

SAMA INSIDER

MARCH 2019

**Building a more inclusive
healthcare system**

**WHO: Ten threats to
global health in 2019**



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

**SOUTH AFRICAN
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2. Abstracts must be typed in English, single line spacing, Arial font size 12

3. The body of the text must not exceed 350 words (this excludes the information listed in point 1)

4. Please adhere to the following format:

- a. Introduction: should be brief and informative and state the aim of the study
- b. Methods: include a description of subjects and research methodology
- c. Results: outline the findings of the study supported by statistics as appropriate. Do not use figures, graphs or tables in the abstract. The data provided must be sufficient to permit peer review of the abstract
- d. Conclusion: provide summary and relevance of the main findings



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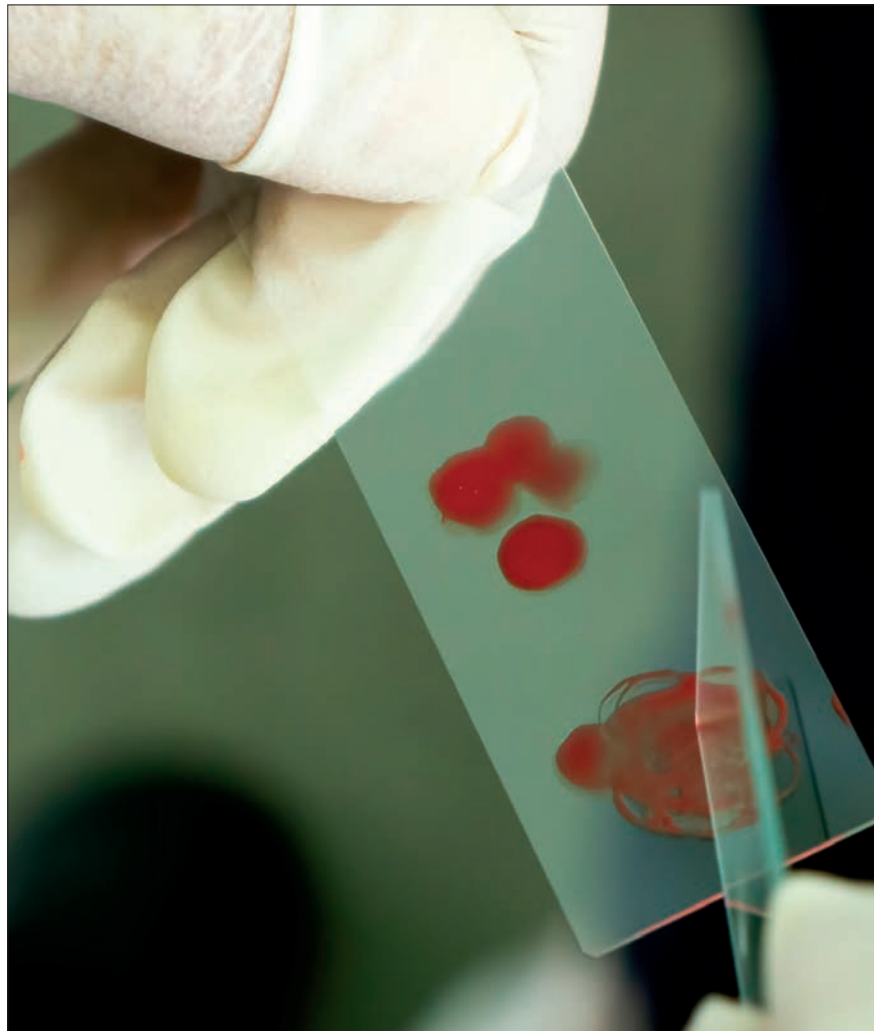
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CONTENTS

MARCH 2019



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- 3 **EDITOR'S NOTE**
Rising to the challenge
Diane de Kock
- 4 **FROM THE PRESIDENT'S DESK**
Building a more inclusive
healthcare system
Prof. Hoosen Coovadia
- 5 **FEATURES**
No first pay cheque for new doctors
in Gauteng
Dr Theresa Mwesigwa
- 6 **E-scripting: Addressing the
disconnect in healthcare**
SAMA Communications Department
- 7 **Ten threats to global health in 2019**
World Health Organization
- 10 **Coping strategies for the
distressed doctor**
Prof. Zukiswa Zingela
- 11 **How Microsoft Office's solutions are
optimising healthcare practices**
Dylan Newham
- 12 **Certificate of illness breakdown**
Wendy Massaingaie
- 13 **SAMED guidance for direct and
indirect sponsorship by device and
technology companies**
Shelley McGee
- 16 **Your financial health: Unpacking
artificial intelligence, and the role of
the company**
Gert Viljoen
- 17 **Sexual harassment in the workplace**
Modisane Lelaka
- 19 **MEDICINE AND THE LAW**
Who else is in the room?
Medical Protection Society
- 20 **BRANCH NEWS**

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Diane de Kock
Editor: *SAMA INSIDER*

Rising to the challenge

The challenge of health is a global one, as highlighted in the article on page 7 by the World Health Organization. Rising to meet this challenge demands a functioning healthcare system that embraces all the citizens of a country.

In his president's message this month, Prof. Coovadia looks at the history of healthcare in our country and suggests that: "In order to allow the widest representation in SA, including different views on what is going on in this country, and its future, and how a democratic health system can complement these social and political options, we should continue the conversation on the elements of the coming age, and its ideal health system ... it would be of great benefit to all if SAMA became the focus and pivotal point of these ideas."

Key to a functioning healthcare system is the health of doctors, particularly their mental health. On page 10, Prof. Zingela looks at coping strategies for the distressed doctor. "Doctors know enough about healthy living strategies, and yet we fail to apply these successfully in our own lives."

On pages 6 and 11 we look at new ways to make the day-to-day functioning of our doctors a little easier – e-scripting, which aims to address the disconnect between doctors, patients and pharmacists, and how Microsoft Office's solutions are optimising healthcare practices.

Practical advice on sick notes and what is legally and ethically required from a medical practitioner when completing and issuing sick notes is covered in Wendy Massainga's article on page 12. And on page 16, Gert Viljoen unpacks the impact of AI on jobs and whether "the company" still has a role to play.

In 2019, as SAMA gears to rise to the challenge of playing a pivotal role in creating a functioning healthcare system for all, may we continue to listen, support and communicate.

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Building a more inclusive healthcare system



Prof. Hoosen Coovadia, SAMA president

In recent years there appears to be an SA, and possibly a universal, tendency to withdraw from the major currents of thinking that emerged after the second world war, when the breadth of new ideas about healthcare and social responsibility for all had expanded, and encompassed large majorities of national and global citizens.

National health systems, with health insurance as the frequently employed mechanism of funding, were being encouraged to accept all human beings as our fellows and, *ipso facto*, as our common responsibilities. Indeed, even in SA during the years of the gradual fading of race discrimination, there were moves towards some type of healthcare for all, black and white, rich and poor, male and female, adult and child.

Amazingly, the new trends were largely, though not exclusively, promoted by the broader coalitions of white government at the time, but this was a brief interlude. Soon, the Nationalist Party emerged victorious in government, and very quickly smashed any such propositions. But these broad ideas of

justice, fairness and equity in health services didn't die – they remained buried under the massive weight of vast expanses of pack ice created by fear of other races and the false vision of a long-lasting system of oppression. These smouldering beliefs didn't totally vanish, and were raised again when another wave of individuals and health-oriented groups pushed their way to the surface of society. These groups transcended the earlier interruptions to achieving a fair health system, and are now with us, not in the majority, yet still around in patches and discrete pockets within our republic. Maybe it is time to reassemble the forward-thinking parts of the population and embark on another, more fruitful, journey.

I quail when I listen to the primitive views of those who have a terribly uninformed opinion of the merits and demerits of a progressive health order that parallels our national search for freedom and democracy. So, in order to allow the widest representation in SA, including different views on what is going on in this country, and its future, and how a democratic health system can complement these social and political options, we should continue the conversation on the elements of the coming age, and its ideal health system.

There are few organisations with the equivalent representativeness of doctors as SAMA, so it would be of great benefit to all if SAMA became the focus and pivotal point of these ideas. We could start by looking at some recent views on these issues, so with this thought in mind, let me include a few considerations from the WHO, which recently launched a report by Margaret Chan, its Director-General (<https://www.who.int/publications/10-year-review/en/>).

