

# SAMA INSIDER

OCTOBER 2018

## SAMA 2018 conference delivers

Merit Awards recognise  
significant contributions



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

**SOUTH AFRICAN  
MEDICAL ASSOCIATION**



# EXPERIENCE MATTERS

Our knowledge and expertise means  
we can protect you into the future.

For professional protection that  
goes beyond defence, visit  
[medicalprotection.org](https://medicalprotection.org)

Medical  
Protection



The Medical Protection Society Limited ("MPS") is a company limited by guarantee registered in England with company number 36142 at Level 19, The Shard, 32 London Bridge Street, London, SE1 9SG. MPS is not an insurance company. All the benefits of membership of MPS are discretionary as set out in the Memorandum and Articles of Association. MPS® and Medical Protection® are registered trademarks.

# CONTENTS

OCTOBER 2018



Source: ZOOM Photography: Christy Strever

- 3 **EDITOR'S NOTE**  
Celebrating progress  
Diane de Kock
- 4 **FROM THE PRESIDENT'S DESK**  
Notification of diseases –  
let's re-open the debate  
Dr Marina Xaba-Mokoena
- 4 **Obituary: Dr Paris Daniel**  
SAMA Communications Department
- 5 **FEATURES**  
SAMA 2018 conference delivers  
SAMA Communications Department
- 7 **Reflecting on the 2018 SAMA  
conference**  
Dr Mzukisi Grootboom
- 8 **Abstract sessions highlight key issues  
through high-quality, innovative and  
relevant research**  
Shelley McGee
- 11 **SAMA Merit Awards recognise  
significant contributions to  
medical profession**  
Prof. Mergan Naidoo
- 15 **PhD thesis motivates the SA  
national MTA**  
Dr Safia Mahomed
- 15 **When the good doctor burns out**  
Prof. Zukiswa Zingela
- 18 **Your financial health**  
Gert Viljoen
- 18 **SAMA Research Masters  
Supplementary Scholarship**  
Dr Daniël J Laäs
- 19 **Derivative misconduct in the  
workplace**  
Simon Buthelezi
- 20 **BRANCH NEWS**



**SPECIALISED SAME  
DAY SURGERY**

**Visit us at [www.cure.co.za](http://www.cure.co.za)**



**DEDICATED TO YOU...OUR PATIENT**



**Diane de Kock**  
Editor: *SAMA INSIDER*

## Celebrating progress

This month we celebrate a successful annual SAMA conference (page 5), the awarding of the prestigious Merit Awards to doctors who have gone above and beyond the call of duty to make a significant contribution to the profession (page 11), a PhD thesis that motivated the SA national transfer agreement recently gazetted into legislation (page 15) and the successful outcome of a SAMA Research Masters Supplementary scholarship on warfarin and its shortcomings (page 18). "My advice to anyone who wants to conduct research is not to get discouraged," says Dr Daniël Laàs.

On page 7, chairperson Dr Mzukisi Grootboom reflects on this year's SAMA conference, and the opportunity it has provided to assess "whether the conference has fulfilled our objectives, review lessons learnt and consider the challenges that arose both before and during the conference."

The parallel abstract sessions, which were presented mostly by young and developing researchers and "highlight key issues through high-quality, innovative and relevant research", are detailed on page 8 by Shelley McGee, and reflect the wide diversity and progress being made by SA researchers.

Burnout among doctors was discussed in both the plenary and parallel sessions of the conference. Two presentations in the parallel section of the conference focused on burnout. Dr Gaynor Balie's research on burnout among obstetrics and gynaecology registrars in teaching hospitals reported high rates of emotional exhaustion and depersonalisation, at higher levels than found in similar studies in other countries. Dr Svetlana Avramenko looked at stress and burnout in a hospital in Gauteng, also highlighting high levels of emotional exhaustion and depersonalisation. On page 15, Prof. Zukiswa Zingela looks at the many roles that doctors fulfill "that require us to wear many hats and different faces, while never losing our core professionalism and dedication ... Is it any wonder that the profession is buckling under the strain?" She goes on to describe symptoms, contributions, the importance of acknowledging burnout's existence, and prevention strategies.

Once again we encourage readers to contribute, give feedback and highlight areas of concern. We look forward to hearing from you.

---

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

Editorial Enquiries: 083 301 8822 | [dianed@hmpg.co.za](mailto:dianed@hmpg.co.za)  
Advertising Enquiries: 012 481 2069  
Email: [dianes@hmpg.co.za](mailto:dianes@hmpg.co.za)

Senior Designer: Clinton Griffin

Published by the Health and Medical Publishing Group (Pty) Ltd  
Block F, Castle Walk Corporate Park, Nossob Street  
Erasmuskloof Ext. 3, Pretoria

Email: [publishing@hmpg.co.za](mailto:publishing@hmpg.co.za) | [www.samainsider.org.za](http://www.samainsider.org.za) | Tel. 012 481 2069  
Printed by Tandym Print (Pty) Ltd

Opinions and statements, of whatever nature, are published in *SAMA Insider* under the authority of the submitting author, and should not be taken to present the official policy of the South African Medical Association (SAMA) unless an express statement accompanies the item in question. The publication of advertisements promoting materials or services does not imply an endorsement by SAMA, unless such endorsement has been granted. SAMA does not guarantee any claims made for products by their manufacturers. SAMA accepts no responsibility for any advertisement or inserts that are published and inserted into *SAMA Insider*. All advertisements and inserts are published on behalf of and paid for by advertisers.

#### LEGAL ADVICE

The information contained in *SAMA Insider* is for informational purposes and does not constitute legal advice or give rise to any legal relationship between SAMA and the receiver of the information, and should not be acted upon until confirmed by a legal specialist.

## Notification of diseases – let's re-open the debate



Dr Marina Xaba-Mokoena, SAMA president

**T**he Health Protection (Notification) Regulations 2010 makes notification mandatory if a patient is suffering from a medical condition or disease that may pose a significant risk to public health. This is government law, and such cases must be reported to government authorities. The collection of this information allows the authorities to monitor the disease, and provides early warning of possible outbreaks.

Examples of notifiable conditions are acute encephalitis, acute infectious hepatitis, acute meningitis, acute poliomyelitis, anthrax, botulism, brucellosis, cholera and malaria.

Other communicable diseases such as listeriosis, TB, human rabies are also notifiable.

In developed countries, even stigmatised conditions (e.g. gonorrhoea, syphilis and

other sexually transmitted infections (STIs)) are notifiable. These countries have partner-notification strategies, and disease intervention specialists. The conditions are curable, and if diagnosed, it is obligatory to bring one's partner to the healthcare professional in order to receive treatment. European countries have used partner notification as one of a range of measures to control STIs since the early 1900s.

Besides clinical benefits, the public health benefits of STI notification are also recognised – such as controlling the spread of STIs, reducing STI morbidity and mortality, reaching people with asymptomatic STIs and people who do not present for diagnosis and/or counselling and treatment.

Considerable variation in ways of implementation exist across countries. Differences in laws, policies, regulations and clinical guidelines contribute to this. This can be done either by patient name, or using a number, as is done in some US states.

STI notification is not the norm in many developing countries, however. HIV/AIDS is a predominantly sexually transmitted infection, and it is notifiable in many developed and developing countries. However, in SA it is not. Partner notification is generally not taking place, judging by the number of new infections, and physicians are ill-disposed to take charge of notification. Some diagnosed patients seem to have an attitude of not wanting to die alone from the disease, and seem to go out of their way to spread it to as many other individuals as possible. This was very much the case before the period of ART

availability and early treatments. One of the problems is people having multiple partners; another is attitude.

The debate about making HIV/AIDS a notifiable disease should be re-opened in our country. It should be treated as a public health issue in the same way as TB is.

It has been discussed by the ANC, and Dr Nkosazana Dlamini-Zuma advocated and supported making it a notifiable condition as early as 1997 - 2012. The SA government prepared draft guidelines for reporting HIV in 1999, but never passed them.

HIV is contagious, but preventable and treatable, even if not curable. ART has revolutionised the disease, allowing a near-normal life expectancy with good adherence to treatment and advice, and it can completely arrest transmission.

The statistics provided by HIV/AIDS notifications would be more accurate than those produced by death certificates, which usually read "pneumonia", "meningitis" or "cancer", which are only complications of the condition.

Critics of giving HIV/AIDS notification status argue that it could increase stigma, but is this not already the case with TB? Data from countries that have implemented notification have shown that to be untrue. As people have even gone so far as to wear T-shirts stating their positive status publicly, it is really of little significance.

A review of current notifiable diseases in SA is long overdue. It is my considered opinion that HIV should be a notifiable disease.

## Obituary: Dr Paris Daniel

*SAMA Communications Department*

**D**r Paris Rorke Daniel, a GP from Welkom, died in a car crash on Thursday 23 August 2018.

He came to Welkom in 1990 to complete his internship year at the Odendaalsburg Provincial Hospital, and stayed on as a private GP.

Dr Daniel joined SAMA in 1991, and was a very active member who served on the Goldfields branch council as a representative,

vice president (2009) and president (2010). He was elected as representative for GPs for the period 2017 - 2020.

A very good golf player, Paris will be missed by the branch council and all the members of SAMA, his patients and his friends.

He is survived by his wife, Joyce, and four children, Veronica, Nico, John and Christiaan.



# SAMA 2018 conference delivers

SAMA Communications Department

More than 250 delegates, some with their families, arrived at the spectacular Sun City venue for the 2018 SAMA conference from 17 to 19 August. The conference theme was "Patient-centred care – putting the heart into medicine". From all reports, the conference delivered, receiving positive feedback from both delegates and the organisers, and arousing debate and discussions on the many subjects covered. An air of excitement pervaded events as delegates participated enthusiastically.

A culmination of many months of hard work by the conference committee, the venue facilitated a wonderful welcome, while the programme covered oral presentations, posters and workshops by leading medical professionals in a stimulating and comfortable environment. More than 20 experts and professionals spoke during the plenary session, highlighting important topics relevant to the theme. "This comes at an important time, and is very relevant to healthcare professionals considering the crises we seem to be facing in the public healthcare system, and the recent findings of the health market inquiry," said Prof. Mergan Naidoo, conference chairperson.

