

SAMA INSIDER

SEPTEMBER 2018

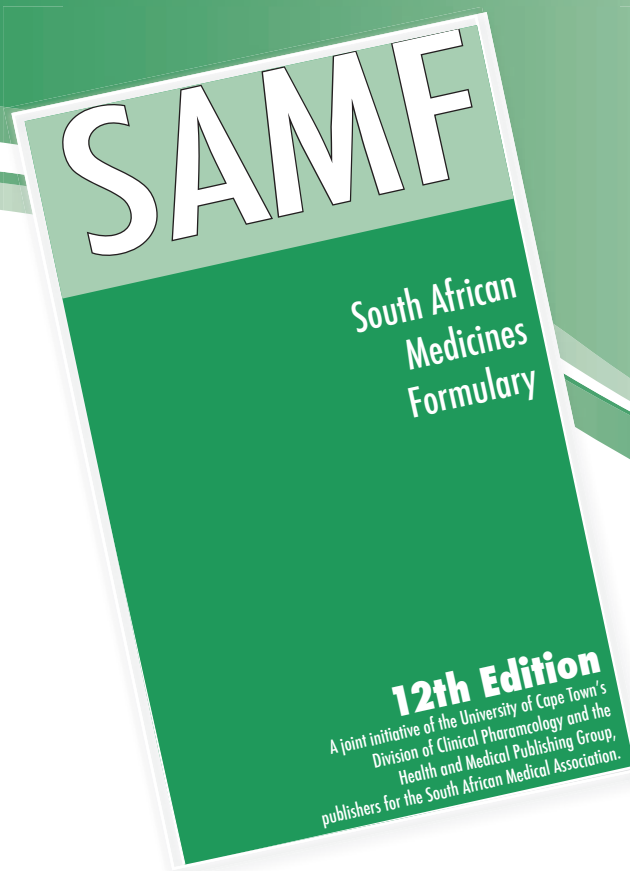
**Death by profession has
a voice: “I am a doctor;
I am human too”**

**Healing hands need
a healthy mind**



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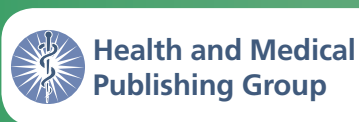
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EDITOR'S NOTE

SEPTEMBER 2018



Diane de Kock
Editor: SAMA INSIDER

Gone but not forgotten: Let's talk about mental health

We have all been deeply shocked and saddened by the death by suicide of Prof. Bongani Mayosi, Dean of the Faculty of Health Sciences at UCT, in July. An article in the *Daily Maverick* by Lydia Caincross, a doctor in the Department of Surgery at Groote Schuur and UCT echoed the feelings of many when she said: "The fact that Prof. Mayosi's job required that he be in the office before dawn and stay late into the night and work weekends and many hours in between is not something we should be proud of; it is something we must examine. Because responsible, caring people will always push themselves to the limit to complete the work that must be done. The failing is in the institution that requires this unhealthy work ethic in order to 'perform.'"

On page 4, a friend and colleague of Prof. Mayosi's, Dr Nosisa Matsiliza writes a tribute, which includes heartfelt words from those who had been closely associated with him in recent years. "These beautiful tributes tell the full story of the Bongani Mayosi that the world got to know." The challenge now is to carry forward Bongani's Light.

Mental illness is a real and daily wall faced by many of our doctors. On page 6, Prof. Zukiswa Zingela's article, "Death by profession has a voice: I am a doctor; I am human too," is an enlightening and valuable contribution: "Doctors can no longer be silent about the devastating effects of mental illness and suicide on the profession," says Prof. Zingela.

Carrying on with this theme, we publish an article on page 7 about mindfulness master Ishan Shivanand's recent visit to SA. "He likened [mindfulness] to sanitising the hands in between patients, and felt that our minds need to be decluttered, to improve the quality of our own mental health, and thus the quality of patient interactions," says Dr Nilesh Patel, Group Chief Medical Officer at Lenmed.

On page 9, we introduce you to the new head of the SAMA Private Practice department, Dr Vusumszi Nhlapho, and on page 11, Shelley McGee and Dr Selaelo Mametja unpack the findings of the recently published Competition Commission health market inquiry's provisional findings.

As part of SAMA's drive to attract new members, SAMA general manager, Dr Thandrayen, has been visiting branches to help with recruitment. Branches now present intern recruits with a new set of scrubs.

We look forward to hearing from readers; let us know what you would like to see covered in *Insider*, submit articles for publication, and give us feedback. This is your magazine!

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

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

Senior Designer: Clinton Griffin

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Tribute to Bongani Mayosi

Dr Nosisa Matsiliza



Bongani taught me how to step into the arena and dare greatly, because that is what he did

UCT and the “Fees Must Fall” protests started. Last year, when I graduated with my PhD, I celebrated that for the first time (out of three), my name was actually pronounced correctly by the dean at my UCT graduation.

I will remain forever indebted to him for shaping the way I see myself in academia and the health industry as a whole. He made me believe that I could do anything. No dream was out of reach! Most of all, I will remember how caring he was for me, for Africa and the future of her children. Your legacy shall live on through me and others whose lives you have touched in the most meaningful way. Thank you for your generous spirit! May we embrace it and pay it forward!

Lala ngoxolo Radebel!

Phumla Sinxadi

You were everything that represented hope for us – Neliswa Gogela

I am struggling to find words to bid my superhero farewell. You were more than our dean; to us, you were life well lived, you were our beacon of hope, and now you are gone, and we are left with immense pain, but we are not broken.

Since your death, I have, like most people who knew and loved you, been struggling and riddled with guilt: “What could I have done to help you?” I think of your last few minutes, and wonder what was going on in your mind, and I always come up with one conclusion: *you must have thought it through, and you had a pretty damn good reason to do what you did.*

I met you in 2006, and you greeted me like you wanted to know me, like you cared and like I mattered. You listened with curiosity as I was blubbing about who I was and where I came from, and in the same breath thanking you for inviting me to be part of this prestigious university. You see, I had dreams and goals, but I had no idea how

When I was asked to write an obituary for Prof. Bongani Mayosi, I knew that I would want to seek contributions from some of those who had been closely associated with him in recent years. Having listened to the outpouring of deep grief and sorrow, the deep appreciation for Bongani in the UCT Faculty of Health Sciences, the country and some parts of the world, I decided that for myself, and probably many others, as evidenced below, Bongani’s death would not be in vain.

He made me believe I could do anything – Phumla Sinxadi

I met Prof. Mayosi when I returned to UCT to specialise in clinical pharmacology. He was instantly keen to find out what my career plans were, what my projected impact was as a woman in science and specifically, my role in transformation at UCT and the impact that would have on black students at UCT. He introduced me to the idea of becoming a clinician scientist, and I was sold. He strongly supported the grant applications that saw me being awarded the Discovery Foundation award, the Wellcome Trust CIDRI [Centre for Infectious Diseases Research in Africa] award, as well as an MRC Senior Fellowship grant. When the National Health Scholars Programme was launched, I was privileged to become the first doctor to be awarded

that scholarship. In 2013, he supported my application to the Novartis Next Generation Scientist internship programme, which led me to land a job as a lead investigator for the first “first-in-man” study to be conducted in Africa, for a drug manufactured by African scientists. Two years later, Prof. Mayosi was one of the people who strongly motivated for a permanent post to be created for me, thus enabling me to gain more experience in drug development in the pharmaceutical industry through the European & Developing Countries Clinical Trials Partnership/WHO Special Programme for Research and Training in Tropical Diseases Career Development Fellowship programme. I was then able to spend a year at a research and development unit at GlaxoSmithKline in London. While in London, we met when he went to deliver the UK alumni lecture at Goodenough College. He described his vision of how he planned to take the UCT Faculty of Health Sciences forward, and how Africa should be the place where other people go to learn how to manage the diseases prevalent in Africa, and how we can expand and build on South-South collaboration to solve the health problems in Africa. Once again, he relayed his vision of creating a critical mass of clinician scientists (1 000 PhDs in 10 years) to solve the prevalent health problems. I was inspired! I couldn’t wait to come back and start working on this vision. This was only 3 days before he came back to

to attain them. There you were, thanking me for responding to your call. You had special gifts, Bongani; nothing was ever impossible for you. I could list, like most people, how you transformed my life and how you helped me achieve my dreams, but it will sound like “Oh well, he was doing his job.”

Allow me to use this famous quote from Maya Angelou: “I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

I can never forget what you said, nor will I ever forget what you did, but I will forever cherish how you made feel. Prof. Mayosi, you had these amazing superpowers; I don’t know if you knew it. You made us, you made me, feel like I could reach for any star. You were and will forever remain the wind beneath my wings. I found myself battling to come to terms with this tragic news, when I had to explain to my children why I was wailing, why I was falling apart. In you we have lost a superhero, and I believe that sometimes superheroes have to sacrifice themselves for the greater good. I sincerely hope and pray with all that I am that you are happy and finally resting peacefully, in Heaven. You were a man with the purest of hearts, you were kind, you were gentle and you were everything that represented hope for us.

