

SAMA INSIDER

APRIL 2018

Unpacking global fees

Healing innovatively –
lessons from young
South Africans



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

**SOUTH AFRICAN
MEDICAL ASSOCIATION**

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APRIL 2018



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Diane de Kock
Editor: *SAMA INSIDER*

Let's keep communicating

This month our focus is on keeping you, our readers, informed about the resources available to you as members of SAMA.

On page 5, newly appointed SAMA general manager, Dr Manivasan Thandrayen, looks at what SAMA does for you. "The answer depends largely on one's commitment to the profession, and one's influence on decision-making."

On pages 6 - 8, SAMA's Dr Selaelo Mametja, Shelley McGee and Wendy Massaingaie unpack the topical and important subject of global fees, from both informative and ethical perspectives. "Rules that offer protection to society must be upheld and reinforced, and those that impair innovative healthcare delivery must be revised."

The SAMA Knowledge Management and Research Department is in the process of creating a CV database of experts to assist with various projects. If this is of interest to you, please see the article on page 13.

JUDASA have recently updated their publication *Internship Survival Guide* to assist junior doctor members of SAMA in adapting to the workplace, an essential read for interns who "run the risk of misuse in the workplace", says Dr Jawitz.

Also on page 14, members are reminded of the new HPCSA annual fees, which are due and payable with effect from 1 April 2018.

Dynamic Rhodes scholar, Dr Farah Jawitz, reminds us on page 15 of the importance of nurturing our young leaders: "The onus falls on all of us to identify and mentor them, so that they may become the voice of change in future."

After years of hard work, Dr Ayodele Aina reports on page 17 that the Vaal River branch has been relaunched. "The spirit of teamwork came into play," says Dr Aina. "In July 2017, the branch acquired a centrally located office space."

Keletso Makwe, SAMA's industrial relations advisor, on page 18 encourages members to report unfair dismissals or labour practices, and assures them that they will receive the support and assistance they need.

This issue reflects the wide body of knowledge and expertise available to SAMA members – let's keep communicating!

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A woman's point of view



Dr Marina Xaba-Mokoena, SAMA president

When I was in the UK, on a bursary to study medicine, I tried to gain entrance to their medical schools, but was told that they generally limited the proportion of female students to 10% of the intake, because upon qualification they usually married, had children and worked part-time only, while the country was in dire need of doctors. Eventually, instead, I was admitted to Stockholm University as I had a Swedish International Development Authority scholarship, although that meant that I had to learn the Swedish language first.

In Sweden, in contrast to the UK, I realised that there were more women in our classes than men, because the system was designed to support them. Even when one had completed one's studies, one's children had places in "day homes", as they called crèches, either at the hospital or nearby, so that one could even go and breastfeed them. Dropping off and fetching one's child was made easy. Fathers could also take paternity leave.

Returning to SA, upon reaching the then-Transkei, I discovered that married women were not allowed to join the pension system, which hit many females hard when they either retired or became widowed, aged about 55 and up. This was unexplainable, and also seemed completely unfair to me.

Partly out of my response to these experiences, I am now a patron of the Medical Women Association of South Africa (MWASA), which was officially launched at the Birchwood Hotel, Gauteng, on 22 November 2014.

MWASA background

On International Women's Day in March 2014, Dr Gwen Ramakgopa, the then Deputy

Minister of Health, convened a consultative meeting with 44 women doctors from across various backgrounds on the need to establish a women medical doctors' association in SA. The call for this meeting was prompted by requests from representatives from other African countries who already had such associations in their respective countries. There was a general desire to create a regional platform affiliated with the international body, the Medical Women's International Association (MWIA).

The meeting was chaired by Dr Nono Simelela, the first black woman to qualify as an obstetrician and gynaecologist in SA. There were also a number of prominent medical women in attendance, including Dr Phophi Ramathovha, the then-chairperson of SAMA and now health MEC in Limpopo, Dr Sibongile Dlamini, the KZN provincial head of the Department of Health, Dr Thula Ngcobo, the first black woman to qualify as a general surgeon in SA, Dr Carol Benn, a specialist in breast cancer, and other women doctors from government and the corporate sector, both specialists and GPs, as well as female medical students. As the outcome of this meeting, the MWASA launch date was set for 22 - 23 November 2014.

The association had a successful launch summit, with full support from the Minister of Health, Dr Aaron Motsoaledi, and Minister of Women, Ms Susan Shabangu. This launch summit included representatives of all races, from all nine provinces in SA, including woman medical students. Dr Motsoaledi gave a compelling keynote address challenging the association to link their activities with the issues he highlighted in his speech, and implored the association to contribute towards the implementation of these strategies. These included the National Strategic Plan, the National Development Plan vision, National Health Insurance and managing the quadruple burden of disease. The outcome of the summit was the following **MWASA Declaration** adopted by the association:

"As the Medical Women's Association of South Africa (MWASA), we declare [our intention to do] the following:

1. To be a non-racial, non-partisan and women-based medical organisation.
2. To implement the resolutions taken by the first MWASA summit, including those that will be undertaken by the MWASA board.

3. To create mentoring initiatives that enhance the potential of medical women and those aspiring to join the profession.

4. To ensure a continued increase in the enrolment of women into the medical profession.

5. To endorse the principles of collectivism and strategic partnerships.

6. To support the agenda and initiatives of the National Department of Health.

7. To promote unity within the medical profession and strengthen the voice of woman doctors.

We affirm our tenacity [and] our ability to tackle a wide variety of tasks and challenges, and we stand ready to use all our skills, our knowledge, our gifts and our collective energy."

MWASA is comprised of women doctors of all ages and races, and in all the different specialties of medicine (including dentists), as well as medical students from their first year of study on.

Since the launch of the association, the different provincial chapters have engaged in trying to recruit woman doctors as members, and carried out various activities on a small scale in their respective provinces. There has, nevertheless, only been a small amount of growth in the membership of the association: hence I felt the need to write about it, for the benefit of *all* woman doctors. A planned summit on 10 - 12 August will be utilised to draw in more female doctors to actively manage key community issues at the national and local levels. The theme for the upcoming summit is the Life Esidimeni happenings, and the outcomes for the mental-health patients who were attached to it. The association plans not only to raise awareness around mental health, but also to group the woman doctors as traditional community carers, to make plans for actions that will help to avoid similar incidents happening in the future. This plan is in keeping with the theme set by the MWIA for the 2016 - 2019 triennium: "Medical women – ambassadors of change".

Again in line with the MWIA, MWASA has a chapter of young doctors in training, "young MWASA", whose objective is to offer support and mentorship to female students. MWASA also has patrons, who are mature doctors. The objective is that they should impart wisdom and direction. It is my objective and wish that woman doctors in our country should join and enrich the organisation, and share their knowledge, wisdom and expertise.

What does SAMA do for me?

Dr Manivasan Thandrayen, general manager, SAMA



Since taking up the post of general manager of SAMA, of paramount importance to me is answering the question on most doctors' minds: How do we ensure that SAMA delivers on its vision of being the representative association for the SA medical profession, and its mission of empowering doctors to bring health to the nation?

The difficulty in responding to this is due to individuals having varying needs. The core of SAMA's existence is based not on private or public sector needs, but on the professional nature of the association.

The following activities are required of such a professional organisation:

- **Issue a code of conduct to guide professional behaviour.** If a member has erred in any way, the profession needs to ensure corrective behaviour.
- **Safeguard the profession's autonomy, and articulate standards.** This requires

SAMA to take care that the profession is not corporatised or dictated to by medical aids and government. SAMA actively engages in policy-making processes to ensure that patients are maximally protected, and that the voice of the profession is included in policy debates. Such engagement processes include, but are not limited to, prescribed minimum benefit reviews, National Health Insurance and input into legislative calls for comments. Whenever possible, SAMA tries to interrogate all health-related policies, ensuring quality healthcare and thus playing an advocacy role.

- **Deal with complaints against professionals.** The ethics committees need to be revived to deal with both the private and public sectors.
- **Provide support for CPD** via learning opportunities and tools for recording and planning. The creation of the Foundation for Professional Development (FPD), and the support of branches and societies, have addressed this need.
- **Publish professional journals or magazines.** The highly subsidised *SA Medical Journal (SAMJ)* is an opportunity for researchers to impart their knowledge to other professionals.
- **Provide networks for professionals** to meet and discuss their different fields of expertise. Although many societies and special-interest groups exist, in the ever-changing technological world, a more appropriate solution is needed.

- **Enable fairer access to the profession,** so that people from all backgrounds can become professionals.
- **Provide career support and opportunities** for students, graduates and people already working. The Education, Science and Technology Committee and the Bursary Committee serve this purpose.