In addition to doctors and healthcare workers, representatives from important healthcare stakeholders, such as the National Department of Health, regulators, funders, administrators and managed healthcare entities, attended the conference. The conference also featured an exhibition by conference sponsors, which generated a lot of interest among delegates, and the annual Doctor's Merit Awards, acknowledging excellence in the medical fraternity.

A well-laid-out exhibition hall was the heart of the conference proceedings, housing sponsor stands, and tables that provided delegates with welcome tea breaks, delicious lunches and a networking cocktail party on the Friday.

## The 21st-century doctor

Delegates were welcomed on Friday morning by SAMA chairperson Dr Mzukisi Grootboom, before the conference kicked off with the first subtheme of the conference, the 21st-century doctor. The first session was chaired by Dr Grootboom, and included a presentation from Prof. Brian Rayner, head of the Division



*The magnificent setting for the gala dinner*



*Buying SAMF at the HMPG desk in the exhibition hall*

of Nephrology and Hypertension at Groote Schuur Hospital and UCT, on the major worldwide epidemic of hypertension, and Prof. Paul Rheeder, a senior specialist physician at the Steve Biko Academic Hospital, who provided an update on diabetes mellitus care.

Many small groups formed in the exhibition hall as delegates joined together for lunch and long awaited catch-ups and discussions.

The second session of the day was chaired by Prof. Mergan Naidoo, and featured Prof. Francois Venter, who spoke about HIV and

the development of treatment: "A lot of new drugs are now on the scene, and there is a possibility of injections in the next 3 years." Dr Bernito Mashiloane, a nephrologist in private practice, spoke about his experiences of renal failure: "Kidney disease is the 9th leading cause of death in the USA, and 9 out of 10 people who have chronic kidney disease do not know it."

After the tea break, SAMA president Prof. Marina Xaba-Mokoena chaired the session presented by Prof. Edward Coetzee, a gynaecologist at UCT, and Dr Karen Fieggen



*Dr Simonia Magardie (SAMA marketing manager), Dr Imtiaz Sooliman (Gift of the Givers) and Dr Manny Thandrayen (SAMA general manager)*

from UCT's human genetics department, on "The perfect baby, genetic profiling: Your patients' expectations". Prof. Coetzee looked at the specialty of foetal ultrasound, what the perfect baby is and the challenge of litigation and insurance in the field: "Perfect medical care does not result in the perfect baby". Dr Fieggen spoke about the human genome project, and genetic screening in and for pregnancy: "We want to give our patients the perfect baby". The last presentation of the day was from Dr William Mapham, who spoke on technological innovations to improve patient-centred care. His focus was Vula, an award-winning mobile network that connects health workers and specialists across 15 disciplines.

After the last presentation on Friday, delegates gathered in the exhibition hall for a networking cocktail function, which once again provided a relaxed environment to chat, nibble on some delicious snacks and speak to sponsors at their stalls. Dr Imtiaz Sooliman, from Gift of the Givers, the largest disaster-response non-governmental organisation of African origin on the African continent, gave an enthralling talk on the "green team's" work around the world. His message was motivating and inspiring: "SA's mobile hospital is equal to the best in the world – our greatest export is our ubuntu." Gift of the Givers has delivered life-saving aid in the form of search-and-rescue teams, medical personnel, medical equipment, medical supplies, medicines, vaccines, antimalarial medication, high energy and protein supplements, food and water to millions of people in 43 countries.

Saturday morning began promptly with a session chaired by Dr Azo Shinta. The

presentations were on: the collaboration in leveraging the integrated patient-centred care model to achieve the triple aim of health reform, by Rosalind Reddy from Medshield; stroke, by Dr Anastasia Rossouw; and heart failure, by Prof. Naresh Ranjith. "The programme was relevant to the current practice of most doctors, and highlighted common clinical problems while at the same time covering areas that are vital to both public and private sector doctors," commented Prof. Mergan Naidoo, after the conference.

After lunch, delegates returned to the conference hall for a session, chaired by Prof. Naidoo, with presentations on HIV, by Prof. Francois Venter, and renal failure, by Dr Bernito Mashiloane. After tea, Prof. Anton Stoltz delivered a presentation on antibiotic stewardship. His take-home message: "If you have one [brain], try to use it slowly, please."

### Quality care for the 21st-century doctor

The second subtheme of the conference, quality care for the 21st-century doctor, kicked off with a session on patient safety by Dr Siphwe Mndaweni from the Office of Health Standards Compliance: "Patient/people-centred care emphasises prevention of illness, and promotes better health, wellbeing and self management." Neurosurgeon Dr Herman Edeling followed, on rendering quality care in a litigious environment, and said, "Doctors are under threat by lawyers and the courts ... the best protection is to deliver quality care."

After lunch, Prof. Shadrack Mazaza chaired a session covering how to measure quality of care in your practice, with a presentation by

### Conference feedback on social media

The SAMA conference was a tremendous success, according to most participants interviewed. Here are some of the comments on social media from delegates:

"Thanks for a well-organised congress."

"The best I ever attended too. The organisation, the topics, the lecturers, the venue. They were all great."

"Excellent conference, thank you very much."

"We appreciate the organisation of this last SAMA conference 2018. We thank the organising committee, the sponsors, the HPCSA representatives, the brilliant speakers and all the delegates."

"Thank you for a great conference"

"Thank you for a great conference.

As a junior doctor this has been my best conference experience. The music in the hall created a chilled environment. We will market it to our young doctors, they will come in numbers."

"Thank you very much for a GREAT conference, this was the best compared to the ones previously held in Sandton Convention Centre. Big Ups to the organisers. Well done, we are proud of you."

"Thank you SAMA for an awesome conference. Was my first attendance and I truly enjoyed every speaker and the vibe. I'm never missing such informative sessions again."

Prof. Naidoo, who said, "Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes, and are consistent with current professional knowledge," followed by a presentation on "Communication – the heart of the consultation" by Prof. Mabuza from Sefako Makgatho Health Sciences University: "The patient will never care how much you know until they know how much you care," (Terry Canale, 2000).

### Dying with dignity

An afternoon session, chaired by Dr Mohamed Abbas, on the subtheme "Dying with dignity" included a presentation by Dr Maria Phalime on the burnt-out doctor: "Medical schools set up a culture that facilitates burnout ... doctor wellbeing is a shared responsibility". She was followed by Dr Sarah Fakroodeen's presentation on the principles of palliative

care: "It is a skill to know when you can no longer cure."

### Gala dinner

The colour theme was black and red, and the hall looked magnificent! Delegates arrived to pre-dinner drinks, before taking their places at the tables. SAMA marketing manager Dr Simonia Magardie welcomed guests, and introduced the master of ceremonies, comedian Riaad Moosa. The president of SAMA, Prof. Marina Xaba-Mokoena, opened the proceedings, followed by Minister of Health, Dr Aaron Motsoaledi, who enlightened the audience on NHI: "The heartbeat of NHI is going to be primary healthcare." The presentation of the SAMA merit awards and the Discovery Awards,

and listening to the Soweto Opera Quadro, rounded off an enjoyable evening.

### Innovations in healthcare

The final subtheme of the conference, innovations in healthcare, on the Sunday, included a thought-provoking panel discussion on NHI, featuring experts from the public, private and academic sectors, and chaired by Dr Vusumuzi Nhlapho. Issues were discussed and debated with the audience. "The NHI debate emphasised that we need more debate! A health CODESA is needed with **all** voices heard, not an echo chamber," said Prof. Mark Sonderup, while closing the conference.

Prof. Sonderup chaired the final session of the conference, where Andy Gray from the

Division of Pharmacology at the University of KZN talked about innovative methods of using evidence-based medicine in patient-centred care: "Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients ... evidence-based medicine is critical to the sustainability of universal health coverage."

A presentation by Dr Stan Moloabi from GEMS on alternative remuneration models and patient centred care concluded with the sentiment, "A CODESA [Convention For A Democratic South Africa] is needed whereby all stakeholders agree on a new healthcare dispensation that improves access."

From all accounts, a successful, relevant and well-received conference.

## Reflecting on the 2018 SAMA conference

Dr Mzukisi Grootboom, SAMA chairperson

As the dust settles on the 2018 SAMA conference, an opportunity arises for us to reflect on whether the conference has fulfilled our objectives, review lessons learnt and consider the challenges that arose both before and during the conference.

In 2009, the SAMA Board took a decision to have an annual conference that caters for the generalist doctor. The content was to appeal to the generalist in both the public and the private sectors. The aim was to update and upskill, and to allow maximum participation of the attendees. In addition, the meeting had to provide enough CPD points to cover the year's requirements, as per the HPCSA rules.

Over the years, the conference has been well supported by our academics, including senior colleagues in the private sector, both GPs and specialists. The attendees, we have noted, have been mainly those from the peri-urban and rural areas, with little support from colleagues in the urban centres who, I would imagine, generally have many more opportunities for continuing medical education.

This year's conference had as its theme "People/patient-centred care". The question is, what is meant by people- or patient-centred care?

Over the past several years, we in the medical profession have come to the

realisation that the way in which we deliver healthcare to our communities has a disproportionate focus on the pathology, rather than the patient who has the disease. There has been a realisation that the patient has to be an active participant in decisions that concern his or her health. The patient must be treated as an individual, with the aim being to have shared power and responsibility over treatment, in a therapeutic alliance.

The WHO has gone further, by defining and building a framework on integrated people-centred health services, and this has been accepted by most member states at the World Health Assembly.

Providing integrated people-centred health services means putting people's and communities' comprehensive needs, and not just diseases, at the centre of health systems, and empowering people to play a more active role in their own healthcare.

How, then, is this expressed by the individual doctor to the patient? Communication lies at the heart of any consultation. This view was eloquently espoused by one of the speakers, Prof. L H Mabuza, as a matter of making communication central, in the first instance. Quoting from Hollins, he explained: "The patient is not just a group of symptoms, damaged organs and altered emotions. S/he is a human being, who is searching for relief,



*Dr Mzukisi Grootboom congratulates Farah Jawitz, winner of the SAMA Award of the Year*

help and trust. The accuracy of the diagnosis, as well as the effectiveness of the treatment, directly depends on the quality of the doctor-patient relationship," and he recommended the following approach:

- building rapport
- asking more open-ended questions
- establishing eye contact (cultural sensitivity)
- exploring the patient's health beliefs
- listening more, talking less
- complimenting effort and legitimising the patient's views and feelings



*Dr Kapil Narain received the Discovery Best Emerging leader award from Phomelelo Moshapo from Discovery Health*

- expressing empathy
- probing for the patient's understanding
- summarising what the patient said (reflective summaries)
- clarifying the patient's expectations
- exploring biopsychosocial circumstances (the patient's family, and social factors).

