

SAMA INSIDER

JULY 2019

Unpacking ethical issues
in SA medicine

**Junior doctors don't cry: The plight of
interns and community service doctors**



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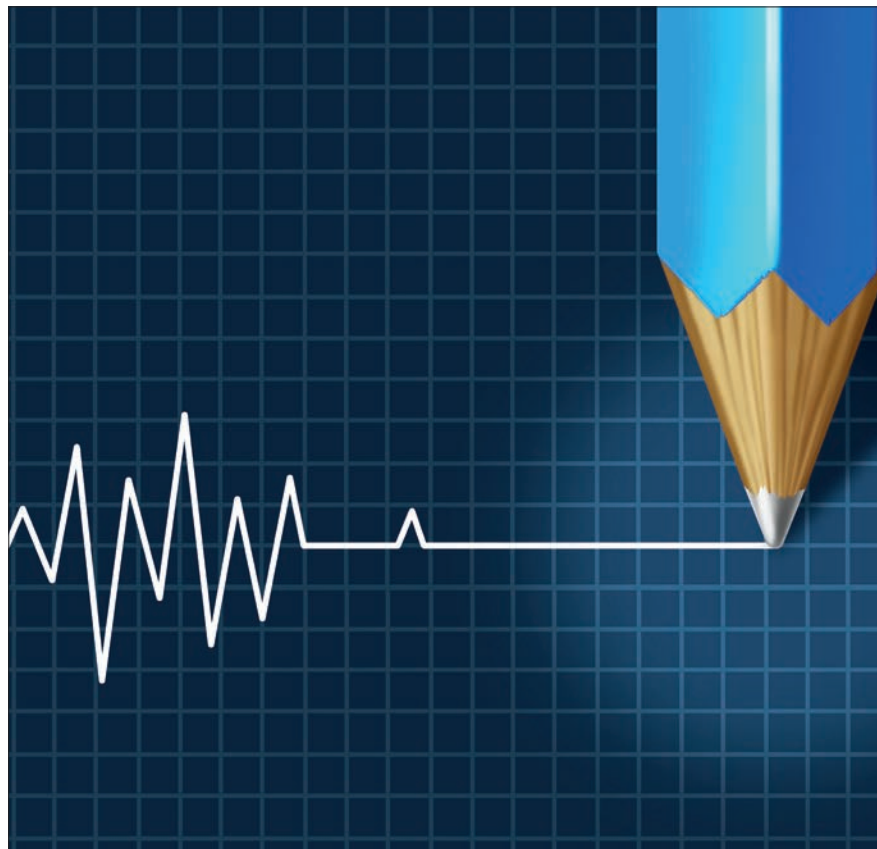
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Health Professions Council of South Africa

1st NATIONAL CONFERENCE

REGULATING HEALTH PROFESSIONALS IN THE 21ST CENTURY

2019

18 – 20 AUGUST 2019
@ EMPERORS PALACE
KEMPTON PARK, GAUTENG



The Health Professions Council of South Africa (HPCSA) will hold its first ever National Conference from 18 – 20 August 2019 at the Emperor's Palace, Kempton Park, Gauteng.

The Conference will provide an opportunity for delegates across all health sectors to engage on regulatory matters in the healthcare environment, including the shifting global and local healthcare trends.

The theme for the event is: **“Regulating the Health Professionals in the 21st Century”**, with a focus on the role of the Regulator in Universal Health Coverage as well as looking at the Regulators' contribution towards advocating for good health and well-being.

The conference will attract delegates from the various disciplines within the health fraternity. The Conference will also feature both local and renowned international speakers within the healthcare industry. There has been a number of emerging trends within the healthcare environment such as innovation, technological advancement, shortage of resources, financial viability and others.

It is envisaged that the Conference will provide practical solutions to these and other challenges faced by healthcare practitioners. The HPCSA National Conference will serve as a “meeting of minds”, at the same time providing a networking environment for healthcare practitioners. The Conference will also feature an exhibition and most importantly the inaugural HPCSA Health Merit Awards to acknowledge fellow colleagues who have contributed immensely in assisting the HPCSA to deliver on its mandate.

