

SAMA

INSIDER

DECEMBER/JANUARY 2019

2019 GOALS

**National Council
elects new leadership**

**Communication the best
medicine against patient
complaints**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
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CONTENTS

DECEMBER/JANUARY 2019



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- 3 EDITOR'S NOTE**
A new year, new leadership
Diane de Kock
- 4 FEATURES**
SAMA's National Council
elects new leadership
Yolande Lemmer
- 5** Introducing Hoosen Coovadia,
SAMA president
SAMA Communications Department
- 6** Attending the Presidential Health
Summit
Selaelo Mameetja
- 7** Meet the SA Academy of
Family Physicians
Prof. Bob Mash
- 8** Communication the best medicine
against patient complaints – experts
SAMA Communications Department
- 9** Solving youth unemployment –
we can all play a role
Tiyani Armstrong
- 11** Obituary: Dr Ivan Berkowitz
SAMA Communications Department
- 12** Collective bargaining –
the numbers game
Simon Madini
- 13** As long as you breathe, you are at risk
MDR-TB: My story
Dr Zolelwa Sifumba
- 15** HPCSA complaints process:
What to expect
Hanneke Verwey
- 16** Malnutrition in 2018: An opinion
Dr Freddy Kgongwana
- 17** 2019 MDCM products
SAMA Private Practice Department
- 18 LETTERS TO THE EDITOR**
Complaint against Resolution Health
medical scheme
Dr W R Bezwoda
- 18** SAMA response: Complaint against
Resolution Health medical scheme
Shelley McGee
- 20 MEDICINE AND THE LAW**
Complications of long-term
nitrofurantoin
Medical Protection Society
- 20** Obituary: Dr Timothy Ndaki
SAMA Communications Department
- 21** **BRANCH NEWS**

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Diane de Kock
Editor: *SAMA INSIDER*

A new year, new leadership

The end of a year often marks a time of reflection, and as we put to bed the last issue of *Insider* for 2018, once again a year of change and huge challenges, SAMA welcomes a new era of leadership to guide and unify the association in 2019.

On page 4, we report on the recent national council meeting held at the end of October, where a new chairperson and vice-chairperson were elected, and Dr Richard Tuft was voted president-elect for 2019 - 2020. New SAMA president, Prof. Hoosen Coovadia, is briefly introduced to readers on page 5 – we look forward to his presidential messages in 2019.

Selaelo Mametja and a delegation of doctors attended the Presidential Health Summit in October (page 6), a meeting which “aimed to address the numerous challenges facing the SA health system, and to work towards strengthening the health system, to provide universal access to quality health services”.

We introduce the SA Academy of Family Physicians on page 7, a professional body affiliated to SAMA, and officially represented by Prof. Shadrack Mazaza on the National Council and the Specialist Private Practice Committee.

The Ethics for All conference is covered on pages 8 and 9, a flagship conference for the Medical Protection Society (MPS) in SA, which protects and supports the professional interests of more than 30 000 healthcare professionals. More than 2 000 people attended the conferences in Cape Town, Durban and Pretoria.

The realities of an internship in SA are highlighted in Dr Zolelwa Sifumba’s article on page 13, who says: “I went from student to patient to survivor to activist, and there was nothing easy about this journey.”

Hanneke Verwey’s article on page 15 will “assist practitioners in understanding what to expect, procedurally, once a complaint has been lodged against them with the HPCSA”.

The power of communication is illustrated on our letters page (page 18), where the SAMA Knowledge Management and Research Department ably address a series of letters from a reader.

One of the key ingredients of good leadership is communication – this is your magazine; let’s communicate.

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SAMA's National Council elects new leadership

Yolande Lemmer, SAMA Governance and Legal Department

SAMA's elective National Council meeting took place over a period of 3 days at the Southern Sun OR Tambo Hotel, from 26 to 28 October 2018.

The first day of the meeting (commencing at 13h00 on Friday) was dedicated to SAMA branch matters. Branch chairpersons and representatives from branches each provided a report on their branch activities since the branch chairpersons forum in May 2017. SAMA's general manager, Dr Manny Thandrayen, presented on relevant topics that carried over from the previous national council meeting in 2016, as well as some items that the branches had forwarded before the meeting for specific discussion there. These included, among others, "geomapping" (the possible changing of branch borders to align with health districts, and the effect that this would have on the membership of certain branches), branch finances and SAMA's progress in its efforts to have an independent Medical and Dental Council established.

Dr Thandrayen reported that SAMA has commissioned an in-depth study to ascertain the exact role and function of clinical associates within the healthcare sector, and that the organisation is actively pursuing interventions insofar as safe working conditions for doctors were concerned.

On the second day of the meeting, a new chairperson, vice-chairperson and president-elect were elected. SAMA is proud to announce that Dr Angelique Coetzee, from Gauteng, was elected as its new chairperson, and is confident that SAMA will make positive strides to continue its major role in the health environment under her dynamic leadership.

Dr Mvuyisi Mzukwa, from KwaZulu-Natal, was elected as vice-chairperson. SAMA would like to congratulate these leaders on their new positions, and is looking forward to gaining from their experience, wisdom and innovative thinking in future.

The last day of the meeting saw the new chairpersons and members of SAMA's committees elected. Following the elections of the chairpersons, the new SAMA board was officially announced.

The board comprises the following members:

Board member	Position
Dr A Coetzee	Chairperson: SAMA
Dr M Mzukwa	Vice-chairperson: SAMA
Dr M van der Schyff	Chairperson: Specialist Private Practice Committee
Dr M N Mabasa	Chairperson: General Practitioner Private Practice Committee
Dr L M B Majake	Chairperson: Audit and Risk Committee
Dr C S Sihlangu	Chairperson: Constitutional Matters Committee
Prof. M Naidoo	Chairperson: Education, Science and Technology Committee
Dr S Toni	Chairperson: Health Policy Committee
Dr M C Human	Chairperson: Human Rights, Law and Ethics Committee
Dr T O Sadiki	Chairperson: Social and Ethics Committee
Dr M Nodikida	Chairperson: Finance Committee



Dynamic leader Dr Angelique Coetzee, from Gauteng, was elected as SAMA's new chairperson



SAMA's new leadership, from left to right: Dr R E Ngwenya (convenor of the task team constituted to investigate and implement a fully functional trade union), Dr M C Human, Prof. M Naidoo, Dr M N Mabasa, Dr M van der Schyff, Dr M Nodikida, Dr L M B Majake, Dr C S Sihlangu, Dr M Mzukwa (vice-chairperson), Dr A Coetzee (chairperson), Dr T O Sadiki, Dr S Toni.



Dr Coetzee and Dr Mzukwa thank outgoing president Dr Marina Xaba-Mokoena. The SAMA board of directors sincerely thanked Dr Marina Xaba-Mokoena for the exceptional manner in which she provided guidance, leadership and oversight during her tenure as president of the association. We wish her and her family well. Her leadership, wisdom, calm nature and sense of humour will always be remembered.

The SAMA president and general manager attend board meetings in an *ex officio* capacity.

On the evening of the second day, a Presidential Dinner was held to officially welcome the SAMA president for the 2018/2019 term, Prof. Hoosen Coovadia, and to say farewell to the SAMA president for the 2017/2018 term, Dr Marina Xaba-Mokoena, who was thanked for her special wisdom and contributions during the latter term. SAMA is honoured to welcome Prof. Coovadia, with his wealth of expertise and experience, into our midst. Dr Richard Tuft was nominated as the president-elect for the 2019/2020 term, and will take over the reins from Prof. Coovadia once his term is over.

The last day of the National Council meeting was also used to discuss and resolve issues of importance to the association, and many resolutions focusing on the unity of the association were passed.

Introducing Hoosen Coovadia, SAMA president

SAMA Communications Department

Prof. Coovadia has been elected as the new president for 2018/2019. His main contributions include critical research into the most serious health problems of children in Africa. He has published more than 350 research papers in leading international and SA journals, on the basic science and pathogenesis, clinical management, epidemiology, prevention and contextual factors for the major causes of morbidity, disability and mortality among Africa's children. His key research has been in the fields of malnutrition, kidney disorders and infectious diseases, especially mother-to-child transmission of HIV through breastfeeding.

He was the international vice-chair of a National Institutes of Health network on paediatric HIV, and has held editorial positions on a number of key journals. He regularly reviews papers for *The Lancet*, and often assesses proposals from the Wellcome Trust and other agencies. He has chaired some major international HIV conferences, and was the chair of the prestigious XIIIth International AIDS Conference held in Durban, 2000. A recipient of numerous awards from universities, public institutions and science organisations, Prof. Coovadia is closely engaged within the democratic organisations working towards the attainment of freedom after apartheid.