The overall conference programme consists of two formats: a series of didactic high-quality talks; and parallel sessions of free papers presented mostly by young and developing researchers from our academic institutions, and SAMA staff. This year there were 22 free papers presented, and 6 poster presentations.

The lectures were on a range of topics, including diabetes, hypertension, HIV/AIDS, renal failure, stroke, heart failure, the use of technology to improve patient-centred care, quality, patient safety, rendering quality care in a litigious society, palliative care, antibiotic stewardship, innovative methods of using evidence-based medicine in patient-centred care, the burnt-out doctor and alternative re-imbursement methods. There was also a panel discussion on the NHI and the Medical Schemes Act Amendment Bills, which evoked a lot of discussion and participation from the conference attendees.

I have taken the trouble to mention the subject matter of most of the presentations to make the point that they were all of a very high quality, and were well received by the delegates. Those members who could not attend really missed out.

The highlight of the conference was the SAMA Awards Ceremony, an event where the profession gives recognition to outstanding work done by our colleagues in their respective fields.

There has been an ongoing debate in the last 2 years among the SAMA Board members as to whether the conference should be an annual or a biennial event. There are those who support the idea of a biennial event, and in the intervening year having regional indabas (mini-conferences) away from the major centres, both so that the organising committee can have a break, and to give the regions/branches the opportunity to organise such events themselves. On the other hand,

there are those who feel that the SAMA conference is a highlight in the SAMA yearly calendar, and we cannot afford only to stage such an event biennially, as this will open up a void and exclude our regular supporters and sponsors. The idea of regional indabas was trialled in 2017, and I was privileged to attend all three events, in East London, Durban and Cape Town. Apart from the fact that none of the cities could ever be classified as an outlying area, what became clear was that there was very little support for the events from our members and sponsors.

Getting sponsorship for the 2018 conference, particularly from the pharmaceutical industry, proved to be a challenge, whereas the same was not the case with previous conferences which were well supported. SAMA will have to devise strategies to address this particular problem. It is my firm view that the SAMA conference should be an annual event. The board will also have to address the issue of an overworked committee. There also needs to be a decision taken soon about the date and venue of the next conference, so that timeous planning can be instituted without too much delay.

I would like to first and foremost thank the SAMA members and all the delegates who attended the conference, the speakers, the Education, Science and Technology (EST) committees (who produced an outstanding programme), the SAMA staff, ICE Solutions (our congress organisers), the conference team at Sun City, and most importantly, our sponsors.

## Abstract sessions highlight key issues through high-quality, innovative and relevant research

*Shelley McGee, health policy researcher, SAMA Knowledge Management and Research Department*

The submitted-abstract programme ran into the main SAMA conference programme on Saturday 18 August. Papers for oral or poster presentation were submitted by medical students, medical practitioners and SAMA members, under the main subthemes of the conference: the 21st century doctor, quality care for the 21st century doctor, innovations in healthcare and dying with dignity.

The abstract programme adjudicators would like to commend all participants on

the high standard of their presentations and posters, and thank them for contributing to the conference. The abstracts received were all of high quality, and the oral and poster presentations were all extremely well-prepared and presented.

The best oral presentations involved a combination of: the scope of the research or work making an important and original contribution to the discipline and/or to patient care, and to the themes of the conference; demonstrating clear objectives, suitable

methodology and appropriate interpretation of results; a good delivery of the presentation itself; and the presenter answering questions professionally and competently.

The poster presentations were judged based on a combination of: content and rigour of research; overall appearance; and presentation of the content.

The best oral presentation and poster winners received complimentary registration for the next Discovery Leadership Summit, as well as for the next SAMA conference in 2020.

The winning oral presentation was that of **Dr Atiya Mosam** of the Wits School of Public Health. Dr Mosam conducted a policy analysis entitled "Regulating the employment of doctors within the private sector in SA", a pressing issue in discussions of how the medical practitioner's world may evolve in the private sector in SA in future. Dr Mosam's aim was to understand the current regulatory environment surrounding the HPCSA policy on employment of doctors, and the implications of such a policy in light of the current health-system policy reforms in SA. The paper concluded that employment of doctors is a possible avenue to decrease costs, but should be restricted to certain areas. It also showed that the policy needs to be adjusted to allow for innovative models, especially in light of possible public-private partnerships for the NHI, but that further research is required on the best models of employment and reimbursement.

The winning poster presentation was that of **Dr Farah Jawitz** and co-author Dr Yakesh Baldeo, entitled "Medical internship and community service placement study – sharing internship experiences." The authors took a refreshing new look at the internship community-service doctor application and placement process, and how this could be better informed. With limited access to professional information, each year, applications are made based on hearsay, with most applicants choosing familiar academic hospitals in major cities over rural and underserved communities. The authors identified the need for a guide that will assist applicants with their choices, and encourage application to a variety of facilities, based on the real-life experiences of others. The presentation examined the survey methods used to capture the actual experiences of multiple junior doctors in various institutions countrywide, and the development of a colourful and informative preliminary guide to assist doctors to make better-informed choices when applying for their posts.

## The 21st-century doctor

**Dr Afolake Amodu** kicked off the proceedings with an interesting look into "Understanding SA parents' decisions to participate in the state-sponsored human papilloma virus (HPV) vaccination rollout campaign". Dr Amodu and co-author Prof. Baldwin-Ragaven had conducted a cross-sectional study in 10 low-income peri-urban primary schools, and within the sample, 95% of parents had accepted, while 5% had rejected, the

vaccination. Sociodemographic factors were not significant determinants of acceptance; however, strong determinants were awareness, information and knowledge about the vaccine.

**Dr Brenda Kubheka** followed this with an entertaining review of "Social media and healthcare professionals: Legal and ethical pitfalls", wherein she sought to review how the use of social media presents benefits and ethico-legal challenges for medical professionals. The presentation addressed online challenges that threaten professionalism, human rights, patient-professional relationships, employer-employee relationships and potential online ethico-legal pitfalls. In addition, Dr Kubheka sought to create awareness about the online "disinhibition effect", which contributes to professionals' lapses in judgment during their online activities.

**Dr Lerato Masenya** presented a novel and thought-provoking investigation into "Creative literature as a path to empathy in the health profession". Dr Masenya examined novels by various SA doctors, and argued that the perspective of the medical professional is invaluable in literary circles in order to facilitate an empathetic approach to the sociopolitical issues affecting life, and healthcare, in SA. She concluded that through literature, readers travel to different locales, and different points in time, and learn about other cultures and peoples. She posited that literature had the potential to improve connections between health professionals and their patients, colleagues and the wider SA community.

**Ms Ishani Dayaram**, a fourth-year medical student, presented a poster on "The attitudes towards HIV and perceptions of HIV services at PHC facilities in Chatsworth", on behalf of her co-author team. The authors concluded that public healthcare facilities are seen to have a lower quality of care than private, but are more readily used for HIV services, while private facilities are not used as frequently, contributing to an overall low uptake of HIV services in this community. Stigma from friends and family was unlikely to affect testing and treatment patterns in the community; however, higher levels of fear of judgement from healthcare workers were reported. This is a possible barrier to continued care.

## Quality care for the 21st-century doctor

**Ms Phomelelo Moshapo** of Discovery Health presented on behalf of Dr Maurice Goodman in support of "Using a shared-value model



*Dr Atiya Mosam received the best research paper award from Discovery's Phomelelo Moshapo*



*Best poster award went to Dr Farah Jawitz*

to support the delivery of person-centred care". "Shared value" is a concept that aligns business strategy with pursuing large-scale social impact, by activating an entire ecosystem of stakeholders in support of a common, socially progressive goal. Ms Moshapo highlighted the many challenges confronting the current healthcare delivery environment, and proposed multiple tools and possibilities aimed at making people healthier, making doctors healthier and more effective in "prescribing wellness" to their patients, and building shared-value initiatives between funders and doctors.

**Dr Manivasan Thandrayen** presented his research work, conducted in private practices in KwaZulu-Natal (KZN), "An evaluation of the remuneration of the general practitioner and its impact on service delivery". This study aimed to evaluate the remuneration of GPs and its impact on service delivery

and motivation at selected private practices in KZN. Actual practice cost information was acquired, and specific questions on motivation and service delivery were drawn and analysed. The study found that GPs are currently underpaid for consultations, and that the average rate of remuneration by a sample of medical aids in 2016 was well below the average study sample rate. Doctors have adapted to the underpayment by investing less in their staff, equipment and themselves, thus affecting service delivery.

**Dr Zolewa Sifumba** detailed her own emotive and harrowing experience with multi-drug resistant (MDR) TB in "TB and me...occupational tuberculosis in healthcare workers". Dr Sifumba's story followed her progression from medical student, to TB patient, to activist, highlighting the underappreciated risk of occupational TB faced by healthcare workers across the world, but especially in high-burden settings such as SA. Dr Sifumba shared the many challenges she faced during and after her diagnosis and treatment for MDR-TB. "Healthcare workers in SA are three times more likely than the general population to develop drug-sensitive TB, and six times more likely to develop drug-resistant TB."

**Dr Brenda Kubheka** returned to the podium for her second presentation, entitled "Medical errors, anger and challenging encounters with patients". This paper reviewed how some medical errors are a product of multiple factors, including working conditions, rapidly evolving technology and managerial and system-functioning factors. Understanding what makes patients angry as a result of an error is the first step towards addressing challenging encounters with patients following error-induced harm. Dr Kubheka examined how important it has become for professionals to possess effective communication, conflict-management and mediation skills, and also made recommendations on how to manage challenging encounters with patients following error-induced harm.

**Dr Sizeka Maweya** then presented "Microbiological profile of organisms causing bloodstream infections between 2004 and 2016 in a tertiary hospital, Limpopo Province, SA", describing data from a retrospective laboratory-based serial cross-sectional study conducted between 2004 and 2006, and from 2014 to 2016. Patient data, including demographics, microbial species and the antibiograms of isolated micro-organisms, were collected and analysed. There was an increase in the number of tests, and hence

the number of isolates, between the two study periods. The study demonstrated that there was a less than 3% drug resistance level against the antibiotics tested for in both time periods. There was no clinically significant change in resistance levels between the first and second study periods.