May you rest now, knowing that your death will never be in vain. Your legacy will shine on forever, for you have touched and rescued many lost and troubled souls.

Sincerely, your biggest cheerleader,
Neliswa Gogela

He believed in the transformation of individuals – Dr Sarah Kraus

My mentorship journey with Prof. Bongani Mayosi started 8 years ago at the bedside, as a second-year resident in internal medicine. The patient I had presented to him had familial dilated cardiomyopathy. Bongani was a man of big ideas, with many interests, but his passion for genetic cardiomyopathies was something to marvel at. He shared that passion with me by planting a seed that day at the bedside, and nurtured it over time, until it grew and became firmly rooted in me. To many, Prof. Mayosi was a beacon of hope, the gold standard to which to aspire. It has been said many times that he was a man who not only believed in transformation, but also worked tirelessly to achieve it. I am proof that his idea of transformation extended beyond political and social definitions – he believed

in the transformation of individuals. I am a white SA woman in whom he wholeheartedly invested – financially, academically and personally. He saw potential in me, and willingly provided me with the platform on which to explore it.

His very painful departure has blessed us by opening our eyes

In the book *Outliers: The Story of Success*, the author, Malcolm Gladwell, makes the argument that success is largely determined by a combination of unique opportunity and hard work. The discipline of hard work was instilled in me by my own father, but the privilege of the rare opportunity to pursue excellence in a field of medicine that I have become deeply passionate about was provided to me by this formidable man. One of the most fundamental lessons he taught me was that it takes a team to accomplish something of value in medical research – choose your team wisely, and give everyone a chance to show you what they are made of. He entrusted me with a project that was important to him, but gave me the freedom and responsibility to build it in my own way. It was an extraordinary challenge, with tremendous expectations, but it taught me the true extent of what I was capable of. In our meetings, he used to talk about all his grand, although frankly unrealistic, ideas for our project and my PhD. In the first few years of my fellowship, I used to leave his office somewhat shell-shocked and overwhelmed. But the following day, I would take his ideas and break them down into their fundamental elements, and reorganise them. I would read, contemplate and think. I would then go back to him, outline the current reality and present him with the potential solution – yes, Prof. Mayosi, I can do what you have requested, but please reflect on what you would like me to cull, in order for it to be possible. He once told my co-supervisor that I challenged him – I can think of no greater compliment. He encouraged me to be self-sufficient, and convinced both his mentor and his mentees to guide me when he was unable to. I feel immensely privileged to be one of those who saw him as a man who sometimes made mistakes, who on occasion had to admit that he was wrong, or lacked the solution to

a problem. He encouraged me to debate, to express my opinion, to disagree. I am deeply grateful for the experience of knowing him, for the confidence he bestowed and the time he gave me. The imprint of his influence is something that I will carry with me for the rest of my life. On the morning after his death, I woke up thinking about a quote that I had sent to him about 18 months previously:

“It is not the critic that counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again. But there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; who spends himself in a worthy cause. Who at best knows in the end the triumph of high achievement, and who at worst, if he fails, at least fails while daring greatly” – Theodore Roosevelt, 1910.

Bongani taught me how to step into the arena and dare greatly, because that is what he did.
Dr Sarah Kraus

I have been able to include only three contributors, because of limited space in the publication. These beautiful tributes tell the full story of the Bongani Mayosi that the world got to know. While listening to the therapeutic conversations of the UCT Department of Medicine, the articulate Prof. Mpiko Ntsheke captured my attention. He related the story of how he decided to institute, in his family life, the “Mayosi hour”. This, he had copied from Bongani’s daily hour that was dedicated time with his own children, as they were growing up.

The big question for me, now, is “How are we going to carry forward Bongani’s Light?” (Siamon Gordon, thank you for being the vehicle for bringing Bongani’s Light to the fore). How do we bring our own light into being, in order to change our world in fundamental ways, just as Bongani changed our world? His very painful departure has blessed us by opening our eyes, our hearts, to new possibilities of even higher levels of excellence. Is it too much to ask that each one of us commits to a daily “Bongani hour” of conscious giving to this nation, in whatever manner, excellence that is infused with love, humility, compassion, kindness, gentleness and dedication to collective upliftment?

Death by profession has a voice: “I am a doctor; I am human too”

Prof. Zukiswa Zingela, HOD, Psychiatry and Behavioural Sciences, Walter Sisulu University

From the heights of idealism to the depths of reality, the journey into medicine is never truly understood, even by those who travel it. Once on the frontline, the days of committing to becoming a healer, taking one's oath and graduating seem so perfect a memory that it almost feels like an alternate reality. How do we become so divorced from the ideal of the healing, nurturing profession, to find ourselves in this alienated existence that feeds on itself? Scores of physicians across the world are dying by suicide. Healers shoot themselves, hang themselves, jump from heights and take overdoses, while society around them continues with somnambulist determination to pretend that all is well. How do we continue our journey in the shadow of this pessimism that stalks us, while holding onto hope that keeps our ideals alive?

Death by profession

Physician death by suicide is not unique to SA. Australia, the USA and the UK are grappling with this same challenge. On paper, the reality is bleak. The USA reports one completed physician suicide a day, one of the highest suicide rates of any profession in the modern world. Some factors thought to contribute to the silent suffering of medical doctors include stigma, perfectionism and the presenteeism that is often expected in the medical profession, i.e. the expectation that the doctor must be available to work 24/7. The default setting, instilled in any doctor, even during training, is that of neglecting their own needs for the sake of healing and helping others. This includes the neglect of one's own mental health needs. Garakani also argues that the societal stigma against mental illness is perpetuated by stigma within the profession itself, which often results in the marginalisation of psychiatry. This perpetuates the illusion that psychiatry is a fringe profession that is not real medicine. This may influence a doctor's help-seeking behaviour when mental illness or mental distress strikes.

The conundrum is not unique to qualified doctors. Medical students face similar challenges. Medical schools are like factories that mass-produce doctors to serve the health needs of humanity. The amount of knowledge

that one must cram into the 6 years of medicine, in order to be judged safe enough to graduate, is immeasurable. There is a degree of inhumanity in the way such excellence is produced. Who can forget the humiliation of being cut down to size in front of fellow students and others by a consultant known for dishing out sadistic punishment to prove how little you know? The push for excellence and sacrificial service that is interwoven into the fabric of being a doctor is ingrained and sharpened on these factory floors. In a bid to produce tougher factory product, to serve the health needs of society, medical students are pushed to the limit and beyond, with no room to falter or deviate from the script. We lose some along the way, and we shrug it off. The cost of shrugging it off is measured in lives lost to suicide, substance abuse and other unmentionables that plague the profession. The resulting toughened factory product is inculcated with a self-sacrificing sense of duty. The cycle continues once the self-effacing medical student has qualified, to become a healer who is excellent at taking care of the needs of others but not at taking care of him/herself. Our sense of duty binds us to the people and communities we serve. It deserts us when it comes to ourselves.

Who heals the healer?

How does the profession heal itself? Who heals the healer? As much as we are dedicated to serve society, society also needs to be made more cognisant of the dire state of doctors' health. Yes, it is one's duty to look after one's health, but if the system one works in does not allow room for you to take on that responsibility fully, then by default, that system has failed you. Similarly, if the systems doctors work in are severely short-staffed and plagued with inhumane working conditions, then the resultant mental distress or mental disorders in doctors should be viewed as a form of employer negligence. Doctors deserve the same care that they give to patients when they too are sick.

What is the extent of the problem?

There has not been much research done to define the extent of mental disorders and

Doctors can no longer be silent about the devastating effects of mental illness and suicide on the profession

suicide rates for doctors in SA. HPCSA Health Committee statistics provide a glimpse of impaired practitioners reported for different disorders, the majority of which are substance use and/or mental disorders. These do not include those who do not come to the attention of the council, despite experiencing significant problems that may affect patient care. Relatively high levels of poverty, the high burden of disease associated with HIV and TB, and violence, all add to the high-pressured environment that SA doctors work in. The expectation is that they will be just as affected, if not more so, by mental and substance-use disorders and suicide as their counterparts in countries like the USA. To devise effective intervention strategies, the extent of the problem needs to be researched and better defined, so that home-grown solutions can be found.

What should be done?

The doctor's corner. Doctors need to prioritise their health, both in and outside of work. The approach should be “When I am well, I can serve well,” rather than this superhuman attempt to overstretch oneself beyond one's limit. Little things help:

Ensure that you have regular annual leave, to spend time with family and friends, and reinforce interconnectedness.

Remember to eat healthy food, exercise regularly, make time for hobbies, etc.

Take short time-out periods during a workday, e.g. a few minutes' tea break. Doctors who work in teams can tag each other, to make sure that the work on the floor is covered while allowing each other space for these time-out periods.