Incoming president Prof. Hoosen Coovadia (above) was inaugurated at the presidential dinner. Prof. Coovadia is a stalwart of the medical profession. "He brings with him a wealth of knowledge and experience to give guidance and direction to the new board. Prof. Coovadia is an exceptional leader who has a strategic outlook on the medical profession, and his inputs going forward will benefit not only SAMA, but the entire medical community in SA," said Dr Coetzee.

Attending the Presidential Health Summit

Selaelo Mametja, *SAMA Knowledge Management and Research Department*

The 2-day Presidential Health Summit was convened on Friday 19 and Saturday 20 October 2018, at the Birchwood Hotel in Boksburg, Gauteng.

It was not clear who from SAMA would be attending until the Presidency offered us seats at the last minute. Nevertheless, SAMA was able to send a delegation of doctors who participated meaningfully in the debates.

The Presidential Health Summit aimed to address the numerous challenges facing the SA health system, and to work towards strengthening the health system, to provide universal access to quality health services. To achieve this aim, the summit recognised the centrality of NHI, and the combined roles of the public and private health sectors in meeting the overall aspirations and goals of SA's national health system in achieving universal health coverage (UHC).

Objectives

The objectives of the Presidential Health Summit were to strengthen the SA health system by:

- advancing our collective efforts to promote good healthcare services, as an essential foundation for health for all
- outlining the roadmap towards a unified healthcare system by committing to rebuild the health system, to provide quality healthcare to all
- identifying actions to strengthen co-ordination, monitoring and evaluation
- identifying actions to strengthen co-ordination to deal with corruption, waste and abuse, to improve accountability and transparency
- addressing solutions to end the health system crisis.

Outcomes

The summit focused on challenges that pose a threat to the achievement of UHC, in both the public and private health sectors. There were five summit goals, which revolved around collective efforts by all players to identify specific actions to solve system challenges.

The summit was organised into nine commissions, the outcomes of which are presented below.

Commission 1: Human resources. The commission made several recommendations: lifting the moratorium on posts, reviewing the

policy on the remuneration of work outside public service, to limit its impact on service delivery, and providing surety that the statutory requirements for internship and community service are met. There is a need to review the distribution of resources between the public and private sectors, and a task team should be established (in my opinion, this may be a better approach than implementing a certificate of need, which may result in resistance).

Short-term goals: ensure that service plans are based on good data, using evidence-based tools. Review the policy on foreign-trained medical practitioners, to address skills shortages and provide support for human resources (HR).

Medium- and long-term goals: ensure that the policies on funding and staffing meet the needs of the health system. Validate and optimise the use of PERSAL ["integrated human resource, personnel and salary system"] and the HR management information system, and review the roles and responsibilities of each sphere of government in relation to health services. The education system should be revised to respond to population needs.

Leadership and governance: the leadership structure in the public sector is characterised by political interference and patronage, and is top heavy, with duplication of roles. Management lacks the necessary skills. The structure should be revised with a view to eliminating duplications, separating the administration of health from politics, and training managers.

Commission 2: Supply-chain management. SA is characterised by frequent stockouts and medicine shortages. To address these issues, the commission recommended, among other measures, the following: addressing corruption, ring-fencing pharmaceutical budgets, engaging the private sector to assist with inventory management, establishing a state-owned and competitive pharmaceutical company.

Commission 3: Public finance. Over the last few years, health has received real-term budgetary cuts. The discordance in priorities between the national and provincial Departments of Health (DoHs) has resulted in inefficient budget and grant allocations, which has impacted on the ability of hospitals to fulfil their mandate of providing quality healthcare. Significant budgetary pressures exist, with over-expenditure and accruals,

including accruals for personnel expenditure, such as overtime and rank promotions. The commission recommended that provincial treasuries should be engaged to prioritise health.

Commission 4: Infrastructure. The National DoH has a health infrastructure plan, but to date, the country has had neither the expertise nor adequate funding to implement the plan. In some cases, health infrastructure construction that has been successfully completed has either cost more than the initial budgeted amount, or the facilities have been constructed either fail to meet the need for the services required, or have not been provided with adequate funding to fully operationalise the new facilities. The commission found that the infrastructure plan must be able to respond to changing population and clinical dynamics, and not remain static.

Commission 5: Quality of health services. Although society is generally more focused on immediate structural improvements, for health practitioners, process measures may be more relevant. Both structural and process measures are necessary for improved outcomes. To achieve quality healthcare, there is a need for all facilities to comply with OHSC [Office of Health Standards Compliance] standards. Medicines and services should be accessible, and it is imperative to improve HR, medicines supply and facilities. Healthcare services need to be patient-centric and based on need, and to prioritise primary healthcare.

The commission also noted that the reality of the existence of both the public and private sectors in SA must be recognised. A harmonious working relationship is needed between these sectors that puts the needs of the people of SA first, and the private sector has a critical role to play in the realisation of NHI. To engage the private sector meaningfully, the inclusive process and mechanism started through the Presidential Health Summit should be sustained, by providing collective leadership and stewardship to unify both sectors around common goals. The recommendations from the health market inquiry report should be implemented.

Commission 6: Health service provision. The commission noted that we need to urgently address accruals through a clear strategy and relevant mechanisms, stop unfunded health-service provision mandates

being given to provincial health departments without consideration of their budgetary impacts, revise the equitable share formula, which should take into consideration internal migration, and address the burden of disease.

Commission 7: Leadership and governance. The commission recommended establishing an anti-corruption forum in the healthcare system, clarifying the roles of hospital boards and committees, expanding management training and focusing performance management around patient-centric outcomes.

Commission 8: Community engagement.

The commission recommended the revision of the concept of community participation in health, to clarify roles and responsibilities. Community structures should be included in the budget planning cycle, and there should be monitoring of budget spending reports, and an approach that takes social determinants of health into account, as a prevention strategy.

Commission 9: Health information systems. A standard electronic health record is essential, to improve health information. This would allow the establishment of a

functional repository, which could be used to measure activity and outcomes in healthcare (enabling, among other things, access to data and information on services availability, and monitoring of the burden of disease and quality outcomes). The commission recommended and supported a review of the current strategy, and appropriate investment. SA needs appropriate information technology (IT) infrastructure, and this is based outside of the health sector. The education system should produce a workforce that can utilise IT developments without further training, while current employees need to be upskilled.

Meet the SA Academy of Family Physicians

Prof. Bob Mash, *president, SA Academy of Family Physicians*



It may surprise you to learn that the SA Academy of Family Physicians (<http://www.saaftp.org/>) is one of the professional bodies affiliated to SAMA. We are officially represented by Prof. Shadrack Mazaza on the National Council and the Specialist Private Practice Committee.

As family medicine is a relatively new discipline in SA (officially recognised in 2007), many policy makers and health professionals are unsure about the contribution of specialists in family medicine to the health system. Family physicians undergo 4 years of postgraduate training, in the same way as other specialists, to, in essence, become expert generalists. Family physicians are trained to work at district hospitals and primary care facilities. In the public sector, they work as clinicians and consultants to the healthcare team, as they are the most highly trained clinicians within the teams, and see

the more difficult or complicated patients. Each team may include nurses, clinical nurse practitioners, clinical associates, junior doctors and community health workers. In addition, family physicians build the team's capacity to deliver high-quality care through mentoring, teaching, training and clinical governance activities. Often they supervise and train interns, clinical associates (mid-level doctors) and registrars. Their training includes acquiring the competencies required for district hospitals in areas such as anaesthetics, obstetrics and surgery. It also includes gaining an understanding of community-orientated primary care, and the ability to support the ward-based outreach teams. In the private sector, family physicians may also work as general practitioners, and medical aids are beginning to recognise their specialist status in terms of their scope of practice and remuneration. Family physicians explain more about what they do in a recent video that can be watched on YouTube (<https://youtu.be/f6ef7pLN2SU>).

A number of research projects have demonstrated that family physicians, although few in number, are making an impact on the quality of clinical processes across the burden of disease, and on the performance of the health system itself. They improve access to a more comprehensive service within each district, and also improve the co-ordination of care with referral hospitals. They improve the quality of care for chronic communicable (e.g. HIV and TB) and non-communicable diseases (such as diabetes and hypertension),

emergencies and maternal and child care. A recent policy brief outlines the initial evidence for their strengthening effect on district health services in more detail (<http://www.saaftp.org/index.php/main-menu/policy-brief>). We believe that primary healthcare teams need a combination of extended reach and coverage, through community health workers in ward-based outreach teams, as well as the inclusion of higher-level competencies, such as family physicians and doctors with postgraduate training in family medicine (we also offer a national 2-year Diploma in Family Medicine).