The WHO is boosting the trajectory of lives saved and improved, by working closely

with global and local partners to achieve impressive health gains in countries and communities. In this way, the organisation is helping to achieve faster improvements in child health and survival, and a better quality of life and advanced life expectancy for people everywhere. The current areas of focus are:

- uniting against neglected tropical diseases
- HIV
- TB
- malaria
- maternal and child health
- vaccines.

The WHO is laying the foundation for better health for all by transforming the organisation so that it runs efficiently and effectively in the decades to come. They have started to make changes that are helping them to work internally and with member states and external partners in a way that is transparent, accountable, trustworthy and responsive.

The WHO plays a unique role as the guardian of health, by engaging with member states and partners in a powerful combination of ways. We should keep in mind that it is a global health guardian through being:

- a champion of equity
- an authoritative source of information
- an honest broker
- an influencer of policy
- an adaptive problem solver
- a voice for the most disadvantaged.

I include these general ambitions of the WHO to move us away from the hugely destructive assertions of the Trump regime in the USA, the Latin American and European authoritarian regimes and some despotic Asian states, and for us to begin discussions around the future of our own health system.

Letters to the Editor

The *Letters to the Editor* page aims to give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare, which you feel should be shared with your colleagues and fellow readers.

Please note that letters:

- should be no longer than 500 words
- can be published anonymously, but writer details must be submitted to the editor in confidence
- must be on subjects pertinent to healthcare delivery
- should be submitted before the 6th of the month in order to be published in the next issue of *SAMA Insider*.

Please email contributions to: Diane de Kock, dianed@hmpg.co.za.



No first pay cheque for new doctors in Gauteng

Dr Theresa Mwesigwa, national chairperson, JUDASA

The end of January: the most exciting time of the year for all workers in the country, as it promises much-needed financial relief for those who last received a salary in the middle of December. And there is no-one more excited than the newly-appointed doctors starting their internships and community service. The anticipation of the first pay cheque is second only to that of graduation. And for many, it is the long-awaited ladder with which to climb out of the clutches of poverty; it offers hope that finally, the life of the new doctor and is or her family is about to change.

However, for approximately 1 000 out of the 1 500 newly appointed health professionals (doctors, nurses and allied health professionals) in Gauteng, the long-anticipated relief did not arrive as promised on 31 January 2019.

It began on the morning of Tuesday 29 January, with rumours circulating that newly appointed doctors in Gauteng were being contacted and informed that they should expect a delay in salary payment by the human resources (HR) departments at their facilities. A sense of confusion and panic started to stir. During the course of the day, an email to the same effect started going around, adding substance to the rumour and escalating the uncertainty and panic that had already taken hold. By the end of that day, an official memo from the Deputy Director of HR at Helen Joseph Hospital had been released, and was being shared widely, confirming what many were still hoping was a cruel hoax: that salaries would not be paid as expected on 31 January. A feeling of stone-cold dread firmly took hold.

The reasons cited for this delay included late capturing data for new staff, and the prioritisation of "statutory appointments" over that of health professionals.

On the morning of the 30 January, under the direction of Dr Ngwenya, convenor of the Trade Union Task Team, the entire SAMA Industrial Relations Department kicked into gear and started contacting all the provincial departments of health to find out if they were anticipating similar issues. The clear and resounding response was "no": they were all on track to pay salaries as expected, at midnight on the 31st. Except Gauteng.



Doctors at Phelosong Hospital scraping together money for lunch, after not being paid their salaries for January

In Gauteng, the Department of Health (GDoH) admitted that they would not be paying salaries on the 1st, but would do so no later than 28 February. As SAMA, we were categorically clear that this was unacceptable. An urgent meeting was convened at the office of the MEC, where it was stated that arrangements had been made for salaries to be paid from 4 February, and no later than the 7th. An agreement was also reached that, given the far-reaching and devastating consequences of the non-payment of salaries, and the threat this posed to many doctors' ability to continue working, special leave would be granted to all unpaid doctors until such a time that they were paid, and a joint statement was released to this effect. And finally, going forward, the GDoH agreed to a proposal by SAMA for the creation of a platform for engagement, to communicate and avert crises of this nature before they happened, and not be reactionary after the fact.

Despite the GDoH's statements and promises, the last group of doctors affected were only paid their salaries on the evening of 10 February. Many were only paid their basic salary, with no compensation for overtime already worked.

In provinces such as the Free State and North West, reports also started coming in from a small number of doctors that they too had not been paid, and through engagements with these provincial departments of health, salaries were paid on 7 February. In KwaZulu-Natal, at the time of going to press, there are doctors who started work as scheduled in January, but have still not been offered contracts of employment, let alone payment of salaries for services rendered.

This failure of the various provincial departments of health to perform one of their most basic functions, the remuneration of employees for services rendered, is disconcerting. When viewed in the context of a National DoH that has not been able to fully occupy and work at its premises since April 2018 due to occupational health concerns, another provincial department whose building burnt down due to the same issues, and the desperate growing push to reduce the NDoH's salary budget through the reduction of internship to 1 year by January 2020, one cannot but conclude that the health system of this country is in dire straits. And, as always, it is the poor who will continue to suffer as a result.

E-scripting: Addressing the disconnect in healthcare

SAMA Communications Department

One of the predicaments facing healthcare at present that impacts most on the wellbeing of patients is the disconnect between doctors, patients and pharmacists. The reality is that co-operation between doctors and pharmacists is vital in ensuring patient medication adherence. However, this does not always happen, and the GP, the gatekeeper to health, faces a daily administration challenge in managing patients' health outcomes.

To address this issue, Marius van der Westhuizen, the chief architect and product manager of Intermedix South Africa, developed the iCanScript e-scripting solution. The result is that Intermedix has partnered with CompuGroup Medical SA (CGM SA), a subsidiary of CompuGroup Medical SE, one of the world's leading medical information technology companies. CGM synchronises healthcare delivery by developing solutions for healthcare professionals, and has more than 400 000 customers worldwide.

Intermedix now offers iCanScript, an e-scripting application developed in SA, and powered by CGM SA. This e-scripting platform is currently used by more than 1 000 doctors in SA, and the number is growing.

What is e-scripting?

Following a patient's diagnosis, a medical prescription is issued. The digital version of this process is known as e-scripting. The iCanScript e-scripting platform makes use of advanced electronic signatures (AESes) for a quick, easy and secure prescription platform that streamlines the prescription process. Doctors can now create a digital script and sign it with a password or PIN, using their personal AES. The patient then selects an e-script-enabled pharmacy from the doctor's application, to which the e-script is routed. The pharmacist prepares the prescription, and the medication is ready for collection. The doctor receives an electronic notification once the medicine has been dispensed, which ensures that they are aware of the patient's medication compliance.

Dr Eloise Malan, an independent medical practitioner, who was the first doctor in Africa to send a fully legally compliant e-script to an enabled pharmacy, says, "At first, I was reluctant, but the benefits convinced us. The connection between the doctor and

the pharmacy, and knowing that my script is going straight to the pharmacy, is great. Instead of sitting in the evenings catching up on admin, emailing and answering requests for repeat scripts, I can do it there and then during a consultation."

How is it legally compliant?

In reference to the legitimacy of the iCanScript platform, Jackie Maimin, a practising pharmacist and the CEO of the Independent Community Pharmacy Association (ICPA), commented, "A script belongs to the patient, and only becomes the property of the pharmacist once the prescription has been dispensed in full. There is a lot of uncertainty around the validity of electronic and digital scripts. What I can say is that in my opinion, iCanScript fulfils the legal requirements for an electronic prescription as outlined in Regulation 33 of the General Regulations of The Medicines [and Related Substances] Act."

Doctors go through a fingerprinting process, authenticated by the Department of Home Affairs, before being issued with their personal AES certificate, to use when digitally signing all their medical and clinical documents.

In his review regarding the iCanScript e-scripting solution with the new AES of the doctor, Mr Pierre Marais, a respected attorney who specialises in SA healthcare legislation, said, "We are therefore of the opinion that the iCanScript e-scripting model ensures satisfactory controls in respect of the safe dispensing of medicine on prescription of a doctor, which safeguards include the integrity of the medicines prescribed, easy detection of any amendment to the original prescription as intended by the doctor or tampering with the signature of the doctor, and the fact that the prescription is kept in a readily accessible manner for reference purposes, and is therefore lawful with complete or full impunity for doctors against charges of unprofessional conduct or unethical conduct by the HPCSA in terms of rule 17 of the *Ethical Rules for Doctors*."