Consult with senior colleagues when a problem in clinical care is encountered. This can make a difference between feelings of guilt that eat at you when things go wrong, and an assurance that you did all you could to offer good care. The hardest lesson, which doctors find difficult to learn, is that even when you have done everything right, there are times when things go wrong and a life is lost. Self-blame is automatic in such instances, but does nothing to bring back the life lost. Instead, it weighs heavily on the doctor's mind, and can result in waning confidence in one's abilities, increasing self-doubt and other negative feelings that can predispose one to depression.

Mortality meetings may be helpful in instances where such meetings are driven by a need to address systemic failures, rather than to apportion blame.

Colleagues in the private sector should consider banding together to form peer support clubs, to allow space to discuss difficult cases, or just for peer contact, to avoid practising in isolation.

The NDoH and the private sector. It is in the interest of the SA public for the National Department of Health (NDoH) to invest resources in research into the extent of mental disorders and suicide in the medical profession, as well as the leading contributory factors in the SA setting. Such research should be prioritised before more lives are lost.

Addressing doctors' difficult working conditions in the public sector should also be a priority for the NDoH. The divorce between national health policies and implementation at provincial level needs equal attention, to ensure that all patients and doctors stand a chance of accessing a better health system at the point of service. Is national health insurance (NHI) the answer? Unless the ailing public health system is fixed urgently, it is unlikely to deliver the pressing answers we seek. If the growing need for doctors' mental healthcare is to be met, then a targeted and sustained investment must be made in growing the numbers of psychiatrists and multidisciplinary teams to meet this need.

Allegations about doctors struggling to make ends meet because of medical aid companies that drag their feet in paying for services rendered need to be fully investigated. This obviously adds to the stress of colleagues in private practice.

In addition, medical curricula need to be urgently revised, at both undergraduate and postgraduate level, to better equip doctors to look after themselves as well as they do their patients. Special attention must be paid to improving doctors' mental health service skills, starting with the amount of time allocated to the psychiatry rotation during medical internship training.

Conclusion

Doctors can no longer be silent about the devastating effects of mental illness and suicide on the profession. The death by suicide of an iconic healer, leader and role model like Prof. Bongani Mayosi has given voice to this suffering.

References available on request.

Healing hands need a healthy mind

SAMA Communications Department

Doctors also get stressed, like everyone else in society. And the fact that people are doctors does not mean that they are immune from the pressures of the daily grind. In fact, in many instances, being a medical professional contributes to stress levels.

Acknowledging this stress, award-winning global mindfulness master, Ishan Shivanand, recently visited SA, where he presented several courses, of between 4 and 5 days each, to a variety of different audiences. During his tour, he spoke at two Lenmed Health Group hospitals, including the Lenmed Ethekewini Hospital & Heart Centre in KwaZulu-Natal.

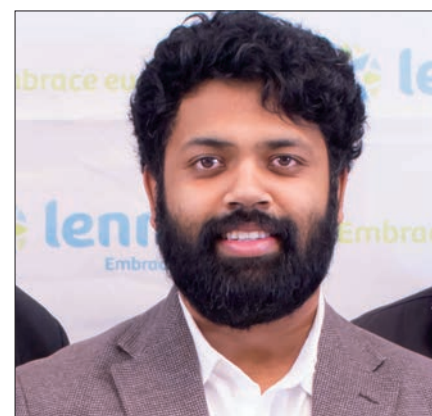
"Our intention was that Ishan would assist medical practitioners in teaching mindfulness techniques to patients. But instead, he felt that practitioners needed to be mindful first. He likened it to sanitising the hands in between patients, and felt that our minds need to be decluttered, to improve the quality of our own mental health, and thus the quality of patient interactions," says Dr Nilesh Patel, Group Chief Medical Officer at Lenmed.

During the sessions, Mr Shivanand taught participating guests meditative techniques, holistic healing protocols and perspectives on mindfulness. He emphasised the fact that patients approach doctors in stressed conditions with the hope of finding cures to their ailments. He said it was therefore critical for medical practitioners to be a positive life force to these patients.

"A human being is a sum total of the body, mind, emotions and impressions. If we can take an integrated approach to treatment, we can experience more powerful and lasting cures to diseases," Mr Shivanand says.

According to Mr Shivanand, medical schools around the world, including Harvard Medical School, have, through research, validated mindfulness and meditation as a means of lowering stress, and thus creating a perfect environment for faster healing.

"Just like doctors sanitise themselves before and after every visit, they ought to sanitise themselves on the emotional, mental and psychic level as well," he says.



Mindfulness master Ishan Shivanand

Lenmed Ethekewini – which celebrates its 10th anniversary this year – is the only private hospital in KwaZulu-Natal offering paediatric cardiac surgery, and has a 15-member paediatric team, representing 11 paediatric sub-specialties.

"We are a unique and unusual hospital, and so we were extremely pleased to

host this unique medical meeting for healthcare professionals. Too often, we get so engrossed in life's daily demands that we forget to recharge ourselves. The session with Ishan reiterated the value of revitalising ourselves," says Mr Niresh Bechan, Lenmend Ethekwini Hospital & Heart Centre manager.

It is a belief shared by Dr Patel, who described his own experience following one of the workshops presented by Mr Shivanand as "remarkable".

"Being in the service industry – as we are – is like no other, and that in itself brings certain demands. However, it is all about how we embrace every day. In

bringing this unique speaker to SA, to our hospitals, we aimed to give our teams an added advantage, and indirectly benefit those we serve. The mindfulness techniques and meditation tools provided by Ishan will definitely enable us to exceed the expectations of our patients, visitors and doctors," says Dr Patel.

Mediation as a form of alternative dispute resolution – the basics

Hanneke Verwey, legal advisor, SAMA Governance and Legal Unit, **Shelley McGee**, Health policy researcher, SAMA Knowledge Management and Research Department

For any clinician, becoming the focus of a medical negligence case can be an emotionally draining experience. In SA, victims of medical negligence (perceived or real) typically seek redress by instituting a civil claim. A lucrative industry has developed around this phenomenon. Legal costs drive up insurance premiums, and fear of litigation causes some doctors to practise defensive medicine, which contributes to escalating costs. The journey to a successful negligence claim is also time-consuming, traumatic and expensive. There have therefore been calls from various stakeholders to turn to mediation to try to resolve these disputes in a more efficient manner.

What is mediation?

Mediation represents an alternative dispute-resolution process to litigation. It can be broadly defined as a voluntary process in which an acceptable and neutral third party acts as a facilitator. The mediator assists parties in isolating disputed issues, in order to develop options and alternatives, and reach a consensual settlement. There are further approaches and ways to define mediation. The different approaches can be analysed through two widely recognised models of mediation, namely evaluative mediation and facilitative mediation.

Facilitative v. evaluative mediation

In facilitative mediation, the mediator facilitates communication between the parties, and creates a structured process in which parties express their concerns, interests and needs, and generate possible solutions.

The mediator controls the process, but does not advise parties regarding the merits of the case, make recommendations, direct parties to a certain outcome or predict what the probable outcome would be should the matter go to trial. The parties control and determine what outcome will best serve their own and their common interests. A facilitative mediator is neutral and objective. The goal of facilitative mediation is to explore the opinions, belief systems and attitudes of the parties, bring underlying issues to the fore and enable parties to reach a mutually satisfactory agreement by themselves.

The main purpose of evaluative mediation is to reach an agreement. The evaluative mediator predicts the possible outcome of a court case, draws the parties' attention to the strengths and weaknesses of their cases, provides recommendations and direction and evaluates the case based on legal concepts and/or industry practice. An evaluative mediator focuses on the legal rights of the parties, as opposed their underlying concerns, interests and needs. As with facilitative mediation, the evaluative mediator structures the process; however, (s)he also directly influences the outcome of mediation. Evaluative mediation is therefore more directive and interventionist.

Supporters of facilitative mediation are of the view that, as parties are empowered to control and own the outcome of their dispute, the likelihood that parties will be satisfied with the outcome is increased. Detractors express concern that facilitative mediation too often ends without an agreement being reached, unlike evaluative mediation, which provides an answer where parties are unable to agree

themselves. Detractors of facilitation also express concern that outcomes can be unfair, and that facilitative mediators are unable to protect the weaker party in the absence of legal representatives. Detractors of evaluative mediation, on the other hand, express concern that the evaluative mediator may not necessarily be correct in his or her evaluation of the case. Many also argue that evaluative mediation is litigation disguised as mediation.

Essential features of mediation

- **Structured:** The mediator is in control of the process, which consists of several joint and private sessions in which parties are encouraged to communicate with each other through the mediator, to explore their needs, interests and concerns. Settlement options are generated during private sessions. A successful mediation is typically concluded during a final joint session.
- **Informal:** Although mediation is structured, it is an informal process. The rules of procedure and evidence do not apply.
- **Voluntary:** Mediation is a voluntary process that can occur at almost any stage of a claim. If a party is not satisfied with the outcome of the mediation, or is unhappy with the direction in which negotiations are going, (s)he may withdraw from the process at any stage before the final settlement is signed. The parties are then free to pursue other forms of alternative dispute resolution or litigation.
- **Without prejudice:** Mediation takes place without prejudice to the rights of the parties. In the event that the mediation fails, anything said or admitted during

the mediation will not be admissible in subsequent litigation between the parties.

