, Brian went for professional help.

After a battery of MRIs, and a lumbar puncture, a neurologist diagnosed MS. He was baffled as back then, MS was relatively unknown. There was no Google (thank goodness!) and available books were very negative.

To start with, the attacks came two or three times a year. This then reduced to one every year or two. After about 7 years, with international travel and stress being at a high, the attacks started becoming more frequent.

His neurologist suggested he give up the stressful life. Being a career man, the shock to his system was enormous. Fortunately, after 28 years of service, the company gave him a fair early-retirement package.



Brian says he was lucky he was so sick, as the next 3 years allowed him to slowly slip into retired life. These days, his trips are to the shops and not overseas. His sports are biokinetics, and he walks at the back of the pack at "run walk for life", and he is training for his third attempt at the 702 Walk the Talk – a far cry from the active sports life he once enjoyed, but hugely rewarding nonetheless.

Intellectually, the latest form of building concentration and memory has been by downloading mind games on his phone. He has recently been introduced to Facebook, and generally spends time deleting emails. To reinforce confidence and manage depression, he regularly sees a psychologist.

Brian also gets his grandsons to do odd jobs with him, and spends rewarding time being the wise old owl answering questions. Hobbies are shopping and cooking, if he can remember the recipe. Work comprises helping as a volunteer at the MS Society (anyone wanting to help at the society will be most welcome. It is hard to find volunteers, and they welcome any assistance).

Brian says life is not what it was, but it's still good and rewarding. Life with MS can be a joy, no matter how small the accomplishments; he says a positive attitude, and strong family support, make all the difference.

Financial wellness and medical law seminar

SAMA Communications Department

Shivdev hosted a financial wellness and medical law seminar on 11 March, in conjunction with SAMA Eastern Highveld branch. The session aimed to provide information and insight on financial wellness and medical law to doctors and specialists.

Prof. Dilip Garach, from Garach and Garach Incorporated – Tax Solutions, and Anthea Gardner from Cartesian Capital, shared information on finance from their fields of expertise. Ulundi Bethrel, health law and ethics consultant, provided insight into the competition commission from a medical perspective.

Prof. Kapil Satyapal, a senior professor and fellow clinical anatomist/surgeon, discussed statistical and factual information regarding litigation against medical professionals, which is highly relevant to the medical fraternity at present.

Doctors travelled from as far as Lichtenberg, Limpopo, Rustenburg, Vereeniging and Carolina to attend the seminar. A large

percentage of the audience was from Pretoria, as well as the East, West, South and North Rand.

The feedback received from the attendees was favourable. A good dose of knowledge was imparted by the eminent speakers. The topics were relevant and insightful, to the extent that it made the attendees think and focus on the issues discussed that will be relevant in their own practices and personal lives.

The following are future topics requested in the feedback questionnaire:

- Sessions on finance
- Creating a profitable business environment
- Creating lean operations without compromising quality
- Personal lifestyle as well as emotional and physical wellness.

In conclusion, the seminar was successful, and delegates look forward to future seminars covering the topics above.



Alex Graham, SAMA Eastern Highveld branch



Alika Maharaj from MPS at their display at the entrance to the seminar



Guest speaker Prof. Dilip Garach received a gift from Mohini Naicker



Prof. Kapil Satyapal, one of the speakers, with Meena Mistry from Shivdev



Guest speaker Ulundi Behrtel with Meena Mistry



Mrs V Moodley, principal of Actonville Primary School, received a donation from Shivdev Training Academy with Meena Mistry and Hester Bosch from Shivdev, and Rosie Wilson (MC), marketing development manager, retail affluent at Old Mutual

Code of conduct – SAMA members

SAMA Communications Department

This is the final 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 the appeal procedure at board level and the grievance procedure for a chairperson and/or vice-chairperson.

Appeal procedure: Board

- A director whose conduct was investigated will have the right to appeal in writing, stating reasons therefor, to the full board of directors within 14 ordinary days.
- The board of directors will make its findings within a period of 4 ordinary weeks from receipt of the appeal.
- The decision of the board of directors must be in writing, stating the reasons for the decision, and will be final and binding.