Maimin continues, "There is a study that shows that there is a ZAR12.5 billion (5.6% of total health expenditure) avoidable cost opportunity, and that significant contributors to this are non-adherence and medication errors. Non-adherence



Dr Eloise Malan, the first doctor in Africa to send a fully legally compliant e-script to an enabled pharmacy

is the largest cost, where, on average, a patient only fills 7 out of 12 prescriptions each year. Some don't even fill the first one. With e-scripting, one can see exactly what is happening with a prescription. For non-adherence, the avoidable cost opportunity is estimated at ZAR5.6 billion – this is where patients don't take their medication and end up in hospital or require other expensive interventions. Dispensing errors also creep in when pharmacists can't read the script, or misread it in terms of the actual medication or strength. With e-scripting, there is no chance of a translocation error.

"It's an absolute no-brainer. It is efficient, reduces costs and reduces errors. In addition, doctors will know exactly what is dispensed for the patient. This is an important sharing of information, as sometimes patients decline certain items on the script, and the prescriber should be aware of this."

The benefits of e-scripting

The iCanScript program with AES is beneficial to doctors, pharmacists and patients alike.

Doctors can be assured that patients receive the correct medication. In addition, access to detailed digital records will allow doctors to review historic prescriptions on a patient's profile for quick review of compliance, and reissue of repeat prescriptions. The

system is quick, safe and secure, and the confidentiality and integrity of digital scripts are guaranteed, as prescriptions cannot be altered once signed with an AES.

Patient care is enhanced through the accuracy of digital prescriptions, as pharmacists do not have to decipher what medication or strength was written on a prescription. Patients select a pharmacy of their choice for collection or delivery of their prescribed medication, and the pharmacy prepares the script on receipt of the digital script. There is no more waiting in queues for the patient. There will also be reduced co-payments, as the doctor, who has access to the formulary medication approved by medical aid schemes, can select appropriate medication that is approved by the patient's medical scheme.

For the pharmacist, there is improved workflow efficiency as a result of the automated delivery of the e-script into the pharmacy practice management system. There is also high-quality customer service, as prescriptions and prescribed minimum benefits claims are prepared before the patient collects the medication. In addition, there is the potential for reduced medical

errors, as digital scripts are highly legible and require less typing input from the pharmacist when filling the script.

Why is e-scripting a big deal?

According to Marius van der Westhuizen, all parties in the health ecosystem are now, for the first time, connected and accountable, as part of a multidisciplinary team taking care of the patient's health outcomes. He adds, "The patient is co-responsible for his or her healthcare, and is involved in his or her healthcare journey; the pharmacist, together with the patient, drives adherence; and the doctor can see what the patient is taking, leading to improved patient care and health outcomes.

"In addition, there is no cost for issuing the AES to doctors, or for the use of the e-scripting technology, as it is embedded in the practice management software."

Dr Bruce Longmore, from Sizimpilo Medical Consulting in KwaZulu-Natal, highlights another reason why e-scripting is helpful: "Scripting is a critical part of the consultation process. Having the ability to access medicine databases and view generic substitution allows us to create legible,

accurate and cost-efficient scripts. AES is the only way to protect the identity of the doctor and help combat fraud, waste and abuse in the healthcare sector.

"Sending scripts directly to the chosen pharmacy's dispensing software allows for swift and accurate dispensing. It also improves patients' adherence to fill their prescriptions."

Van der Westhuizen concludes, "We are proud to have finally found a solution to the great disconnect in SA healthcare, to ensure improved health outcomes for patients by bridging the gap between doctor and pharmacist."

The National Department of Health has gazetted the use of AES digital signed prescriptions as per Section 37 of the Electronic Communications and Transactions (ECT) Act No. 25 of 2002, and the proclamation appeared in *Government Gazette* 41064 (No. 859) section 34, dated 25 August 2017, in terms of section 35 of the Medicines and Related Substances Act No. 101 of 1965. The Act can be accessed at <http://www.mccza.com/documents/959cb9e1Test.pdf>.

Ten threats to global health in 2019

World Health Organization

The world is facing multiple health challenges. These range from outbreaks of vaccine-preventable diseases such as measles and diphtheria, increasing reports of drug-resistant pathogens and growing rates of obesity and physical inactivity, to the health impacts of environmental pollution and climate change, and multiple humanitarian crises.

To address these and other threats, 2019 sees the start of the WHO's new 5-year strategic plan. This plan focuses on a triple billion target: ensuring that 1 billion more people benefit from access to universal health coverage, 1 billion more people are protected from health emergencies and 1 billion more people enjoy better health and wellbeing. Reaching this goal will require addressing the threats to health from a variety of angles.

Here are 10 of the many issues that will demand attention from the WHO and health partners in 2019.

Air pollution and climate change

Nine out of 10 people breathe polluted air every day. In 2019, air pollution is considered by the WHO to be the greatest environmental risk to health. Microscopic pollutants in the air can penetrate respiratory and circulatory systems, damaging the lungs, heart and brain, killing 7 million people prematurely every year from diseases such as cancer, stroke, heart and lung disease. Around 90% of these deaths are in low- and middle-income countries, with high volumes of emissions from industry, transport and agriculture, as well as dirty cooking stoves and fuels in homes.

The primary cause of air pollution (burning fossil fuels) is also a major contributor to climate change, which impacts people's health in different ways. Between 2030 and 2050, climate change is expected to cause 250 000 additional deaths per year, from malnutrition, malaria, diarrhoea and heat stress.



In October 2018, the WHO held its first ever Global Conference on Air Pollution and Health in Geneva. Countries and organisations made more than 70 commitments to improve air quality. This year, the UN Climate Summit in September will aim to strengthen climate action and ambition worldwide. Even if all the commitments made by countries for the Paris



Agreement are achieved, the world is still on a course to warm by more than 3°C this century.

Non-communicable diseases

Non-communicable diseases, such as diabetes, cancer and heart disease, are collectively responsible for over 70% of all deaths worldwide, or 41 million people. This includes 15 million people dying prematurely, aged between 30 and 69.

Over 85% of these premature deaths are in low- and middle-income countries. The rise of these diseases has been driven by five major risk factors: tobacco use, physical inactivity, the harmful use of alcohol, unhealthy diets and air pollution. These risk factors also exacerbate mental health issues, which may originate from an early age: half of all mental illness begins by the age of 14, but most cases go undetected and untreated – suicide is the second leading cause of death among 15-19 year-olds.

Among many other things, this year the WHO will work with governments to help them meet the global target of reducing physical inactivity by 15% by 2030 – through such actions as implementing the ACTIVE policy toolkit, to help get more people active every day.

Global influenza pandemic

The world will face another influenza (flu) pandemic – the only things we do not know are when it will hit, or how severe it will be. Global defences are only as effective as the weakest link in any country's health

emergency preparedness and response system.

The WHO is constantly monitoring the circulation of influenza viruses to detect potential pandemic strains: 153 institutions in 114 countries are involved in global surveillance and response.

Every year, the WHO recommends which strains should be included in the flu vaccine, to protect people from seasonal flu. In the event that a new flu strain develops pandemic potential, the WHO has set up a unique partnership with all the major players to ensure effective and equitable access to diagnostics, vaccines and antivirals (treatments), especially in developing countries.

Fragile and vulnerable settings

More than 1.6 billion people (22% of the global population) live in places where protracted crises (through a combination of challenges such as drought, famine, conflict and population displacement) and weak health services leave them without access to basic care.

Fragile settings exist in almost all regions of the world, and these are where half of the key targets in the sustainable development goals, including on child and maternal health, remain unmet.

The WHO will continue to work in these countries to strengthen health systems so that they are better prepared to detect and respond to outbreaks, as well as able to deliver high-quality health services, including immunisation.

Antimicrobial resistance

The development of antibiotics, antivirals and antimalarials is one of modern medicine's greatest successes. Now, time with these drugs is running out. Antimicrobial resistance – the ability of bacteria, parasites, viruses and fungi to resist these medicines – threatens to send us back to a time when we were unable to easily treat infections such as pneumonia, tuberculosis, gonorrhoea and salmonellosis. The inability to prevent infections could seriously compromise surgery and procedures such as chemotherapy.

Resistance to TB drugs is a formidable obstacle to fighting a disease that causes around 10 million people to fall ill, and 1.6 million to die, every year. In 2017, around 600 000 cases of TB were resistant to rifampicin – the most effective first-line drug – and 82% of these people had multidrug-resistant TB.