- **Confidential:** Regardless of whether or not a settlement is reached, parties are bound to an agreement that whatever is said during the mediation process (whether during joint or private sessions) will remain confidential.

Differences between mediation, litigation and arbitration

- In mediation, the parties determine the outcome. In litigation and arbitration, an independent third party (judicial officer or arbitrator) determines the dispute.
- Parties choose the mediator or arbitrator themselves. Parties usually choose someone with knowledge of and experience in the subject matter of the dispute. In the case of litigation, a court-appointed judge presides over the matter.
- In mediation, parties need not be legally represented. Parties are, however, permitted to instruct legal counsel and to have their lawyers present. In litigation and arbitration, all parties are usually represented by legal counsel.
- Mediation takes place in private, and parties are bound by a confidentiality agreement. If a matter goes to trial, the dispute is a matter of public record. Parties to an arbitration can protect their privacy by insisting on a confidentiality clause in the arbitration agreement.
- Mediation and arbitration are less expensive than litigation.
- In arbitration and litigation, merits and quantum are typically separated, especially in the case of complex disputes. In the case of mediation, it is possible for some cases to settle in one session; however, a separation of issues may be necessary.
- Mediation and arbitration allow for earlier disposal of disputes. Even if a settlement

cannot be reached, mediation can still be a useful tool to narrow the issues, thereby saving time.

- Mediation is less traumatic for the parties than litigation and arbitration. Unlike in litigation and arbitration, no cross-examination takes place, and it is not an adversarial process. Mediation furthermore enables parties to restore their relationship and dignity.
- Mediation allows the doctor to explain to the patient what actually happened. Medical disputes often arise or escalate because of poor communication, which makes mediation especially suitable to resolve disputes where a lack of communication lies at the heart of the dispute. In the case of litigation and arbitration, open communication is not encouraged.
- Mediation allows parties to consider an unlimited scope of possible settlement solutions, unlike litigation and arbitration, where parties are limited to an award of damages. Plaintiffs who have suffered harm as a result of medical negligence are, of course, entitled to monetary compensation. Mediation, however, allows parties to conceive of settlements that add further value beyond a lump sum of money. In litigation and arbitration, damages are only awarded to a plaintiff if (s)he is able to prove, on a balance of probabilities, that the doctor's negligent conduct resulted in harm. Plaintiffs thus walk away with nothing when an inherent or unavoidable error has occurred. This need not be the case when the dispute is mediated.
- Mediation is less formal than arbitration and litigation. Parties are not bound to procedural and evidentiary rules. In the case of litigation, the matter is presented in court, where arguments are made, witnesses testify and are cross-examined and documentary evidence is presented. Rules of evidence and procedure are

followed. The arbitration process is similar to litigation, but does not occur in a courtroom, and the arbitrator has some discretion with respect to relaxing the rules of evidence and procedures.

- Mediation rejects the law as the sole means to resolve conflict, whereas disputes are decided according to complex legal principles in litigation or arbitration.
- Expert involvement is permitted in the case of mediation, but not necessarily in all cases. Experts are typically required in the case of complex disputes, or to break deadlocks. Expert evidence to understand the full extent of injury and prognosis should be obtained before entering into mediation involving any financial compensation. Expert evidence is instructive, and cases are usually decided on the basis of such evidence in litigation and arbitration.
- Mediation is binding once a written agreement has been signed by the parties. A mediation agreement may be made an order of court. Court judgements are binding, although subject to appeal and review. An arbitration award is binding, but subject to a review by a court and appeal to a further arbitrator or panel. The arbitration award may be made an order of court.

Conclusion

Mediation may, in many instances, offer an effective mechanism for the disposal of disputes between doctors and patients. Although mediation has been used to settle medical disputes in other jurisdictions for years, the uptake in SA has been relatively slow. The drive for mediation will have to come from all stakeholders, including the medical profession. Lawyers will also have to approach mediation in good faith, and not merely rubberstamp or abuse the process to test the waters for litigation.

Meet Dr Vusumuzi Nhlapho, new head of PPD

SAMA welcomes the new head of the Private Practice Department (PPD), Dr Vusumuzi Nhlapho, who joined us on 1 June this year. Here he chats to SAMA marketing manager, Dr Simonia Magardie

Tell me about your background? I was born in Rietfontein, a farm just outside Balfour (in the former Transvaal), where I stayed until the age of 12. I recall that we had to travel more than 20 km to

get to school. As was typical of most farm schools at the time, the highest grade at the school was standard 4 (now grade 6). As a result, most of the children on the farm, those who were fortunate enough to even

get to standard 4, joined the farm's labour force at this point.

I was fortunate that my late father, who had not received any formal education, but was wise, and my mother, who has a standard 2

education, were both committed to education. They also had the active support of my school teacher, Mr M Mbele, who truly epitomised dedication.

At the age of 13, I left for Katlehong, on the East Rand, to continue my studies at Nokulunga Primary School. This was an intense period of personal growth and development. For the first time, my eyes were opened to a far bigger world of sociopolitical developments in SA. Issues that I had only vaguely understood up until that time, such as the Soweto uprising, made sense for the very first time.

Young as I was, I was challenged to re-evaluate my understanding of the history of SA as previously taught, and I gained a fresh perspective on the position of the African (Bantu, as then derogatively referred to) in the SA political landscape. Through participation in the debating society, we explored a range of issues, and the appreciation that as students, we did not have to accept the status quo at in either our school environment or, more importantly, in the country. Making a positive difference wherever you are would subsequently become my motto, as it is to this day.

As a top student in the East Rand Region for the junior certificate examinations, I was awarded a ZAR500 bursary by Shell. This was the capital amount I used to open my first ever bank account at the post office, a proud moment indeed.

The award ceremony was addressed by the late Prof. TW Kambule, a well-known mathematician. This was a truly affirming and inspiring experience, and had a lasting impression on me. Prof. Kambule emphasised the role and value of education as a life-transforming and liberating agent, a message that I and my contemporaries (close friends such as Prof. Z Vilakazi, now Deputy Vice-Chancellor for Research at Wits University) took to heart. I then went on to complete my matric at St Alban's College in Pretoria, through an Anglo-American scholarship.

The mid 80s were politically volatile in SA, with activists disappearing. I joined a number of young people who were afforded the opportunity to pursue our studies abroad, another significant milestone in my growth and development. I registered for pre-med studies at Wesleyan University, Middletown, USA, with majors in molecular biology and comparative politics. Wesleyan was an intellectually stimulating environment, and a hub of dynamic political activism. As one of the leaders in the Southern African Action Group, I was actively involved in educating the American public about the struggle against

apartheid, the disinvestment campaign and the destructive effects of American foreign policy in southern Africa, and Angola specifically.

We worked very closely with the office of Ms Lindiwe Mabuza, the first Chief Representative of the ANC appointed in the USA, which gave a major boost to the anti-apartheid movement, both at universities and in the USA generally. With the momentous events of the 90s, and the release of Nelson Mandela and other political leaders, we were excited to return home, and I completed my medical studies at Wits.

I hold postgraduate qualifications in occupational medicine from the UK and Canada, and have worked in a number of industries: transport, mining, hydroelectricity, forestry and managed healthcare.

This diverse industry experience has helped me gain an in-depth understanding of health policy issues from both local and international perspectives. Access to quality healthcare remains a challenge globally. In SA, the scenario is further complicated by the fact that there are large disparities between the private and public sectors; less than 20% of the SA population is medically insured. The state therefore has to cater for the nearly 85% of the uninsured population in a manner that ensures quality healthcare.

Universal health coverage (UHC), as a principle, is widely accepted globally, and is proposed as a solution to SA's health challenges. The current debate about the modalities of UHC in SA is critical and timely. These are debates that I am passionate about, and the struggle to ensure access to quality healthcare for all South Africans continues, with SAMA at the forefront of these engagements.

Why did you decide to join SAMA? I first became a member of SAMA as a medical student, and was active as the JUDASA representative for the North West Province. I believe that SAMA should serve as a conduit to represent the medical profession, and all doctors, on matters relating to the profession. SAMA is, among other things, committed to empowering the medical profession in SA to bring health to the nation, and I am strongly aligned with this commitment. Because of this synergy with SAMA's commitment, I welcomed the opportunity to serve as the head of the PPD. To bring health to the nation, a collaborative engagement among the different stakeholders is critical.

The importance of the voice of the medical doctor, as a provider of essential services, cannot be overemphasised, and this is the role that SAMA plays on a daily basis, as we interact with a number of strategic partners in



Dr Vusumuzi Nhlapho

the healthcare industry, both in the private and public sectors.

To underscore the point, SAMA is actively involved in the discussions around the National Health Insurance (NHI) Bill, the Medical Schemes Amendment (MSA) Bill and the health market inquiry (HMI) submissions. Being part of SAMA, and at the centre of policy developments currently, was a major pull, and will allow me to utilise my expertise and understanding of the healthcare industry.