**Dr Daniël J Laàs** (co-author Prof. Mergan Pillay) presented "An evaluation of warfarin usage of an urban district level hospital in KwaZulu-Natal. The authors aimed to evaluate the quality of care of patients on warfarin and to determine its cost effectiveness at Wentworth Hospital. Quality of care was assessed through a structured patient interview, and cost-effectiveness of warfarin by a retrospective review of all costs over 6 months, compared with the equivalent costs of direct-acting oral anticoagulants (DAOCs). Several areas of patient dissatisfaction with regular monitoring on warfarin were identified. The authors concluded that it is important to consider the impact that warfarin has on patients' quality of life, and the potential benefits of the DAOCs, although these would only be considered cost-effective compared with warfarin if their current prices were to be approximately halved.

**Dr Christopher Webster** completed the session with a presentation of his "Qualitative investigation of 28 individuals with type 2 diabetes (T2D) who followed a low-carbohydrate high-fat (LCHF) diet over the long term". The study recruited participants with a confirmed history of T2D and who had followed an LCHF diet for longer than 6 months. One-on-one in-depth interviews were conducted to explore several aspects of participants' experiences on the diet. Major themes that emerged from the interviews were: increased control of eating; increased sense of control of weight, diabetes and health; the ease with which they found the LCHF diet could be sustained; difficulties in certain social situations; and apathy and/or negativity from medical professionals.

In a later poster presentation, **Dr Sibusiso Phinzi** and co-author M H Sebitloane examined "Peripartum hysterectomy audit at Port Shepstone Regional Hospital [PSH], SA: A 5-year review". The authors aimed to determine the incidence of peripartum hysterectomy and to audit maternal and neonatal outcomes in patients who had had a peripartum hysterectomy. The peripartum hysterectomy incidence at PSH was 4.7/1 000, and associated with a high perinatal death rate of 37.3%. Uterine atony, ruptured uterus

and sepsis were the common indications for peripartum hysterectomy.

**Dr Elaine Saayman** examined "The rise of hepatitis C/HIV co-infection among people who inject drugs (PWIDs) in Tshwane" in her poster presentation. Point-of-care screening for HIV, HBV and HCV, and blood samples from eligible infected participants, were obtained between 2015 and 2017. The period prevalence of the cohort infected was 69.2% ( $n=737$ ) for HCV and 34.0% ( $n=362$ ) for HIV cases. Co-infection was detected in 31.1% ( $n=331$ ) of participants, with 22.1% ( $n=235$ ) HCV/HIV and 4.3% ( $n=46$ ) HCV/HBV/HIV-infected. Focused harm-reduction interventions, including point-of-care diagnostic tools and community-based treatment protocols, are required to develop a patient-centred management approach.

**Dr Steve Selepe** presented the final poster of the day, entitled "Basaloid squamous cell carcinoma (BSCC): Case review." Dr Selepe explained that BSCC is a rare and aggressive variant of cancer which arises mainly in the aerodigestive tract. Dr Selepe presented the case of a 29-year-old male with progressive hoarseness over 6 months. The patient had a 10-year history of smoking and alcohol use. The patient was diagnosed with T4N0M0 BSCC of the larynx. The patient was offered total laryngectomy in April 2013. Treatment included resection of the tumour and postoperative radiotherapy. The patient is still alive and has not experienced disease recurrence during 6 years of follow-up.

## Innovations in healthcare

**Dr Solomuzi Ngcobo** opened this session with a review of "Blood transfusion and obstetric haemorrhage in SA." This analysis examined the factors related to blood supply that may have contributed to maternal morbidity and mortality pre and post an SA National Blood Service and Department of Health intervention aimed at improving blood supply to maternity units. Multiple recommendations for blood supply improvement were been made in 2011. Provinces have had varying levels of success in implementing the recommendations, ranging from 30% of hospitals in the Eastern Cape having implemented some recommendations, to 85% in Gauteng and Mpumalanga hospitals. National hospital transfusion committee (HTC) coverage increased markedly from 30% to 85%, and all hospitals with functioning HTCs had implemented most of the recommendations.

**Dr Elton Dorkin** presented twice under this subtheme. His first presentation was a policy review of "Clinical decision-making in the context of NHI". He addressed the fact that the medical-scheme industry generally, and notably the NHI, interprets the challenges in the provision of healthcare as primarily as financial, economic and structural problems, while the underlying scientific enterprise is not comprehensively addressed. Dr Dorkin concluded that the role of the scientific enterprise needs to be better articulated and incorporated into healthcare financing models than is currently the case, and advocated that this should be supported by a strong, independent, well-funded institutional framework (e.g. National Institute for Clinical Excellence (NICE) or US Preventive Services Task Force (USPTF)) that incorporates adequate considerations of how doctors are trained, and the philosophical underpinning of medicine.

Dr Dorkin's second presentation was the product of his MBA research, entitled "Do routine medical examinations improve the health risk and work engagement of company senior executives?" The observational study examined the changes in health, behavioural and physiologic parameters over a 2-year period (2013 - 2015) in participants in an executive health programme. In keeping with the general consensus, routine examinations as part of an executive health programme of otherwise healthy individuals find many health risks, but have little effect on modifying them in the short term (2 years). The findings suggest that an executive health programme based on medical examinations alone cannot reliably and consistently improve health risk.

**Ms Nomfundo Maseko** took the audience on a journey through the "Communication heart of consultation." Ms Maseko examined aspects of communication in clinical

practice. She looked at the expectations of communication from both doctor and patient perspectives, as well as at barriers that prevent effective communication between doctors and patients. Patient-centred care requires making a conscious effort to respect the patient's values, expressed needs and preferences, as well as providing emotional support and alleviating anxiety and fear, involving family and caretakers at the patient's request, communicating medical information comprehensibly and ensuring physical comfort for patients.

**Dr Gaynor Balie** presented a concerning account of "Burnout amongst obstetrics and gynaecology registrars in teaching hospitals for the University of the Witwatersrand Medical School". A cross-sectional study was conducted using electronic surveys, and all registrars were invited to participate. High rates of emotional exhaustion and depersonalisation were reported, as well as poor sense of personal accomplishment. The levels recorded were higher than those in studies conducted in other countries, with a higher rate of combined emotional exhaustion and depersonalisation recorded in the study population. The study was able to identify only a few risk factors, but these need closer scrutiny as ways to minimise burnout.

In keeping with the burnout theme, **Dr Svetlana Avramenko** presented a poster entitled "Stress and burnout in doctors in one of the hospitals in Gauteng". Dr Avramenko and her co-authors undertook a cross-sectional study to determine the levels of stress and burnout in doctors in a regional hospital in Gauteng, using three different subscales of burnout to correlate with the different types of stressors at work. High levels of emotional exhaustion and depersonalisation were clear, and one-third of participants experienced low levels of personal accomplishment.

It is hoped that these findings will help to develop better organisation of the working environment, and specific programmes to improve relationships at work and reduce the level of stress, and eventually, prevent psychological impairment.

**Dr Dirk Hagemeister** presented a review of regulatory issues in "Employer-generated complaints to the statutory registration authority." Dr Hagemeister aimed to illustrate the multiple legal frameworks relevant for the employer-employee relationship regarding healthcare workers' conduct. At least three legal frameworks are of relevance for the employer-employee relationship in the SA public healthcare sector, namely the Labour Relations Act (LRA), the Public Service Act and the profession-specific acts such as the Health Professions Act, the Nursing Act and the Pharmacy Act. Employer-generated complaints deny the employed healthcare professional the procedural fairness provided for by the LRA, and substitute it instead with the proceedings of an often less-than-effective statutory registration authority.

### Dying with dignity

**Dr Ryan Jacobs** explored the controversial subject of euthanasia in "Medical students' perspectives on euthanasia and physician-assisted suicide (E/PAS) and the prospects of legalising these practices in SA." The study involved a convenience sample and a paper-based, semi-quantitative descriptive study design, sampling third- to fifth-year medical students at Stellenbosch University in 2016/2017. The sample was largely in favour of legalising E/PAS. The majority (80.1%) of participants indicated that they would prefer a dedicated ethics committee to decide who receives E/PAS. However, multiple views of other affected stakeholders are necessary to properly inform policy.

## SAMA Merit Awards recognise significant contributions to medical profession

**Prof. Mergan Naidoo**, chairman, SAMA Education, Science and Technology Committee

Every 2 years, a call goes out for doctors to nominate colleagues who they feel have made significant contributions to the profession, their communities or SAMA. This year, as previously, the Education, Science

and Technology (EST) committee had the difficult task of selecting from among some very esteemed colleagues, settling on the final eight candidates after much consideration and thought. The Merit Awards ceremony,

held in the King's Ballroom of Sun City on 20 August, was afforded the glitz and glamour of the prestige it deserves. The audience were entertained by the ever-popular Dr Riaad Moosa, and by the Soweto Opera Quadro.



Dr Perisamy Govender

The Minister of Health, Dr Aaron Motsolaedi, and the chairman of SAMA, Dr Mzukisi Grootboom, handed out the awards to the deserving recipients.

The first award was the **Medal of Transformation, Equity and Justice**, a human rights award. The criterion for this award is having taken up the fight in this cause. The individual must campaign for justifiable changes within the medical fraternity, such as SAMA unity, or equal opportunity across the race or class divides, in academia, industry, state structures and the community. The awardee may also champion the cause of equity in the delivery of medical and healthcare services, especially to the poor, the needy, the indigent and the disabled. For his contribution to human rights, equity and justice, the 2018 award went to **Dr Perisamy Neelaphithambaran (P N) Govender**.