Drug resistance is driven by the overuse of antimicrobials in people, but also in animals, especially those used for food production, as well as in the environment. The WHO is working with these sectors to implement a global action plan to tackle antimicrobial resistance, by increasing awareness and knowledge, reducing infection and encouraging prudent use of antimicrobials.

Ebola and other high-threat pathogens

In 2018, the Democratic Republic of the Congo saw two separate Ebola outbreaks, both of which spread to cities of more than 1 million people. One of the affected provinces is also in an active conflict zone.

This shows that the context in which an epidemic of a high-threat pathogen such as Ebola erupts is critical – what happened in rural outbreaks in the past does not always apply to densely populated urban areas or conflict-affected areas.

At a conference on Preparedness for Public Health Emergencies held last December, participants from the public health, animal health, transport and tourism sectors focused on the growing challenges of tackling outbreaks and health emergencies in urban areas. They called for the WHO and partners to designate 2019 as a "Year of action on preparedness for health emergencies".

The WHO's R&D [research and development] Blueprint identifies diseases and pathogens that have potential to cause a public health emergency, but lack effective treatments and vaccines. This watchlist for priority research and development includes

Ebola, several other haemorrhagic fevers, Zika, Nipah, Middle East respiratory syndrome coronavirus (MERS-CoV) and severe acute respiratory syndrome (SARS), and disease X, which represents the need to prepare for an unknown pathogen that could cause a serious epidemic.

Weak primary healthcare

Primary healthcare is usually the first point of contact that people have with their health-care system, and ideally should provide comprehensive, affordable, community-based care throughout life.

Primary healthcare can meet the majority of a person's health needs during the course of their life. Health systems with strong primary healthcare are needed to achieve universal health coverage.

Yet many countries do not have adequate primary healthcare facilities. This neglect may be due to a lack of resources in low- or middle-income countries, but possibly also a result of a focus in the past few decades on single-disease programmes. In October 2018, the WHO co-hosted a major global conference in Astana, Kazakhstan, at which all countries committed to renew the commitment to primary healthcare made in the Alma-Ata Declaration in 1978.

In 2019, the WHO will work with partners to revitalise and strengthen primary healthcare in countries, and follow up on specific commitments made by in the Astana Declaration.

Vaccine hesitancy

Vaccine hesitancy – the reluctance or refusal to vaccinate, despite the availability of vaccines – threatens to reverse progress made in tackling vaccine-preventable diseases. Vaccination is one of the most cost-effective ways of avoiding disease – it currently prevents 2 - 3 million deaths a year, and a further 1.5 million could be avoided if global coverage of vaccinations improved.

Measles, for example, has seen a 30% increase in cases globally. The reasons for this rise are complex, and not all of these cases are due to vaccine hesitancy. However, some countries that were close to eliminating the disease have seen a resurgence.

The reasons that people choose not to vaccinate are complex; a vaccines advisory group to the WHO identified complacency, inconvenience in accessing vaccines and lack of confidence as key reasons underlying hesitancy. Health workers, especially those



in communities, remain the most trusted advisors and influencers of vaccination decisions, and they must be supported to provide trusted, credible information on vaccines.

In 2019, the WHO will ramp up work to eliminate cervical cancer worldwide by increasing coverage of the HPV vaccine, among other interventions. 2019 may also be the year when transmission of wild poliovirus is stopped in Afghanistan and Pakistan. Last year, fewer than 30 cases were reported in both countries. The WHO and partners are committed to supporting these countries to vaccinate every last child, to eradicate this crippling disease for good.

Dengue

Dengue, a mosquito-borne disease that causes flu-like symptoms, and can be lethal and kill up to 20% of those with severe cases, has been a growing threat for decades.

A high number of cases occur in the rainy seasons of countries such as Bangladesh and India. Now, dengue's season in these countries is lengthening significantly (in 2018, Bangladesh saw the highest number of deaths in almost two decades), and the disease is spreading to less tropical and more temperate countries such as Nepal, which have not traditionally seen the disease.

An estimated 40% of the world is at risk of dengue fever, and there are around 390 million infections a year. The WHO's dengue control strategy aims to reduce deaths by 50% by 2020.

HIV

The progress made against HIV has been enormous, in terms of getting people tested, providing them with antiretrovirals (22 million are on treatment) and providing access to preventive measures such as pre-exposure prophylaxis (PrEP, which is when people at risk of HIV take antiretrovirals to prevent infection).

However, the epidemic continues to rage, with nearly a million people every year dying of HIV/AIDS. Since the beginning of the epidemic, more than 70 million people have acquired the infection, and about 35 million people have died. Today, around 37 million worldwide live with HIV. Reaching people such as sex workers, people in prison, men who have sex with men, or transgender people is hugely challenging. Often these groups are excluded from health services. A group increasingly affected by HIV is that of young girls and women (aged 15 - 24), who are at particularly high risk and account for one in four HIV infections in sub-Saharan Africa, despite making up only 10% of the population.

This year, the WHO will work with countries to support the introduction of self-testing, so that more people living with HIV know their status, and can receive treatment (or preventive measures, in the case of a negative test result). One activity will be to act on new guidance announced in December 2018 by the WHO and the International Labour Organization to support companies and organisations to offer HIV self-tests in the workplace.

Coping strategies for the distressed doctor

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

Physician mental distress implies intangible pain or suffering in the distressed doctor. As intangible as it is, it still represents real and, at times, overwhelming suffering. This may be the result of overt mental disorders, such as anxiety disorders, depression or bipolar disorder, or covert psychological difficulties such as substance abuse or other addictions, behavioural problems, relationship difficulties or conflict in the workplace.

Physician distress may also have more permanent and tragic outcomes, such as suicide or even homicide. The heart-breaking end to a colleague's life, who died by suicide in early 2018, and also took the life of his son, is still fresh in the minds of colleagues who were at medical school with him. We are also well aware of the overwhelming evidence on physician suicides across the world. Very few of us are unfamiliar with Pamela Wible and her quest to highlight the distressed doctor's plight, and yet the carnage continues.

Physician mental distress

HPCSA statistics reveal various causes of doctor impairment in SA. The real numbers are probably much higher, if one considers doctors whose functioning may be impaired by mental distress but who do not necessarily attract HPCSA scrutiny. Most of the causes are linked to mental health issues or mental distress. On 1 October 2018, the HPCSA had 46 091 practitioners registered with its Medical and Dental Board. In May 2018, there were 345 practitioners (197 male, 143 female, 5 unlisted/unknown) who were under HPCSA health committee management. Of these, 225 were medical practitioners.

Up to 40% of medical practitioner impairment in the HPCSA database is due to substance abuse/dependence, and 31% is due to a mixture of different mental disorders, including bipolar disorder, anxiety disorders and unspecified mental disorders. This means that just over 70% of causes of impairment in medical practitioners can be linked to mental distress. It is worthwhile keeping in mind that anxiety disorders are the most common mental disorders, followed by depression. These conditions, and other causes of mental distress such as bipolar disorder, may all be associated with substance-use

disorders. Distress in doctors may be linked to occupational, relationship or financial stressors, and may conversely manifest in the same life areas, i.e. with occupational, relationship and financial strife.

The greatest obstacle to accessing help is denial and lack of insight

The usual assumption is that doctors are supportive of each other, and yet lack of collegial behaviour and poor peer support can also be an integral part of what ails the profession. The HPCSA's ethical and professional rules provide a strict ethical code that prohibits a practitioner from casting reflections on the probity, professional reputation or skill of another person registered under the National Health Act No. 61 of 2003 or any other health Act. Despite this, instances of colleagues attacking colleagues, and going as far as committing actions tantamount to defamation, remain a persistent challenge, which adds to the distressed doctor's plight.

Destressing the distressed doctor

When mental distress manifests as a specific mental disorder, the greatest obstacle to accessing help is denial and lack of insight. This may be even more pronounced in doctors, possibly because of our perfectionistic outlook and reluctance to acknowledge problems when we are affected by human frailties. This leads to delayed help-seeking behaviour, and even to refusal to accept treatment. Although doctors are experts at diagnosing illness, we fail ourselves when it comes to recognition of our own distress, and even more so to taking corrective steps to get help.