So, if these are the family physicians, what is the SA Academy of Family Physicians? The academy is not only a professional body for family physicians, but is also open to membership from other medical practitioners who work in family medicine and primary care settings. The guiding vision of the academy is to “promote optimal health for the people in SA through advocacy, support and the development of the primary healthcare team, and the establishment of an equitable, humane and integrated district healthcare system”.

At a regional and global level, the academy is SA's official body in the World Organization of Family Doctors (Wonca). Wonca was recently part of the Global Conference on Primary Health Care in Astana, Kazakhstan (<http://www.who.int/primary-health/conference-phc>) that launched a new global intergovernmental commitment to primary healthcare (including SA). The Astana Declaration is a renewal of the historic Alma

Ata Declaration that led to the “health for all” movement. The declaration states that “we are convinced that strengthening primary healthcare (PHC) is the most inclusive, effective and efficient approach to enhance people’s physical and mental health, as well as social wellbeing, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals.”

The academy also supports the ideals behind SA’s commitment to re-engineering primary healthcare and implementing NHI. Improving the quality of primary healthcare and district health services is essential to improve the social foundation of SA society. NHI is vital to improving equity and enabling universal health coverage for all South Africans.

Beyond these lofty social and policy goals, what does the academy actually do for its

members? It advocates for the discipline of family medicine, and its contribution to the health system in both the public and private sectors. In the public sector, we hope that provincial departments of health will commit to employing more family physicians at district hospitals and primary care facilities. We also hope that they will provide an increase in the number of registrar posts, to enable the discipline to go to scale (every programme should ideally have 10 new registrars per year). Our short-term goal is to have a family physician at each district hospital, community health centre and/or subdistrict in the country. In the private sector, we are negotiating with medical aids to properly recognise the specialty.

The Academy also offers its members an annual National Family Practitioners Conference. The next conference will be held in Johannesburg from 23 to 25 August 2019,

and will focus on the primary healthcare team, and their alignment with the ideals of NHI. The academy is also an approved accreditor for CPD activities with the HPCSA, and offers a variety of face-to-face and internet-based CPD. In addition, we offer the *SA Family Practice Journal* (<http://www.safpj.co.za/index.php/safpj>), which also publishes CPD, as well as original research articles.

Last but not least, the academy co-ordinates training in family medicine across all nine SA medical schools, through its national Education and Training Committee. This committee strives to improve the quality of the training programmes. The academy has an active collaboration with the Royal College of General Practitioners to train clinical instructors in the workplace, and to improve the quality assurance and formative assessment of these trainers.

Communication the best medicine against patient complaints – experts

SAMA Communications Department

Medical and dental professionals provide care, consultation and aid to millions of patients every day. Their skill and ability in solving sometimes complex health matters is what they have spent years learning, honing their talents to best serve those who come to them for help.

But these professionals may be accused by patients of not doing enough – or not doing the right thing – to make them or their families better. Situations such as these can escalate quickly, with patients sometimes turning to the HPCSA for remedy.

“Doctors often feel isolated in these situations, and when this happens, it’s our duty to as their medical defence organisation to assist them in the best way we can, whether this is assisting them in dealing with a complaint to the HPCSA, a clinical negligence claim, a disciplinary procedure or preparing for an inquest,” explains Ms Margi van Gogh, regional director of the Medical Protection Society (MPS).

MPS is the world’s leading protection organisation for doctors, dentists and healthcare professionals, and protects and supports the professional interests of more than 30 000 healthcare professionals in SA.



MPS assists medical professionals in SA through an annual Ethics for All conference, which was most recently held in held in October 2018, and outlined the latest in legal and ethical developments relating to them. The conferences are held in various locations around SA, including Cape Town, Durban and Pretoria, with a similar programme and speakers at each location.

In this way, doctors, dentists and other healthcare professionals are kept informed

of important legal and ethical issues in the profession, and how to manage problems should they arise. Speakers from the legal and medical fraternities are invited to present, as are, importantly, those from legislative authorities and statutory bodies and boards.

At the recent conference in Pretoria in early October, Adv. Stephen Farrell, SC, spoke on the processes of the HPCSA and the legal obligations of practitioners. Throughout his presentation, Adv. Farrell noted that

the biggest problem between healthcare professionals and their patients is poor communication.

"There is a perception that the HPCSA and Health Professions Act [No. 56 of 1974] are there to punish healthcare workers. What must be understood, though, is that when a doctor receives a letter from the HPCSA, a process has been put into effect that is prescribed by legislation," explained Adv. Farrell.

He said the Health Professions Act envisages a fair procedure, where the doctor is given a fair opportunity to state their case, and that in all cases, the doctor's version of events is asked for. "It's normal to be defensive when this happens, but doctors must ask themselves some key questions when these complaints arise. And, besides communication, I rate proper notes that are contemporaneous and comprehensive as the second most important part of any defense by a medical practitioner," he noted.

Adv. Farrell explained that once the HPCSA's processes are underway, they must continue to a resolution, one way or another.

"When you are in this situation, where you have received a letter and a patient has complained, you must stop what you are doing and apply your mind to the patient's complaint immediately. You must get their files and account files, and their hospital files if there are any; you must do everything you can, and be thorough, to determine how you reached your clinical decisions," he advised.

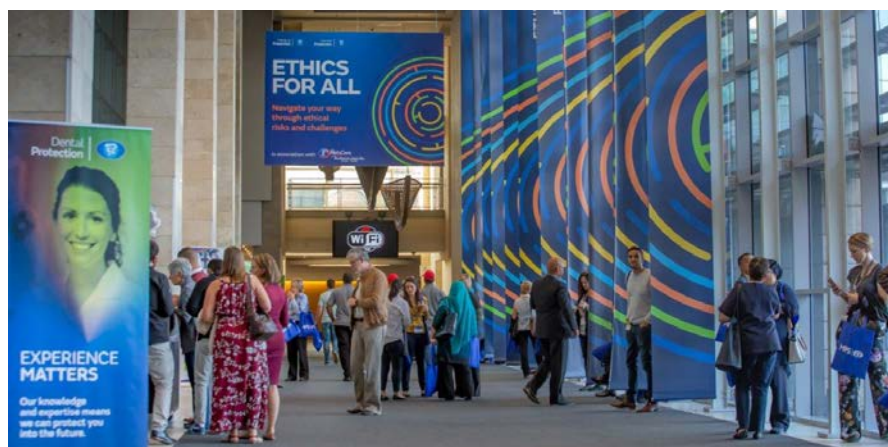
Echoing his sentiments, Dr Mark O'Brien, international medical educational consultant to MPS, and medical director and cofounder of the Cognitive Institute, noted that communication with patients is vital.

"Unmet patient expectations are the most significant predictors of patient dissatisfaction with a clinician," he noted, adding, "Though they may not have the technical knowledge, patients can discern quality of care by the follow-through on promises made by a clinician, and the quality of communication by the clinician."

Dr O'Brien said that while many studies have focused on individual clinician performance, little attention has been given to the impact of individual performance on teams or on other clinicians.

"The question should not be, 'Do I make mistakes?' – it should rather be: 'What is the error rate for everyone in the room?'" he said.

Dr O'Brien used the example of the doctor who is always late for a shift. He noted that this behaviour may have a negative impact on everyone else who works with that doctor, and that their error rate might be increased because



of one person's unprofessional attitude towards his patients, work and colleagues.

"Our research shows that certain clinicians are error-generating machines, and that unprofessional behaviour can increase risk. Clinicians in these situations need to manage this risk. One way is to create an anonymous portal for clinicians to share information among themselves," he explained.

Speaking on issues of litigation from a clinician's perspective, Dr Graham Howarth noted that doctors must be aware of the elements of litigation, and not automatically assume the worst. Dr Howarth is the head of medical services for Southern Africa for MPS.

He noted: "Be aware that the cards are not always stacked against you as a clinician; the burden of proof falls on the claimant."

He added that there are three hurdles a claimant has to jump if he wants corrective action against a clinician.

"The complainant must establish where the doctor's duty of care begins and ends, if there has been a breach in this duty of care and, importantly, causation – the patient must show the harm that is caused by the act or omission of the doctor," he said.

Dr Howarth said that these three factors need to be uppermost in clinicians' minds when faced with litigation, and that their notes will play a central role in framing a defense.

He said in cases involving clinicians, the test is to consider what a reasonably competent practitioner would have foreseen the likelihood of harm to have been, and what steps could have been taken to guard against it.

He said that clinicians need to remember that a patient must prove that the harm they suffered is a result of the clinician's negligence, or something the clinician did or did not do.

"Our central message to clinicians, though, is to steer clear of litigation. How do you do this? You constantly ask yourself if what you are

doing is what a reasonable doctor would also do. If you apply this, then legal action might be taken against you, but not successfully," he noted.