Dr Govender graduated with an MB ChB from the University of Natal in 1964. He was very active in medical politics, and in 1967, was dismissed from King Edward VIII Hospital for leading a protest against racially disparate salary scales. He left MASA (the Medical Association of SA) in 1968, and helped to found the medical guild in Durban. In 1972, he helped break down racial discrimination in the SA Medical and Dental Council. He was instrumental in blocking the removal of black students from the University of Natal between 1973 and 1975. With the assistance of Profs Jerry Coovadia and Walter Loening, he helped form the National Medical and Dental Association (NAMDA) between 1978 and 1983. In 1983 he helped to facilitate NAMDA's incorporation into the UDF, while at the same time defending private doctors' right to dispense medication. In 1987, he helped to unify the various family practitioner organisations. He was a member of Society of Dispensing Family Practitioners and the



Prof. Gerhardus Lindeque

National Medical and Dental Forum, and in 1998, he decided to join the unity movement in SAMA, and played an active part in unifying the profession. He served on the SAMA Board of Directors of from 1998 to 2009, and was president of SAMA during 2003 - 2004. He also served on the EST committee from 1998 - 2003, and was a very dynamic chair. Under his guidance, Merit Awards were once again introduced to SAMA. In 2015, at his own expense, he established a medical camp in Chatsworth, Durban, to provide medical assistance to the victims of xenophobic violence. At the age of 88, he is still serving his community.

The second award is entitled the **Fellowship in Art and Science of Medicine Award**. This award is given to an individual with an iconic international footprint, who has won international acclaim for excellence in the practice of medicine as both an art and a science. Awardees constitute an exclusive group of members who have been awarded the Fellowship for breakthrough contributions to medicine, for moving the frontiers of medicine forward or widening the horizon for the greater understanding of medicine as both art and science, while fully acknowledging the philosophical and ethical constraints of the profession. The selected individual should also champion the cause of healthcare despite obstacles; a previous awardee was the late Prof. Bongani Mayosi. This award is equal in prestige and status to the Heroes in Medicine Award (Canada), or becoming a Member of the Institute of Medicine (USA). For his impact on art and science in medicine, this year's recipient was **Prof. Gerhardus Lindeque**.

He graduated with an MB ChB from the University of Pretoria (UP) in 1976. He did his postgraduate training at Stellenbosch University (Tygerberg Hospital), and obtained

his FCOG (SA) in 1983 and his MMED (O&G) *cum laude* in 1984. In 1989 he was awarded an MD (US). The following year he was appointed as HOD of the UP Department of Obstetrics and Gynaecology (O&G). Within UP, he became Chair of Health Sciences in 2002, and Deputy Dean in 2011. His special interest in obstetrics and gynaecology was oncology, and he has 94 scientific publications and over 40 chapters in textbooks. He was a member of the SASOG council, and during his tenure as president, the council underwent major transformation. He works tirelessly in the academic sphere, and was president of the College of Obstetricians and Gynaecologists of SA from 2008 to 2012, and president of the Colleges of Medicine (SA) from 2012 to 2015. He was an elected member of the Medical and Dental Board of the HPCSA from 2004 to 2010, and an appointed member from 2010 to 2015. Within the HPCSA he was asked to serve on numerous committees. As a delegate to the International Federation of Gynaecology and Obstetrics (FIGO), he managed to get an SA delegate voted on to the FIGO council, and through his efforts the FIGO world congress was held in Cape Town. He has supervised eight doctoral theses. In recognition of his great contribution to medicine, especially in obstetrics and gynaecology, the Royal College of O&G awarded him the Fellowship of the Royal College of O&G *ad eundem* in 2006. He was also awarded the Fellowship of the Academy of Medicine of Singapore in 2015. He has indeed made a major contribution to obstetrics and gynaecology, both in the academic sphere as well as in all fields in SA.

The next Merit Award was for **Extra-Ordinary Service to Medicine**. This awardee must have made an outstanding contribution to medicine in a dedicated field. The incumbent must have pursued with single-minded purpose a chosen area of interest in medicine, and made a substantial contribution in the research, promotion and advancement of that field. Their work must extend beyond the ordinary terrain of medicine and extend into the wider community and nation. Publication of work in internationally accepted medical journals is a prerequisite. For her extraordinary service to medicine, the award this year went to **Prof. Rudo L Mathiva**.

This year's awardee started what is still her current job as HOD in Critical Care in 1998. During this 20-year period, she has worked tirelessly to expand the service delivery platform for critical care across multiple state-



Prof. Rudo Mathiva

sector hospitals and geographic regions by fighting for and successfully expanding training platforms, which resulted in increased numbers of critical-care specialists being certified to provide this scarce skill in the SA setting. In her role as vice president of the Critical Care Society of Southern Africa, she has extended her positive influence beyond the reaches of her provincial post, enhancing the knowledge of doctors, nurses and allied healthcare professionals. She has also been extensively involved in the setup and examination of the subspecialty trainees as a convener, moderator and examiner for the Colleges of Medicine of SA, under the colleges of paediatricians, physicians, anaesthesiologists, surgeons and obstetricians. Her trainees have established the provision of critical-care services in two additional provinces, and at secondary level hospitals within Gauteng. Her plan to enhance critical-care education beyond SA's borders has been realised by means of the biennial Ventilation Through the Ages (VTA) Symposium, and the recent delivery of basic courses in Nigeria and Kenya, with planned courses for Botswana and Namibia. Her achievements within the critical-care department at Chris Hani Baragwenath need to be highly commended regarding the provision and maintenance of a world-class ICU service in the face of dire resource limitations.

The **Lifetime Achievement Award** is presented to an individual who has dedicated his or her life to the single-minded pursuit of medicine as a career, and served it with distinction, making the profession proud. His or her loyalty, dedication and professional conduct is worthy of emulation. This year's lifetime achievement award went to **Prof. Jannie F M Hugo**.

He was nominated in this category as he has gone above and beyond the call of duty. He maintains an excellent standard in clinical medicine, teaching and research. He has led



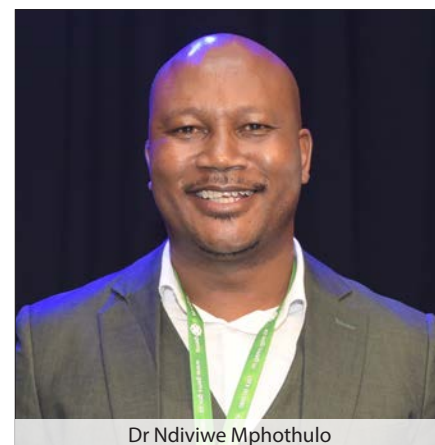
Prof. Jannie Hugo with Dr Aaron Motsoaledi

the UP Department of Family Medicine for the past 7 years, and currently leads a large contingent of stakeholders in implementing community-oriented primary care (COPC) in the City of Tshwane, with a focus on the integration of care between home, clinic and hospital. The UP COPC Research Unit was set up to develop a living laboratory within a service delivery and education platform. He previously worked at Medunsa for 17 years, where he set up the Madibeng Centre for Research, of which he is still a board member. He also led the initiative to establish the Clinical Associate profession, a mid-level clinician programme in SA. He has worked on the following projects:

- the development of the UP COPC Living Laboratory
- NRF 2013 - 2015 multidisciplinary investigation of authentic learning in the Bachelor of Clinical Medical Practice Curriculum Research Project
- developing education strategies to improve the supply and retention of medical practitioners in rural and underserved areas in SA (Collaboration for Health Equity through Education and Research (CHEER)).

Building and guiding an unbelievably creative, committed and diverse team at UP Family Medicine is a fascinating journey that requires on-going decisive action, reflection and adaptation. This team was awarded the University Laureate Award For Education Innovation in 2012 and the HELTASA (Higher Education and Training Association of South Africa) national teachers award in 2013.

The **Spirit of Medicine Award** is awarded to an individual who has provided extraordinary service to community or nation extending beyond the field of medicine. This award is made to doctors who



Dr Ndiviwe Mphothulo

have distinguished themselves both in the field of medicine and also in areas beyond, in creating an enabling environment and/or living habitat or working in the wider interests of mankind. This includes championing the cause of the poor, indigent and dispossessed within a given ecosystem. The award is given for selfless service to medicine without a view to material gain or in pursuit of personal aggrandisement and pretension, or for displaying by precept and example that medicine is a "calling" and service in the name of the profession, a special privilege. The 2018 Spirit of Medicine Award was presented to **Dr Ndiviwe Mphothulo**.

Among the many things he does for his community, Dr Mphothulo gives talks to schools, communities, youth and churches on health and education matters, helps with funerals of indigent families, helps the very sick and poor for free and helps with funds for education for poor students.

He was part of the first wellness clinic at Taung Hospital in 2004, where he transformed the TB ward into be a centre of excellence. He established the decentralised MDR-TB unit in 2009, and personally managed more than 200 MDR-TB patients. He has served as the North West Province representative for the Rural Doctors Association of SA (RuDASA), and is a board member of the Southern African HIV Clinicians Society. He was also the conference chairperson for the 2017 SA Rural Health Conference. He has received the following awards:

- SA Rural Doctor of the year, 2015
- Best performing North West doctor's MEC award, 2013
- Best presentation award, 2008 SA TB conference
- Chief director HIV/AIDS, STIs and TB (HAST) award for best MDR-TB doctor in North West Province, 2017.



Dr Jayshina Punwasi

He is committed to rural health in the community of Taung. He is a doctor who is immersed in the community, and assists with their social and healthcare needs.

The **Young Leaders Award** is awarded to a doctor no more than 35 years old at the time of nomination. This award is made to an individual, on the recommendation of public sector colleagues, who has been a top undergraduate and postgraduate student and has provided an extraordinary leadership service to the public sector. This year's award went to **Dr Jayshina Punwasi**.

She qualified at UCT in 2007, and completed her internship at Steve Biko Academic Hospital, Pretoria, during which time she received the top intern award. As a medical officer at Leratong Hospital she served as curator for interns and junior doctors, and received recognition for service excellence in 2012 and 2014. She completed a Master of Business Administration (MBA) with distinction through Wits, and she is currently undertaking a Master's degree in public health, also through Wits. In 2017, she was appointed as clinical manager at Helen Joseph Hospital, with acting CEO responsibilities. She is the youngest clinical manager at the hospital, and is responsible for overseeing internal medicine, psychiatry, the emergency department, critical care and primary healthcare. She continues to mentor junior doctors, and serves on many committees. She is extensively involved in clinical governance activity at the hospital, and has made a difference at clinical and leadership levels. She has supported senior colleagues in improving the efficiency and effectiveness of their departments.