Other programme highlights include:

- Interactive sessions that focus on the emerging gaps in the current regulatory framework in relation to universal health coverage and the impact of the current ethical rules in the delivery of universal health coverage to ensure a sustainable healthcare system.
- Issue-based breakaway sessions that will allow delegates to explore different perspectives on the workforce environment, the required skills and capabilities, the role of education and training systems in preparing health practitioners for future, Ethical Engagement in the Digital Era, and Digital Innovation and the Wave of the 4th Industrial Revolution.

For registration and event details please visit the HPCSA website at

 www.hpcsaconference.co.za. **Practitioners can direct their specific queries to** @ conference@hpcsa.co.za

or call  064 640 2493  [ConferenceHpcsa](https://twitter.com/ConferenceHpcsa)  [ConferenceHpcsa](https://www.facebook.com/ConferenceHpcsa)



Diane de Kock
Editor: *SAMA INSIDER*

See you at the conference

The SAMA conference, taking place in Durban this year from 8 - 10 August, promises to be an informative event, an opportunity to connect with colleagues and learn from over 30 invited local and international specialists and experts. The theme "Leadership and quality in healthcare: Let's close the gap" speaks to the future of healthcare in SA. "This conference," says Angelique Coetzee, SAMA chairperson, "offers medical professionals a unique opportunity to engage with experts and specialists, [to] expand their clinical knowledge base and, ultimately, provide better quality healthcare to all our citizens." For more information, see page 5.

In this bumper issue, we look at the plight of interns and community service doctors and the very real challenges they face on a day-to-day basis, particularly in light of the recent attacks at Pelonomi Hospital. "We need to be supportive of one another, through peer support, mentorship and facilitating ease of access to mental health services for our junior colleagues," says the author, Prof. Zuki Zingela.

On page 7, Brandon Ferlito looks at some of the current ethical issues in medicine in SA. "A high standard of ethical decision-making is essential in the medical profession, as such decisions often have long-lasting effects on future medical practice."

Shelley McGee and Selaelo Mametja unpack SAMA's submission after the recent Competition Commission's health market inquiry seminars on pages 10 and 11. "SAMA maintains that focus on quality of care and clinician autonomy needs to be considered ahead of what have become unilateral attempts to curtail costs."

We all need to become educated on the health effects of climate change. Jolene Hattingh and Selaelo Mametja's article on pages 12 and 13 reports on a just transition workshop and round table discussion hosted by COSATU, and provides interesting insight. "The educational focus should be on being proactive instead of reactive about issues affecting climate change, health and the community," write the authors.

"Is informed consent really objective and scientifically measurable, or is it simply subjective?" is a real and challenging question posed by Adri van der Walt in her article on pages 14 and 15 on whether written consent is informed consent.

We publish a letter (and response) from a reader on page 4, and happily report on the numerous activities held at SAMA branches recently. Enjoy the read!

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WHO recognises burnout as an illness

The WHO has for the first time recognised burnout in its International Classification of Diseases (ICD), which is widely used as a benchmark for diagnosis and for health insurers.

The decision, reached during the recent World Health Assembly in Geneva, is expected to help put to rest decades of debate among experts over how to define burnout, and whether it should be considered a medical condition.

In the latest update of its catalogue of diseases and injuries around the world, the WHO defines burnout as “a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed”.

It said the syndrome was characterised by three dimensions: “(i) feelings of energy depletion or exhaustion; (ii) increased mental distance from one’s job, or feelings of negativism or cynicism related to one’s job; and (iii) reduced professional efficacy”.

According to the classification, “burnout refers specifically to phenomena in the occupational context, and should not be applied to describe experiences in other areas of life.”

The updated ICD list, dubbed ICD-11, was drafted last year following recommendations from health experts around the world, and approved at the World Health Assembly.

“This is the first time burnout has been included in the classification,” said WHO spokesperson Tarik Jasarevic.

The ICD-11, which is to take effect in January 2022, contains several other additions, including classification of “compulsive sexual behavior” as a mental disorder, although it stops short of classing the condition together with addictive behaviours.

It does, however, for the first time recognise video gaming as an addiction, listing it alongside gambling and drugs such as cocaine.

The updated list removes transgenderism from its list of mental disorders, meanwhile,

listing it instead under the chapter on conditions related to sexual health.