I believe SAMA has delivered on most of these levels, although it is a work in progress.

Individuals also join SAMA for reasons relating not only to the professional aspect, but for added benefits such as help with labour relations for employed doctors, public relations and advice and protection against unwarranted litigation on doctors in the private sector. A minority of doctors join for the benefits of discounts on goods and services through our network of service providers.

So has SAMA delivered?

Goods and services discounts can actually ensure that your subscriptions are paid for. The table below shows some of the potential savings, illustrating how paying the subscription can be profitable.

The SAMA Labour Relations Department deals with complaints, grievances, disciplinary processes and collective bargaining at various levels. SAMA is recognised by the National Department of Health as a formidable force, since it is the country's trade union and professional medical body with the largest number of doctors.

Potential savings from member discounts

Company	Product	Discount, %	Discount, ZAR	Savings, ZAR
AA	Advantage Roadside Assistance Package principal member	12.5	1 115	139.37/year
AA	Advantage Plus Roadside Assistance principal member	12.5	1 895	236.87/year
Alexander Forbes	Home and household insurance premium	20	5 247	1 032/year
APLS	Two-day Advanced Paediatric Life Support course	10	5 000	500
Barloworld	New Polo 1.00 Comfortline Tsi -AW13LV	7	248 189	18 529
BMW	BMW 118I A/T (including extras)	19	505 000	100 000
DLT Media	Custom pack of 8 magazines	10	310	31 00
Ford	Fiesta 1.0 Ecoboost Trend MT	5	100 785	10 785
Hertz	Mercedes C180	49	979/day	474
Kia	Picanto 1.0LS Man	5	114 030.70	5 701.53
Mini	Mini Cooper S 3 Door A/T price including extras	12	490 000	85 500
Tempest Car Hire	Kia Rio	80	400/day	179
Tracetec	Tracetec Recovery Unit	20	1 499	300/year
Inter Africa	Foreign exchange commission: USD10 000 (most places charge 2% - 3%)	1.75	124 440	311 - 1 550

The gains that occupational-specific dispensation achieved, which were 16% - 96% increases in remuneration for public sector doctors, were due to a collective approach by SAMA members, specifically using remuneration studies to assist in negotiations, which none of the others unions undertook.

Working conditions in the public sector, however, have not improved. In fact, these have worsened. Are working conditions SAMA's duty to police? Yes. Trade unions and professional organisations are obliged to monitor and advocate for change, but this requires a collective approach to convince the government to comply. It also requires getting our members not to abdicate their responsibilities, when in management

positions and during consultations for referral of patients.

Private sector autonomy is currently threatened by corporate intrusion. Medical aids, with their desktop doctors and clinician experts, dictate unreasonable terms to doctors, which at times force underservicing, as patients are unable to afford co-payments, so that altruistic behaviour can result in an increase in the cost of healthcare.

SAMA has spent millions of rands on litigation to defend the noble profession to ensure it retains its autonomy, and it is in the interests of doctors to unite to fight against meddling corporates.

Apartheid taught us that a divided nation is a conquered nation. Similarly, a

divided profession is a profession ready to be consumed by short-sighted government and private sector minions climbing the corporate ladder.

So the answer to "What does SAMA do for me?" depends largely on one's commitment to the profession, and one's influence on decision-making. It is therefore critical to choose your leaders wisely, so that professionalism emerges as a uniting force, and changes are achieved from within the structures.

To further understand your needs, we are considering issuing a survey on how SAMA can improve its output to you. The information we glean from this will be crucial to our operations in the future, and I urge you to please participate in it.

Unpacking global fees

Dr Selaelo Mametja, Shelley McGee, SAMA Knowledge Management and Research Department

The notion of global or bundled fees has been around for a long time, but the issue has really come to a head in the last few years in SA. Several specialist groups have been in discussions with medical scheme administrators regarding the application of global fees to certain procedures and patient groups. Two concerned specialist groups approached the HPCSA for an opinion on whether it would be acceptable for healthcare professionals to participate in the proposed global fee arrangements, given the provisions of its ethical rules.

The HPCSA acted in April 2017 to urge practitioners not to sign contracts and agreements that could be in violation of the ethical rules. At around the same time, the SAMA Governance and Legal Department provided a similar opinion – that participating in global fees arrangements might result in a contravention of the rules.

Global fees were discussed conceptually in the context of global fee structures, where teams of health professionals treat patients who are members of certain funders, and an agreement dictates a **single lump sum fee** that covers the costs of all treatment for the patient, including the costs of, for example, hospitals, doctors, physiotherapists and pharmaceutical care.

This article is intended to explain the various reimbursement mechanisms, what

they are, how they are being implemented in the country and their unintended consequences.

Reimbursement mechanisms

Fee-for-service (FFS): Services are unbundled and paid for separately. This payment model has been in place in the SA private sector for some time. Despite its limitations, FFS is useful in increasing access and productivity, and attracting and retaining healthcare professionals is a priority. Unfortunately, it tends to incentivise overservicing, placing a payment burden on users and increasing the costs of healthcare.

Capitation agreement: A fixed capitation amount is paid per month to the healthcare professional or establishment for each patient a scheme covers. Members must select their preferred healthcare professional. This model can contain costs, and is best suited to primary healthcare in a well-managed health establishment where there is a fair competition. It can, however, result in underservicing, so it is imperative to monitor the quality of healthcare. It has been noticed in some countries that pure capitation does not work, and needs to be coupled with some FFS to encourage additional medical care where necessary and appropriate. However, this is costly.

In order to determine the correct capitation amount, reliable data is required, such as member demographics and overall disease prevalence and severity. The UK, Canada and Australia include socioeconomic measures in determining capitation amounts. It is difficult to engage appropriately without data. A lack of appropriate risk-adjustment would have negative implications for doctors who serve a very sick population.

The issue of global fees has really come to a head in the last few years in SA

Currently in SA, each scheme usually unilaterally determines the capitation amount and the price of capitation contracts. These arrangements may or may not cover all actual healthcare costs. Some capitation agreements do not include services such as procedures, or medication for dispensing practices. When a shortfall in healthcare coverage occurs, doctors are often not permitted by the scheme to balance the bill. Inadequate capitation amounts increase the risk of underservicing, violating the ethical rules.

Case-based global fees: A global fee is paid to an establishment or health professional

for the care of a particular event, e.g. a joint replacement. This fixed amount is paid to the healthcare provider for a particular condition's treatment, laboratory work, imaging and rehabilitation. Risk-based global fees have been proposed; however, clinicians do not have adequate data to assess the risks, and schemes may want to transfer risks to doctors. While global fees may be the ideal, it is important to really address disease coverage and unintended consequences.

Global budget: Budgets are allocated to a healthcare establishment for delivery of services. The SA government health system uses global budgeting, where budgets are allocated to facilities at provincial level. Services are provided within budgetary constraints. Unfortunately, fixed budgets, if poorly managed, can result in poor resource allocation, which can lead to healthcare-provision rationing.

Transitioning from FFS is seen as a solution for effective healthcare delivery in SA. However, FFS is not the only cause of ineffective service delivery. There are multiple factors at play, and the success of any alternative reimbursement mechanism is dependent on how we fix these issues.

Understanding the healthcare delivery platform in SA

Medical scheme members contribute a certain amount, and ideally select a plan option that meets their needs. Regardless of option type, all medical schemes are to provide for prescribed minimum benefits (PMBs). The Medical Schemes Act No. 131 of 1998 allows schemes to use managed care interventions such as scheme formularies, protocols, authorisation processes, designated service providers (DSPs) and selected disease coverage. Limitations on disease coverage, scheme formularies and managed care protocols need to be developed taking into consideration evidence-based medicine principles, cost-effectiveness and affordability.

Tensions arise when, for various reasons, members cannot access appropriate healthcare, including PMBs. Frequently, the reason is that a patient's plan type does not cover a particular clinical intervention, even when this is determined by clinical guidelines or standards of care. Medical schemes make funding decisions, not healthcare decisions. When scheme-funding decisions deviate from what healthcare practitioners consider the standard of care, quality of care suffers, complication rates may be higher and eventually higher

level, costly interventions or unavoidable hospitalisation may be required. The Council for Medical Schemes (CMS) and Health Quality Assessment (HQA) collect quality-of-care data from managed care organisations and medical schemes. Their results have shown an overall low quality of care within medical scheme populations, the underlying causes of which have yet to be investigated.