**Service Excellence in the Private Sector** is a new award initiated by the Gauteng North branch that rewards doctors in the private sector who have been practising medical for at least 10 years, made a difference in their



Dr P J Senoamadi

community and who show compassion and empathy towards patients. It is incumbent on the person submitting the nomination to show the "making a difference" element in the application. This year's award went to **Dr P J Senoamadi**.

He is a multi-award-winning medical practitioner, with special interests in diabetes mellitus and non-communicable conditions. He is a health and wellness coach and a social entrepreneur. He is the founder of Folang Medical Centre in Limpopo Province, one of the few diabetes centres in the province that has introduced holistic integrated care, and his patients have had excellent outcomes. He works with a multidisciplinary team. Folang Trust, a not-for-profit organisation founded in 2007, provides humanitarian aid by promoting healthy and sustainable communities in healthcare through leadership, education and sport.

He was the winner of the Black Management Forum Manager of the Year award in 2013, in recognition of the role he plays in supporting communities, particularly youth. He is a two-times winner of the Centre for Diabetes and Endocrinology (CDE) award, in 2012 and 2016. He hosted a sixth world Diabetes Day commemoration in 2017 in his home town, which was attended by approximately 10 000 people, who were screened and educated about their health. He is also a motivational speaker who gives talks to the community.

The **SAMA Award of the Year** is an award given to a doctor who has contributed distinguished service to SAMA of an extraordinary nature. This year, it was awarded to **Dr Farah Jawitz**.

This remarkable young doctor, as an intern at Khayelitsha and now a community service doctor at Mossel Bay Hospital, has continued to advocate on issues concerning junior doctors. This has been achieved by



Dr Farah Jawitz

means of her involvement as Western Cape chairperson and national working group member of Junior Doctors Association of SA (JUDASA), her position as part of the national task team of the National Department of Health (NDoH) addressing the working hours of junior doctors and being an executive member of the Junior Doctors of Africa (JDA). She has shown her commitment to fulfilling her duties as an advocate for junior doctors by means of her involvement in the placement of 2018 interns and community service doctors. This involved meeting on a continual basis with the NDoH over 2017 and 2018 to attempt to resolve numerous issues plaguing the placement of doctors. She provided continuous nationwide feedback through various channels to all junior doctors during the application process, and ensured that any concerns were brought to the attention of the NDoH. Her contribution to the 2018 internship and community service placement was invaluable. She was also at the forefront of ensuring safer working hours for junior doctors with her involvement on the NDoH national task team. Her influence has been profound, and she has contributed successfully to changes in the HPCSA's guidelines on the maximum continuous shift length allowed for junior doctors, reducing it from 30 to 26 hours. She has also been working hard to ensure a more robust and representative leadership for SA junior doctors by heading up nationwide road shows to establish provincial executive committees for JUDASA ahead of the 2018 JUDASA annual general meeting, where a national executive committee was appointed. It is her commitment to serving the community, her contributions to the public health sector and her involvement in advocacy, with a true interest in the rights and wellbeing of junior doctors, that makes Dr Farah Jawitz a worthy candidate for the SAMA Award of the Year.

## PhD thesis motivates the SA national MTA

Dr Safia Mahomed, senior lecturer, School of Law, UNISA; honorary senior lecturer, School of Clinical Medicine, Steve Biko Centre for Bioethics, Wits



*The new SA national material transfer agreement was one of the outcomes of Dr Safia Mahomed's PhD thesis*

In July 2018, a national material transfer agreement (MTA) was gazetted into legislation. This bold step by the Department of Health attempts to regulate the transfer of human biological materials (HBMs) in health research across SA's borders, to protect vulnerable research participants, and local researchers and institutions. The provisions contained within the MTA are rooted in the fundamental principle of human dignity, which cannot be separated from human health research, and are in keeping with the principles of the WMA's Declaration of Taipei on Ethical Considerations regarding Health Databases and Biobanks. SAMA contributed significantly to the development of this declaration.

The MTA applies to both HBMs and data. While the transfer of materials across national borders occurs both in individual research projects and biobank research, the complexities associated with the latter are far-reaching, and range from social and ethical to legal issues. The key areas of concern involve uncertainties with regard to: what type of informed consent should be used; how secondary uses of materials should be approached; who in fact owns the materials after they are obtained; how far privacy and confidentiality measures should extend; to what degree benefit-sharing should be implemented; and what provisions an MTA should contain. There appear to be more questions raised than answers when one attempts to find solutions to these difficulties. In addition, these complexities have often been viewed as hurdles to the research process. With no clear answers, and no concise ethico-regulatory framework in place, research ethics committees (RECs) have been responsible for making decisions in respect of these concerns. One way in which to consolidate and effectively regulate the questions raised above is to incorporate them into an MTA.

The SA MTA includes various provisions, and incorporates broad consent into its application. Broad consent should not be confused with blanket or open consent, in which informed consent is a once-off, all-encompassing process. Broad consent requires that the research participant consents to a framework for future research of certain, and specific, types. This framework includes ethical review of each specific research project by an independent REC,

and the implementation of strategies to regularly update the participant, as well as the provision of ongoing withdrawal opportunities. Should anything in the research framework change, the participant would need to re-consent. However, should it be impossible or impracticable to re-consent, the REC should make a considered determination in this regard. The MTA further provides that the institution that provides the materials remains their custodian, even after transfer. This terminology offers a paradigm shift towards custodianship that allows for the obligation of "caretaking," which fits more appropriately with the principles of respect and dignity for participant materials. The MTA incorporates benefit-sharing mechanisms, and provides examples of what a benefit may constitute (e.g. the sharing of information, publication rights for local researchers, transfer of technology and capacity building). Health Research Ethics Committee (HREC) oversight is also emphasised throughout the MTA, and all uses of the materials, including secondary uses, must be approved by an HREC. The obligations of the HREC in this regard are set out clearly within the MTA. With regard to privacy and confidentiality, the MTA provides safeguards, should the materials become identifiable for any reason. There are also provisions on termination, dispute settlement and publication rights.

The objectives of the MTA include enhancing the trust relationship between participant and researcher, thereby facilitating and fostering health research to achieve its ultimate purpose: to generate new science with the intention of benefiting human wellbeing and health.

## When the good doctor burns out

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

We fulfil many roles as doctors – besides saving life or limb – that require us to wear many hats and different faces, while never losing our core

professionalism and dedication. We are mothers, fathers, wives, husbands, daughters, sons, siblings, cousins and friends. Some of us are also students and/or supervisors,

mentors and guides. We give a lot of ourselves to everybody around us, leaving little space for personal needs and interests. By default, immediate family, extended

family, friends and friends of friends often use us as Wikipedia or Google for any medical niggles, real or imagined. Other crises are also laid at our door, even if they have nothing to do with medicine, simply because we are seen as the “take charge” people who know what to do when others are at a loss. With all these wants and needs of others pulling us in different directions, we become neglectful of our own. We feel guilty about taking time off, even when sick. It is not unknown for a doctor to “forget” to take annual leave and to continue soldiering on in the midst of chaos. Our training primes us to carry on, and our profession compels us. Is it any wonder that the profession is buckling under the strain?

### When burnout comes calling

In its 2018 physician lifestyle survey, Medscape found that 42% of the 15 000 doctors who responded, from 29 specialties, reported burnout, while 15% reported depression. Drummond, in an article on physician burnout, provides stats showing that one in every three doctors is experiencing burnout at any given time. So, what is burnout, and why are so many doctors experiencing it?

Burnout manifests as three core symptoms linked to work-related stress – stress that is unrelenting to the point of being overwhelming:

- emotional exhaustion
- lack of efficiency, or a reduced sense of personal accomplishment
- depersonalisation brought on by work related stress.

The emotional exhaustion can lead to feeling so run down that you have no energy or reserves to invest in most aspects of your job, with a loss of interest in and inability to engage fully with patients, colleagues or significant others. The depersonalisation aspect of burnout manifests as an emotional distancing from patients and others, and even pervasive cynicism and sarcasm that permeate various aspects of your life. Perceptions about lack of efficiency can introduce self-doubt, and affect your level of functioning and ability to be decisive at work.

Christina Maslach and colleagues devised the Maslach Burnout Inventory, which is a standardised survey that screens for burnout. There may be delayed self-recognition of burnout, or a reluctance to act even when one has insight into its presence. Complicating things even further

is the fact that burnout, although described by many researchers over the years, is not a well-delineated, fully fledged condition, and does not have clear treatment guidelines. It is also not listed as a diagnostic entity in the *DSM-5*, although there is overlap between the core symptoms described for burnout and depression. For example, loss of energy and the change in usual efficiency or sense of accomplishment are common to both conditions, while depersonalisation may be seen in a number of mental disorders, including depression, even though it is not a core diagnostic criterion. Some researchers propose that burnout should be taken as part of a continuum of depression, rather than a separate entity.

### Our training primes us to carry on, and our profession compels us

Irrespective of one's interpretation of the current literature on burnout, the fact that close to half of the 15 000 Medscape cohort described themselves as suffering from it implies that it exists as a recognised concept in the real world, away from textbooks and diagnostic criteria. Moreover, it can impact significantly and negatively on a doctor's productivity and work efficiency. A *JAMA International Medicine* meta-analysis refers to the profound physical and emotional consequences burnout can have for both doctors and patients. One of the consequences it describes is reduced efficiency of healthcare systems in delivering high-quality, safe care to patients. Examples of how this may manifest include preventable adverse events, such as prescribing improper medications, or failing to make appropriate and necessary referrals. The authors also describe a 1.96-fold increased risk of patient safety incidents, and a 2.28-times increased risk of reduced patient satisfaction reports.

Contributors to physician burnout include:

- medical training that demands that you give your all to your medical career, no matter what. Inherent to the classical style of medical training is a lack of acknowledgement of one's needs, and neglect of all aspects of self-care.

- a strenuous work environment with under-resourcing, short-staffing and general lack of appreciation. The result is overwork, with little say afforded to the individual doctor in the running of health systems or institutions. This can contribute to feelings of powerlessness and can fuel loss of emotional investment in all things to do with work.
- a profession that is intolerant of mistakes, due to the gravity and finality of the consequences when things go wrong, i.e. death.
- the nature of our work, which deals with people's pain, whether physical or emotional. It is our job to relieve their pain and distress. Most of the time we do this successfully, but due to the mortality of man, it cannot be done indefinitely. It therefore stands to reason that at times we will be unsuccessful. We are less accepting of this than those in other professions, however, due to our overactive sense of responsibility and perfectionism.