WMA welcomes decision on burnout

The WMA has welcomed the decision by the World Health Assembly to classify work-related burnout as a problem that influences health status, and to include it in the new version of the International Classification of Diseases. WMA President, Dr Leonid Eidelman, said: “For too long, burnout among physicians has been largely ignored. Emotionally exhausted physicians are a danger to patients and a danger to themselves. The cost in terms of human lives and money is appalling. I hope that the World Health Assembly’s decision will lead to a new approach that addresses multiple factors, including working conditions for physicians around the world.”

Swiss court temporarily suspends IAAF decision

The WMA has welcomed the decision of a Swiss court to temporarily suspend the International Association of Athletics Federations (IAAF)’s testosterone regulations.

Dr Leonid Eidelman, President of the WMA, said: “We are delighted that the Swiss court has listened to the objections to the IAAF rules, which would have forced Caster Semenya to take testosterone-reducing medication to compete in her athletic events.”

“It now means that the IAAF can give further consideration to this issue.”

“The WMA continues to have strong reservations about the ethical validity of these regulations, and our advice to physicians remains that they should take no part in implementing them.”

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.

Our thanks to Dr Greeff for her letter, and to Dr Graham Howarth for his response.



Re: Wrongly reassured over benign cyst

I am a bit concerned at the recommendation that all samples excised should be sent for histological examination.

I have never sent a sebaceous cyst for histology, although I must confess that I always open the cyst (when it comes out intact) to confirm the diagnosis.

Apocrine adenocarcinoma is stated to be a rare diagnosis (I have not come across such in over 60 years as a GP – rarity or misdiagnosis?).

Therefore, it is of paramount importance that the diagnostic features and differentiation be publicised.

Sincerely,

Dr F P B Greeff

Dear Dr Greeff,

Thank you for your letter in response to the MPS case study “Wrongly reassured over benign cyst” in the May issue of *SAMA Insider*.

You raised concerns about the recommendation that all samples excised should be sent for histological examination.

Local and national guidance states that all excised material should be sent off for histological analysis. I appreciate that the diagnosis in this case was rare, as pointed out by you. I don’t think a GP would be criticised for not considering this rare diagnosis, but regardless, if the local and national guidance had been followed, the diagnosis, however rare, would have been made.

Yours sincerely,

Dr Graham Howarth, head of medical services, MPS, Africa

SAMA conference 2019 – taking healthcare in SA forward

SAMA Communications Department

The SAMA 2019 conference will be held in August, with around 30 specialists and experts examining various aspects of leadership and quality in healthcare in SA.

The theme of the conference is “Leadership and quality in healthcare: Let’s close the gap”, and both local and international speakers will address this theme in different streams over 3 days from 8 to 10 August. The conference will be held at the Southern Sun Elangeni & Maharani Hotel in Durban, KwaZulu-Natal.

Prof. Mergan Naidoo, chairman of the SAMA Education, Science and Technology Committee, says that this year’s programme promises to be informative and educational for all participants.

“It will encompass oral presentations, posters and workshops led by experts in the field. We are also proud to announce that this year’s programme will include international speakers from the USA who are actively involved in making a difference in healthcare,” he notes.

The two international speakers from Washington, DC are Prof. A Latif and Prof. S Bhagwanjee. They will speak on the opening day under the track on leadership and management, and organisers say these presentations are not to be missed.

In his welcome to delegates, Prof. Naidoo also noted that this year’s theme resonates well with the future direction of healthcare.

“It speaks to the accreditation of sites by the Office of Health Standards Compliance and various initiatives of the national health insurance (NHI). It also resonates with the discussions emanating from the private sector in SA.”

Dr Angelique Coetzee, SAMA chairperson, says she is excited about the theme of the conference as it touches on one of the critical elements of providing quality healthcare in SA: leadership.

“Doctors are leaders in the community and are well placed to provide expert and professional insights into the provision of quality healthcare. This conference offers medical professionals a unique opportunity to engage with experts and specialists, and in so doing, expand their clinical knowledge base and, ultimately, provide better quality healthcare to all our citizens,” she says.

The opening session on Thursday will set the scene for the conference, under the banner of “Leadership in healthcare”. Dr Jonathan Broomberg, CEO of Discovery Limited, will explore this topic, outlining where current attitudes and approaches are failing.

Addressing issues of quality in private practice, Prof. M N Chetty, chairman of the IPA [Independent Practitioners Association] Foundation, asks “How does accreditation of GPs improve quality?”, while Dr S Kabane, CEO of the Council for Medical Schemes, will look at medical scheme measurement of doctors’ quality, and asks how “Funding decisions and alignment with clinical guidelines” support quality healthcare services.