Family, friends and peers can be invaluable in assisting a doctor with a mental disorder to seek help. In extreme cases, when the distressed doctor's behaviour places his or her life or the lives of others at risk, the family or close associates may have to turn to the

Mental Health Care Act No. 17 of 2002 to empower him or her to seek help. Although not ideal, it has saved lives when applied judiciously. When a doctor is significantly impaired by mental illness or distress, then a submission also needs to be made to the HPCSA on the doctor's condition. This is often misunderstood by affected doctors as a punitive step, yet it seldom leads to such severe sanctions as to prevent the doctor from practising. The usual outcome is for the affected doctor to be enabled to practise medicine with guidance and supervision from peers while undergoing treatment.

Doctors know enough about healthy living strategies, and yet we fail to apply these successfully in our own lives. A healthy diet with a regular exercise routine and a healthy work-life balance go a long way towards destressing the pressured lives we lead. Good sleep is essential for the rejuvenation and revival of a stressed mind. Social interconnectedness complements this holistic approach. Harvest and develop other interests, where possible, to allow space for focusing on something pleasurable outside of your work. When such interests are balanced and consist of non-harmful or non-habit forming activities, they add to a balanced life.

During work days, short breaks are a must to boost waning energy levels. Missing meals is something we all do, even though we are well aware of the detrimental effects. If necessary, set an alarm for short breaks of up to 10 minutes, every 2 to 3 hours. In an 8-hour day, that equates to a period of up to 30 minutes taken for breaks during the work day, which may save your sanity, and possibly your life.

When the distressed doctor is overwhelmed

There may be times when our usual coping strategies fail. This may manifest as burnout, hopelessness, and giving in to previously checked unhealthy behaviours (e.g. binge drinking, bingeing on harmful illicit substances, going on gambling sprees, engaging in inappropriate sexual behaviours). In extreme cases, it may lead to decompensation with persistent and or intrusive ideas of self-harm or suicide. It is a good idea to have a "distress buddy", a go-to person whom you trust, be it a therapist, a formal or informal counsellor or a

trusted friend. This person is someone you can contact at any time of the day or night, and who you trust to be there for you. Alternatively, have the contact details for a helpline on your phone, and within easy access should you need them (see box).

Keep a confidential diary of your thoughts and feelings for retrospective analysis and reference, to help you learn from your mistakes. Use a hierarchy of positive behaviours or actions to help you battle the blues when they hit. This entails making a list of five to ten non-harmful activities that you

enjoy, and that usually help you feel better. On a bad day, you use the list by running through the activities from the first to the last, and repeating the cycle again if it becomes necessary, until the overwhelming feelings pass. And no matter how hopeless a situation feels at a given moment in time, the further time moves away from that point, the less overwhelming it may seem. One underused and underestimated tactic is distraction from the immediate problem. This serves to de-escalate the immediacy of the crisis, while allowing for space to consider alternative solutions.

Conclusion

As much as the plight of the distressed doctor is a real and sometimes unavoidable occupational hazard, a career in medicine has the potential to be fulfilling and life-affirming for those who choose this path. Peer support for the distressed doctor is crucial in ensuring that this noble profession of ours survives this surmountable challenge.

The South African Depression and Anxiety Group 24 hr helpline: 0800 12 13 14

How Microsoft Office's solutions are optimising healthcare practices

Dylan Newham, HOD, School of Information Technology, FPD/FSI

Microsoft has committed to working with national healthcare regulators, healthcare providers and other stakeholders in SA. This is to ensure that their technologies can be used to enable the healthcare sector in ways that meet international standards, national compliance and regulatory requirements.

Microsoft is opening its own data centres in SA in 2019. This new cloud region will offer enterprise-grade reliability and performance, combined with data residency. This will provide a tremendous opportunity for economic growth, and increase access to cloud and internet services for organisations and people across SA, and the rest of the African continent. This new investment is a recognition of the enormous opportunity for digital transformation in Africa, and is a major milestone in the company's mission to empower every person and organisation on the planet to achieve more in a safe, secure and legally compliant manner.

Microsoft stands ready to support healthcare organisations in South Africa with the Microsoft cloud, which includes Microsoft Azure, Office 365 and Microsoft Teams for healthcare, which can be used to meet and enhance levels of compliance with regulatory requirements.

How Office 365 improves healthcare

Office 365 is an integrated experience of apps and services, which include Microsoft

Word, Excel, PowerPoint, Outlook, One Drive, Teams and more. These applications can help hospitals and practices improve patient care and reduce operational costs by improving collaboration and communication between doctors, nurses, administrators, staff, and independent specialists.

Microsoft Office 365 is a cloud-based service, which means you can access important documents stored on the cloud from anywhere, and on any device. In terms of sharing and access, the cloud can't be beaten, as you can designate user permissions based on document sensitivity and user seniority. With the cloud, sharing information becomes effortless. Files and documents can be shared quickly and securely with patients and colleagues. Even though the cloud is online, you can work offline and sync your data later, which is helpful if you are not always connected to every system or computer in your organisation.

OneDrive cloud storage for patient information is far more secure than paper records or local servers. When you use a compliant cloud storage solution such as Office 365, you feel more confident in your ability to maintain and share secure records with your patients and partners, because you no longer have to worry about violating the law. Interestingly, Microsoft Azure cloud storage is the only hosting environment certified by the US Food and Drug Administration (USFDA) for the storing of clinical records.

Software is also kept up to date, as it is applied as soon as it becomes available. So rather than having to manually update every station and computer in your organisation, you can simply sit back and let Office 365 take care of things for you. In light of recent ransomware attacks and data breaches (mostly due to old computers using outdated software), you can instantly appreciate the benefits of the cloud.

Collaboration enabled by Microsoft Teams for healthcare

Improving quality of care depends on many things – including overcoming complex care environments, and cybersecurity threats. Since Office 365 is built for teamwork, healthcare organisations can increase the effectiveness of their quality improvement processes and co-ordination of treatment plans, while also enabling research projects.

Every day, many times a day, health teams get together to address patient care issues, tackling quality, safety and management issues. Unfortunately, many teams rely on outdated modes of communication, without an easy way to centralise health team notes, create actionable plans and visualise patterns of patient symptoms. Critical patient information can fall through the cracks with these outdated processes. Using Microsoft Teams for healthcare creates a single place to interact as a team. This integrated space for

collaboration allows providers to be in tune with their patients, and improves the quality of care.

With Microsoft Teams for healthcare you can:

- measure and visualise impactful best practices across your organisation
- identify patient care issues, and potential causes
- share ideas with your health team via natural conversations.

Reimagining this process is one way that Microsoft 365 can empower health teams to work together securely, with intelligent tools and solutions to share ideas and improve

quality of care. Microsoft has a long track record of building security and privacy into the way they design and develop software. To build a trusted cloud platform for health teams, Microsoft has more than 1 100 internal controls to meet multiple regulatory requirements and industry standards.

The Foundation for Professional Development (FPD), in collaboration with the Foundation for Sustainable Innovation (FSI), has recently launched the FPD School of Information Technology (IT) to assist doctors, nurses and practice staff with their Microsoft training requirements. We can help with the provision of training, whether your practice has

basic needs such as Outlook, Word, PowerPoint or Excel, or whether you need more in-depth training for maintaining your own databases and data warehouses. As a Microsoft Certified Education Partner, we are accredited to offer over 28 Microsoft Certifications. All our courses are internationally certified. Further to being a Microsoft Education Partner, FSI also holds various Microsoft Certifications, including cloud partner, independent software vendor and applications developer. A list of our courses can be found on the FPD website: <https://www.foundation.co.za/it-courses>.

References available on request.

Certificate of illness breakdown

Wendy Massaingaie, legal advisor, SAMA Governance and Legal Department

This article deals with certificates of illness, or sick notes as they are more commonly known. There has been a steady increase in the number of fraudulent sick notes being investigated by the HPCSA, and those medical practitioners found guilty of issuing them are liable to pay a fine, and will be criminally charged. Therefore, it is important for medical practitioners to remain vigilant, and be aware of what is legally and ethically required from them when completing and issuing sick notes.

The Basic Conditions of Employment Act No. 75 of 1997 addresses sick notes in section 23 as follows:

“(1) An employer is not required to pay an employee in terms of section 22 if the employee has been absent from work for more than 2 consecutive days or on more than two occasions during an 8-week period and, on request by the employer, does not produce a medical certificate stating that the employee was unable to work for the duration of the employee’s absence on account of sickness or injury.

(2) The medical certificate must be issued and signed by a medical practitioner or any other person who is certified to diagnose and treat patients and who is registered with a professional council established by an Act of Parliament.”

Therefore, a valid sick note will be accepted by an employer if, in the medical practitioner’s professional opinion, the employee was unable to perform their duties due to an illness or injury.