Grievance procedure: Chairperson and/or vice-chairperson

- A grievance against the SAMA general manager must be raised with the chairperson or vice-chairperson. The chairperson or vice-chairperson will, within 30 ordinary days of receiving the grievance notice, either resolve the grievance

or appoint a grievance committee, or refer the grievance to the board. If the person being complained against is the chairperson, the grievance notice must be sent to the vice-chairperson, and vice versa. In the event of both the chairperson and vice-chairperson being the subject of the same or a similar complaint, the grievance notice must be forwarded to the general manager, who must ensure that it is forwarded to the rest of the board (excluding the implicated board members) without delay.

- If the chairperson or vice-chairperson resolves the grievance, they must inform the aggrieved member in writing within 7 ordinary days after the outcome.
- If the chairperson or vice-chairperson appoints a grievance committee, the committee must within 30 ordinary days resolve the grievance, and inform the aggrieved member of the outcome in writing within 7 ordinary days of its decision.
- If the chairperson or vice-chairperson refers the grievance to the board of directors, the board of directors will within 30 ordinary days after referral of the grievance resolve the grievance, or appoint a grievance

committee to hear and resolve the grievance.

- If the grievance is not resolved to the satisfaction of the aggrieved member, the member may, stating the reasons therefor, within 14 ordinary days of being informed in writing, refer the grievance to the next meeting of the SAMA national council, also in writing. At such a meeting, if any member(s) is or are conflicted or implicated on the issue, such a member must recuse him- or herself.
- A decision following the procedure by the national council will be final and binding, and minuted with the reasons therefor.

SAMA commitment

As medical practitioners, SAMA members are committed to doing what is right and honourable. SAMA members set high standards for themselves, and aspire to meet those standards in all aspects of their lives – at home and in service to their profession. This code articulates the behaviour that is mandatory in the role of SAMA members, who believe that the medical profession is shaped by the collective conduct of individual medical practitioners.

KZNCB annual conference and awards

Dr Manivasan Thandrayen

After a successful branch council re-election process, the KwaZulu-Natal Coastal Branch (KZNCB) held their annual conference, general meeting and awards ceremony at the Holiday Inn Marine Parade, Durban on 25 and 26 March 2017. Several of the previous branch councillors were re-elected, but the election did attract a few newcomers.

The members elected as branch councillors are:

Dr S Ramji – president

Dr M Mzukwa – chairman

Dr Z M Bikitsha – vice chairman

Dr M Naidoo – immediate past chairman

Dr LJ Mphatswe – secretary

Dr M Thandrayen – treasurer

Dr M J Grootboom – specialist representative

Dr A R Cassim – GP representative

Dr A Hussain – EDC representative

Dr Y Baldeo – councillor

Dr Z A Gilani – councillor

Dr I Govender – councillor

Dr IC Maise – councillor

Dr A Chetty – immediate past president

The conference was attended by public and private sector doctors under the theme "Is SA ready for an integrated primary healthcare system?" The keynote speakers on the first day

of the conference focused on the National Health Insurance (NHI), and gave a current situation analysis of healthcare in the KZN province.

Dr S T Mtshali, the head of KZN – health, gave a detailed assessment of the challenges, and mentioned that solutions were limited due to financial constraints. Dr A Coovadia, a health economist, provided historical and international perspectives on healthcare delivery systems and made suggestions on how best to implement the NHI. She highlighted the 10 most successful national healthcare initiatives in the world.

Day 2 focused on how technology can be used to improve healthcare delivery.

Dr V Nhlapo provided input based on the experience of Discovery Health, and made suggestions on how some of the new technologies may be included in the NHI rollout in order to improve patient outcomes.

KZN's world-renowned sexual health expert, Dr P Ramlachan, shed light on the sensitive subject of erectile dysfunction. He presented an informative and practical educational session with great humour and advice. Other speakers included Dr A Hussain, Dr Y Baldeo, Dr A Chetty and Dr N Singh.