Prof. Carol-Ann Benn, a surgeon at the Netcare Breast Care Centre of Excellence in Johannesburg, and one of the country’s top breast cancer experts, will open the Friday programme under the track focusing on women’s health. She will speak on “Breast cancer: Focusing on quality of care in prevention, detection and treatment – the Flamingo Project”.

Ms Lisa Vetten, PhD Fellow at the Wits City Institute of the University of the Witwatersrand, will conclude the morning session with a discussion on gender-based violence.

Dr Anban Pillay, deputy director-general at the National Department of Health, will provide an update on NHI, including providing some insights on its implementation in SA.

Other topics to be covered at the conference include quality in healthcare, mental health affecting doctors, mentorship of junior doctors, the legal implications and medicinal purposes of cannabis and a session on malpractice claims against practitioners, to be presented by Medical Protection Society.

The opening function of the conference will be held at uShaka Marine World on Thursday night. A significant announcement regarding a joint wellness programme between SAMA and Discovery Health will be made at this event.

One of the highlights of the conference will be the gala dinner and the merit awards announcements, which recognise excellence in healthcare in SA. This event will be held at the Durban International Convention Centre, and will have an exciting carnival theme with lots of surprises in store for all attendees.

“Durban is an exciting venue for this conference as it offers delegates the opportunity to also bring their families if they want to; there is so much to do and see in this great city that no-one will feel left out. Importantly, though, the theme of the conference is something we believe is appropriate and significant in SA now, and I encourage all healthcare professionals with an interest in taking healthcare in SA forward to register and attend,” concludes Dr Coetzee.



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2019**

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Let's close the gap



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Junior doctors don't cry: The plight of interns and community service doctors

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

Obtaining a medical degree does not bring your training to a close. On the contrary, it means the beginning of yet another learning curve. The HPCSA requires 2 years of internship, followed by a year of community service, before you can be issued with a licence to practise independently.

As much as a new graduate is a medical doctor, he or she still has to meet specific learning and training needs, as captured in the HPCSA intern logbook, in order to progress. The system you will be placed in is by no means perfect. Even though it is supposed to be a standardised vocational training process, where you are placed as an intern or community service doctor can have a profound effect on your career pathway, and may even influence a major decision about whether to stay in the medical profession or, instead, to carve a different path.

Challenges facing junior doctors

Placement woes and uncertainty: Interns and community service doctors have to apply for placement through a centralised National Department of Health (NDoH) system. Although there may be a degree of choice in terms of where one is placed, a fair number of interns or community service doctors end up placed in areas far from family and friends, simply depending on the luck of the draw. Those who are married or in committed relationships also need to factor in their partner's choice over and above considerations regarding other family and extended family.

A dreaded outcome for a newly qualified doctor remains that of not getting an internship or community service placement at all. This leaves the affected doctor in limbo, and obviously unable to register as an independent practitioner at the end of the usual 3 years. This situation, of a qualified doctor sitting at home, unemployed, sounded unbelievable until we witnessed this bizarre occurrence a little over a year ago. The strange phenomenon of an unemployed doctor was made even stranger by the fact that some areas still had significant doctor shortages. Since that time, the NDoH has vowed that this will never happen again. We live in hope.

Unwieldy hierarchical work environment:

The field of medicine is notoriously hierarchical, with set norms, both overt and covert, that force a junior doctor into an obscure corner. This is despite the system relying heavily on the intern as a workhorse. In some work environments, junior doctors' voices are not expected to be heard, unless specifically asked for their opinion. Even then, as a junior you may feel easily intimidated in the company of senior colleagues, registrars, specialists and HODs. The lowest rung of the ladder is usually made up of medical students, who are at least afforded some protection by virtue of still being students. The intern, however, is expected to deliver an infallible work record, carrying out all duties promptly, accurately and efficiently, even in the face of systemic failures or shortages in their work environment that might limit their performance – while never being allowed to forget that they are still completing their training. This can lead to presenteeism (where the junior doctor turns up for work even when unwell) absenteeism for the sake of self-preservation when the pressure overwhelms, or attrition.