Also speaking at the seminar was Dr Munyadziwa Kwindi, ombudsman of the HPCSA, and a member of the medicolegal task team of the Department of Health.

"Constantly ask yourself if what you are doing is what a reasonable doctor would do"

Dr Kwindi noted that part of the problem at the HPCSA is that the body only has seven healthcare professionals on staff, but that it is looking at increasing this number in future.

"We have removed legal people from our investigations level, and are now only involving people with medical healthcare backgrounds. This is important because we need to have people who understand the clinical encounter, and we need to proceed with complaints with minimal support from a legal perspective," he said.

As part of making the processes of the HPCSA better, Dr Kwindi said various measures were being looked at as part of the council's turnaround strategy.

More than 2 000 medical and dental professionals attended the three-leg seminar tour by MPS in Cape Town, Durban and Pretoria.

For more information on MPS visit <https://www.medicalprotection.org/southafrica/home> or the HPCSA website, <http://www.hpcsa.co.za>.

Solving youth unemployment – we can all play a role

Tiyani Armstrong, head of learnerships, FPD SHIP Department



valuable on-the-job training and workplace exposure.

Why would a medical practice be a good host organisation for a learner? Learners who are enrolled in a business administration learnership or a generic management learnership need to be exposed to a number of managerial disciplines in a workplace environment. Medical practices create an ideal opportunity for learners to take part in administrative as well as managerial activities.

What are the benefits of hosting a learner?

Learnerships are designed to benefit both the participating parties:

- Learners receive access to sponsored education, as the relevant SETA covers their tuition costs, and better access to workplaces, for practical experience. While enrolled in the learnership, learners also receive a monthly stipend to cover any travel costs related to their workplace immersion. Upon successful completion of the learnership, learners receive a nationally recognised qualification.
- The host organisation can benefit from learnerships by gaining access to the services of enthusiastic young learners for a 12-month period at no cost to itself, and by encountering possible future employees.

Is there a downside to hosting a learner?

The major expectation of the host organisation is that it provide some oversight and mentoring for learners, to ensure that they have opportunities to apply their learning, and to benefit the organisation. A concern often raised by host organisations revolves around issues of employer-employee relationships. To allay such fears, most interns are employed by intermediary organisations such as the Foundation for Professional Development (FPD), and seconded to the host organisation. In this model, FPD is responsible for all human resource management aspects of their learnership.

FPD has for the last 15 years implemented robust learnership, internship and fellowship programmes. Various programmes have been funded by both local and international organisations, and have yielded excellent results.

Should you wish to host a learner in your practice, please contact FPD on (012) 816 9000/9136, or email tiyanet@foundation.co.za.

There are an estimated 600 000 unemployed graduates in SA, contributing to the country having one of the highest youth unemployment rates in the world. However, if graduates undertake a 1-year structured learnership or internship programme, this increase their chances of employment by 27% directly after the learnership. This percentage increases to about 39% a couple of months after the learnership, when the candidates are actively looking for employment. This increase in employability is due to the learners having acquired a national qualification, along with the skills needed by employers. Learnerships are vocational education and training programmes designed to facilitate the linkage between structured learning and work experience, and are often a requirement for obtaining certain registered qualifications. Doctors are familiar with the internship programme that they had to complete as part of their own training, and are ideally positioned to host interns in their practices. A well-run medical practice offers several opportunities for non-clinical internships, in such fields as human resources management, office administration, finance, management assistance, information systems management and office management. As interns receive stipends, there would be no financial obligation on any medical practice that hosted a non-clinical intern.

Why were learnerships created? Although well developed in areas of study such as medicine, nursing and teaching, many qualifications offered in SA had a disconnect between what was taught in the classroom

(theory) and the realities that students experience when entering the workplace (practice). This disconnect was seen as contributing to the high unemployment rate among graduates. Taking into consideration the benefits of work-based experience, such as that acquired through a learnership, and in order to address employer concerns around the disconnect between theory and practice, the Skills Development Act No. 97 and the Skills Development Levies Act No. 9 were passed by parliament in 1998 and 1999, respectively, and structures and processes to transform skills development in SA were put in place.

Learnerships are overseen by the Sector Education and Training Authorities (SETAs). These entities were created to ensure that qualifications offered are related to a specific occupation or sector of the economy. There are 21 SETAs, who jointly identify National Qualification Framework (NQF)-aligned learnership programmes that help participants to gain formally recognised qualifications while getting on-the-job experience.

How are learnerships organised? SETA-endorsed learnership participants are enrolled in a 12-month programme. These candidates are placed within a participating organisation under the supervision of a mentor, for the practical training component of their learnership. Learners spend 80% of their learnership period in the workplace, and only 20% of the time in the classroom for their theoretical training. This translates into the learner reporting for duty on a daily basis, as would an employee, while only being required to attend classroom training for 3 days per month. The learner forms part of the host organisation's workforce, while receiving

Obituary: Dr Ivan Berkowitz

SAMA Communications Department

Ivan was born in Cradock in the Eastern Cape on 21 July 1939. He attended Cradock Boys' High and matriculated in 1956, before proceeding to UCT, obtaining the MB ChB in 1964. While in Cape Town he played first team rugby at UCT – he had the height and weight!

He served his internship at Livingstone Hospital in Port Elizabeth in 1965, and was a medical officer (registrar) until 1967.

His interest was in obstetrics and gynaecology (O&G). He obtained the MRCOG in 1971, and the FRCOG in 1984, from the Royal College of Obstetrics and Gynaecology.

Ivan married Harriet on 9 July 1967; he had a son and daughter, and five grandchildren.

In Port Elizabeth, he became senior specialist in O&G at Livingstone Hospital from 1998. Later, he became head of O&G for the whole of the PE hospital complex, a position he held from 1998 to 2010.

Ivan was a regular golfer and a member of Wedgewood Country golf club, and his hobbies were oil paintings and making "teddies", which amazed his colleagues!

He practised O&G privately from 1972 until 2012. During this time, he served on SAMA's Eastern Province branch from 1993 to 2017, and was elected president in 2000, becoming chairman of EP branch council from 2009 to 2013.

Ivan "Berkie" Berkowitz will be sorely missed by his colleagues, friends, patients and family. He passed away on 27 July 2018.



Protecting the public and guiding the professions

The Health Professions Council of South Africa (HPCSA) is a statutory body established by the Health Professions Act, 56 of 1974 (as amended).

The HPCSA is committed to protecting the public and guiding the professions. In order to safeguard the public and indirectly the professions, registration in terms of the Act is a prerequisite for practising any of the health professions registerable with Council.

The HPCSA has a mandate to regulate the healthcare professions in the country in aspects pertaining to education, training and registration, professional conduct and ethical behavior, ensuring Continuing Professional Development (CPD) and fostering compliance with healthcare standards.

Vision

Quality and Equitable Healthcare for All.

Mission

To enhance the quality of healthcare for all by developing strategic policy frameworks for effective and efficient co-ordination and guidance of the professions through:

- Setting contextually relevant healthcare training and practice standards for registered professions
- Ensuring compliance with standards
- Fostering on-going professional development and competence
- Protecting the public in matters involving the rendering of health services
- Public and stakeholder engagement

- Upholding and maintaining ethical and professional standards within the health professions.

Values

In fulfilling its roles of regulator, guide & advocate and administrator, the HPCSA holds the following values central to its functioning.



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Collective bargaining – the numbers game

Simon Madini, *organising and collective bargaining officer, SAMA Industrial Relations Department*

A plethora of definitions have been advanced in an attempt to explain bargaining, especially collective bargaining. Though they differ in their presentation, these ideas all subscribe to the notion that bargaining is not an individual action but a collective effort, the purpose of which is to come up with a mutual agreement on an entire range of pressing issues that affect the group as a whole.

While it may sound simple, collective bargaining can fool a number of people. The adverse effect of numbers can drastically reduce collective bargaining to collective begging. SA labour law, while promoting and encouraging freedom of association and the right to organise, also allows wide room for determinations and collective agreements that pose a threat to those very same rights.

Section 18(1) of the Labour Relations Act No. 66 of 1995 (LRA) states: "An employer and a registered trade union whose members are a majority of the employees employed by that employer in a workplace, or the parties to a bargaining council, may conclude a collective agreement establishing a threshold of representatives required in respect of one or more organisational rights referred to in section 12, 13 and 15."

This section of the LRA is then translated into collective agreements where the employer and the majority union(s) will set a threshold in bargaining councils sometimes so high that minority unions will be forced to enter acting arrangements with the admitted unions.

An acting arrangement means that another union allows you to sit on the bargaining council, so that you can raise the issues that affect your members, and engage on them.