What is your vision for the department?

The SAMA PPD is at the centre of the highly competitive and often complex private healthcare industry in SA. As such, our focus is on dealing with all the issues that affect doctors in private practice (or as many as possible). These issues range from policy discussions on healthcare, strategic engagement with multiple stakeholders (funders, the National Department of Health, HPCSA, Council for Medical Schemes, etc.), to regulatory matters with regard to clinical and ethical issues.

My vision is to ensure that at its core, the PPD strives to not only improve the financial viability of the private healthcare industry, but also enhance the quality of professional life for doctors, and the service that the public receives. We will engage more robustly with the representative associations for doctors, and ensure that individual SAMA members are kept apprised of all significant developments within the organisation, and the industry as a whole. A number of meetings are, for example, planned to engage doctors on the NHIB, MSAB and HMI, in preparation for SAMA's submissions.

The PPD will spend significant time on ensuring that SAMA works closely with our strategic partners and doctor representative organisations, to ensure that a unified voice

for doctors is fostered. To that end, SAMA has signed memorandums of agreement with a number of independent practitioner associations IPAs to form a working forum to articulate a united voice of GPs on key issues.

How do you experience the staff members in your department? First and foremost, I was warmly welcomed by all members of my department, and the SAMA family in general. I have a small but highly competent team of

professionals who are executing on a daily basis the mandate of PPD, as directed by the General Practitioners' Private Practice and the Specialists' Private Practice Committees.

As SAMA is a member-based organisation, each and every member of my team is committed to providing the highest standard of customer service. The team is actively involved in all matters relating to clinical coding for doctors, and, in association with

other departments, actively promotes the SAMA brand through quality service. There is complete alignment between the vision of the department and its commitment to delivering exceptional service.

What do you do in your free time? I don't have much free time, as I am still engaged in a number of professional organisations in the mining and occupational health sectors, but I enjoy squash and the outdoors.

Finding alternative work for pregnant employees

Keletso Makwe, industrial relations advisor, SAMA Industrial Relations Department

When an employee falls pregnant, in most instances, the expectation of such an employee is that the employer will modify her job description to make her life easier. The reality, however, in most cases, is that the employer is not willing to make any adjustments to accommodate the employee.

SAMA has been approached on a number of occasions by members who are in need of advice and/or assistance in this regard. A case that is commonly seen is one in which members do not wish to participate in commuted overtime. The reasons given, among others, are the following:

- the symptoms are overwhelming
- their doctor has recommended a lot of rest, due to the strain to the body
- medication is making them feel sick
- the workload, especially when on call, is overwhelming
- in some instances, members have concerns about the possibility of contracting disease from patients and transmitting it to unborn babies.

Concerns raised by employees/members are in most cases genuine and worth listening to, and should be addressed by the employer. SAMA has in the past intervened, and engaged the employer on the concerns raised, and also advised members on the possible outcome.

For example, in *Manyetsa v New Kleinfontein Gold Mine (Pty) Ltd* (JS706/14) [2017] ZALCJHB404 (7 November 2017), the employer had no suitable alternative work for the pregnant employee, and it was found that her original work area was hazardous. The court found that the employer had fulfilled its obligations under both its policy and the Basic Conditions of Employment Act (BCEA) No. 75 of 1997. It also found that the employer was justified in placing the employee on unpaid leave, due to there being no suitable alternative work for her.

The Labour Court confirmed that, while the employer's policy obliged it to make every endeavour to find suitable alternative work for its pregnant employees, it did not provide a guarantee that such alternatives would be found, and neither is there an obligation on the employer to create suitable alternatives.

The Labour Court did, however, note that section 26 of the BCEA, the Code of Good Practice and the employer's policy are in contrast to the International Labour Organization's Maternity Protection Recommendation 200 (nos 183 and 191), which obliges an employer to provide the employee with paid leave in such circumstances.

The above LC case law, as well as legislation that does not entirely protect affected pregnant employees, should not, however, deter employees from seeking help from the employer. Where the employer fails to address the situation, or shows lack of interest, employees who are SAMA members should not hesitate to approach the organisation for assistance.

The union will approach the respective employer with a view to resolving the matter. Should the matter remain unresolved, it will refer it to the Bargaining Council/Commission for Conciliation, Mediation and Arbitration (CCMA), or the Labour Court. This is based on the principle that each case is judged on its own merits.

The Competition Commission health market inquiry publishes its provisional findings

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

The Competition Commission health market inquiry (HMI), which commenced in 2014, was at last able to release its preliminary findings in early July 2018.

The HMI was conducted with the very specific mandate of identifying features of the private healthcare sector that, alone or in combination, can prevent, restrict or distort competition. This

involved an in-depth examination of a truly complex health system with multiple actors, regulations, influencing factors and monitoring and evaluation practices.

As SAMA has participated in a number of submissions, workshops and meetings as the process has unfolded, we believe that the Competition Commission team has examined and uncovered far more than just those factors relating to competition in the private sector. While these have extended beyond the original mandate of the inquiry, we hope that some of the results may translate into positive improvements for both the patients who make use of privately provided health services, and of course the health practitioners in this sector.

The HMI was hindered from early on by challenges from stakeholders, and difficulties in obtaining the data that were necessary to attempt to make evidence-based recommendations about private healthcare services, funding, medical schemes and patient choice. The limitations in the data have been openly acknowledged by the HMI, and they have welcomed any additional input into their analysis and findings.

SAMA has actively pursued the submissions, data and information that has informed all of the findings and recommendations of the HMI, and will be submitting a response to the draft report in September 2018.

Summary of findings

The HMI identified multiple market failings in the private sector, to which it attributes its failure to deliver better value to consumers. These extend from market fragmentation and governance failures, to lack of transparency and damaging regulatory structures.

Regulatory failure. First and foremost, the inquiry found that the evolution of the private sector into its current form has been the result of several regulatory failings. The particular factors identified were that facilities require a licence to operate, but little more, and that healthcare practitioners are licensed to practice, but are subject to little regulation beyond this.

Funders in the system are regulated, but the regulatory regime is incomplete, and is often simply not adhered to as intended by the legislation.

Practitioner supplier-induced demand. Supplier-induced demand refers to a situation where the utilisation of healthcare services is unnecessarily promoted by suppliers of services who stand to profit off this activity. The HMI believes that several incentives in the market have promoted over-servicing by medical practitioners, which includes increased admission to hospitals, increased length of stay and higher

levels of care and use of more expensive care than can be explained by the disease burden of the population.

The HMI, probably correctly, identified that the fee-for-service environment tends to incentivise the preservation of solo practices, and does not encourage integrated care models. Where new models of care have been attempted, uptake has been slow.

In addition, the HMI believes that there is not a lot of accountability on the part of practitioners. While GP networks, for example, do monitor quality assessments, the indicators are still debated, and the results are not made public. Quality-assurance processes and peer review still remain weak, and are not truly reporting on health outcomes, but rather process outcomes.

Having examined the underlying analysis and assumptions made by the HMI in its analysis, the SAMA Knowledge Management and Research Department disagrees with several of the assumptions made in relation to these analyses. Data has been highlighted as a limitation by the HMI, and in their analysis, they were only able to adjust for some of the factors that may be influencing treatment patterns in the population – there appear to have been many clinical, epidemiological and benefit design drivers omitted, some knowingly, some apparently unknowingly, by the HMI analysis.

Some of the cost drivers, such as technological advancement and medical malpractice insurance, have been excluded. Furthermore, some assumptions made are, in reality, inaccurate. It would also seem that there were errors with the categorisation of data. SAMA is in the process of examining and challenging some of the findings, those against practitioners in particular.

Where we are probably in agreement with the HMI findings is on the fact that much could be done to improve the efficiency of care delivery that medical aid members receive. We believe that this can best be achieved by developing payment models that incentivise better quality of care, allowing practitioners the freedom to treat patients appropriately, while holding practitioners and schemes accountable for clinical outcomes and appropriate funding, respectively.

Concentration in the funder environment. The concentration in the funder market is of concern to the HMI. Discovery Health and Medscheme dominate the administrator market, and it does not appear that there is much room to challenge these two giants in the industry. In a normal competitive industry, the large profits made by the administrators

should by now have attracted competition to disrupt and challenge their position, but the barriers to entry appear to be high. This the HMI considered a market failure in competition terms.

The HMI also found that the multiple benefit options and schemes make the environment incredibly confusing for consumers (SAMA would say the same for our medical doctors), and medical scheme members have difficulty choosing plans that really bring them value for money.

The HMI believes that the medical schemes do not adequately hold their profit-making administrators accountable for ensuring that they get value from the supply side of the market, and that they are not effectively using their buying power or contracting abilities to ensure reductions in premiums and protect their members from out-of-pocket expenditure. Furthermore, the HMI alleges that the Boards of Trustees do not always act in the best interest of members.