In addition to the above, the *Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act [No. 56 of] 1974* specifies the requirements for a valid certificate of illness. Rule 16 of the Act reads:

A medical practitioner is not obliged to issue a sick note where there is no legitimate reason for one

“16. Certificates and reports:

(1) A practitioner shall grant a certificate of illness only if such certificate contains the following information: (a) the name, address and qualification of such practitioner; (b) the name of the patient; (c) the employment number of the patient (if applicable); (d) the date and time of the examination; (e) whether the certificate is being issued as a result of personal observations by such practitioner during an examination, or as a result of information which has been received from the patient and which is based on acceptable medical grounds; (f) a description of the illness, disorder or malady in layman’s terminology,

with the informed consent of the patient – provided that if such patient is not prepared to give such consent, the practitioner shall merely specify that, in his or her opinion based on an examination of such patient, such patient is unfit to work; (g) whether the patient is totally indisposed for duty or whether such patient is able to perform less strenuous duties in the work situation; (h) the exact period of recommended sick leave; (i) the date of issue of the certificate of illness; and (j) the initial and surname in block letters and the registration number of the practitioner who issued the certificate.

(2) A certificate of illness referred to in subrule (1) shall be signed by a practitioner next to his or her initials and surname printed in block letters.

(3) If preprinted stationery is used, a practitioner shall delete words which are not applicable.

(4) A practitioner shall issue a brief factual report to a patient, where such patient requires information concerning himself or herself.”

A valid sick note must meet the requirements above in order for it to be legally acceptable. It is important to note that sick notes can be backdated, where the patient only consults the medical practitioner at a later stage, as long as it is the medical practitioner’s professional opinion that the patient was unfit for duty during the stated period. Furthermore, the diagnosis does not need to be disclosed unless the patient specifically consents to the nature of the illness or injury being stated in the sick note. This is

based on the patient’s right to confidentiality as well as the doctor-patient relationship, which upholds the respect of privacy.

In conclusion, it is important to remember that a medical practitioner is not obliged to issue a sick note where there is no legitimate reason for one. The medical practitioner has to comply with the law, and bear in

mind that their professional reputation will be at stake should they be found to have issued a fraudulent sick note. Always ensure that the sick note is completed accurately and honestly, and personally signed by the medical practitioner. Furthermore, all medical stationery containing professional or personal information must be kept safe, as

loss of a medical certificate pad may be seen as professional misconduct. Lastly, should a medical practitioner become aware that their medical certificate pad has been lost, or is being used fraudulently, this must be reported to the SA Police Services.

An example of an acceptable sick note can be found below.

Dr (initials and surname)

MBChB (full qualifications)

MP number

Physical address

Date: _____

Certificate of illness (based on consultation/examination OR information from patient/backdated)

Patient’s name: _____

Patient’s employee number: _____

I have examined the patient on the date of this certificate and in my professional opinion the employee is unable to perform his or her normal duties on the dates specified below as a result of the following illness or injury:

OR (delete whichever section is not applicable)

Based on information provided to me by the patient during a subsequent consultation and examination and in my professional opinion, based on acceptable medical grounds, the employee was unable to perform his or her normal duties on the dates specified below as a result of the following illness or injury:

Please note that the patient has consented to a full description of the illness/injury on this certificate – indicated by his/her signature hereto.

Signed: Patient: _____

Initials and surname (patient): _____

OR (delete whichever section is not applicable)

Please note that the patient has not consented to a description of the illness/injury on this certificate – as indicated below.

I, _____, do NOT consent to any information in respect of my illness or injuries being shared with my employer, as indicated by my signature hereto.

Signed: Patient: _____

Initials and surname (patient): _____

In my aforesaid professional opinion, the employee will be/was (delete the inapplicable) unable to report to work for the following period:

From _____ to _____

Signed: Doctor: _____

Initials and surname (doctor): _____

SAMED guidance for direct and indirect sponsorship by device and technology companies

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

During 2017 and 2018, SAMA reported on new developments in the regulation and marketing of medical devices.

SAMED is the SA Medical Technology Industry Association, to which a number of our local and multinational medical device and technology companies belong. As the

national trade association, SAMED aims to provide members with a collective, objective and credible platform to engage with all stakeholders.

In 2017, SAMED launched its *Medical Device Code of Ethical Marketing and Business Practice*.

While the marketing of medical devices and technology is not currently regulated in SA, SAMED has aligned itself with both its US and European counterparts in efforts toward self-regulation of the industry. As part of this, SAMED and its member companies have agreed to stop allowing members to **directly** sponsor healthcare professionals (HCPs) to attend third-party organised conferences and other meetings.

As of 1 January 2018, therefore, no SAMED member company is permitted to sponsor a specific doctor of their choice to attend a third-party organised educational event.

Third-party organised educational events are defined as activities of any type that are planned, budgeted, managed and executed, in whole or in part, by or on behalf of a person or entity other than a medical technology company, to fulfil HCPs' educational needs.

Companies can still provide **indirect** sponsorship and support, in the form of an educational grant or donation of funds, to support bona fide independent, educational, scientific and policy-making conferences that promote scientific knowledge, medical advancement and the delivery of effective healthcare.

HPCSA guidance

It is worth noting that direct sponsorship of HCPs by supplier companies is also not in line with the HPCSA's *Good Practice Guidelines* booklet 11 (Guidelines on over-servicing, perverse incentives and related matters).

In section 3.13, the HPCSA guidance booklet discusses acceptable behaviour related to continuing professional development (CPD):

"3.13.1 Collaborative efforts

Historically, there has been a close collaboration between HCPs and the pharmaceutical and health supply industry that extended particularly to CPD.

Healthcare is to a large extent self-governing, and practitioners must ensure that their participation in such collaborative efforts is in line with their ethical duties towards patients and society.

3.13.2 Educational needs of targeted group

CPD activities should address the educational needs of the targeted healthcare group.

3.13.3 HCP organisations

The decision on content and choice of CPD activities, as well as funding arrangements, lies

ultimately with the HCP organisations, such as professional associations, their branches and groups, who should not be in a position of conflict of interest by virtue of any relationship with the funding body.

The organisers may acknowledge financial or other aid received, but should not identify any specific products. Generic names of products should be used rather than trade names in the course of CPD activities.

3.13.4 Funding

Funds for CPD activities should preferably be in the form of an educational grant payable to the healthcare provider organisation arranging the activity.

3.13.5 Travel, lodging and other expenses with regard to the attendance of CPD events.

No travel or lodging costs or other expenses should be paid by the industry directly to the individual HCPs to attend a CPD event.

However, indirect funding or scholarship of CPD events may be permissible in instances where such sponsorships are paid to the organisers of the CPD events, who in turn will identify, through a transparent selection process, deserving candidates, based on such factors as a historically disadvantaged individual's status, gender or geographical location in terms of rural and inaccessible locations, or young practitioners and developing practitioners etc.

The organisers may extend reasonable honoraria and imbursement for travel, lodging and meal expenses to speakers. The principal event should at all times centre around education and not around meals, entertainment or other hospitality, the cost of which should not exceed that level which the recipients might reasonably be expected to incur for themselves under similar circumstances.

3.13.6 Travel, lodging and other expenses with regard to the attendance of international conferences.

3.13.6.1 It is a well-established practice and an acknowledged fact that HCPs and educators should be exposed to new knowledge and insights into their respective professions and disciplines by attendance at international conferences, either locally or overseas. It is, however, also of the utmost importance that young and upcoming HCPs and educators and those from disadvantaged backgrounds be given an equal opportunity to expand their knowledge and understanding with regard to their respective professions and disciplines by attendance at international conferences.

3.13.6.2 It will, therefore, be permissible for companies to sponsor delegates to attend international conferences, either directly or through professional associations or societies, with the proviso that a fair and transparent process should be followed in the election and sponsoring of delegates to attend such events, especially with regard to the attendance of such conferences by young and upcoming HCPs and educators, and those from disadvantaged backgrounds.

3.13.6.3 Sponsorships should be earmarked for specific educational events and conferences, and not for holiday purposes.

3.13.7 Distinction between education, training and product promotion.

A distinction should be made between education and training on the one hand, and product promotion on the other.

HCPs cannot earn continuing education units for attending product launches or other product promotion events.

No travel, lodging or other expenses of HCPs should be paid for attendance at product promotion events or product launches. However, modest meals may be provided."

Additional guidance available from SAMED

To assist technology companies, event organisers and HCPs in navigating this new world, SAMED has posted several detailed documents on its website, one of which contains guidance on the specifics of conditions set for indirect sponsorships and grants.