As SAMA, it is imperative that we recruit every unorganised member, so as to increase our voice in the bargaining council. Collective bargaining is a numbers game.

Another important aspect of collective bargaining is the need for association or alliance with like-minded organisations. This improves the chances of your issues being supported, and included in resolutions of the council. To make a meaningful impact in negotiations, an organisation needs a strong and vibrant collective bargaining component, with all the necessary resources to ensure that

matters relating to workers' interests are dealt with accordingly.

International standards on the right to freedom of association

The right to freedom of association is described as the judicial and moral entitlement of workers to form trade unions, to join trade unions of their own choosing and to see that such a trade union functions independently. The right to freedom of association is a fundamental right that is protected in a number of international instruments. The International Labour Organization (ILO)'s Declaration of Philadelphia (adopted on 10 May 1944) holds that freedom of expression and association are essential to sustained progress.

International standards on the right to collective bargaining

The right to collective bargaining is a fundamental right that is confirmed by member states of the ILO by virtue of their membership. This right is protected in a number of international instruments. Part of the 10-point plan adopted by the ILO in the Declaration of Philadelphia is the effective recognition of the right of collective bargaining, and the co-operation of management and labour in the continued improvement of productive efficiency, and collaboration of workers and employers in the preparation and application of social and economic measures.

Union has to keep growing its numbers

When establishing a union, either sectoral profession specific or as an allied organisation, it is key that its growth pattern is very well articulated. This would include, among other issues, the analysis of possible mass recruitment by employers, and the interest of employees in joining that sector. Certain professions and skills are only needed by employers up to a limited and capped number. This then dictates whether a union operating in that sector or profession has the potential to grow beyond the needs of employers or the service rendered by its members.



The SA public service is a very complicated and politicised sector, and this has the potential to complicate collective bargaining processes. It is very politically aligned in structure, and favours the left in its political principles. The best and only way to survive is by having the numbers. Whether the collective bargaining processes may lead to a strike or resolve matters amicably, it is key to always be on the safe side – the majority side.

Conclusion

SAMA as an organisation occupies a critical space in the health sector, with more-than-capable personnel to drive processes on core issues for its members. While we are a profession-specific organisation, our influence goes beyond the scope of public health. We also influence policy processes such as the review of the public service salary structure, and our inputs are recognised by other unions. While we have a responsibility to continue to grow our membership numbers, it is necessary to note that SAMA is vibrant and strong, and will continue to exert its influence and drive the policy development process to the standard required by its members.

In light of the above, the best strategy to keep a member-driven organisation strong and relevant is its organising ability, and service delivery. Recruitment of new members must be a priority for every SAMA member. As our numbers grow, so does our influence. With the limited number of employed doctors in the public service, SAMA cannot afford to lose members, or to have public-service doctors who are not members.

As long as you breathe, you are at risk

MDR-TB: My story

Dr Zolelwa Sifumba



My name is Zolelwa Sifumba. I am a medical doctor doing my internship in KwaZulu Natal. I am an occupational multidrug-resistant-TB (MDR-TB) survivor, and this is my story.

I always wanted to be a medical doctor, to follow in my father's footsteps. So when the time came to apply for university, I applied to study medicine. Fortunately for me, the university of my choice accepted me, so it was off to UCT to chase my dream.

Medical school was challenging from the beginning, and we were warned about the tough work we had ahead of us, but told nothing, really, about the risks to our health that we would face in this career.

I woke up one morning to find a painful lump on my neck, just above my right clavicle. This was the first time I had noticed it, and already, it was 3 by 3 cm. This scared me, so naturally my friends and I discussed a differential diagnosis. We had been taught to put TB at the top of our list – but what was realistically a possibility was pushed to the back of my mind, because, well, we didn't get TB. Boy, was I wrong...

The lump grew bigger and more painful, and I decided that it was time to see a doctor. The doctor decided to do a fine needle aspiration of the lump, and told me that in our setting, it was likely to be TB. Again, I rejected the idea. That was not possible, right?

The lump continued to grow, so on my second trip to the doctor, he made an

incision into the node, commenting that this was definitely TB, and a he took a biopsy of the node. I was referred to the local clinic to commence treatment, in the anticipation that this was indeed TB. Again, I told myself that this was not possible, but I went along with it.

That weekend I received a phone call that would change my life. With a phone call from a lab technician, it was official. Somehow, I had managed to contract TB. Isoniazid and rifampicin resistant. But I had no idea how. It might have had something to do with the TB patients in the wards I worked in, but was that even possible? If it was, this was the first that I had heard of it. Surely sicknesses were for patients? Surely this was a mistake, as I was sure that I was HIV-negative, and I definitely did not live in a one-bedroom house with 10 people. I was a UCT student, well-off at home, and my lifestyle wasn't particularly unhealthy. So why? How? The denial, anger, bargaining and depression happened all at once. I tried to make sense of it all.

I honestly had no idea that my occupation put me at high risk of contracting this illness – that in fact, healthcare workers and students are a high-risk group, being three times more likely than the general population to develop drug-sensitive TB, and six times more likely to develop drug-resistant TB. I found all of this out during my treatment, when I joined a non-governmental organisation named TB Proof, in the Western Cape. Here, I met other healthcare professionals who had been diagnosed with TB, both sensitive and resistant, as a result of occupational exposure. I was later introduced to students in my faculty who had also had TB. This felt wrong. Why had we not been told? Or should we just have known? Should we just have known that since we would work with people with all sorts of different illnesses, we would sooner or later contract one? We had been told about needle sticks and HIV, but this was bizarre.

I continued to try make sense of it all throughout treatment, which people around me did too, resulting in my facing heavy stigmatisation. I read article after article by healthcare workers saying that they had worked in the public sector for years and

had never got sick, and that those who did must have other illnesses (as a codeword for HIV). Stigma. Stigma from healthcare professionals. Denial.

I went from student to patient to survivor to activist, and there was nothing easy about this journey

I went from student to patient to survivor to activist, and there was nothing easy about this journey. It has been the hardest thing that I have had to endure in my life, and it is honestly a miracle that I've made it through.

Throughout treatment, I considered suicide, because of the side-effects that I faced on a daily basis, and fear of the possible side-effects that would follow. I would not be able to carry on living if the injectable stole my hearing, as it did another student, in Khayelitsha, who would later become my friend and fellow activist. I thought that she might be able to do it, but I definitely would not. I carefully read the package inserts of each of the drugs, and quickly realised why I had not been warned.

I will state now that the current treatment for drug-resistant TB is inhumane. I congratulate our Minister of Health, Dr Motsoaledi, for calling for an injection-free treatment regimen in SA, and the WHO for endorsing the call. When I speak about my experience, I always describe that injection as feeling like hot lava being injected into you, causing intense pain that burns and stings, eventually shooting down your legs and up your back, pain that lasts until it is time to be injected again the following day. It is torture, in my opinion, and a major contributor to treatment interruption (I reject the word "defaulter").

Just imagine for a second that you are the breadwinner at home, and your ability to provide is taken away by the debilitating

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side-effects of medication. Your initial illness has completely resolved, and for this you are grateful, but you are instructed to continue the treatment. You are faced with a choice: to continue, and allow your family to suffer, or to stop, and return to work.

Healthcare professionals as a high-risk group

A conversation needs to be had among us all, as healthcare workers and students, current and future. We are human before all else and

we need to remember that we too are at risk of contracting illnesses. Whether rich or poor, HIV-positive or not, we are all included in the demographic for TB.

Currently TB is the number one killer infectious disease, and we are at the interface of this war on our communities daily. Day in and day out, we are faced with coughing patients, people who come to us with this airborne disease that kills millions every year, and so it is time that we had this conversation. Doctors are dying, nurses are

losing their hearing, physiotherapists are losing their jobs and people are leaving the profession.

It's time we had this conversation. We need to accept that we are at risk.

It is time that we protected ourselves from this disease that is deadlier than Ebola or HIV/AIDS.

My name is Dr Zolelwa Sifumba and I am an occupational MDR-TB survivor and activist. Please listen now, and listen carefully: As long as you breathe, you are at risk.

HPCSA complaints process: What to expect

Hanneke Verwey, *SAMA Governance and Legal Unit*

The 2009 regulations promulgated under the Health Professions Act (HPA) No. 56 of 1974, as amended, prescribe the disciplinary procedures and possible penalties in respect of registered practitioners. The purpose of this article is to assist practitioners in understanding what to expect, procedurally, once a complaint has been lodged against them with the HPCSA.

Lodging of complaints

A complaint is lodged in writing, and then referred to the registrar of the HPCSA. Upon receipt of a complaint, the registrar will analyse the complaint, categorise it according to its significance and seriousness and record the complaint against the name of the practitioner concerned, as it appears in the register.