Junior doctors don't cry: If lucky, an intern or a community service doctor may be placed in a well-resourced centre which provides adequate supervision and opportunities to learn new things. However, in less well-resourced settings, supervision may be haphazard at best, leading to junior doctors having to shoulder a lot more responsibility than they should. They are still expected to keep their heads down, and just do their 3 years without disrupting the systems they are placed in. Even if there are problems, they are expected to grin and bear it. Junior doctors don't cry.

The usual response from the old guard to calls for better treatment of junior doctors is to say, "We had it worse and we survived". Yes, we had worst-case scenarios such as non-stop, adrenaline-filled, 48-hour days of work, and yes, we may have survived. But that is no way to live if one wants quality of life, a healthy body and a healthy mind. We have had tragic cases of doctors being involved in fatal accidents as a result of a gruelling, sleep-deprived work schedule. The high

suicide rate among medical practitioners is a stark reminder of how important self-care is for survival of the profession. Caring for the carers must include a recognition that junior doctors may face challenges that are unique to their experience, in addition to the usual stressors that all doctors face.

Financial burdens: Studying medicine is expensive. It also takes longer than the average degree to qualify, resulting in medical students amassing a significant amount of debt by the time they qualify. The debt must be paid off with interest. Add to this the burden of being financially responsible for family and extended family members, the pressure to buy what will often be your first car, paying for disability and dreaded disease cover and medicolegal insurance, starting to save for your pension and so on, and you have financial responsibilities suddenly added to someone who until yesterday led the life of a student. If not financially savvy, junior doctors can end up being caught in a debt trap, where credit suddenly comes easy and they start to live beyond their means.

Safety and security: Health professionals are at increasing risk of being attacked while at work. This reality affects junior doctors just as much as seniors, if not more, especially considering the new experience of exposure to difficult, pressured work environments with, at times, intoxicated and violent patients. Add to this the violent crimes such as robbery, hijackings, rape and assault that affect the whole country, and one begins to get a picture of just how under threat a junior doctor may feel if their work environment is not adequately protected or secured. The attacks that took place at the doctors' quarters in Letaba Hospital in November 2018, and the recent attacks in Pelonomi Hospital, including the attempted rape of a doctor, are examples of the serious criminal acts that doctors have to face.

Mental health and wellbeing: The challenges already mentioned can take a heavy toll on junior doctors' mental health. Interventions often target increasing resilience in doctors and other health professionals, without necessarily focusing on the systemic failures that contribute to mental ill-health in the doctor's work environment. The weakness of this simplistic approach is that the health

systems that break doctors are therefore allowed to continue unchanged, despite the growing recognition that they are inherently flawed. To enumerate the systemic issues again, they include demanding working hours, short-staffing, demands for delivering high-quality healthcare with diminishing resources, inflexible governance structures, with diminishing autonomy and a sense of loss of control due to top-down decision-making at health institutions, and an increase in medicolegal claims.

The stigma associated with mental health issues is ever prevalent, with self-stigma entrenching and perpetuating the tendency for doctors not to seek help. Junior doctors may therefore feel stuck if mental health problems arise just as they are starting out in their careers. This may influence their willingness to ask for help and support, and problems with substance abuse may also arise and become a source of deteriorating mental wellbeing, and dysfunction.

Facilitating a supportive reception and welcome into the profession

To improve these conditions for junior doctors, the following are recommended:

- The HPCSA requires that all internship placement sites should have an intern co-ordinator. This person should be chosen carefully by the institution, to ensure that he or she is someone up to the task, who is approachable and available for interns.
- Supervision should be available around the clock as needed, to ensure that the

intern or community service doctor has the necessary guidance and support to develop into an independent, level-headed medical practitioner.

- The social side of life should be catered for, as this ensures that junior doctors have the rest periods, rest spaces and access to recreational facilities that can foster de-stressing. Access to library facilities is equally essential, because this is also the time that junior doctors may be busy exploring their career pathways, which may include preparing for further studies.
- Ease of access to health services, including mental health services, should be facilitated, with information made freely available on how to access care when needed. Junior doctors should be encouraged to at the very least have hospital cover plans, in case an emergency comes up that requires hospital care.
- Information on local peer support groups should be provided, with an introductory

session arranged so that new junior doctors can have an opportunity to meet senior colleagues.

- Mentorship programmes that match junior doctors to available and willing senior peers can also add to a positive experience that may help to support and inspire junior colleagues.