Rules that offer protection to society must be upheld and reinforced, and those that impair innovative healthcare delivery must be revised

While there are challenges with FFS, the problem is not necessarily the reimbursement mechanism only, but also the failure of the current payment system (FFS coupled with managed care arrangements) to adequately ensure efficient, appropriate and necessary healthcare coverage. This is compounded by the failure to review and update PMB regulations on a regular basis. The current mode of delivery focuses more on costs of healthcare and containment than quality of care.

Desired alternative reimbursement mechanisms

Moving from FFS to an alternative reimbursement mechanism (ARM) requires innovative thinking on healthcare coverage. ARMs can be successful when there is an expansion of coverage to currently unfunded elements of care, and a reduction in unnecessary expenditure.

Medical schemes often ration necessary elements of healthcare, such as radiology, laboratory work and medicines. When such elements are not funded, doctors cannot improve quality of care. Factors necessary for a successful ARM are:

- **Adjustment of risks.** A capitated or global fee service should not only look at the standards of care for the overall membership, but also adjust for differences in demographics and comorbidities, to ensure that doctors who

serve high-risk populations have access to the necessary resources to enable them to provide good quality of care.

- **Standards of care defined by healthcare professionals.** These should be in accordance with evidence-based principles, and medical schemes should not unilaterally decide on formularies and protocols, including fees. Health professionals must take the lead in defining standards of care. Should there be requirements to limit coverage of particular interventions due to unaffordability, this should be demonstrated in a transparent manner. Doctors engaging in risk-transfer arrangements need to be aware of risk transfers due to unfunded healthcare.
- **Integrated practice units/group practices/multidiscipline practices.** Global fee payments require integrated care. This immediately benefits beneficiaries as they do not have to navigate a complex healthcare system. However, doctors and other health professionals must be aware of possible violations of the ethical rules, particularly when global fee arrangements result in underservicing or sharing of fees (which are specifically prohibited in the ethical rules).
- **Systematic outcomes measurements.** Health outcomes, including process indicators, should be measured in a transparent manner, using standards of care as the basis for process outcomes. Some medical schemes use poor indicators to define quality. Currently, schemes do not share claims data openly. HQA and CMS collect data to assess quality of care, and on average, only a third of chronic patients have claims related to the care required. Any form of ARM requires honest interrogation of the poor quality of results in the private sector. Is it the result of e.g. schemes refusing to fund necessary care, members not attending to their care, or doctors not requesting required pathology tests?
- **Systematic cost measurement and reporting.** Hospitals, professionals, managed care organisations and administrators must be open about their costs, showing transparent measures of such costs. Note that we are starting from very high base administration and managed care costs. ARMs require efficient administrative and managed healthcare processes, and the means to assess performance in terms of member satisfaction and access to benefits. Current inefficiencies in the system have the potential to undermine any attempts to introduce ARMs.
- **A balance between cost saving and fair remuneration.** Implementation of an ARM should not seek to reduce remuneration

of healthcare professionals through forced arbitrary discounts from FFS arrangements. Doctors must ensure that they are fairly remunerated, maintain their evidence-based clinical autonomy and are not influenced to underservice patients.

- **Cost-neutral administration.** The implementation of an ARM has the potential to increase administration costs through third-party players who are contracted to disburse global fees. The risk-determination process must be transparent, and doctors must familiarise themselves with possible risks and their magnitude before entering into a risk-transfer arrangement. Doctors should not accept responsibility for costs incurred for care that is unrelated to the specific medical condition covered by the global

fee, or complications arising from poorly designed managed care interventions.

- **All elements of care included.** All costs of treating patients with the necessary standard of care should be inclusive. The shifting of costs to patients is a barrier to accessing healthcare.
- **Cohesive regulations.** A successful ARM needs cohesive and patient-centric regulation.

CMS must continue regulating medical schemes to ensure that they offer evidence-based interventions, co-ordinate quality of care and implement regulatory interventions, and that the selection of DSPs is not based on arbitrary measures. CMS must look closely at administration

costs, as ARMs have attracted other middle players who need to be reimbursed, which can increase such costs at the expense of clinical care. Furthermore, decisions need to be made on how these middle players will be regulated. Inequities generated by option plans must also be carefully considered. The stratification of an ARM by option type will exacerbate inequities.

The HPCSA needs to consider a revision of the ethical rules, bearing in mind that all reimbursement mechanisms have the potential to violate the rules. Those rules that offer protection to society must be upheld and reinforced, and those that impair innovative healthcare delivery must be revised, ensuring at all times that basic protective ethical rules are not compromised.

Ethical implications of global fees

Wendy Massaingaie, legal advisor, SAMA Governance and Legal Department

This article deals with the media statement released by the HPCSA on 13 April 2017. The statement called for medical practitioners to refrain from entering into any global fees agreement, where a single payment is made to a healthcare team to cover all costs including hospitals, either monthly, or for a defined episode of care such as hip surgery. The article focuses on whether medical practitioners should comply with the media statement.

Information obtained

In the *Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act [No. 56 of] 1974*, rule 7 of the act deals with fees and commission, and states the following:

"7. Fees and commission

(3) A practitioner shall not offer or accept any payment, benefit or material consideration (monetary or otherwise) which is calculated to induce him or her to act or not to act in a particular way not scientifically, professionally or medically indicated or to underservice, overservice or overcharge patients.

(4) A practitioner shall not share fees with any person or with another practitioner who has not taken a commensurate part in the services for which such fees are charged.

(5) A practitioner shall not charge or receive fees for services not personally

rendered, except for services rendered by another practitioner in his or her employment or with whom he or she is associated as a partner, shareholder or *locum tenens*."

From the above, it is clear that a global fees agreement will result in the sharing of fees, which is prohibited under the ethical rules. This may also lead to a situation where medical practitioners overservice their patients in order recoup more fees in accordance with the agreement.

Global fee agreements are not in line with the HPCSA ethical rules

Booklet 1

Clause 2.3.2 of booklet 1 (*General Ethical Guidelines for the Health Care Professions: Guidelines for Good Practice in the Health Care Professions*) is concerned with the medical practitioner's duty to ensure that the patients' best interests are met. It reads as follows:

"Best interests or wellbeing – non-maleficence: Healthcare practitioners should not harm or act against the best

interests of patients, even when the interests of the latter conflict with their own self-interest."

Medical practitioners are tasked with the ethical responsibility of safeguarding the patient's wellbeing and best interest. The global fees agreements may place this responsibility in jeopardy.

Booklet 5

Clause 2.9 of booklet 5 (*Guidelines for Good Practice in the Health Care Professions: Guidelines on Overservicing, Perverse Incentives and Related Matters*) addresses perverse incentives. It states the following:

"'Improper financial gain or other valuable consideration' means money, or any other form of compensation, payment, reward or benefit which is not legally due or which is given on the understanding, whether express, implied or tacit, that the recipient will engage or refrain from engaging in certain behaviour ... which is either:

- illegal; and/or
- **contrary to ethical or professional rules;** and/or
- **which, in the opinion of the HPCSA, may adversely affect the interests of a patient or group of patients.**" [emphasis added].

Clause 2.14 deals with overservicing, and reads as follows:

“Overservicing means the supply, provision, administration, use or prescription of any treatment or care (including diagnostic and other testing, medicines and medical devices) which is medically and clinically not indicated, unnecessary or inappropriate under the circumstances or which is not in accordance with the recognised treatment protocols and procedures, without due regard to both the financial and health interests of the patient.”

In addition to the above, clause 3.1 discusses overservicing in more detail, and states the following:

“Healthcare practitioners shall not:

3.1.1 Provide a service or perform or direct certain procedures to be performed on a patient that are neither indicated nor scientific or have been shown to be ineffective, harmful or inappropriate through evidence-based review.

3.1.2 Refer a patient to another healthcare practitioner for a service or a procedure that is neither indicated nor scientific or has

been shown to be ineffective, harmful or inappropriate through evidence-based review.”

With regards to contracts, clause 3.12 provides as follows:

“Healthcare practitioners shall not enter into a contract to work in a particular health establishment or service on the understanding that the healthcare professional generates a particular amount of revenue for such health establishment or service.”

Therefore, as previously stated, global fee agreements are not in line with the HPCSA ethical rules, and as such, are not permissible. Medical practitioners are tasked with protecting the doctor-patient relationship and treating patients accordingly, without doing anything that could be construed as taking advantage of them. Furthermore, it is clear that medical practitioners cannot enter into contracts with people or entities not registered under the *Ethical Rules of Conduct*, and to do so would result in an undesirable corporate ownership.

The global fee agreements should be fully examined to ensure that they do not amount to undesirable corporate ownership.