### The conundrum of the injured healer healing themselves

To conquer the malaises of burnout, depression and other causes of mental distress that plague us, we must first acknowledge their existence. In understanding this reality, we also have to accept the part we play in perpetuating unrealistic expectations of ourselves as unbreakable superhumans. The caring nature of our profession that is nurtured throughout our training has to include a caring approach towards ourselves and our own wellbeing. It does not mean compromising on quality and standards. Instead, it implies a recognition that on days when I am not functioning at my best, I should be able to acknowledge this to myself and colleagues around me, so that asking for help is not perceived as weakness but as an early indicator that they need to adapt and increase support until I can function at a higher level again. Many of us cope with our workload most of the time. But all of us have days when we are not firing on all cylinders. Such days are a realistic part of any profession. They should not be considered anathema to medicine. Our work systems should be geared to respond with contingency measures when such instances occur.

Prevention strategies that foster resilience, as a guard against burnout, should be encouraged. Self-care includes ensuring

a more balanced work-life schedule, and maintaining social interconnectedness through positive relationships with family, friends or other support networks. Professional bodies and doctors' network groups can form an extension of this connectedness and encourage a sense of belonging which can counteract isolation and aloneness. Cultivating professional relationships with colleagues and seniors through mentorship, consulting with experts when faced with clinical or ethical dilemmas, and general collegial support may boost ability to cope with pressures at work. Healthy lifestyle habits such as getting enough sleep, exercise and proper nutrition are crucial in promoting and maintaining optimal energy levels. Psychological health also benefits from optimal physical health. Taking time out before exhaustion and despair set in about one's negative work circumstances is also crucial. Being aware

## **"Dr Burnout" does not always have to be at everyone's beck and call 24/7**

of self-critical thoughts or self-talk, and learning to adjust one's thinking around these thoughts, is an important skill that some people may practise automatically, but if it does not come naturally, it assists to develop and hone the ability. Self-help books on mindfulness and cognitive behavioural techniques may also assist. Being able to vent to a sympathetic ear may assist in adjusting one's perspective when things feel overwhelming. A good mentor

or guide can make an enormous difference to how the average doctor learns to deal with work problems, especially early on in one's career, which is the most vulnerable time for doctors. Taking sabbaticals where possible to focus on other areas of interest may also assist.

For as long as doctors have not internalised the importance of wholistic self-care, the profession will continue to be predisposed to burnout. Equally important is for doctors to differentiate between being in the service of our fellow countrymen and women, and being in servitude to our sense of duty and dedication. Servitude implies enslavement to our profession, while being in service inherently includes a period when doctors should be able to put up an "out of service" sign, even if temporarily, to allow for rest and recuperation in times of need. "Dr Burnout" does not always have to be at everyone's beck and call 24/7. He or she also deserves a break.



 **Investec**

Experience  
**One  
Place™**

**Bank | Invest | Protect**  
locally and internationally

**We save you time** with seamless banking,  
investing and insurance in One Place™

Find out more 

## Your financial health

**Gert Viljoen**, managing director, VPROF – a medical practice administrator, medical bureau and professional accounting firm dedicated to supporting the business activities and patient care of independent medical practices around SA

### Business interruption insurance

Statistically, almost three-quarters of businesses that suffer a major catastrophic event (such as a flood or a fire) never recover: 43% never trade again, and a further 29% go out of business within 2 years.

Fortunately, you can easily protect your business from that sort of risk by insuring against not only loss of assets, but also loss of profits while you get the business back up on its feet again. Read on for our suggestions on what to insure for.

Catastrophes such as floods and fires do occur, and there is insurance designed to cater for this type of event. There are two different types of insurance cover for such a catastrophe: one to repair or replace the assets damaged (your normal insurance policy); and one to compensate you for the losses incurred during the time it takes to get the business going again. The latter is known as “business interruption” or “loss of profits” insurance.

Since nearly three out of four businesses never recover from a catastrophic event, it is important to ensure that your business interruption insurance has been carefully thought through.

### What to insure for

You need to have a good grasp of your costs, and expected sales and gross profit. You don't want to underinsure, so if your business is growing, reflect that fact – for example, if you expect 10% growth (and trends in your business justify this expectation), show this to insurers, or you won't be paid out this additional amount.

It is important to make sure that all your projections are well grounded and can be defended, as they will be closely scrutinised by loss adjusters in the event of a claim. Therefore, the better you understand your costs, the less chance there is of having a claim either rejected or adjusted downwards.

Another critical factor to consider is the indemnity period. This is the length of time that you will be covered for, while out of business. For example, if you put a 6-month indemnity period in your policy, you will only get paid out for 6 months even if it takes 12 months to get your business back on its feet again.

Spend time with your accountant getting to grips with your revenues and costs, and use a reliable insurance broker.

### Misrepresentation on CVs is getting worse

“CV fraud” is a growing problem that all employers should guard against when hiring new staff in any capacity.

Prevention being, of course, much better than cure, vigilance during the recruitment process is key here – with our labour laws as complex and full of pitfalls as they are, you could find it very difficult to fire a lying employee down the line.

We share some thoughts on how to build up a thorough picture of a job candidate, and on how to detect dishonesty in his or her CV, even in these days of restricted access to personal information.

Not surprisingly, considering what we hear every day in the news, employers are finding that candidate employees are more and more often embellishing and misrepresenting aspects of their careers, as well as omitting embarrassing aspects altogether.

It is also becoming increasingly difficult to get a thorough picture of a candidate for a position, due to increasing restrictions being placed on personal information. This tends to make previous employers wary of sharing information about their employees, and more and more employers now give out no information at all.

The consequences of making a mistake when recruiting are damaging, as the process

is time-consuming and adversely affects staff morale, which can lead to a business losing or making less money.

### A matter of trust

The relationship between employee and employer is based on trust. Abusing this trust by falsifying a CV breaks down this relationship, as the employer begins to doubt what the employee is doing, and this usually results in a downward spiral, leading to disciplinary hearings and often dismissal. The business then has to start the whole recruitment process again.

Labour courts have found that falsifying a CV is a dismissible offence, and that there is no need to prove that the misrepresentation led to your decision to appoint the candidate.

While this is encouraging, in practice, many cases end up being lost by the employer due to some procedural error found by the court.

### Dealing with falsehoods

As noted above, it is becoming harder to obtain a true picture of a prospective staff member. Think, perhaps, of joining the many companies now using informal networks, such as by canvassing management in your organisation, or building up human-resource groups in the applicable industry. Often this approach leads to the employer finding “someone who knows someone”, and from there, a more accurate picture of the employee's past can be put together.

Why not also pursue someone who commits a dismissible offence – if necessary, charge the person, and go through the full disciplinary process? Then, be honest with another employer as to why the employee left or was fired. This way at least it will spare other employers making costly appointments, and – who knows? – it may begin to spread throughout the sector and come back to benefit your business directly one day.

## SAMA Research Masters Supplementary Scholarship

**Dr Daniël J Laäs**, SAMA Research Masters Scholarship recipient, writes about his research

**T**here are two rules in life that I try my utmost to follow: the first is to try everything at least once, and the

second is that if something is broken – fix it. Therefore, when my intern supervisor, and later research supervisor, suggested

we carry out a research project on warfarin and all of its shortcomings, I jumped at the opportunity.



The initial formulation of the research proposal was a formidable task for a novice. But with childlike excitement, and a fair amount of guidance, we submitted the proposal and awaited ethical clearance.

Then reality set in. This research project would require funding, and a significant amount of it, which is something that novice researchers never seem to factor in when starting a new venture. Soon, I became the personification of each of the “Kübler-Ross” stages of grief.

First, denial: “No, it won’t cost that much; it will be easy.” Then anger – “Why did I do this to myself?” followed by bargaining: “Okay, if we budget well we can do this,” and on into depression: “This is never going to work; I should just give up.”

But luckily, acceptance and a new determination were quick to follow: “This is a great opportunity and we can find funding. I will make it work.”

SA has a rich medical history, and there are many of our colleagues who have brilliant research ideas, but unfortunately most of these ideas remain just that – a thought, an idea. I suspect that one of the reasons for this is lack of funding. Conducting research is (unexpectedly) expensive, and one needs significant resources, and time, to produce a quality paper. Two things counted in my favour: I had a very supportive academic supervisor, and I was the recipient of the SAMA Research Masters Supplementary Scholarship.

Our research was, by most standards, relatively inexpensive, but the expenses accumulated nonetheless. Within a short time period of time, our total expenditure already exceeded ZAR10 000. A scholarship such as this one from SAMA gives one room to breathe, and to conduct a study without the typical financial constraints that plague most junior researchers. We could afford to employ a data collector who could assist me when my clinical duties clashed with my research. I was able to pay study and research fees, get access to multiple international journals and upgrade the software that we used to analyse the data. This empowered me to spend more time doing research and analysing data, and less time worrying about where the money was going to come from.

Most medical professionals are excited about conducting novel research and tackling the unknown, but very few get past the fourth

stage: the proverbial “depression” phase. This financial stonewall to research is daunting to overcome, and serves as a very potent deterrent for anyone who is new and eager to tackle a topic. Just as fees must fall, so too must the financial barriers that stop young minds from conducting research. Access to medical journals should be free, registration fees need to be reduced and conducting research needs to be incentivised by government and higher education institutions. The late Prof. Stephen Hawking said: “No-one undertakes research in physics with the intention of winning a prize. It is the joy of discovering something no-one knew before”. Let us encourage this joy of discovery, as it is a fundamental building block in improving quality of care.

My advice to anyone who wants to conduct research is not to get discouraged. Ask for help: there are a great many institutions (such as SAMA) that have excellent bursaries and scholarships up for grabs. Apply for these scholarships, send in your CV, show up for the interview, wear a tie and trust in your own abilities. You might just pleasantly surprise yourself.

The end result was that we were able to get both of our articles accepted for publication, and we presented our research at the recent SAMA Conference in Sun City.

*Baie dankie SAMA, siyabonga kakulu.*

## Derivative misconduct in the workplace

Simon Buthelezi, industrial relations advisor, SAMA Employed Doctors Department

Derivative misconduct originates from the premise that employees owe their employer the duty of faith, in that they cannot withhold from their employer knowledge of wrongdoing committed in their presence by other employees that is detrimental to the employer’s business. Employees often believe that it is not their duty to protect the employer’s property, even though their continued employment depends on the stability of the business.