After reviewing the seriousness of the complaint, it is within the registrar's discretion to refer minor transgressions to the HPCSA ombudsman for mediation. The regulations define a "minor transgression" as conduct which, in the opinion of the registrar, based on the documents submitted, is unprofessional, but of a minor nature, and does not warrant the holding of a professional-conduct inquiry.

Mediation

The ombudsman will attempt to mediate any minor transgressions referred to him. The ombudsman will communicate with both the complainant and the practitioner, following which (s)he will make a determination, in an attempt to resolve the matter, and request that the parties indicate whether or not they accept such determination. If both parties

agree to abide by the determination, it will be confirmed in writing, and will bind both parties as a final resolution of the matter.

If either of the parties do not accept the determination, the matter will be referred back to the registrar, who will in turn refer the matter to a preliminary committee of inquiry (PRELIM) for consideration. The information obtained by the ombudsman during the mediation process will remain confidential, and will not be disclosed to PRELIM.

PRELIM

There are two mechanisms by which a complaint may be referred to PRELIM. As mentioned above, the registrar may refer the complaint to PRELIM if mediation was unsuccessful, or, upon receipt of a complaint, the registrar may also refer the matter to PRELIM. Before doing so, the registrar may call for further information, or an affidavit confirming the complainant's allegations. The registrar must also first notify the practitioner of the complaint, by forwarding him or her a copy of the complaint, together with copies of any further information or affidavits, and must request that the practitioner provide the registrar with a written response within 40 working days, or such period as the registrar may reasonably allow. The letter of explanation may be used as evidence against the practitioner in the event of a professional-conduct inquiry.

If the practitioner fails to submit a written explanation, or fails to confirm in writing that (s)he wishes to exercise his or her right to remain silent, the matter will be referred to PRELIM without a written response from the

practitioner. Ignoring the council's request for a written response to the complaint constitutes contempt of council.

After having considered the documentation, PRELIM may request that the practitioner appear before them to give a response, explain why (s)he did not reply to the council's correspondence (if applicable) or exercise his or her right to remain silent. The practitioner may be accompanied by a legal representative; however, the legal representative will only enjoy observer status, and will not be permitted to participate in the discussion. The meeting is conventionally intended to be of a collegial nature. The primary function of PRELIM is investigative. PRELIM is tasked with deciding whether or not a prima facie case exists against a practitioner, and determining whether a disciplinary inquiry should be held. If the practitioner has failed to reply to the request for a written response to the complaint, the accusation of contempt of council will also be considered by PRELIM.

If PRELIM decides, after due consideration of the matter, that there are no grounds for taking further action, it will note and accept the practitioner's explanation, and give reasons for so noting. If PRELIM is of the view that there are grounds for a professional-conduct inquiry, it may direct that an inquiry be held. Hereafter, a pro forma complainant will be appointed and (s)he will draft a charge sheet. The pro forma complainant may not simply add charges which deviate from the issues identified by PRELIM. For example, if PRELIM found that the practitioner had failed to obtain informed consent, a misdiagnosis

charge may not be added to the charge sheet without PRELIM's authorisation. The charge sheet will be served on the practitioner, requiring the practitioner to attend a professional-conduct inquiry on a certain date.

Once PRELIM has decided that there are grounds for a formal inquiry, it is within their discretion, in certain circumstances, to endorse the charge sheet with an offer that a practitioner may pay an admission of guilt fine as an alternative to attending an inquiry. Practitioners are advised to obtain legal advice when deciding whether or not to pay the fine. It will typically be in the best interest of the practitioner to pay the fine if the charges will be very difficult, or impossible, to defend, and the admission of guilt fine is not excessive. A guilty finding, whether it is made by a professional-conduct committee (PCC) or via an admission of guilt fine, will reflect on the practitioner's Certificate of Status.

A further possibility is that PRELIM may decide that the practitioner's conduct only constitutes a minor transgression, in which case it will impose one or more of the penalties provided for in section 42(1)(a) of the HPA, and instruct the registrar to formulate the charges in writing. The practitioner must accept or reject the penalty within 14 days. If rejected, a disciplinary inquiry will be held. The PCC, following an inquiry, will not be limited to the penalty so rejected, and may impose the sanction it deems appropriate.

Professional-conduct inquiry

Prior to the inquiry, the respondent or his or her legal representative may request further

particulars to those on the charge sheet. A pre-inquiry conference will be held between the pro forma complainant and the practitioner (respondent) or his or her legal team in an effort to determine the issues in dispute, indicate any exceptions, objections or points *in limine* that will be raised at the inquiry, exchange documents that a party intends to use at the inquiry, etc.

The PCC will be composed of at least two public representatives, two persons in the profession in which the respondent is registered, at least one of whom must be registered in the same discipline as the respondent, one member of the board and one legal assessor. The PCC will not include any of the PRELIM members. The respondent may be legally represented, and the complainant will be represented by the pro forma complainant appointed by the registrar. The procedure at professional-conduct inquiries is similar to court proceedings, although less formal, in that the respondent will be asked to plead to the charges, evidence is given under oath, witnesses may be subpoenaed, parties may lead evidence and examine witnesses (including expert witnesses), documents and expert reports are exchanged, etc.

At the conclusion of the inquiry, the PCC will deliberate *in camera* and inform the parties of its findings within such period as may be determined by the PCC. If the respondent is found guilty, the pro forma complainant must address the PCC on a suitable penalty and furnish details of previous convictions, if any. Similarly, the respondent will be given an opportunity to lead evidence in mitigation,

and address the PCC on a suitable penalty. If a guilty plea was entered, the sentencing phase will commence once the guilty plea has been accepted by the PCC. After deliberating *in camera*, the chairperson will inform the parties of the penalty decided on, which shall be in force and effect from the date determined by the PCC. In addition to imposing a penalty, the PCC may also, if indicated, impose practice restrictions and refer the matter to a performance assessment committee.

Appeal

Both parties may appeal to the appeal committee (AC) against the findings or penalty, or both, of the PCC. The appeal must be lodged within 21 days from the date of the decision. The AC must consider the appeal on the papers, allow representations and arguments from both parties, deliberate *in camera* and thereafter, advise the parties on its findings. The AC's decision may only be reviewed and set aside by the High Court.

Conclusion

When a complaint is lodged against a practitioner with the HPCSA, the process is usually traumatic and overwhelming, especially so if the practitioner is not familiar with it, and does not know what to expect. Practitioners are therefore advised to consult the aforementioned regulations if a complaint is lodged against them. SAMA members are encouraged to contact the Governance and Legal Department, should they require advice or guidance in this regard.

Malnutrition in 2018: An opinion

Dr Freddy Kgongwana, CEO, DGMAH

The following question was asked at the recent SAMA/Dr George Mukhari Academic Hospital (DGMAH) Malnutrition and Non-Communicable Diseases CPD seminar: "Do we eat to live, or live to eat?" The consensus answer was that we eat in order to live.

The dictionary definition of malnutrition is as follows: "the lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat". Synonyms for malnutrition –

undernourishment, malnourishment, undernutrition, poor diet, unhealthy diet, lack of food, inanition, hunger, famine, anorexia, starvation – accentuate the importance of good and adequate nutrition.

SA is currently facing economic pain and pressure, and coupled with more than 25% unemployment, the chances of an increase in the incidence of malnutrition have become even greater. Two reports have been released that show the unacceptably high proportion of children in poor living conditions. Statistics

SA (Stats SA)'s *Profile of the Youth* and the UCT Children's Institute publication *South African Early Childhood Review* reports show that SA's stunting rate lies well above the trend for most countries that are at similar level of economic prosperity. It is also reported that 33% of households and 45% of individuals are poor in SA. This situation eventually translates to an increase in the prevalence of malnutrition in communities.

New data released by Stats SA in 2015 show that the poverty headcount had increased to 55.5% in 2015, from a series low

of 53.2% in 2011. This translates into over 30.4 million South Africans living in poverty in 2015, and one wonders what the figure is in 2018. The relationship between poverty and malnutrition cannot be ignored, nor the impact this has on the human capital needed to sustain our economy and our democracy in SA.

The threat of non-communicable diseases is another epidemic waiting to happen, and we need to be ready and proactive in tackling this looming healthcare and economic challenge for the population, healthcare system and government of SA. This reality speaks also to adult malnutrition, and the malnutrition of the affluent.

Adult malnutrition

Common causes of adult malnutrition are health and dental problems, medications that interfere with appetite or cause nausea, living alone (social isolation), mental health

problems such as depression, and excessive alcohol consumption.

The factors responsible for malnutrition in children also apply to adult malnutrition.