As it currently stands, global fee agreements are in conflict with the ethical rules, and entering into such would entitle the HPCSA to impose any sanctions under the *Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act*.

Recommendations

- Medical practitioners should not enter into global fee agreements, as doing so would be in contravention of the HPCSA's ethical rules.
- Clear guidelines should be developed by the HPCSA regarding global fee agreements.
- The HPCSA, as well as relevant stakeholders, should be engaged to find a solution to this problem.
- All medical practitioners should be made aware of the dangers of entering into global fee agreements.

The Life Esidimeni tragedy: Constitutional oath betrayed

Prof. A Dhai, director, Steve Biko Centre for Bioethics

From the second paragraph, this is a reprint of Ames Dhai's editorial that appeared in the December 2017 issue of the South African Journal of Bioethics and Law (SAJBL). Reprinted with permission.



Prof. Ames Dhai, PhD, MB ChB, FCOG, LLM, PGDip IntResEthics

Outrageous ethical transgressions were brought to light during the recent Life Esidimeni (LE) tragedy arbitration, and the health ombud's report on the matter. Also highlighted were the unstinting efforts by many others to prevent the predicted disaster. The head of department, the director of mental health services, and the overall head and MEC in the Gauteng Department of Health unfortunately ignored their endeavours. Healthcare professionals pledge upon graduation to ensure they uphold the best interests of patients and respect their human rights. Executive council officials undertake similar promises as well.

As a member of a provincial executive council, Q D Mahlangu was required to take an oath (or solemn affirmation) in line with

schedule 2, section 5 of the Constitution of the Republic of SA when sworn in. The Constitutional requirements are as follows:

“Oath or solemn affirmation of Premiers, Acting Premiers and members of provincial Executive Councils:

The Premier or Acting Premier of a province, and each member of the Executive Council of a province, before the President of the Constitutional Court or a judge designated by the President of the Constitutional Court, must swear/affirm as follows:

I, A.B. swear/solemnly affirm that I will be faithful to the Republic of South Africa and will obey, respect and uphold the Constitution and all other law of the Republic; and I undertake to hold my office as Premier/Acting Premier/ member of the Executive Council of the



province of C.D. with honor and dignity; to be a true and faithful counsellor; not to divulge directly or indirectly any secret matter entrusted to me; and to perform the functions of my office conscientiously and to the best of my ability."

According to the ombud's report, the MEC was not aware of the total number of patients who had died in a project that she had authorised during the "conscientious" performance of a function of her office. While she indicated in an interview with the ombud during the enquiry that he headed into the LE tragedy that the decision was a collective one, and not hers individually, and that there were no dissenting views in their meetings, she is alleged by many to have said that "her decision is final and non-negotiable and the project had to be done", and that she left no room for "engagement". Staff members felt powerless, and had to deliver to her the outcome of a project they did not believe in – a cost reduction from ZAR320/day in LE, to ZARR112/day at the non-governmental organisations to which the patients were sent. He goes on to state that there was a general culture of fear and disempowerment among staff that hampered them from challenging or engaging with authority. There was an overwhelming revelation of feelings of frustration, which came from across all sectors of the department below the director's level, during oral evidence gathered in the enquiry.

The MEC was bound by the oath she took when sworn in as a public servant at the level of the provincial executive council to ensure

the realisation of the Constitutional promises to the patients and families in the LE tragedy. Moreover, she was also bound to function conscientiously and with honor and dignity, i.e. the worth and value felt by and bestowed on persons. By not abiding by this oath, not only did she wrong the patients and families, but she also disgraced her office and brought it into disrepute. She abused the power of her office and used it to mete out a "reign of terror" similar to that of a repressive state, resulting in moral distress for staff members who powerlessly tried to deliver to her the outcome of a project they did not believe in. Furthermore, instead of humanitarian considerations, the project focused on narrow economic ones.

Of note is that, during the interview, the MEC stated that "when a policy decision is taken, you don't know how it will unfold and what is going to happen ... the risks associated with it." Implementing a policy decision without having any idea of its feasibility and "how it would unfold" contradicts the Ekurhuleni Declaration on Mental Health of April 2012, where a commitment was made that all users of mental-health services would participate in the planning, implementation, monitoring and evaluation of mental-health services and programmes. With proper planning that included all stakeholders, and assessing whether the policy was operationally and administratively feasible, possibly by a pilot, the tragedy could have been averted. The declaration also commits

to physical infrastructure that is conducive to the needs and human rights of people with mental disorders and disabilities. As MEC, the ultimate responsibility resided with her – she did not ensure that their accommodation needs were provided for and that their human rights were respected. Providing equitable, cost-effective and *evidence-based* interventions is an additional commitment of the declaration. Deinstitutionalising patients into the community was an intervention in mental healthcare – however, when implemented, it was not evidence based.

Because the deinstitutionalising intervention was not evidence based, and because of her statement on not knowing how a policy decision could unfold, the Gauteng Mental Health Marathon Project (GMMP; its official title) can be likened to an experiment. One of the definitions of experiment is "a course of action tentatively adopted without being sure of its outcome". Therefore, the GMMP could be perceived as one massive experiment that included highly vulnerable subjects who, because of this vulnerability being exploited, suffered serious harms and wrongs. The entire project, with patients being herded and taken to "concentration camps", as described by their families, and subjected to cruel, degrading and inhumane conditions, is a distressing reminder of Hitler's Nazi war atrocities, where the vulnerable were considered to be subhuman, of decreased intelligence, of no moral status and lacking human dignity – and hence exploitable.

What is highlighted in this tragedy is the political appointment of a member of the provincial executive to run the provincial Department of Health who either did not understand or chose to ignore the Constitutional oath she took when sworn in. She ran her department in a similar fashion to an authoritarian leader in a repressive state, and betrayed that oath. Furthermore, she was not trained as a healthcare professional, and therefore had limited to no understanding of why health professionals feel such a grave calling, and why they must abide by a much higher level of professionalism than those in other careers. Political appointments, without any consideration of competence, fail our patients and fail our country, and result in politics determining the ethics of healthcare – a moral pathology that must be eradicated for the ethical crisis that we find ourselves in to be comprehensively addressed.

References are available on request.

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MEMBER BENEFITS

Staying healthy – building resilience and avoiding burnout

Dr Suzy Jordache, senior medical educator at the Medical Protection Society

Rates of burnout within the medical profession are significant. Studies from across the world quote rates of 12 - 80%, depending on the dimension of burnout studied. Prevalence varies according to specialty, gender, age or career stage and practice setting.

The impact this has on physician wellbeing, patient safety and patient satisfaction is now a recognised challenge for all who work in healthcare.

SA is no different. Doctors work long hours in a high-pressure, overburdened healthcare system, and the ability to retain doctors has long been a challenge. Their determination and dedication to meet the demand and fulfil personal and patient expectations can lead individuals into a very unhealthy relationship with work, which spills over into family life and personal health. As Prof. David Peters, Head of the Centre for Resilience in the UK, states: “Long term drowning in high levels of adrenaline and cortisol eventually makes you ill. But before that, it makes you stupid and unfriendly.”

Litigation and complaints are often seen to arise against the background of a burnt-

out, unhealthy doctor – diagnoses are missed, errors occur and patients and families experience unempathic, dismissive care.

What exactly is burnout?

Burnout is an occupational hazard. The well-recognised Maslach Burnout Inventory (MBI) proposes three dimensions:

- Emotional exhaustion (EE)
- Depersonalisation – a cynical attitude with distancing behaviours (DP)
- Low sense of personal accomplishment (PA).

In 2013, a cross-sectional study by Rousseau collected data from doctors across 27 facilities in the Cape Town Metropolitan Municipality community healthcare clinics and district hospitals of the provincial government of the Western Cape. Of 132 doctors included in the analysis, 76% had experienced burnout, as indicated by high scores in either the EE or DP subscales. The high number of hours, heavy workload, poor working conditions and system-related frustrations were ranked as the most important contributing factors to burnout. More experienced doctors had lower levels of burnout, as evidenced by their

lower scores in the EE and DP domains of the MBI.

Burnout reflects an uneasy relationship between people and their work. Avoiding burnout is about building the opposite of burnout – engagement. Christina Maslach and Michael Leiter propose that “When burnout is counteracted by engagement, exhaustion is replaced by enthusiasm, bitterness by compassion and anxiety with efficacy.”

What can be done to avoid or reverse burnout?

Avoiding or reversing burnout and building resilience requires careful attention to developing good individual coping strategies in the workplace. Organisational policies and procedures must ensure that these coping strategies are respected and enforced.