This guidance document, and templates, have been prepared by SAMED as a suggested guide only for medical technology companies and third-party grant recipients. The guidance document contains a good deal of detail on the rationale around the decisions to stop direct sponsorships, as well as advice, and templates to guide organisations through the issues of arranging and managing indirect sponsorship for delegates to attend events.

We encourage members and those involved in organising conferences, seeking sponsorship or providing sponsorships to familiarise themselves with the marketing code, and the detailed guidance related to it, and to apply the appropriate HPCSA ethical rules when making decisions on these matters.

All the important codes and guidance documentation are available at <http://www.samed.org.za/Codes-of-Practice.aspx>.



MERCEDES-BENZ VANS ARE PERFECTLY SUITED FOR MEDICAL PROFESSIONS



Mercedes-Benz Southern Africa is the leading mobility solutions provider in the region, offering a comprehensive range of products and services.

Part of Mercedes-Benz SA, the division remains a leader through four vehicles that continue to pioneer the segments they operate in.

Mercedes-Benz V-Class

The Mercedes-Benz V-Class has redefined the multipurpose vehicle (MPV) segment, as it sets new benchmarks in its segment with its design and host of innovations.

The V-Class combines room for up to eight people, and exemplary functionality, with high-class appeal, comfort, efficient driving enjoyment and safety. This makes the Mercedes-Benz the perfect vehicle among MPVs for medical professionals who appreciate boundless space but do not want to sacrifice style and comfort.

Whether travelling with the whole family, heading out for a mountain bike holiday with friends or driving prominent guests to a red carpet event – the new V-Class provides optimum flexibility when it comes to use of the luxurious interior.

With the three equipment lines, the V-Class Standard, V-Class BlueTEC and V-Class BlueTEC AVANTGARDE, an Exterior Sports package and an Interior Design package available for each line, and a host of optional extras, the V-Class can be individualised to suit any taste and requirement. As a result, it meets a wide variety of customer needs, and is just as attractive for families as it is for people who

need a variable and spacious interior for their leisure and sports activities.

Mercedes-Benz X-Class

The SA double-cab landscape was radically transformed after the Mercedes-Benz X-Class was launched in May 2018.

The X-Class established a completely new vehicle segment, as the first double-cab from a premium manufacturer. This high-quality vehicle, with passenger car-like characteristics and comfort features, is poised to be the first of its kind.

The X-Class convincingly combines the versatility of a double-cab with the luxury of a passenger car, which is exactly what doctors have been asking for, for so long. The X-Class is robust, with exceptional load capacity and off-road capability, yet it's also aesthetically pleasing, dynamic to drive, comfortable and safe.

The X-Class was launched with two design and equipment lines, for different lifestyles and working environments. The X-Class PROGRESSIVE is aimed at consumers who are seeking a rugged bakkie with extra styling and comfort functions, while also being a comfortable yet prestigious vehicle for private or dual use.

The X-Class POWER is the high-end line. It is aimed at customers for whom styling, performance and comfort are paramount. As a lifestyle vehicle beyond the mainstream, it is suitable for urban environments as well as for sports and leisure activities off the beaten track. Its design and high level of equipment reflect an independent and individualistic lifestyle.

Mercedes-Benz Sprinter

For the commercially minded doctor who perhaps has more than one income stream, the Mercedes-Benz Sprinter is the perfect income generator. Panel van, tourer or bus, the Sprinter offers a number of variants and configurations for industries such as taxi, trade, service and logistics, mobile homes, speciality conversions and new business owners. This unmatched versatility means that there is a sector-specific solution for any requirement.

Mercedes-Benz Vito

Offering tangible external strengths, maximum benefit and low costs, the Mercedes-Benz Vito is a versatile and real professional among mid-size vans. Although it offers an exceptionally high payload, the purchase price and maintenance costs are exceptionally low.

From skilled crafts and trades to retail, service providers and shuttle services – the Vito is truly one vehicle for all. The Vito panel van is available with two different drive systems, and with up to 1 344 kg of cargo capacity, it has the highest payload in its class.

Meanwhile, the Mixto combines the advantages of a panel van with those of a people mover, which we like to refer to as the Tourer. The Tourer sees Mercedes-Benz opening an entirely new chapter in passenger transport. There are two versions available: the versatile Vito Tourer PRO and the premium Vito Tourer SELECT. By virtue of this complete model family, the Tourer can be tailored to accommodate all types of passenger transport.

Your financial health: Unpacking artificial intelligence, and the role of the company

Gert Viljoen, *VPROF*

VProfessional Services (VPROF) is 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. Gert Viljoen keeps us up to date on the impact of artificial intelligence (AI), and whether “the company” still has a role to play.

AI and the changing face of jobs

No one knows for certain what the rise of AI will actually mean to us as businesses or employees. A common reaction is one of fear – “Will I lose my job to a machine or an algorithm?”, “Will my business be disrupted and destroyed?”, “Should I be throwing more time and resources at looking for the next big AI thing?”, and so on. This is partially a result of all the media hype around how the ever-accelerating rise of the robots will destroy jobs and threaten our livelihoods.

However, a recent World Economic Forum (WEF) report puts a far more positive spin on it all. Here we discuss what the WEF predicts for 2022, and suggest three practical steps that your business should take now to ensure that you adapt and thrive.

There has been fear that the rise of AI and robots will considerably reduce the work force. New research concludes that there will be winners and losers as AI becomes entrenched in economies, but there will be far more winners. The WEF predicts that actually, 58 million new jobs will be created – 75 million jobs lost, but 133 million created.

The trick facing business is how to get onto the winning side, as those businesses that will be most affected by AI, and those who quickly get it right, will have a substantial profit enhancer, because AI will, in the medium term, drive down business costs.

Adapt and thrive! What you need to do:

The first issue is acquiring more resources in terms of technology (AI will need far greater processing power, and new AI machinery), upskilling your labour force and employing new staff.

Secondly, consider approaching other players in your industry to put together a plan that will bring in a future stream of skilled employees. This task is too big for one business to undertake.

You will also need to instil in your staff the idea that they will need to continually improve their skills.

What type of employee will you require?

Recruiters in the developed world are now focusing on people with problem-solving skills, since AI will throw up technical and competitive challenges on an ongoing basis. Staff need to be able to quickly solve these problems.

**“Artificial
intelligence is a tool,
not a threat”
Rodney Brooks,
roboticist**

As technical people will become more of a value driver in business, having “soft skills”, such as good communication and being effective in teams, will also become sought after.

A new era is starting, and the news is fairly positive – AI should create more jobs, reduce business costs and greatly enhance productivity. Don't be caught on the wrong side of this revolution!

Does “the company” still have a role to play?

The concept of “the company” has historically proven to be a unique way of achieving prosperity worldwide, but it is facing serious challenges. Competition is falling, poor decision-making is on the rise, innovation is being stifled, performance is weakening and (of particular importance to us in SA), strong governance and ethical values are under siege.

How does this affect you? Well, on the positive side, there is already a process of renewal and experimentation underway, a

process that will almost certainly unleash a new wave of global growth.

That's a wave you will want to catch!

Concepts that the West has taken for granted are now being openly questioned, such as whether liberalism is bad, and capitalism flawed, and whether the company delivers what it set out to do.

These are valid questions, and we should re-evaluate these concepts, particularly the role of the company.

What the company does: Over the past few centuries, Western ideas have globally been the most successful, and have resulted in Western dominance. One of the key facets of this success has been the company.

This has proven a unique way of achieving great prosperity, as:

- Limited liability has seen companies prepared to take risks, which has been the key driver in innovation (without innovation, economies will stagnate).
- Companies are organisationally efficient, and have fostered good leaders, built up working skills and implemented good practices.
- Through the market, companies are the most efficient allocators of resources, and can raise large amounts of capital to achieve their objectives.
- Companies have thrived in the competitive environment of a market economy.

Examples abound, such as Bill Gates setting up Microsoft to be highly effective in using existing technology to improve company operations.

So what's the problem? The first is a falloff in competition, which leads to poor decision-making and can stifle innovation. Facebook, for example, in a little over 15 years has become monolithic, and has now been shown to sell people's private information.

Secondly, companies have become focused on making money, to the detriment of what they actually do – e.g. delivering a banking service. In the long term, this leads to lower performance.