Schemes continue to pay for prescribed minimum benefits inappropriately, and there is no mechanism in place to enforce compliance. The HMI also found that many medical schemes fail to manage their designated service provider networks adequately.

Concentration in the hospital environment. The hospital environment was also identified as extremely concentrated, dominated by the three large hospital groups. This essentially puts the hospitals in an extremely powerful position in terms of negotiations with funders, making cost savings in this sector difficult to achieve.

The HMI also expressed concern over the distribution of these facilities, which are concentrated in the urban areas, and are issued licences in areas where other facilities already exist.

Key recommendations which SAMA will be addressing with the HMI

Supply-side regulator. The HMI recommends that an independent supply-side regulator be established to oversee and manage functions related to “healthcare capacity planning, economic value assessments, the determination and implementation of appropriate payment mechanisms (including the determination of fees) and outcome measurement, registration and reporting”.

According to the HMI, locating these functions within a single supply-side regulator will ensure coherence in policy development and implementation.

In our previous submissions, SAMA has acknowledged a lack of infrastructure for outcomes measurements, and a lack of funding for guidelines development and technology assessment by an independent body. We believe that these functions are necessary for the health system, and that our medical doctors should play a role in these functions.

Tariffs. Most of our private-sector doctors have experienced the frustration of the “tariff vacuum” left by a Competition Tribunal ruling against SAMA, the Board of Healthcare Funders and the Hospital Association of SA in the early 2000s, and the subsequent failure of the National Health Reference Price List process. This often leaves patients financially exposed to co-payments and balanced billing.

The HMI has recognised this challenge, and recommended several options for addressing it. Regulated pricing is their first option: a system in which stakeholders representing providers, funders, government and civil society will make simultaneous submissions on fee-for-service tariffs, within a multilateral setting that will be managed and governed by the supply-side regulator.

The second proposed option is a system of multilateral tariff negotiation, whereby the stakeholders are encouraged to bargain and reach agreement within a framework set by the supply-side regulator. If they fail, the regulator

will refer the dispute to the independent arbitrator for final decision.

Both of these options could see a return to the multilateral negotiations that were previously outlawed by the competition commission – although these new structures would seek to be far more transparent and inclusive than the old negotiating tables.

Practitioner payment models

The HMI recommendations are strongly in favour of a move away from the fee-for-service models to alternative reimbursement options. They do recognise, however, that it is important that these models promote financial risk-sharing and contain costs and volumes, while preserving or increasing quality of care.

The HMI also recognises that it is not in a position to prescribe how the transition of payment mechanisms should take place, and acknowledges the need for a variety of alternative forms of practice and methods of payment.

Alongside this, various recommendations they have made include the recommendation that schemes report on what they have done to promote value-based contracting, address supply-induced demand and contain non-healthcare expenditure.

There is also a recommendation for a review of the HPCSA ethical rules to allow for

multidisciplinary practices and global fees, and mechanisms for the encouragement of geographic-based new entrants into the market to service underserved areas.

Clinical coding. The HMI recognises the importance of coding systems and the integral role that they play in payment systems. It recommends that coding systems across the sector be standardised, to facilitate the meaningful sharing of information.

It is for this reason that the recommendation is for the proposed supply-side regulator to also be given the responsibility of the management of coding systems. As SAMA has for some time been the custodian of the CPT system as pertains to SA, we get special mention in this section as owning the intellectual property rights.

Looking forward

Many of the findings of the HMI have been valuable, and the opportunity to explore and air the challenges faced by stakeholders in this system will have an important impact on policy in the future.

SAMA is at the forefront of examining the potential impact of the proposals on our member doctors, and will be raising concerns where we feel that they misinterpret or misrepresent the role of the medical practitioner.

The need to professionalise health professions education

Dr Elize Venter, HOD, Academic Programme Development and Quality Assurance, FPD

Traditionally, faculty in the health sciences have been appointed on the basis of clinical expertise, with little to no attention being paid to educational expertise. More recently, academic appointments have also emphasised research abilities as desirable qualities; however, educational expertise is still seldom given priority.

A number of recent studies have shown that today's students have very specific views around what constitutes a good medical educator, some of which are shared by the health education community. A number of national and international organisations aim to strengthen health professions education (HPE); two of these are the SA Association of Health Educationalists (SAAHE) and the Sub-Saharan

Africa FAIMER (Foundation for Advancement of International Medical Education and Research) Regional Institute (SAFRI).

These organisations acknowledge that being a clinical expert and an accomplished researcher does not automatically prepare faculty for the complex and evolving role of being an educator. The incorrect assumption that intelligent people who have been students for many years will have assimilated the skills needed to be a successful educator has often resulted in little or no support for staff development in this area at tertiary institutions.

The environment in which health education takes place is changing rapidly, calling for an ongoing process of programme development. The geographical distribution of many diseases

is changing, healthcare delivery systems are being reformed, new technologies are having increasing impacts on clinical practice and the public, and the regulatory environment demands greater accountability on the part of healthcare professionals. These changes place huge pressure on educators to adapt their educational strategy and approach to ensure the production of health professionals who provide better care to patients. High-quality medical education is a vital prerequisite for high-quality patient care.

Not only does the education of health professionals need to prepare them for a dramatically changed practice environment, but the type of instruction demanded by a new generation of students has also

changed. To really meet the future needs of students, health professions educators will need to have the vision, knowledge and skills to plan, deliver and improve sound educational programmes. It is essential to ensure that those who train healthcare professionals create and deliver effective educational programmes that result in high-quality health services. HPE is an ongoing process, which must adapt to the profession's changing dynamics with respect to technology, patient needs and service delivery. In addition, leadership development is now recognised as a critical component of faculty development in HPE, along with teaching skills.

As a health professions educator, you need to apply leadership and management skills to lead universities and other education institutions in a rapidly changing global environment, while working in close collaboration with a range of healthcare delivery partners. The complexity and pace of change in healthcare means that the need for effective leaders and leadership development has never been so important. According to McKimm and Swanwick, educational leaders can no longer rely entirely on formal positional authority, but must seek to develop and display appropriate leadership characteristics and qualities. It is increasingly recognised that people at all levels in an institution have the potential to perform and display leadership. Hence leaders in HPE should receive the necessary training to develop their leadership skills.

Faculty development has become an increasingly important component of medical education. It can provide medical educators with knowledge and skills in teaching and learning, student assessment, programme evaluation, leadership and administration, as well as research scholarship. In response, HPE programmes are emerging worldwide to train faculty in teaching and learning within the higher education context, with the motivation of improving patient care through the improved education of future healthcare professionals. In addition, formal qualifications in the HPE field are becoming increasingly popular, due to the "professionalisation" of medical education.

According to Steinert, the demand for accountability in higher education is continuously gaining momentum, resulting in escalating pressure to change professional conduct in HPE. As such, the primary purpose of HPE programmes is to improve the instruction and professionalisation of HPE activities for faculty in colleges of medicine, dentistry, pharmacy, nursing, physical therapy and other health professions schools. The concept of the professionalisation of HPE is defined as the process of giving HPE a professional character, identity or status. It involves establishing a suitable and accreditable qualification, satisfying both national and international needs in HPE.

Responding to the above trends, the Foundation for Professional Development (FPD), with technical input from SAFRI, has developed an e-learning Postgraduate Diploma in Health Education and Leadership, tailor-made to help health educators develop the educational and leadership skills required to meet the increasing complexity of HPE in a fast and continually changing educational landscape.

References available on request.



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Sample to Insight

Celebrating Nelson Mandela's centenary by giving back to the community

Bokang Motlhaga, junior marketing officer, SAMA Marketing Department

As the world arose to commemorate Nelson Mandela on 18 July, on his centenary, through various activities aimed at giving back to the community, SAMA was no exception. SAMA co-ordinated two corporate social investment projects on this day.

The day commenced with a revamp of the paediatric oncology ward children's play area at Dr George Mukhari Academic Hospital, followed by a drop-off of groceries and goods at Sungardens Hospice.

Dr George Mukhari Academic Hospital is located in Ga-Rankuwa, a township situated approximately 37 kilometres north of Pretoria. The hospital caters for the greater Ga-Rankuwa area, but also sees patients from other surrounding areas, such as Mabopane. SAMA staff saw a need to embrace the spirit of Madiba in accordance with his love for children, by collecting toys, story books, colouring books and coloured pencils to make over the children's play area at the hospital. This revamp was preceded by a handover of a hamper full of baby essentials to the mother of the first baby born on 18 July.

Sungardens Hospice offers a programme of specialised palliative inpatient care to patients living with life-threatening illnesses. The hospice also provides support to families



Some of the staff from SAMA and Dr George Mukhari Academic Hospital with the children who experienced the made-over play area for the first time

of such patients, and offers accredited palliative-care training. The SAMA staff took along groceries for the patients.

The expressions of gratitude from staff at Dr George Mukhari Academic Hospital and the children who experienced the play room

immediately after the makeover, and the staff at the Sungardens Hospice, showed that the SAMA staff had indeed done them a great service, reinforcing Barack Obama's depiction of Nelson Mandela as a man who believed in the power of action.