For healthcare workers, evidence suggests that this requires focus on physical and emotional wellbeing, and ensuring that a sense of calling is not eroded.

- **Physical wellbeing:** Developing rituals and routines that promote regular healthy

Individual strategy	Organisational support
Physical wellbeing • Eat regular, healthy meals and snacks throughout the day. • Drink water frequently throughout the day. • Ensure you get 6 - 8 hours good-quality sleep per 24 hours. • Be comfortable: wear suitable clothing for temperature and tasks.	• Provide hot and cold healthy food 24 hours a day. • Ensure drinking water is available throughout clinical and non-clinical areas. • Arrange shift patterns that allow adequate preparation and recovery time, flexibility and autonomy over swaps and allocation. • Ensure good climate control throughout all clinical and non-clinical spaces.
Emotional wellbeing • Ensure adequate energy to enjoy time away from work; develop the ability to “say no”. • Become self-aware: practise mindfulness, reflection and journaling. • Talk to others about the impact of caring, especially when things go wrong or are particularly distressing. • Avoid boredom: ensure a variety of work, and delegate where possible. • Take regular micro-breaks to recover energy before performing again.	• Consider enforcing maximum hours – promote a culture where courage is not required to “say no”. • Provide spaces for quiet thinking/walking/being. • Encourage debriefing after critical events and consider implementing Schwartz Rounds. • Pay careful attention to job plans to ensure that doctors are spending at least 20% of their time at work on tasks that are meaningful to them, and offer training in good delegation skills. • Enforce breaks between patients or operations or on long ward rounds.
Sense of calling • Reconsider why you went into medicine in the first place • Recognise and celebrate your own achievements and successes • Thank others.	• Use language that reflects the values, mission and purpose of healthcare practitioners • Collect evidence of individual and team success, and celebrate it • Congratulate and reward events and achievements of individuals.

eating, hydration and sleep underpins all other more sophisticated strategies. Unfortunately, many doctors find that the organisational culture requires them to have considerable courage to be able to “say no” to skipping breaks and taking on extra shifts. Prioritising personal wellbeing can be a significant challenge for many. Often, doctors give much of their energy to their work, and arrive home exhausted and unable to enjoy or participate fully in time with family and friends, fail to exercise or eat healthy food, or relax into restorative sleep.

- **Emotional wellbeing:** Coping with the stress of working with suffering patients day

after day requires attention to emotional wellbeing to avoid secondary traumatic stress disorder or compassion fatigue. Mindfulness, journaling, and Schwartz rounds are evidence-based techniques that promote self-awareness and resilience. Many organisations in the UK, USA and Australia are embedding Schwartz rounds into their institutions to enable all staff to come together and talk about the effect of caring for themselves and their teams.

- **Sense of calling:** A sense of mission and purpose can also build resilience. Remembering why an individual chose medicine, and celebrating achievements

that align with these values, can be a powerful way to bounce back in an environment that constantly challenges and surprises. Organisations can support this by collecting evidence and stories of good practice, and celebrating, rewarding and thanking staff for it.

Evidence strongly suggests that individuals cannot build or maintain resilience in isolation. It is crucial that the organisation understands this, and works with individuals so that they can be happy, healthy, safe and productive at work.

References are available on request.

KMRD to create CV database

SAMA Knowledge Management and Research Department

The SAMA Knowledge Management and Research Department (KMRD) would like to create a CV database of experts from which to appoint those with relevant skills to assist with its various projects on an ad hoc and part-time basis.

These projects will include current and prospective health-policy analysis, and there will be calls for comments when required. Also included will be the compilation of essential medical list comments, inputs into the Council for Medical Schemes’ prescribed minimum benefit definition project, call for comments on the health-market inquiry, and

the development of and inputs into clinical guidelines.

In addition to relevant undergraduate medical and health qualifications we are looking for experts with knowledge about or skills related to:

- public health
- the private sector
- research
- health economics
- evidence-based medicine
- guideline and clinical protocol development
- publications
- health law and health policy.

We are also looking for medical specialists, particularly for inputs into the Council for Medical Schemes benefit definitions, which define member entitlements for their conditions.

To be a part of our specialist database, please submit a detailed CV to careers@samedical.org, indicating clearly in the subject line: Knowledge Management and Research Department Experts.

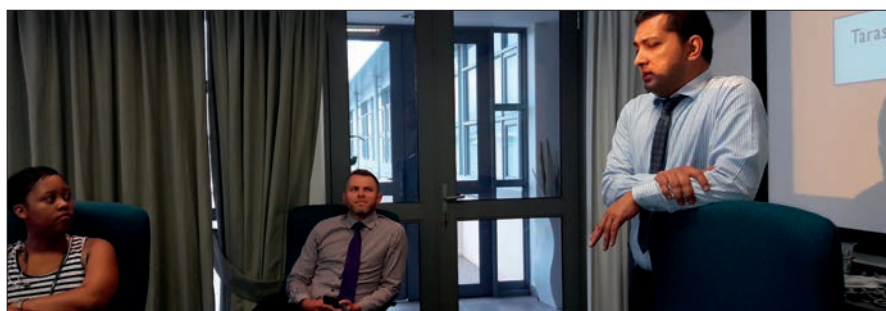
For further information, please contact: Dr Selaelo Mameja at Selaelom@samedical.org, or call 012 481 2089 or 079 895 7869.

CPD meeting on medical confidentiality a success

SAMA Communications Department

Western Cape branch attended a CPD meeting, sponsored by Sanlam, at the Hermanus Provincial Hospital in February. The meeting, attended by 15 doctors, was very interesting and informative. Yanush Singh, a financial planning (market) specialist at Sanlam who has a law degree spoke about medical confidentiality.

A follow-up meeting, also sponsored by Sanlam, was held on 16 March at the same hospital, and the topic was informed consent.



Yanush Singh from Sanlam talks about medical confidentiality at the Hermanus Provincial Hospital

It's a jungle out there – here's your survival guide

SAMA Communications Department

Junior doctors around the world often have difficulty fitting in to their new internship surroundings. To support them, the Junior Doctors Association of South Africa (JUDASA), which is part of SAMA, developed an internship survival guide.

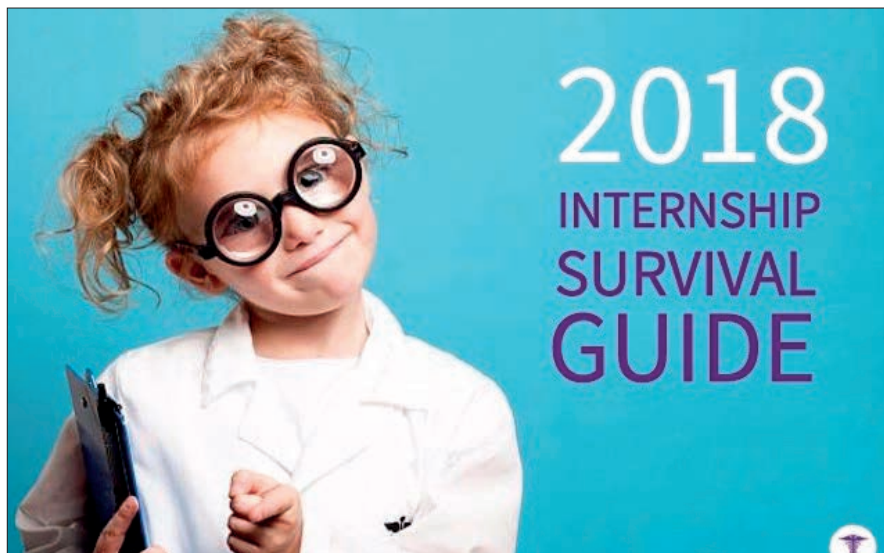
The JUDASA *Internship Survival Guide* is a document aimed at assisting junior doctors in SA in adapting to the workplace.

"JUDASA feels strongly that due to various work-related themes not being taught in the undergraduate curriculum, interns run the risk of misuse in the workplace. With the aim of clarifying issues before they arise, JUDASA's internship guide contains summaries of the latest key internship concerns, including working hours and commuted overtime, salary packages and an introduction into the management structure within the workplace," explains Dr Farah Jawitz, JUDASA Western Cape chairperson, who was one of the doctors who amended the existing guide.

Dr Jawitz says JUDASA has been known over the last few years for leading public conversation and facilitating policy change on topics related to junior doctors across the country.

Pertinent issues such as working conditions and safe working hours, as well as the transition of the annual internship and community-service applications from a paper-based to an online system, were initiated by junior doctors.