Malnutrition of the affluent

The major issue here is the predominance of junk food or fast food consumed by the affluent, at the expense of balanced, nutritional food. As a consequence, the risks for obesity and diabetes mellitus (as well as other non-communicable diseases) increase in this cohort.

Conclusion

Malnutrition is a serious challenge and impediment to sustainable economic development and growth for SA. It is also part of the vicious cycle of poverty – economic pressure, political instability, poverty.

As representatives of the healthcare sector in our country, we need to be vigilant,



Dr Freddy Kgongwana, DGMHA CEO, Sindisile Nyawo, Abbott Nutrition SA, and Hanlie Pohl, dietician

and also be advocates for good and proper nutrition for our communities. SAMA also needs to lobby the private and public sector to work together to combat this silent killer of the SA economy.

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SAMA Private Practice Department

The 2019 SAMA Medical Doctors' Coding Manual (MDCM) products, the MDCM book and the eMDCM, will be available from mid-December 2018.

2019 MDCM book

The 2019 MDCM book orders can be placed via our SAMA website from 1 December 2018; however, delivery will only take place from mid-December 2018.

The 2019 version reflects the current scope of practice of medical doctors, and is vastly improved from the previous versions, in that it incorporates:

- all code-related interpretations with the code, for easier and quicker reference
- the comprehensive coding structure for medical doctors, with updated information up to and including 2019
- separate sections for the Road Accident Fund and the Compensation Fund.

The discounted price for SAMA members is ZAR632.50 for the first copy; for subsequent copies, and for non-SAMA members, the price is ZAR1671.13. Both prices exclude delivery.

If opting to collect the books from one of our offices, there will be no delivery fee

2019 electronic MDCM browser prices (VAT incl.)	
1st licence for SAMA members	Free
1st licence for non-SAMA members	ZAR997.58 per licence
2nd - 10th licence	ZAR831.13 per licence
11th - unlimited number of licences	ZAR500.46 per licence

charged. They can be collected from SAMA Head Office, Block F, Castlewalk Corporate Park, Nossob Street, Erasmuskloof Ext. 3, Pretoria (entrance in Kuiseb Street), or the HMPG Office, Suite 11, Lonsdale Building, Lonsdale Way, Pinelands, Cape Town.

2019 eMDCM (electronic version) – available from 1 January 2019

The first licence of the 2019 eMDCM is **free** to SAMA members in private practice (including limited private practice). As a SAMA member, please log in using your username and password to qualify for this free licence. Only the first licence is free; additional licences will be charged for.

The 2019 updated programme includes:

- all the 2019 procedural codes for medical doctors
- easy-to-use search functionality

- functionality to calculate own fee for each code
- interpretations and/or comments attached to some codes
- ICD-10 codes based on the ICD-10 Master Industry Table added for convenience.

The eMDCM has a 1-year licence period valid from 1 January 2019 to 31 December 2019. Please direct any product queries to our Coding Department on 012 481 2073 or email samaproducts@samedical.org and we will gladly assist you.

For any computer /IT-related queries, please contact SOSiT on 087 550 1715 or email support@sosit.co.za.

Please go to the SAMA website for more information and to place your orders (for the book or electronic version): <https://www.samedical.org/products>.



Letters to the Editor

Below are two letters to the editor received from Dr W R Bezwoda in September and October 2018. Shelley McGee addresses relevant details (due to space constraints we are unable to publish the examples that were enclosed) in her response printed on this page. We thank Dr Bezwoda for the letters, and encourage readers to open up the lines of communication. Ed

Into your invitation to cite and to document specific problems regarding “managed healthcare and formularies” encountered with specific medical schemes, I enclose the following example of a communication from Resolution Health as an example. Despite numerous letters and phone calls pointing out that what they purport to be treatment for metastatic colon cancer is not in fact appropriate, they adamantly refuse to concede that the problem is theirs, and that they are not funding adequate treatment for their member.

A complaint to CMS [the Council for Medical Schemes] was met with their usual response that the complaint was sent to the scheme, which has so many weeks to respond, followed by a complete failure to do anything further when the prescribed response period had elapsed by some weeks.

A complaint to the Department of Health has sent me back into the loop of having to first complain to CMS, with no one taking responsibility to enforce the statutory duty of care.

I invite you to publish the information supplied in order to encourage other members of the medical oncology community to also provide their own examples, as well as to comment on the acceptability of the formulary that Resolution Health is purporting to follow.

This follow-up letter was received from Dr Bezwoda on 1 October:

Enclosed is a copy of a letter from CMS, together with my response to their handling of my complaint. Although I am happy that my patient may well be reimbursed for the treatment that she has received thus far and going forward, I do not consider that the handling, by CMS, of this matter has been adequate, as per my reply to them.

My understanding of the position in SA law is that when trustees or others who have a duty of care so blatantly fail in this duty, a more vigorous reaction than a couple of lines in a letter to them is required, particularly when, as detailed and proven by documents submitted, it cannot be regarded as mere “clerical/human error”. How are we to trust CMS as a proper regulator/adjudicator of medical schemes when they do not hold the schemes to the proper standards?

SAMA response: Complaint against Resolution Health medical scheme

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

In our original response to Dr Bezwoda's letter, published in the July 2018 *Insider*, wherein he expressed concerns regarding frustrations that he had experienced in dealing with medical schemes, administrators and their managed care programmes and medical advisors, we invited doctors to submit examples of these challenges, so that we can begin to discuss these in an open, transparent and frank way. Dr Bezwoda soon obliged by sending us the case of a patient, Mrs L, a member of Resolution Health medical scheme, whom he was treating for metastatic colorectal cancer.

Dr Bezwoda's original letter to the editor, at the beginning of September 2018, decried a decline of funding for the patient's treatment plan, in a rather sloppily written email from the pharmacy administration department at the scheme, which also provided the scheme's supposed formulary for the treatment of metastatic colorectal cancer. Dr Bezwoda's

concern at that time was that the scheme formulary supplied was blatantly incorrect for the disease being treated, and he had already escalated his concerns to the scheme, then the Council for Medical Schemes (CMS) and the Department of Health, but the situation was not yet resolved, 2 months later.

Indeed, even to the untrained eye [Shelley is a pharmacist, with no real specialist training in oncology – Ed.] the formulary supplied was clearly incorrect for the diagnosis, and we confirmed quickly through enquiry that the incorrect formulary supplied in the cut-and-paste email from the scheme to the doctor was not the correct scheme formulary for metastatic colorectal cancer. Additionally, the email response from the scheme had no information on processes or contacts by which to appeal the decision. Dr Bezwoda apparently did his best to convince the scheme that they had made a mistake, and to talk to someone

clinical, and when this was refused, took his case to the CMS. The treatment application was declined on 9 July 2018, and the case submitted to the CMS on 16 July.

At this point, wheels did start turning, and the CMS sent the complaint to the scheme, which responded to the CMS by early August, with an explanation of what had occurred. The CMS then deliberated and found that the scheme had acknowledged that the incorrect protocol had initially been sent to the oncologist, and that the protocol supplied did not relate to the condition to be treated.

The CMS also found that the scheme had been incorrect to decline funding of the entire treatment plan for the patient, as two of the three medicines prescribed were prescribed minimum benefits level of care for the patient's condition, and were to be found on the managed care protocols that the scheme follows.

The CMS also found that the scheme had further delayed resolution of the issue by refusing to transfer the oncologist's calls/queries to the relevant medical advisor at the scheme, to discuss the appropriate/alternative treatment protocol with a peer/qualified medical doctor. The scheme was ordered to review their decision and refund the patient for expenses incurred as a result of the treatments given. A letter to this effect was sent to Dr Bezwoda on 28 September.

The fundamental issue. All of this meant that the patient, Mrs L, had self-funded the palliative treatment for colorectal cancer, for which she was actually entitled to coverage, for 3 months. Medical scheme members, the clinical community and the medical scheme community should take a truly dim view of this situation.

The legal and governance issues. We highlighted, in our initial response in July 2018, the fact that regulation 15 (D) of the Medical Schemes Act (MSA) No. 131 of 1998 requires that managed care programmes run by

medical schemes, or third parties, should be administered by qualified healthcare professionals who should oversee funding decisions, and that the appropriateness of these decisions should be overseen by peers. This was clearly not the case in the Resolution application and decision process, unfortunately.

Additionally, even when the oncologist attempted to appeal the issue, it seems that the scheme refused to allow him the platform to explain a blatantly obvious administrative error on their part. This resulted in what was an otherwise unnecessary complaint to the CMS, and further delays to the patient accessing appropriate care.

Section 57(6) of the MSA places the responsibility for ensuring that the interests of the scheme beneficiaries, in terms of the rules of the medical scheme and the provisions of the Act, are protected at all times. Mrs L's were not.