Pay off "black tax" to focus on your future

Sanlam

The term "black tax" has cemented its place in SA's vocabulary. It is clear that the financial obligations that many young people have to their extended families results in them battling to keep up their own savings. Kenosi Magosha, head of Client Solutions for Recurring Savings at Sanlam, says managing family expectations when it comes to money is the one of the ways to improve this situation.

"While it's called 'black tax', it's evident that young people from other race groups also sometimes find themselves in a situation where they have to financially provide for their parents

and relatives. This financial dependency can become a vicious cycle if not managed properly because, ultimately, it could take away from the collective family's ability to grow wealth or lead to the individual who is the provider now being forced to rely on her own children later in life – simply because she is unable to save her money for other purposes," she says.

The 2017 Sanlam Retirement Benchmark Survey highlights financial obligations to extended families, and ad hoc requests for financial assistance, as the second biggest source of stress among middle-class consumers. Magosha says that to avoid

overburdening themselves to the point where they cannot save for their own future, young people need to manage their families' expectations from the moment they get their first job, to ensure that support is sustainable and leads to progress for the family.

She suggests that instead of being the centre of provision, it is better to empower family members to earn their own income, thereby increasing the collective family's earning ability.

"Empowerment doesn't have to be a university degree. There are vocational training facilities and practical skills that can

be learnt to help individuals become self-employed, e.g. training as an electrician. This may require you to make sacrifices for a year or three, but it will help you to free up more money to direct towards your savings goals over time."

Magosha says that the burden of black tax may disproportionately fall on certain family members, and such individuals need to have frank and honest conversations with their families. She explains that the desire to provide might be rooted in personal traits such as care and generosity, but it can also be rooted in guilt for the sacrifice that the family made to put the individual through school. She says people need to reflect on their reasons for supporting extended family and, if the emotion of guilt plays a role, they need to ask themselves why they feel this way.

"It's a privilege to be able to give to someone else. Ask yourself, why is there an emotion of guilt, instead of a celebration of how far you've come to be able to give? If you do not deal with these emotions, it can cause bitterness, and even breed a manipulative relationship between the giver and the recipient."

Magosha explains that looking after parents is part of the African culture. However,

she says, giving is a personal choice and one that you need to be comfortable with.

"If you are not going to give, and instead enrich yourself materially, ask yourself what would happen if you lost it all tomorrow. On the other hand, if you give because you cannot say no, or because you believe giving reflects well on you or status in life, you may be doing yourself and others a disservice, where you create dependency. Make sure you are at peace with your arrangement."

How to balance your financial obligations

- Choose your battles: Pick certain things that you are willing to support – for example, education. That way, you will not get ad hoc financial requests for parties or fashion items.
- Set a deadline: Let it be known upfront when you expect to see the fruit when helping someone, to allow you to focus on your savings objectives.
- Plan for the unexpected: Invest in financial vehicles such as funeral cover that can help you smooth out financial stress related to helping when there are family funerals.
- Give, but don't spoon-feed: Do not destroy the person that you are giving to by letting

them depend on you. Help them empower themselves so that they too can give to others.

- Let everyone take responsibility: Work with your extended family to help them make sound financial decisions when they start earning an income. Sometimes you need to let everyone experience the discomfort of their bad financial decisions for them to learn to make better decisions.
- Exercise financial discipline: You cannot do an infinite number of things with a limited amount of money. You need to trade off, otherwise you will end up so heavily indebted that you may even lose your assets.
- Put money aside for yourself: Give what is left after you've saved for retirement. Ensure that you will retain independence in your old age, otherwise you will perpetuate the cycle of dependency.
- Instil financial discipline in your immediate family: Start with your own children. Let them know that you have a budget to stick to when you shop. Start managing their expectations too, from a young age, by limiting impulsive spending and talking about money with your children or the young people in your life.

2018 - 2020 ADASA committee elected at AGM

SAMA Communications Department

An Academic Doctors Association of SA (ADASA) AGM was held on 25 July 2018 at the Wits Faculty of Health Sciences' Phillip V Tobias Building. The keynote speaker at the event was Prof. Martin Veller, dean of the Wits Faculty of Health Sciences and chair of the SA Committee of Medical Deans.

Prof. Veller spoke on the state of academic medicine in SA, highlighting the fact that despite local challenges, at least five SA universities made it to relatively high positions in important international ranking lists. Challenges include managing greater numbers of undergraduate students, as well as maintaining the ongoing quality training of specialists. There are problems with regard to adequate funding to facilitate this growth and the employment of qualified medical personnel, including interns,

community-service doctors and newly qualified specialists, as well as regarding maladministration, corruption in different provincial departments of health, and political interference from and affiliation of decision-makers. While there are also internal problems at certain universities, he alluded to several proposed solutions as well. These include: academic medicine should remain the mainstay in public healthcare; clinical governance should be strengthened and improved, to enable universities' capacity in terms of training graduates; safe working environments must be secured and employee wellness programmes must be made available to students and practitioners; and decision-makers must be held accountable. He concluded that academic medicine plays a vital role in ensuring access to universal healthcare.

SAMA board chairman, Dr Mzukisi Grootboom, outlined SAMA structures, including the SAMA membership and professional affairs committees, SAMA branches and the different head office departments. He also highlighted certain challenges, including continued membership cohesion through the Employed Doctors Committee, access to quality healthcare and assessment of outcomes, as well as the current transitional environment in terms of the proposed implementation of the National Health Insurance (NHI).

Prof. Mark Sonderup, SAMA board vice-chair and chair of the Employed Doctors Committee, led a discussion with the attendants on the commuted overtime contract (COT) update, the remuneration model for doctors and dentists, e-disclosure, the crisis with interns and community-

service placements, implementation of the NHI, joint appointees and the Colleges of Medicine of SA.

Prof. Bernard Janse van Rensburg, interim ADASA convenor, presented a brief overview of ADASA committee activities, and the current situation, in order to look ahead. The last ADASA committee meeting was held in May 2013, with matters on the agenda such as remunerative work outside public service (RWOPS), the NHI, the ADASA constitution and joint appointees. Changing the ADASA constitution, to extend membership from each of the medical schools around the country to members nominated by each of the affiliated SAMA speciality groups, was considered at the time. The current ADASA position referred to the disestablishment of the SAMA trade union in 2016, the operation of the interim structure and involvement in consensus discussions in January 2017 with regard to overtime negotiations.

Looking ahead, nine priorities for the ADASA committee 2018 - 2021 term of office were identified:

- active engagement and building of structures
- effective representation of all disciplines
- RWOPS and COT
- structured contracts with both employers
- memorandums of agreement with universities and provinces
- alignment with stake holders such as the Committee of Medical Deans
- effective subcommittees at each of the different schools of clinical medicine
- representation from all specialist associations
- council representation in all SAMA branches with schools of clinical medicine.

The following ADASA committee was elected for the 2018 - 2021 term of office:

- Prof. B Janse van Rensburg: chairperson
- Prof. M Sonderup: vice-chairperson
- Dr K Thandrayen: treasurer
- Prof. D Basu: secretary
- Dr D Hagemester: additional member
- Dr O Harbor: additional member.



Attendees at the ADASA AGM

Dr Thandrayen breaks new ground recruiting interns

SAMA Communications Department

New SAMA general manager, Dr Manny Thandrayen, has been breaking new ground by personally visiting branches to assist in recruiting interns to SAMA. Part of Dr Thandrayen's initiative is for the branches to present interns countrywide who register with SAMA with a new set of scrubs.

Recently, KwaZulu-Natal (KZN) Coastal

branch hosted an intern registration at Prince Mshiyeni Memorial Hospital. The registration was well attended, and 12 new interns were recruited to join the SAMA family.

Western Cape branch also visited Groote Schuur hospital to hand out SAMA scrubs to 22 new intern members and will soon be visiting other hospitals in the area.



Dr Thandrayen (fourth from left) with Dr Akhtar Hussein and the interns in their new scrubs



An intern at Groote Schuur hospital shows off his new SAMA scrubs

No news is not always good news

The Medical Protection Society shares a case report from their files

Child J, a 1-week-old baby girl, was noticed to have a clicking right hip when she was seen by the community midwife. A referral to the orthopaedic clinic was requested, and child J was reviewed by orthopaedic intern, Dr M, 3 weeks later. Dr M confirmed that there was no relevant family history, and examined Child J. Dr M documented that there was no clicking of the hips, and Ortolani and Barlow tests for assessing hip stability were negative. Dr M discharged the baby back to the care of her GP.

During a routine check-up at 8 months, Child J's GP, Dr X, found that she had limited rotation of her right leg, and immediately arranged for her to have an X-ray. Two days later, following the X-ray, specialist radiologist Dr R described the results as follows: "The left hip is normal. The right hip appears dislocated, with associated moderate acetabular dysplasia."

However, due to a failure in the system, the report was simply filed away, and Dr X did not receive a copy at his practice.