"By placing this guide in the hands of junior doctors, we empower them to continue to learn about healthcare, not just as a practice, but as a system that impacts



The JUDASA Internship Survival Guide cover

the lives of both carers and patients," she says.

The guide is opened by words of encouragement from the current JUDASA chairperson, and contains the contact details of relevant JUDASA representatives in the event of a junior doctor needing to seek assistance.

The aims of the organisation are:

- to represent the professional and legitimate needs and interests of junior doctors
- to form good relations between the junior doctors, and with other medically associated groups, hospitals, public and private institutions and government
- to serve the medical profession
- to promote health for all by striving for an affordable, non-racial, non-sexist, comprehensive and effective unitary

health system to which all have the right of equitable access.

The guide is written largely for those doing their internship, but includes information directed at community-service doctors and junior medical officers as well. The survival guide is updated every 3 years, and includes references from recent National Department of Health policy documents and HPCSA guidelines.

"Since the current crop of medical interns [has] experienced such a difficult and delayed internship application process, there is much excitement about the release of a guide that aims to make their first employment experience just a little bit easier," concludes Dr Jawitz.

New HPCSA annual fees

SAMA Communications Department

The HPCSA published board notice 27 of 2018 in the Government Gazette on 2 March 2018, announcing that it intends to prescribe the annual fees payable by registered practitioners, as set out in the schedule. The amount of the annual fee payable for 2018 by medical practitioners is

ZAR1 830, and for specialists ZAR1 865.00. The schedule of all annual fees payable to the HPCSA is available on the council's website under [www.hpcsa.co.za/Fees/Annual fees](http://www.hpcsa.co.za/Fees/Annual%20fees).

The annual fee payable by a person registering with the council for the first time, in terms of the Health Professions Act

No. 56 of 1974, shall be a pro rata amount of the applicable annual fee, and calculated according to the month of registration after the due date for payment of annual fees.

We wish to remind members of SAMA that the annual fees shall be due and payable with effect from 1 April 2018.

Healing innovatively – lessons from young South Africans

Dr Farah Jawitz, chairperson, JUDASA Western Cape



It's not often that when reflecting on who makes a difference in our healthcare system, or how, we turn to stories of individuals. I've been fortunate to have personally encountered a handful of inspiring colleagues who have gone above and beyond what was expected of them, to pursue dreams of effecting change both little and large.

The first such encounter was with the pioneering Inclusive Healthcare Innovation

initiative by the Bertha Centre for Social Innovation and Entrepreneurship at UCT, back at its inception in 2014, where I met a young man from Khayelitsha. Sizwe Nzima, founder of Iyeza Express, had broken into the health innovation space at a startling pace, delivering chronic medication to the doorsteps of patients in Khayelitsha via bicycle. With little more than a dispensing license, his two-wheeler and an entrenched knowledge of the makeup of his community, Sizwe had hit his mark.

It was this introduction of human-centred design in which the needs of the user dictate the design of the SA innovation space that sparked a trail of new local initiatives. Quick to follow were mobile-based projects such as Vula Mobile, a medical referral application that changed the face of referral pathways in the Western Cape, and EMGuidance, a clinical guidelines application that every healthcare worker in SA should have installed on their phones.

But innovation and change do not necessarily equate to a commercial product. Systemic change is something quality-improvement teams are constantly striving to achieve. As a trend in our country's history, young people have always been at the forefront of such improvements. Reflecting on the 2007 occupation-specific dispensation

strikes and the more recent Safe Working Hours and Unemployed Doctors campaigns, it is clear that it is the perspectives of our junior doctors in particular that we need to capitalise on.

We need to nurture our young leaders

Internship and community service are themselves part of an ongoing process that as Reid *et al.* outline, in a recently published article evaluating the postgraduate training of healthcare practitioners, will continue to evolve. It is within this dynamic environment that we will uncover our country's strongest talent. We need to nurture our young leaders. The onus falls on all of us to identify and mentor them, so that they may become the voice of change in future.

This article has been adapted from a presentation given by Dr Jawitz at the SAMA KZN Coastal branch intern welcome function, during which a bright and energetic new JUDASA KZN Provincial Executive Committee was elected. We congratulate Farah, who has been awarded a prestigious Rhodes scholarship for 2 years of study at Oxford University, from 2018.

Genomics centre in Cape Town to decode genes

SAMA Communications Department

The African Genomics Centre, a first for the continent, is already under construction at the SA Medical Research Council (SAMRC) head office in Cape Town. In February this year, the SAMRC cemented its collaboration with the Beijing Genomics Institute (BGI) through the signing of a formal agreement that guarantees an exciting future for this new state-of-the-art research facility. Operations are due to begin in mid-2018, boosting research to enable precision medicine for SA.

BGI is at the forefront of the global scientific progress on genetic science and DNA sequencing, while SA has identified an opportunity, through this partnership, to build the country's capacity for whole human-genome sequencing.

"The development propels SA into a new era of medical research, and means that we join a small, but growing, group of countries that are pioneering this type of innovation," said Prof. Glenda Gray, president of the SAMRC, during the signing ceremony that took place on top of Table Mountain in Cape Town on 16 February.

Said Prof. Gray, "This novel field of research harnesses the science of genomics for personalised medicine. Knowledge of the DNA sequence has become an important part of understanding disease. By establishing the sequence of an individual's genetic material, it is possible to identify mutations that are specific to that person. These genetic tools will help us understand SA's diverse gene pool and convey insight into treatments for common diseases like diabetes."



Dr Li Ning, centre, chief development officer, BGI, with Prof. Glenda Gray, president of the SAMRC, during the signing ceremony that took place on top of Table Mountain in Cape Town

The centre will be a vital national asset, able to contribute to the better understanding of factors that impact on the health of South Africans and to inform strategies to improve their response to diseases. This means that conditions that contribute to our heavy burden of disease in the country, such as hypertension, stroke, heart disease, diabetes and cancer, can be diagnosed more quickly and more accurately, and treatments delivered in a more targeted, effective and cost-efficient way.

Dr Li Ning, chief development officer, BGI, said that the collaboration is positive for science, and it will strengthen bilateral relations between China and SA, as both countries have contributed to the establishment of the facility through research capacity, funding, equipment and other infrastructure needed to operate the centre.

“BGI congratulates the SAMRC on its commitment to scientific advancement and for having in place the building blocks that this type of initiative requires. We have already learned much from each other and from what we respectively bring to the collaboration as partners. We are truly enthusiastic about the scientific breakthroughs we can look forward to, as well as the many benefits they will afford to SA and Africa,” said Dr Li.

About the African Genomics Centre

The SAMRC and BGI are partners in the establishment of the African Genomics Centre, located at the SAMRC head office in Cape Town. The dedicated African Genomics Centre builds on SA's previous participation in the Human Heredity and Health in Africa initiative (H3Africa).

When it opens its doors in mid-2018, the centre will become an invaluable national asset and the first facility on the African continent capable of conducting large-scale studies on whole genome sequencing. Equipped with the latest technology and know-how, and backed by a strong training component, the centre will realise the potential for localised cutting-edge genomic research and the generation of new knowledge on the African population genome.

As a developing nation, SA seeks to build a more sustainable, locally powered healthcare environment, and to utilise available financial and human resources more effectively to reduce the burden of disease and improve the nation's health.

Knowledge of the DNA sequence has become a crucial part of understanding and responding to disease. Mutations specific to an individual can be identified by establishing the sequence of their genetic material. Having sight of these sequences helps in recognising the cause or stage of a disease, or the risk of future disease. It also helps to predict the likely benefits or side-effects of a particular medication.

This is relevant because many medicines were developed outside Africa, having been researched on study populations with a different gene pool. Yet, the African population – and SA in particular – shows a large amount of genetic diversity. Hence medicines may be less effective, especially in the case of lifestyle diseases such as cardiovascular conditions, diabetes and cancer.

Genomics paves the way for personalised treatment – medicines and other treatments can be prescribed not just for their general

effect on a disease, but also for the way they interact with a patient's genetic makeup. It is therefore imperative to create a knowledge base of the African population genomics.

The centre will also enable SA scientists to overcome limitations in local bioinformatics capacity. This is a big-data initiative that requires a robust ability to work with huge sets of data to create and sustain bioinformatics pipelines and local databases on population genetics.

About the SAMRC

The scope of the SAMRC's research includes basic laboratory investigations, clinical research and public health studies. Research at the SAMRC focuses on the top 10 causes of death in SA. To assist with delivering on this vital mandate, the organisation is led by the National Department of Health, and works with other key stakeholders such as the Department of Science and Technology, SA and international science councils, medical schools, universities, research institutions and international collaborators.