What recourse against a scheme in a case like this? Dr Bezwoda's final concern is that the measures employed by the CMS against

the scheme, namely a recommendation that staff receive training on appropriate application of protocols and managed care, and a reminder that the board of trustees have a fiduciary duty to the members, are simply not sufficient for the regulator to hold schemes and their contractors to account on such issues. SAMA would certainly agree. While the MSA contains a provision for regulations penalties to be applied to a medical scheme or administrator in respect of the late payment of benefits owing to a member or a supplier of service, there is nothing relating to penalties that can be applied in cases like this, where, arguably, managed care processes have failed a patient, and duty of care to the medical scheme beneficiary has been neglected at multiple levels.

We are exceptionally grateful for submissions of this nature, which allow us as a society to start interrogating common problems that our doctors face on a day-to-day basis, as well as challenges in keeping schemes, managed care companies and their scheme clinical staff and trustees accountable to their members.

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Complications of long-term nitrofurantoin

The Medical Protection Society shares a case report from their files about a patient on long-term medication who began to feel short of breath

Mrs D was a 70-year-old retired teacher who had struggled with recurrent urinary tract infections. Urologists had advised her to take antibiotics in the long term as a prophylactic measure, and advised alternating between trimethoprim and nitrofurantoin.

Sixteen months after commencing nitrofurantoin, Mrs D began to feel short of breath, especially when she was walking her dog. She was also feeling tired and generally unwell, so she visited Dr W, her GP. Dr W documented a detailed history, noting that there was no orthopnoea, ankle swelling or palpitations. He also noted the absence of cough, wheeze or fever. Dr W referred back to a recent echocardiogram that was normal, and mentioned that Mrs D was an ex-smoker. He conducted a thorough examination including satisfactory blood pressure, pulse and oxygen saturation, and commented in the notes that Mrs D's chest had bilateral air entry with no crackles or wheeze, and no dullness on percussion. Dr W stated that her heart sounds were normal, and that there was no pitting oedema. He organised a chest X-ray initially.

The CXR reported patchy peribronchial wall thickening, and suggested a degree of heart failure. Dr W advised a trial of diuretics, which made no difference. Mrs D continued to feel short of breath and drained over the next few weeks. Gradually her breathlessness got worse, and she noticed it even when she was sitting and reading.

Four months later, Mrs D was admitted to hospital in respiratory failure. A high-resolution CT scan showed pulmonary fibrosis, with the likely diagnosis being subacute pneumonitis secondary to treatment with nitrofurantoin.

Within a month of withdrawal of nitrofurantoin she improved clinically, becoming

less breathless, and her respiratory failure resolved. At a respiratory follow-up 10 months later, she was found to be breathless after about 365 metres of walking, and quite fatigued, but able to carry out all her daily activities, including walking her dog.

Mrs D made a claim against Dr W. She alleged that he had failed to consider that the long-term use of nitrofurantoin may have caused her symptoms.

Expert opinion

The Medical Protection Society (MPS) sought expert opinion from a clinical pharmacologist and a GP. The clinical pharmacologist referred to the relevant edition of the SAMF, which stated on nitrofurantoin: "Patients on prolonged therapy should be examined regularly for the development of pulmonary or nervous system abnormalities."

She commented that although the SAMF records the need to examine regularly, the exact definition of "regularly" is not given. In her view, it should have been every 6 months.

The expert GP said that many doctors would be unaware of the need for monitoring, and that it was probably rarely done in practice. However, he accepted that when prescribing an unfamiliar drug, a GP would need to reference the SAMF.

MPS served a letter of response rigorously defending Dr W's actions, pointing out that he had seen Mrs D early in her clinical course, had documented a very thorough history and examination and had made a reasonable initial management plan. As a result of this, the case against Dr W was dropped. However, the GP practice partnership, which was indemnified by another organisation, faced a claim regarding the alleged lack of monitoring for lung complications in patients on long-term

nitrofurantoin. This claim was settled with no contribution sought from MPS.



Learning points

- Detailed contemporaneous notes assist in defending cases. GPs should document a thorough history and examination, including any negative findings.
- MPS sees a number of claims regarding inadequate monitoring of long-term nitrofurantoin, with patients developing pulmonary complications. Many claims relate to inadequate monitoring.
- Expert opinion sought on these claims advises that SAMF guidance for monitoring should be followed.
- To screen for pulmonary complications such as pulmonary fibrosis, doctors should advise patients starting on nitrofurantoin to attend urgently if they develop breathing problems. They should be reviewed for respiratory symptoms at least 6-monthly, and more frequent monitoring considered.

Obituary: Dr Timothy Ndaki

SAMA Communications Department

The former vice-president of the Ciskei Medical Council, and SAMA member of more than 35 years, Dr Timothy Ndaki, passed away on 24 October.

Dr Ndaki worked at the Mount Coke Hospital as a part-time anaesthetist, paediatrician and

TB physician for 20 years. He furthered his studies in the USA, and upon his return, went into private practice.

A memorial service for Dr Ndaki was held at the Holy Trinity Anglican Church in King William's Town on 30 October, where

outgoing SAMA president, Dr Marina Xaba-Mokoena, served as programme director.

SAMA extends heartfelt condolences to the family and friends of Dr Ndaki, a special man who lived a full and fruitful life. He will be missed.

SAMA visits Kimberley Hospital

SAMA visited Kimberley Hospital on 26 September 2018 for the intern monthly meeting.

Dr N Wagget and Dr C Buxey, members of the Junior Doctors Association of SA Northern Cape branch council, delivered a presentation on the SAMA member benefits, and spoke about the importance of joining SAMA, and what interns should do if they have problems at their places of work. Six interns signed up as SAMA members, and the branch is expecting more signed application forms to be returned. The meeting was well attended.



Doctors at Kimberley Hospital attending the intern monthly meeting

Hosting a symposium on TB

The Griqualand West branch, in partnership with the Department of Health, hosted a CPD symposium on multidrug-resistant TB on Saturday 6 October 2018 at the Garden Court, Kimberley. The topics discussed at the symposium, which were presented, respectively, by Dr L Mvusi, Dr G Sibeko, Dr R Leyet, Ms S Padayachee, Dr N O Ndjeka and Dr F Conradie, were "Finding missing TB Cases", "SBIRT [screening,

brief intervention, and referral to treatment] to improve adherence in TB/HIV", "New bedaquiline data shows reduction in TB mortality cases", "Pharmacovigilance", "Introduction of new drug-resistant TB treatment guidelines" and "Ethical issues in the management of drug-resistant TB".

The symposium was well attended, the presentations were excellent and case studies were discussed – a very informative session.



Dr F Conradie (presenter), Dr N O Ndjeka (presenter) and Dr I N Blanche (SAMA GWB vice-chairperson) at the CPD symposium on TB

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Vacuum wonder shoes are a cost-effective answer to pain caused by various conditions – for example, restless legs, lower back pain, diabetic foot ulcers and blood flow problems. Invented and patented by Len Haasbroek (79), out of desperation, grabbed the vacuum cleaner and rubbed the suction pipe over his sore legs and feet. "This was in January last year, and after the suction with the vacuum cleaner, it turned out to be the first night in many years that I got relief from the restless legs," says Len. "Now, more than a year later, I sleep like a baby every night and I don't know about the pain in my legs anymore."

After years of pain and suffering, and thousands of rands worth of medication for his restless legs, Len Haasbroek (79), out of desperation, grabbed the vacuum cleaner and rubbed the suction pipe over his sore legs and feet. "This was in January last year, and after the suction with the vacuum cleaner, it turned out to be the first night in many years that I got relief from the restless legs," says Len. "Now, more than a year later, I sleep like a baby every night and I don't know about the pain in my legs anymore."

The vacuum wonder shoes are gumboots with specially designed pipes that attach to a vacuum cleaner. "The shoes become airtight, and with the sucking action of the vacuum cleaner, blood circulation is stimulated. The quicker blood circulates through the body the more oxygen is absorbed – oxygen-rich blood has huge advantages for the body. While the blood circulation is increased, lymph circulation is also stimulated," maintains Len.

He uses the vacuum wonder shoes daily for half an hour, and says that there is an overall improvement in his health.

Various other people have also used the vacuum wonder shoes, with great success. One user had a gangrene-infected limb, which was going to be amputated. After a few months' use of the shoes the wound healed, and the amputation was no longer necessary. Some other success stories include improvements of eczema, lower back pain, bad digestion and headaches. "The most wonderful thing about the invention is the privilege of having been able to help people to relieve pain and suffering in their lives. It is like a dream that has now become a reality," he said.

Advice: Len 082 419 6444 | lenserate@gmail.com
Patent Number: 2017/08100 | Sales: Marita 079 763 9274



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