Many such situations arise when an employer notices that team misconduct is happening, and employees fail to disclose it to their employer. It is treated as a breach of the duty of faith, or a negation of the common-law duty to act in good faith towards an employer, and

viewed as serious misconduct, which may lead to dismissal, depending on the nature of the incident.

### Prevalence of derivative misconduct

Judging from a number of cases dealt with by our courts, it is clear that the issue of collusion in committing misconduct, otherwise known as team misconduct, is a serious matter in many workplaces, and a very common phenomenon, as employees are likely to remain mute about it, believing that the employer will not be able to identify the perpetrators. This is mainly experienced during strikes or protest actions, and in workplaces where the temptation to commit theft is very high.

Retail industries face huge losses due to theft, and in many cases those responsible for such pilfering are never detected, as a result of unco-operative employees. In any group action, such as protest or violent industrial actions, self-control seems to take a back seat, and many employees become prone to reckless behaviour. It is here where collective misconduct is often noticed.

### Dealing with derivative misconduct

A well known case is that of Foschini Group v Maidi and Others, in which five employees were charged with “gross negligence by failing to secure assets of the company”, and they were eventually dismissed by the employer.

The principle established by this case is that the employees should have been part of the team in the affected store, and therefore shared collective responsibility.

Another case in point is that of Western Platinum Refinery Ltd v Hlebelo and Others. In this case, the employer believed that Hlebelo was aware of losses of precious metals, yet he failed to make full and frank disclosure to the employer. In the end, however, the Labour Appeal Court found that during the investigation, the employer deviated from a focus on the losses that it was faced with, and focused instead on Hlebelo's lifestyle, such that the employer lost the case.

A case which shocked many employees is that of Chauke and Others v Lee Service Centre CC t/a Leeson Motors. The Labour Appeal Court confirmed that an employer who suffers continuous loss and is unable to identify the perpetrators, and has reasonable grounds to believe that such perpetrators are among the employees, is justified in dismissing all employees in that group.

### Challenges in dealing with collective misconduct

Disciplining employees for collective misconduct is not an easy task for employers, as it still calls for a thorough investigation, and moreover

a very focused one, as any deviation from focus, such as that observed in the Hlebelo case, can end up being very costly, and there must be reasonable grounds to believe that employees were part of the unacceptable conduct, or at least knew about it and did not report it.

It should go without saying that any employee who had been on leave during the period when the employer suspected team misconduct cannot be charged; however, this presents huge problems if the employer does not know when the collective misconduct started, as establishing reasonable grounds to believe that the employee knew about the misconduct is key to a successful case.

## Griqualand West host CPD meeting

The Griqualand West Branch hosted a successful CPD meeting on 31 July 2018 at the Kimberley Club Boutique Hotel. The topic discussed at the meeting, which was presented by Dr L Du Plessis, was red flags for recognising childhood leukaemia in daily practice.

Dr du Plessis qualified as a physician from the University of Pretoria in 2003, and completed her paediatric training (MMed Paeds) at the University of the Free State in 2012. She was excited to receive a 3-year

fellowship in haematology, oncology and bone marrow transplant at British Columbia Children's Hospital in Vancouver, Canada. Her fields of interest include therapy-related side-effects in children receiving chemotherapy (she is hoping to contribute to finding ways to deliver safer treatment) and targeted therapy, and enhancing a patient's own immunity to treat cancer. The long-term hope is that this expensive modality of care will be made available to children in resource-limited settings.



Left to right: Dr DB Mattison (council representative for state doctors), Dr MJ Ngundu (council chair), Dr L Du Plessis and Dr TF Konso (branch councillor).



Dr DA Kistan, a first-year intern, excited to receive her scrubs and a gift from the branch after joining the KZN Midlands branch on 22 August. The scrubs are proving to be very popular.



On 31 July, the KZN Midlands branch held a CPD meeting at Grey's Hospital. The topics were "Medicine and workplace law", by Mr S Buthelezi, and "NHI and the Medical Aid Schemes Amendment Act", by Dr M Grootboom and Dr M Thandrayen. Left to right: Dr M Thandrayen, Dr M Grootboom and Dr G T T Buthelezi (branch chairperson).



Dr A F Cassimjee (right) from KZN Midlands branch had the privilege of receiving his framed Life Membership Award certificate from Dr M Grootboom (left).



West Rand branch secretary Tracey Gurnell (above) and Sarah Molefe from head office hosted a CPD event at the Leratong Hospital on 27 July.



Dr Jay Punwasi, West Rand branch chairperson, and branch secretary Tracey Gurnell, at a recent well-attended annual Netcare/SAMA symposium on 24 and 25 August at Misty Hills conference venue, which the branch co-sponsor.



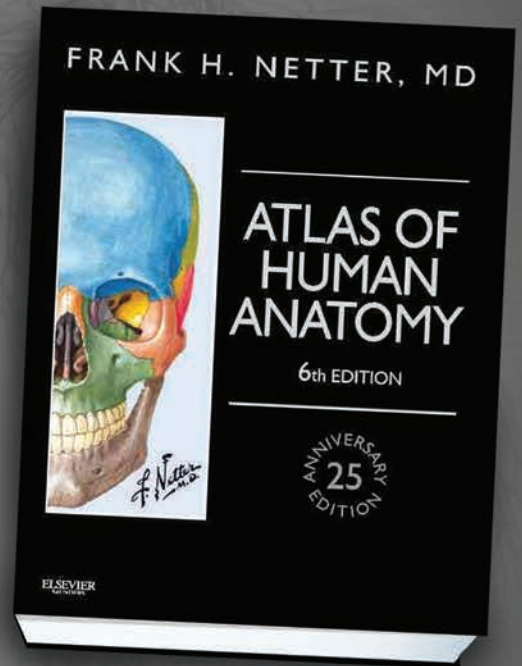
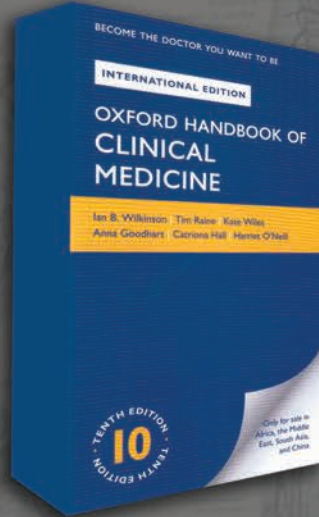
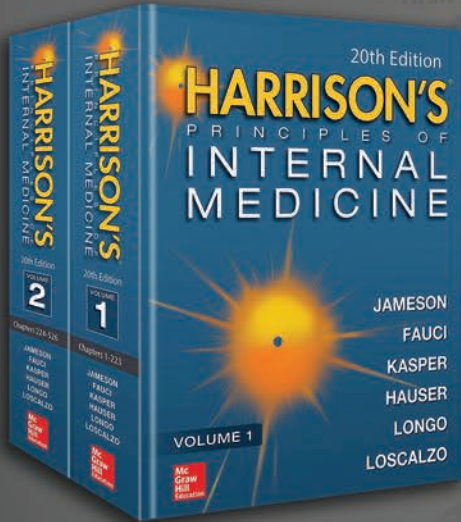
## ELIXIR LIVE

The perfect on-the-go paperless solution to manage your practice and patients in a secure cloud-based environment!

Contact us on 0860 98 00 98 or email [sales@medemass.com](mailto:sales@medemass.com)



# THE HOUSE OF THE BEST MEDICAL BOOKS FOR ANY MEDICAL PRACTITIONER



- HARRISONS PRINCIPLES OF INTERNAL MEDICINE (VOLUME 1 AND 2) (DVD INCLUDED)
- COOVADIAS PAEDIATRICS AND CHILD HEALTH
- OXFORD HANDBOOK OF CLINICAL MEDICINE
- NETTERS ATLAS OF HUMAN ANATOMY
- KUMAR AND CLARK'S CLINICAL MEDICINE
- TALLEY AND OCONNORS CLINICAL EXAMINATION
- DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-V)
- CLINICAL OBSTETRICS: A SA PERSPECTIVE
- CLINICAL GYNAECOLOGY
- DORLANDS ILLUSTRATION MEDICAL DICT

**AND MANY MORE AT OUR STORES.  
CONTACT OR VISIT US AT THE STORES BELOW:**

## WESTERN CAPE

TYGERBERG  
UNIVERSITY OF STELLENBOSCH MEDICAL  
CAMPUS  
TEL: (021) 932 0203  
EMAIL: TYGERBERG@VANSCHAIK.COM

PAROW  
PAROW CENTRE  
TEL: (021) 930 2480  
EMAIL: VSPAROW@VANSCHAIK.COM

RONDEBOSCH  
MAIN ROAD  
TEL: (021) 689 4112  
EMAIL: VSRBOSCH@VANSCHAIK.COM

## FREE STATE

BLOEMFONTEIN  
UNIVERSITY OF THE FREE STATE  
TEL: (051) 444 3048  
EMAIL: VSBAND@VANSCHAIK.COM

## KWAZULU NATAL

DURBAN  
UMBULO ROAD  
TEL: (031) 101 3080  
EMAIL: DURBANMED@VANSCHAIK.COM

DURBAN  
CNR STALWART SIMELANE AND BRAM FISCHER STREETS  
TEL: (031) 332 2009/2049  
EMAIL: VSDURBAN@VANSCHAIK.COM

## GAUTENG

GA-RANKUWA  
SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY  
TEL: (012) 521 3882  
EMAIL: VSMEDUNSA@VANSCHAIK.COM

JOHANNESBURG  
WITS UNIVERSITY MEDICAL SCHOOL  
TEL: (011) 717 2012  
EMAIL: VSMEDICAS@VANSCHAIK.COM

## EASTERN CAPE

MTHATHA  
WALTER SISULU UNIVERSITY  
NELSON MANDELA DRIVE  
TEL: (047) 495 0005  
EMAIL: MTHATHANMD@VANSCHAIK.COM

PORT ELIZABETH  
NELSON MANDELA UNIVERSITY  
MISSIONVALE CAMPUS  
TEL: (041) 504 1103  
EMAIL: VSMISSIONVALE@VANSCHAIK.COM