About BGI Genomics

BGI Genomics is the division of BGI Group that provides a full menu of next-generation sequencing and clinical testing services to support academic research, drug development and diagnostics. The company operates service laboratories under global quality standards in the USA, Denmark, Hong Kong and mainland China. BGI Genomics leverages its unequalled genomic research experience and massive sequencing capacity to provide customers with high-quality data and fast turnaround at affordable prices.

Vaal River branch relaunched

Dr Ayodele Aina, chair, SAMA Vaal River branch

The SAMA Vaal River branch has been in existence for many years, but due to the hold that lethargy has on some of us, coupled with the mindset with which we are conditioned to look out for ourselves, or no-one else will, while the few elected leaders did everything humanly possible to get the branch running for several years, they were hindered by challenges that led to inactivity and a subsequent lack of growth.

We might say that the attitude of some members of the Vaal River branch in the past was similar to that of spectators who merely watch things happen, or the ignorant (the overwhelming crowd) who don't know what is happening. Some of us sat on the fence observing and complaining about the problems within the organisation and enjoying our membership benefits, rather than seeking out ways to serve, solve problems and become doggedly committed to the mission and vision of SAMA at the Vaal River branch level.

I remember clearly that for more than a year, until I got tired, I ignorantly attended the SAMA Gauteng branch at Wits, driving after work from Vaal River, where I reside and work, to attend its monthly meetings, when I could have actually given my support to the Vaal River branch.

In April 2017, the Vaal River branch participated in the SAMA electronic elections, and subsequently, six visionary branch councillors, determined to no longer be consumed with pursuing only their own interests, took up the project to relaunch the Vaal River branch.

The ability to take a team from "getting the job done" to "surpassing every goal and expectation with flying colours" requires an understanding of the difference between what it means to manage a group of people and to lead a group of people. The spirit of teamwork came into play, as although no one person can be the best at everything, when we combine our unique abilities, we can be best at virtually anything. Some great leaders may be born that way, but there are certain traits that great leaders have in common that anyone can practise and adopt to become effective. The current branch councillors display the following traits: they **inspire action, are optimistic, show integrity, support and facilitate the team, have confidence, communicate and are decisive.**



Vaal River task team and Sanlam representatives: back row from left: treasurer Dr Frans Engelbrecht, councillor Dr Nyembo Muteba, chairperson Dr Ayodele Aina, general secretary Dr Seabata Motloji, task team member Dr Wynand Msibi. Front row from left: branch secretary Victoria Matsose, task team member Dr Luwaji Aderinmola, Sebokeng intern curator on behalf of management Dr Seatile Mofokeng, general private practice practitioner representative Dr Therine Rademan, task team member Dr Mongatane Moime, Sanlam financial adviser Ms Selmie Harris, Sanlam financial adviser Jason du Plessis

In July 2017, the branch acquired a centrally located office space, furnished proudly in a style that supports the taste of visiting branch members and non-members alike, which helps to explain the progressive recruitment drive outcome and the boost in current membership retention and willingness to participate, in the short space of time since the relaunch project.

The branch chairperson's presence and presentation on behalf of the branch at the intern orientation programme at Sebokeng Hospital on 5 January 2018 was a first in the history of the Vaal River branch, and a follow-up presentation requested by the interns curator, Dr Mofokeng, to a larger target group revealed the need for interns and SAMA members to "get together" with the SAMA Vaal River branch councillors.

The SAMA Marketing Department played a tremendous role in all these activities, and through them, Sanlam sponsored a "get-together" function held on 6 February 2018 at the Vaal River branch office. Talks at the function were on life within and outside medical school, and the realities of being medical practitioners in a demanding world.

The expertise displayed by the Sanlam financial adviser, Ms Selmie Harris, in the absence of Ms Madeleine Van Wyk, is beyond

commendable. She briefly advised us on how best to manage our finances through tax reduction, budgeting, asset protection, income protection and a having a hospital plan. The company's financial products were addressed with passion and a great sense of humour, and attendees were left asking themselves, "Why not Sanlam?"

The event was open to SAMA members and non-members alike, and it was well attended, highly interactive, participatory, informative and a huge success, all within about 6 months of the relaunch. Attendees remarked that they look forward to ongoing involvement of this kind.

The key to the current collective success of the Vaal River branch since the relaunch project began is attitude rather than aptitude. In other words, it's not ability, it's mentality. 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 people with the wrong attitude.

Who is an employee? The locum doctor perspective

Keletso Makwe, *industrial relations advisor, SAMA*

This is a question that is often asked when locum doctors have a dispute with their “employer”, especially in the case of a dismissal. The latest trend from institutions is to arrive at a Commission for Conciliation, Mediation and Arbitration (CCMA) hearing and confidently make submissions to the commissioner that the dismissed doctor was not an employee on the grounds that (s)he was a locum doctor.

SAMA recently represented a member at the CCMA after referring an unfair dismissal dispute. The respondent argued that the doctor was a locum, and therefore not an employee. (S)he further defined a locum as: “a freelance practitioner, and expected to be flexible, adaptable, resourceful, professional, quick to establish relationships, familiar with different systems and able to independently manage risks”.

After both parties made submissions, the commissioner made a ruling in favour of the applicant (the dismissed employee). This victory was a milestone for SAMA, as there is a growing tendency in some healthcare institutions to use this argument to get away with unfairness. In arriving at the findings, the commissioner considered the following factors:

- The applicant rendered personal services to clients/patients of the employer.
- The applicant personally performed the service relating to the patients, and did not employ others to provide the service.
- The employer had the right to control the applicant in providing the services.
- The employer chose when and on which days to make use of the services of the applicant/employee.
- Remuneration and benefits were fixed

payments to the applicant in providing the services.

- The place of work was at the consulting rooms of the respondent, which provided to the applicant all the “tools of the trade” required to perform the services.

The Labour Relations Act No. 66 of 1995, Section 200A, and the Basic Conditions of Employment Act No. 75 of 1997, Section 83, confirm the relevance of all the above factors referred to by the commissioner.

In this case – Denel (Pty) Ltd v Gerber 201 2005 9 BLLR 849 (LAC) – the labour court judge found the applicant to be an employee, and not a subcontractor as the respondent alleged.

Other factors that may be considered in deciding whether someone is an employee or a subcontractor are:

- **Provision of training.** If an employer provides training to a person in connection with the employer’s methods or systems, this is usually a strong indicator of an employment relationship. An employer would not normally provide training to an independent contractor. A self-employed person is responsible for ensuring his/her own training and for ensuring that (s) he is competent to perform the services that (s)he offers. As with all other factors, the provision of training to a person does not necessarily exclude an independent contractor relationship. The provision of training cannot be used as a deciding factor in itself. The principle is that each case will be judged on its merits.
- **Place of work.** The fact that the person works at only one place may be an indi-

cation of an employment relationship; however, the fact that a person does not work only at the employer’s premises does not indicate the absence of an employment relationship. It is becoming more frequent these days in certain industries that employees work from home, while the employer provides all necessary computer and other office equipment, and so the fact that the employee works from home – and very often regulates his/her own working hours – does not exclude an employment relationship. A factor that would point to an employment relationship in such circumstances would be whether the employee is still subject to the direction and control of the employer.

- **Termination of contract on death of employee.** It is common knowledge that when an employee dies, any employment contract ceases to exist, whereas the death of an independent contractor does not necessarily terminate the contract.

A ruling by a court, CCMA commissioner or bargaining council as to whether a person is an employee or an independent contractor is an important decision, and could have an adverse effect on the person concerned: if declared an independent contractor, then the person has no protection under labour legislation.

Conclusion

Members should report any unfair dismissals/labour practices they may face to SAMA, without fear of being assumed to be independent contractors, and they will receive the support and assistance they need.

Call for papers

SAMA Communications Department

All medical students, medical practitioners and members of SAMA are invited to submit abstracts of their scientific research to be considered for a poster or oral presentation at the 2018 national SAMA conference.

Papers and abstracts can be submitted online on: <https://www.eiseverywhere.com/eSites/311592/My%20Profile>. The closing date for submissions is 31 May 2018.



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 500 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 10th 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. Our thanks to Dr Ingle for the contribution printed below.