Thirdly, companies need to be constantly vigilant in maintaining strong governance and ethical values. The current malaise in SA has seen many once-respected large businesses ruined, by assisting with state capture or allowing corrupt executives to enrich themselves at great cost to the company.

In a nutshell, we need to fix the company and make markets competitive again.

Time for renewal and experimentation: Today's issues have happened in the past.

At the turn of the 20th century, many of the large conglomerates were broken into smaller, more manageable pieces to bring competition back into these industries. This was highly successful.

In SA, the Competition Commission has been effective in curbing anti-competitive behaviour.

The King Report on Corporate Governance has led to improved governance practices, and has laid down a strong template for companies to follow.

Many new businesses have experimented with new approaches in organisational structure – at Spotify, for example, managers serve and report to their teams.

Companies have led the way in business for a long time, and already we are seeing new shoots appearing as part of their renewal. This, along with experimentation, will almost certainly unleash a new wave of growth.

Catch that wave of growth! Look at your business and see how it can be made more effective.

Sexual harassment in the workplace

Modisane Lelaka, *industrial relations advisor, SAMA Industrial Relations Department*

The purpose of this article is to educate members around sexual harassment, and to give guidance should a member find him- or herself in such a situation.

What is sexual harassment?

Sexual harassment is any unwanted conduct of a sexual nature. In the case of *J v M Ltd* (1989) 10 ILJ 755 (IC), de Kock defined sexual harassment as follows:

Anyone in the workplace may be either a perpetrator or victim

"In its narrowest form, sexual harassment occurs when a woman (or a man) is expected to engage in sexual activity in order to obtain or keep employment, or obtain promotion or other favourable working conditions. In its wider view it is, however, any unwanted sexual behaviour or comment that has a negative effect on the recipient. Conduct which can constitute sexual harassment ranges from innuendo, inappropriate gestures, suggestions or hints, or fondling without consent or by force, to its worst form, namely, rape. It is, in my opinion, also not necessary that the conduct be repeated."

Sexual harassment often consists of behaviour that is repeated and persistent, but it can also occur in a single incident. It may include unwelcome physical, verbal or non-verbal conduct. In physical terms, harassment

may include physical contact, touching, sexual assault and rape, and strip-searching by or in front of the opposite sex. Verbal sexual harassment includes unwelcome innuendoes, suggestions and hints; sexual advances; comments with sexual overtones, sex-related jokes or insults; graphic comments about someone's body; and inappropriate enquiries about a person's sex life. Non-verbal forms include unwelcome gestures, indecent exposure and the unwelcome showing of sexually explicit pictures and objects.

Anyone in the workplace may be either a perpetrator or victim. The harasser might be the victim's supervisor, a supervisor in a different area, a co-worker, or someone who is not an employee of the organisation, such as a client or customer. *Quid pro quo* harassment is when someone in the organisation – an owner, employer, supervisor, member of management or co-employee – asks for or pressures an employee or a job applicant for sexual favours in return for giving or helping him or her to get a job, a promotion, a salary increase or any other benefit.

The Code of Good Practice

The Code of Good Practice on the Management of Sexual Harassment Cases, as contained in schedule 8 of the Labour Relations Act (LRA) No. 66 of 1995, stipulates that sexual harassment does not have to be repetitive. The code further provides that either repetitive/persistent sexual harassment or a single incident of serious misconduct can lead to a dismissal. The Code states that an employee may be dismissed for serious misconduct or for repeated offences.

Case study

An employee of the Department of Health (DoH) had a sexual relationship with a colleague from another hospital, also employed by the DoH. The sex acts had been consensual, but once when they met in the employer's offices outside of working hours, the perpetrator sedated the victim under the pretence that he was helping her with a medical condition. The victim complained to the employer about the incident. The man was charged with engaging in a sexual act with the female colleague on work premises; for sexual harassment; and lastly, for using the employer's property to commit the act. The victim had not complained or refused any sexual advances before, but because she was disorientated at the time of this incident, she was not in a position to consent or refuse, which meant that the act was ruled to be sexual harassment.

In disciplining the perpetrator, the employer can either utilise an informal process for minor sexual harassment offences, or formal process for severe and repeated offences. Severe cases include sexual assault, rape and strip searches.

It is important to always recognise the different forms of sexual harassment. Members are advised to obtain copies of their employer's sexual harassment policies from their respective human resources offices. Victims can lodge grievances with their respective employee relations officers.

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Who else is in the room?

The Medical Protection Society shares a case report from their files

Mrs D, a 56-year-old civil servant, was admitted for a colonoscopy. She had presented with a two-month history of intermittent dull left hypochondrial pain, flatulence, bloating and loose stools. On two occasions she had had painless bright red rectal bleeding. Blood tests were essentially normal, apart from a mild increase in her inflammatory markers.

The gastroenterologist, Dr K, suspected diverticulitis, and planned to carry out the procedure himself, along with a biopsy, if required. Dr K discussed the colonoscopy and its possible complications with Mrs D, and obtained her consent. As part of the usual preparation for the procedure, Mrs D was given conscious sedation with fentanyl and midazolam.

She had understood that a doctor and a nurse would be present throughout the colonoscopy, but when she overheard men's voices discussing non-clinical matters, such as repairing computers and a printer, this was unacceptable to her while she was physically exposed.

Dr K confirmed that he had personally gained consent from Mrs D, and advised her of the usual risks and complications. He also confirmed that while the patient was being prepared for the colonoscopy, it was normal practice for him or her to be covered by a blanket or sheet, so that there would be no unnecessary exposure of intimate body areas. This, he said, had been explained to Mrs D before she had been sedated.

It was possible, Dr K said, that Mrs D had overheard Dr K talking to another staff member, Mr D, an IT technician, in the corridor before the procedure, but at no time had there been another male present in the room, either before or during the colonoscopy. Dr K would, he said, have sought Mrs D's consent before including any other male staff members in the room. But as it was, Dr K and the female nurse were the only personnel in the room with her.

The patient complained to the HPCSA, and Dr K sought the assistance of MPS. We assisted him in preparing a full explanation in response to the HPCSA complaint, and the complaint was therefore dismissed by the preliminary committee of inquiry.

Do not make any assumptions about patients' expectations of procedures

Dr K carried out the colonoscopy in accordance with standard practice, and found multiple diverticulae and a small polyp in Mrs D's descending colon, which he removed for histopathology.

One week later, Mrs D submitted a formal complaint to the hospital. She complained about Dr K's disregard for her modesty, the extreme distress she had experienced while undergoing the procedure and the inappropriate hospital environment in which the colonoscopy took place. She said that she had overheard the voices of unknown males who she presumed were IT staff close by in the endoscopy room. These male voices, she said, were laughing inappropriately and commenting on details inside the room.

During the procedure, Mrs D was obviously in a state of undress, and she complained that this had caused her extreme upset both at the time and when she reflected on it later.



Learning points

Don't forget that patients can sometimes overhear medical staff having conversations while invasive procedures are taking place. It is possible that, under pressurised conditions, when patients are feeling vulnerable, these might be misunderstood by the patient. Many sedatives can also cause anterograde amnesia, so memories can be unreliable.

It is important to inform patients if other staff members, such as medical students, will be present at the time of these procedures.

Do not make any assumptions about patients' expectations of procedures. It may be necessary to be explicit about seemingly obvious matters, such as the degree to which the patient might be exposed during a procedure.

Transkei branch welcomes interns

Over 90 interns joined SAMA Transkei branch recently at a welcoming party held at the Nelson Mandela Academic Hospital. Each intern received SAMA scrubs and a bag as a welcoming gift.

The branch plans to expand the initiative to include medical officers and consultants, in an effort to promote SAMA visibility, and to recruit more members.



SAMA board member and acting director, clinical governance, Nelson Mandela Academic Hospital, Dr Nodikida, presenting SAMA scrubs and a bag to Dr Qumba, a medical intern



Branch chairperson Dr Mbambisa with intern Dr Golifili



Dr Siyotula, branch council member (left) and branch chairperson, Dr Mbambisa excitedly hand over SAMA branded bags and scrubs to new interns

Intern orientations at Paarl and Worcester Hospitals

Cape Town branch visited Worcester Hospital on 21 January this year, and Paarl Hospital on 23 January, for intern orientations presented by branch secretary Emily Nel. Both were well attended.



Emily Nel chats to interns at Worcester Hospital



Dr Ilse Moolman happily shows off her SAMA scrubs



Paarl Hospital intern Dr Amy Maralack with the scrubs she received from SAMA

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SAMAREC:

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CPD:

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

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