The gala dinner was a grand affair, with a special thanks to sponsorship from Medis, Smart Medical Solutions, PPS and Lancet Laboratories. The following branch members were honoured with the following awards:

SAMA KZN CB Leadership Award – Dr Mergan Naidoo, who during his tenure as branch chair managed to serve as a national councillor, became a member of the board of directors of SAMA after taking over as the chair of the Education, Science and Technology Committee of SAMA and successfully leading the national SAMA conference in 2016. He also completed his PhD and published several papers.



From left: Dr M Mzukwa, Dr Z M Bikitsha, Dr M Thandrayen, Dr Y Baldeo, Dr A Chetty, Dr A Hussain, Dr M J Grootboom, Dr N Singh and Dr M Naidoo

SAMA KZN CB Young Leaders Award – Dr E Ati, who in the last 4 years has demonstrated committed leadership to his peers by being elected as the chairperson of the SARA, after serving successfully as the JUDASA secretary general and representing junior doctors at senate level at UKZN, CMSA, HPCSA and SAMA national council. He was also elected as a member of the Constitutional Matters Committee and vice chairperson of the Human Rights, Law and Ethics Committee.

SAMA KZN CB Loyalty Award – Dr M Thandrayen, for his dedication to the branch and its members. He has attended

all the branch council meetings in the last 4 years, running the office's financial and administrative tasks, attending to member queries in the public and private sector on a voluntary basis and sometimes travelling long distances to attend to members' problems.

The event ended with speeches by the outgoing chairman, the new chairman and the president. It was observed as a celebration of the previous branch councillors' hard work and the administrative support of Mrs F Khan. The event was enjoyed by all that attended from the various regions of KZN.

Goldfields elects new branch council

Congratulations to the following newly elected branch council at SAMA OFS Goldfields branch in Welkom:

Chairperson: **Dr P W Nieuwoudt**

Treasurer: **Dr D J Botes**

Secretary: **Dr T P Taute**

Representative specialists: **Dr J P Spangenberg**

Representative GPs: **Dr P R Daniel**

Representative labour relations: **Dr P S Janse van Rensburg**

Representative for CPD: **Dr P W Nieuwoudt**

The branch would also like to draw members' attention to the fact that Lifeline Free State offers the following services free of charge:

Kopano Building, Welkom:

- HIV-counselling and -testing services (HCT)
- Trauma debriefing and crisis counselling from 08h00 to 16h00 weekdays.
- Round table, 204 Community Centre, 127 Koppie Alleen Road, Jan Cilliers Park, Welkom
- Chronic-medicine pick-up point from 08h00 to 16h00 weekdays.

Creating awareness in Welkom

The SAMA OFS Goldfields branch recently supported a community-outreach awareness campaign for children with special educational needs arranged in Welkom for April 2017. An amount of R5 000 was sponsored to a local publication, *EntooZ*, to publish an article to make the Goldfields community aware of the needs of these children.

Statistics show that the number of children with special educational needs is growing

daily, from ADHD, Asperger's syndrome and autism through to dyslexia and hearing, sight and speech problems. These children need support, acknowledgement of their being "different" and acceptance of many of their difficulties.

This campaign is to make the community aware that these children can thrive in mainstream education, with support from the various professionals who provide therapeutic programmes especially suited to their needs.

Safety at Lowveld branch

The Lowveld branch has been dealing with a number of safety issues recently, including one of their doctors being held up in an armed robbery at Mapulaneng last month.

Health workers looking for jobs have also been warned to be on the lookout for a jobs-for-cash scam in Lydenburg, Mpumalanga. A qualified nurse who had been unemployed for two years thought he had had a stroke of luck when he received a call for a job

interview hours after he had applied for a post advertised online. He travelled almost 150 km to the interview at Lydenburg Hospital, only to find that he was one of several people who had fallen for a scam by an alleged jobs-for-cash syndicate. The scam offers jobs at public hospitals using the Department of Health logo. The scammer could not be traced as the SIM card was not registered. Amounts of R800 - R1 500 had been requested to secure the jobs.

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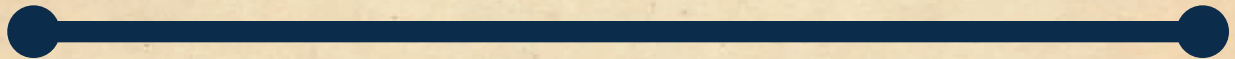
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