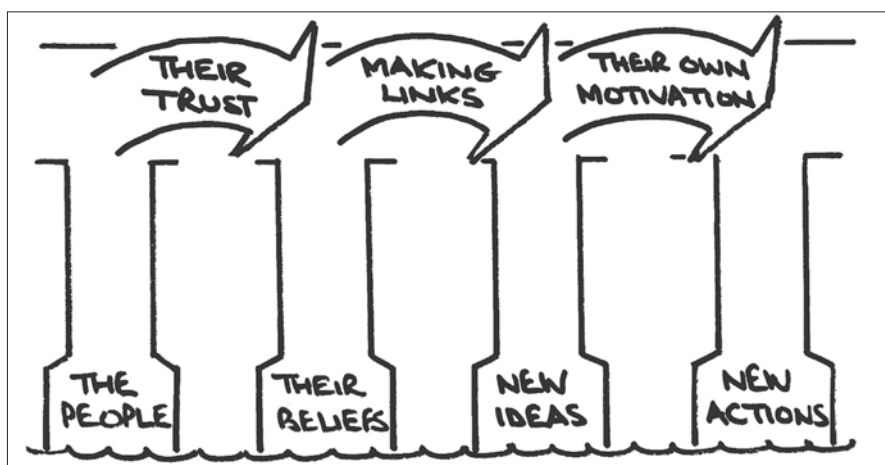


Yours sincerely, health education

More than 50 years ago, at All Saints Mission Hospital in rural Transkei, we changed our approach to infant malnutrition by starting Nutrition Rehabilitation Units, and discovered how to talk to the people around us about better health. This called for major changes to the professional roles that we, both doctors and nurses, had acquired in our training. Those days were like a honeymoon for health education in SA – an inspiring marriage of hearts and minds from all around the country.

We discovered the reality of problem- and community-based learning long before those terms became fashionable

All Saints Hospital joined with Mount Ayliff Hospital to begin a Health Education Project (1971 - 1974). This led to the formation of the Transkei Health Education Association (1975). Nationwide, there was the South African National Council for Health Education



The bridge for health education

(SANCHED), with its annual conferences (1977 - 1984) under the charismatic leadership of the late Dr Renate Westphal. What was so special about the movement was the enthusiasm and thirst for guidance from grassroots health workers.

People used to ask, sometimes critically, what is this health education? Where is this discipline? Where are the textbooks? We wanted to see cadres of health educationists whose training concentrated on communication skills, always backed by highly qualified specialists in what today is called an integrated model. This was then a worldwide trend, although in SA it was

unpopular with the top nursing professionals of the time.

By listening to the problems and experiences of the communities we worked among, we discovered the reality of problem- and community-based learning long before those terms became fashionable.

That kind of health education depends not on financial, but on relational resources. It is not an "add-on", but is integral to community-oriented healthcare. I do not know what place it finds within today's training, but I do wonder why SANCHED has had no successor.

Ronald Ingle (retired)

Delayed diagnosis – patient presents with persistent gastric symptoms

The Medical Protection Society shares a case report from their files

Mrs F, a 30-year-old housewife, visited her GP, Dr O, with a 4-week history of diarrhoea. Dr O arranged a stool sample for microscopy and culture (which was negative) and prescribed codeine. Four months later, Mrs F was still suffering from diarrhoea, especially after meals, and she had started to notice some weight loss. She returned to the surgery, and this time saw Dr P, who examined her and found nothing remarkable, but decided to refer her to a specialist gastroenterologist in view of her persistent symptoms.

Consider all past consultations, particularly if patients do not see the same practitioner each time

Mrs F was seen 4 months later by a gastroenterologist, who attributed her symptoms to irritable bowel syndrome (IBS). She underwent a sigmoidoscopy, which revealed no changes, and was diagnosed with functional bowel disease.

Four years later, Mrs F developed difficulty passing stools after the birth of her second child. She was referred back to the gastroenterologist and underwent a further sigmoidoscopy, which again revealed no abnormalities. She was referred for pelvis physiotherapy.

Two years later, Mrs F returned to her GP and consulted Dr G with the sensation of a lump in her rectum preventing her from defecating. She reported incomplete bowel emptying and the need to manually evacuate. She was referred back to the gastroenterologist, who arranged a barium enema, which was reported as normal.

Three months later, Mrs F visited the practice again, with a 2-week history of diarrhoea and



abdominal cramps. Dr B saw her on this occasion, and diagnosed her with possible gastroenteritis. He arranged a stool culture, coeliac screen and routine bloods.

Mrs F returned a week later for follow-up with Dr Y, reporting ongoing diarrhoea with no rectal bleeding. Dr Y noted the recent normal barium enema and sigmoidoscopy, and normal stool culture. The blood tests were still pending, so Dr Y sent Mrs F to hospital to get them done. The results for the coeliac screen were normal.

Another 3 months later, Mrs F was still symptomatic, and attended Dr P with diarrhoea and bloating. No abnormalities were found on abdominal and rectal examination. Dr P diagnosed IBS and prescribed amitriptyline.

Over the next 3 weeks, frustrated at the lack of resolution of her symptoms, Mrs F had several GP appointments with Drs G, P, O, B and Y. She was referred for a colonoscopy and pelvic ultrasound – both of which were normal. She was referred to a colorectal surgeon and a family history of pancreatic insufficiency was discussed during the outpatient appointment. Faecal elastase confirmed pancreatic insufficiency and a CT abdomen scan revealed obstructing pancreatic duct calculi. She underwent endoscopic retrograde cholangiopancreatography (ERCP) and Frey's procedure, neither of which resolved her

Learning points

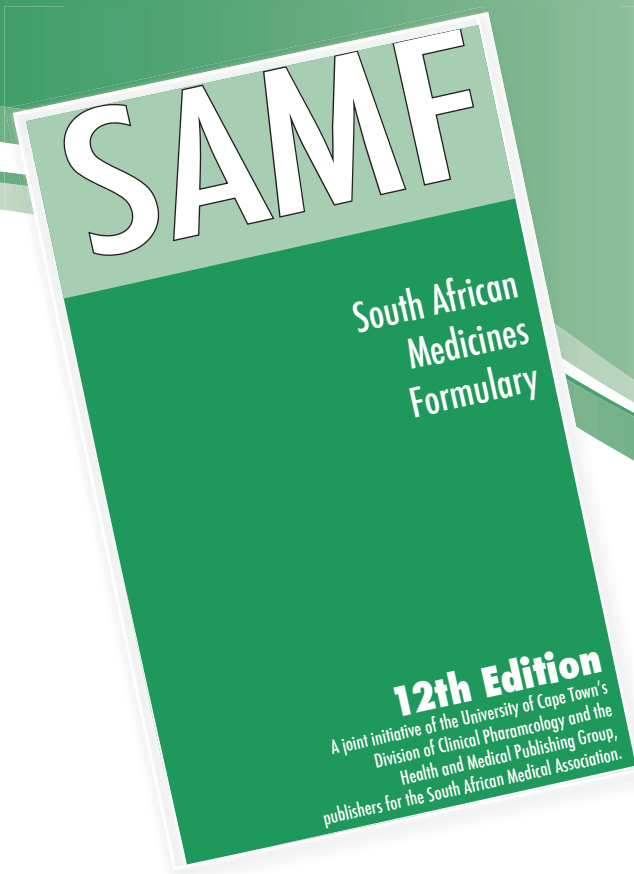
- Where patients are repeat attenders with ongoing symptoms, it is important to consider alternative causes for their symptoms.
- Careful documentation of consultations is imperative, and greatly assists when defending claims.
- Where patients are repeat attenders, it is important to consider all past consultations, particularly if patients do not see the same practitioner each time, to ensure that continuity of care is not impacted.

symptoms, and, at the time of the claim, Mrs F was considering a total pancreatectomy.

A claim was brought against Drs P, Y and O for failing to take into account Mrs F's family history of chronic pancreatitis and arranging a specialist referral and follow-up investigations.

Expert opinion

On the basis of the medical records and the evidence provided by the doctors involved, the GP expert was supportive of Drs P, Y and O. Given that Mrs F did not mention her family history of chronic pancreatitis, there was no reason to suspect pancreatic insufficiency as a cause for her symptoms. The claim was subsequently discontinued.



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WHAT WE ARE ABOUT

SAMAREC:

Evaluating the ethics of research protocols developed for clinical trials conducted in the private healthcare sector. Ensuring the protection and respect of rights, safety and well-being of participants involved in clinical trials and to provide public assurance of the protection by reviewing, approving and providing comment on clinical trial protocols, the suitability of investigators, facilities, methods and procedures used to obtain informed consent.

CPD:

Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association is one of the institutions that have been appointed by the Medical and Dental Professions Board of the Health Professions Council of SA to review and approve CPD applications.

For further information please contact the SAMAREC/CPD Secretariat on 012 481 2000 OR email us on samarec@samedical.org or cpd@samedical.org