Three weeks later, Child J's mother brought her in with a minor cold, and asked about the X-ray results. Dr X reassured her that he had not heard anything and it was therefore a case of "no news is good news," but he promised to check up on it. Unfortunately, the clinic was very busy, and he forgot to look into it.

Child J was reviewed at 16 months, when her mother complained that she "walked funny". Child J had an obvious limp, and on examination her right hip was clearly abnormal. Dr X made an urgent referral to the orthopaedic clinic, and a specialist paediatric orthopaedic surgeon, Dr B, confirmed the diagnosis of developmental dysplasia of the hip.

Child J was initially treated with a closed reduction and immobilisation with hip spica, but on follow-up at 3 months, the hip appeared dislocated again. An osteotomy was performed and appropriate immobilisation applied, but unfortunately, months later, the dislocation reoccurred, and the dysplasia also seemed to have deteriorated. Child J was referred to a sub-specialist paediatric orthopaedic unit, where she was seen by Dr P, a specialist in hip dysplasia. Dr P arranged for Child J to have specialised physical therapy, and explained to her parents that it was likely

that she would require further surgery within the next few years, although it was still too early to predict when, or what kind of surgery she would need.

Child J's parents brought a claim against all the doctors involved in the management of their daughter's care. They alleged that Dr M should have requested an X-ray to exclude the dislocation on the initial visit to the orthopaedic clinic. They also alleged that Dr R failed to ensure that the report made it safely to the practice, and that Dr X had not checked the X-ray, but had dismissed their concern. The parents also claimed against the orthopaedic surgeon, Dr B, for failing to treat their daughter's hip appropriately.

Expert opinion

The Medical Protection Society (MPS) sought expert opinions from a paediatric orthopaedic surgeon, and a GP.

The orthopaedic expert considered that Dr M, the orthopaedic intern, had demonstrated an acceptable standard of care. The examination of the baby was normal, with no suggestion of a dislocated hip, and was well documented. There was no family history to suggest higher risk; therefore, an X-ray was not indicated at that time.

The expert GP's opinion on the care provided by Dr X stated that the standard of care was below a reasonable standard, since he failed to follow up the investigation that he had rightly requested. The expert expressed sympathy for Dr X, who had diagnosed the abnormality appropriately, but then failed to follow up on the investigation. If the mother's account of the next consultation was right, he had missed a second opportunity to review the X-ray report. All of this translated into a long delay of several months in the surgical treatment of Child J's hip.

The orthopaedic expert commented that the surgical treatment by Dr B was in keeping with acceptable practice, and that the failure was caused by the advanced state of the dysplasia, which had made the hip very unstable.

The supportive orthopaedic expert's report enabled MPS to extricate Dr M and Dr B from this action. Dr R accepted that there had been a clear administrative error that had allowed the system to file the report without it

being sent to the relevant practice for action. The failings in this case meant that it was considered indefensible, and it was therefore settled for a substantial sum.



Learning points

- Good history-taking and careful documentation of physical examination can make a huge difference if a patient makes a claim against you, which can often be many years after the event.
- When you request a further test or examination, you are responsible for ensuring that the results are checked and acted upon.
- All administrative systems need a safety net, where results are checked so that abnormal results are not missed. It is vital to ensure that you have a robust system for acting on tasks that arise from a consultation.
- Poor outcomes are not necessarily the result of negligent medical management. Sometimes poor outcomes are a result of the particular condition. You can help to protect yourself from criticism by always ensuring that your records outline the rationale for any decision that you have taken.

Free eye-care services for more than 500 patients to honour Madiba



Patients registering

On Mandela Day, SAMA Lowveld branch, together with the Nelspruit Lions Club, organised an eye-care clinic day for more than 500 people over 40 years old. Held in the parking area of the Plaza SPAR centre, the day was run by 6 optometrists, 2 doctors and 20 volunteers from the Lions Club. The City of Mbombela local municipality supplied food, and the SA National Council for the Blind assisted with registrations.

Patients received blood-sugar level tests and blood-pressure tests, with referrals to Dr Bongzi Baloi and two other doctors for any abnormal vital signs, before their eyes were tested and screened to receive a free pair of spectacles (donated by SUPERSPAR and Sanlam), and a free meal for the day. This was the Lowveld branch's third outreach event

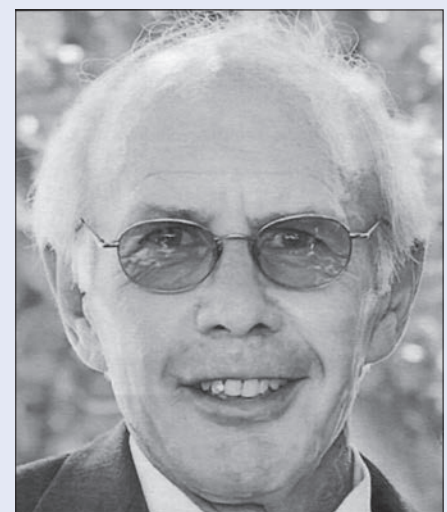
for 2018, and the event was covered by SABC 2 countrywide, and in the local newspaper, *Lowvelder*.

Dr Abraham Varghese, president of the Lowveld branch, said this was their way of honouring Madiba. "We have been doing this for about 8 years, and our motto is to serve the community. This year we decided to attend to more people because of Madiba's birthday," he said.

The branch received 14 glucose meters with strips from Pharmaco to issue to the diabetic patient cases. Kiaat Private Hospital provided three nurses, and the Mbombela Blood Service also provided staff to assist with blood-pressure and sugar tests. Sukuma Pharmacy in Mbombela also sponsored consumables, and their services, to ease the patient flow.



Doctors consult with patients diagnosed with diabetes, and refer them to the nearest clinic or hospital in their area



Dr Anton Mostert

Farewell

Dr Franz Antonie (Anton) Mostert, a lifelong member of the SAMA Goldfields branch in Welkom, passed away on Sunday 15 July 2018. Dr Mostert was a retired GP in Welkom, and had been a member of SAMA since 1976. He was well known in the community, and all his friends, patients and colleagues will miss him.

It is also with great sadness that we inform you of the passing of Dr E H Hills, a retired GP from Hennenman, on Tuesday 17 July 2018. Dr Hills was a member of SAMA Goldfields branch. He joined SAMA in 1960.



The Lions Club in Nelspruit invited SAMA Lowveld branch to their presidential induction event on 23 July 2018 at Bateleur Estate, Nelspruit. A certificate was presented to Drs Baloi and Malumane, acknowledging the branch's commitment to the Lions Club eye-care projects. From left to right: Mr Koos Schoonraad, Dr Abraham Varghese (SAMA council president), Mrs Val Graham, Lions district governor, Mr Ian King and Mr Feju Chaney.

First basic life-support course launched

The Lowveld branch hosted their first basic life-support training course at Rob Ferreira Hospital on 10 July 2018. Dr R Ismail from the Department of Health was the instructor, and feedback from the attendees was very positive. Doctors are looking forward to follow-up courses such as advanced cardiac life support (ACLS), advanced trauma life support (ATLS) and paediatric advanced life support (PALS), at venues closer to home. Unfortunately, the branch will not be able to offer free courses, due to financial constraints, but would like offer discounts on training expenses, to keep the doctors training local.



At the practical sessions

Border Coastal thank Dr Kim Harper



Kim and Angela Harper

On 30 July, Border Coastal branch councillors had a get-together dinner at Sanook Eatery in Beacon Bay Crossing, East London, to honour Dr Kim Harper for his long and dedicated service on Border Coastal branch council. The evening was attended by Dr Kim and Mrs Angela Harper, Dr Anastasia Rossouw, Dr Richard Makomba, Dr Simon and Dr Holly Comley, Dr Sharon Harbor, Dr Tanya Wantenaar, Dr Madeleine and Mr Tom Muller, Dr Tshepile Tlali and Mrs Stella Kaschula.

Since 2004, Dr Harper has served in various roles: branch councillor, clinical secretary,

treasurer, national councillor, branch chairman and president. He was always available and willing to assist members with issues that they raised, and was involved in the day-to-day running of the branch.

Dr Harper was also very involved in arranging many CPD events, including workshop series and 2-day weekend workshops, covering a number of very relevant topics.

His presentations as chairman and treasurer at our AGMs were very professionally drawn up and presented, with great attention to detail.

He has left very big shoes to fill.

West Rand CSI project

West Rand branch runs various corporate social investment projects in their region, and thought it would be a good idea to involve the learners from the Rant-en-Dal school for autism hostel, which relies on community involvement and donations to help in making it a happier place for learners. SAMA is proud to be a part of the project, and took 15 children from the hostel to the local Spur.

SAMA also identified an increasing need for various necessities for the cerebral palsy children, toddlers and babies undergoing treatment in Leratong Hospital's paediatric ward and outpatients department, and asked local residents to donate old car seats, toys, colouring books, etc. The drop-off point for donations is the SAMA West Rand office.



The children loved their outing to the Spur

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