Internship training and community service years can be a rewarding, unforgettable experience that presents a young doctor with opportunities for skills growth, inspiration and the ability to meet their thirst for more knowledge. Supervisors and senior doctors have an obligation to be supportive, while stimulating junior colleagues to start forging a pathway for themselves to a fulfilling career. For the sake of doctors' mental health and the future of the profession, as the medical fraternity we need to be supportive of one another, through peer support, mentorship and facilitating ease of access to mental health services for our junior colleagues.

SAMA and JUDASA say they are horrified at the attempted rape of a female junior doctor at the Pelonomi Tertiary Hospital in Bloemfontein.

"This is a highly concerning event. It is discouraging that the safety and security of healthcare practitioners in public institutions is an issue that has still not been prioritised by the Department of Health, especially at this hospital where a similar incident has occurred before," says Dr Angelique Coetzee, SAMA chairperson.

Dr Coetzee says that SAMA is greatly concerned and dismayed at the shocking frequency of assaults on healthcare practitioners at public institutions. She says these assaults threaten the lives and wellbeing of colleagues as well as patients. "The safety of all healthcare practitioners in our public institutions is of paramount importance and, as such, SAMA calls on the Minister of Health, together with the Minister of Police, to urgently assess safety and security at these institutions," Dr Coetzee notes.

Unpacking current ethical issues in SA medicine

Brandon Ferlito, *bioethics researcher*, Dr Selaelo Mametja, *HOD, SAMA Knowledge Management, Research and Ethics Department*



Medical ethics is about judgement, and involves examining a specific issue, which is usually clinical in nature, using an array of moral theories, facts and logic to evaluate the merits and difficulties of that issue. This is done to determine the best outcome or solution to a problem. However, medical ethical issues are far from black and white, or right and wrong. Ethical problems usually involve complex issues that require critical analysis and often, introspection.

Every day, medical practitioners face difficult ethical and legal dilemmas. These

dilemmas often concern medical treatments, practices, hospital management and other matters arising in the medical industry.

A high standard of ethical decision-making is essential in the medical profession, as such decisions often have long-lasting effects on future medical practice. Additionally, given SA's past and current complex demographics, it is hardly surprising that there are numerous difficult dilemmas that medical practitioners encounter. We present some of the current ethical issues in medicine in SA.

End-of-life issues

Euthanasia and physician-assisted suicide (PAS) have for decades formed a contentious topic. However, the general population is ageing, and our ability to keep terminally ill people alive is ever-expanding. The subject of euthanasia and PAS has gained global importance, and rightfully so – there have already been a number of life-ending practices that have been legalised or decriminalised in a few developed countries (Belgium, the Netherlands, Switzerland and certain states of the USA), where their effects have been well documented.

Conversely, in countries such as SA, where euthanasia and PAS are illegal and often seen as immoral, there is an urgent need to discuss their feasibility, as well as their associated benefits and consequences. There is an equally urgent need to reach consensus, as requests for such practices in SA are becoming more frequent, particularly among the terminally ill.

Jacobs, in the *SA Journal of Bioethics and Law*, states that “the relative ease with which patients who desperately seek to end their life through either [of these methods], and are able to access them – by applying for them in countries where the pertinent laws and regulations are adjudged to be more liberal – is alarming.” This emphasises the importance of and need for clear laws, regulations and ethical guidelines for each country in relation to life-ending practices, particularly in countries such as SA.

SAMA will be conducting a study to assess the attitudes and perceptions of doctors around euthanasia and PAS, including legalisation and their willingness to participate, and will provide feedback to members.

Medicine, digital innovation and artificial intelligence

The convergence between biological innovation and computer science has the potential to drastically improve human health through precision medicine, the availability of data for improved quality of healthcare and innovative research, and an improved ability to diagnose diseases and to promote self-care. The increase of advanced technology in medicine increases the importance of ethical issues that may arise from its use. Ethical issues such as confidentiality, respect for autonomy, professional conduct and quality of care are just some that must be considered. Although digital innovations such as telemedicine, electronic health records and wearable devices have many advantages, physicians need to remember that their fundamental

ethical obligations do not change. Moreover, according to Mahomed, “artificial intelligence systems can potentially become discriminatory and lead to stigmatisation, if the systems are not properly tailored to reflect the specific characteristics of a population group. Over-reliance on the use of technology, without fully understanding the effects and consequences of the systems, could also prove to be problematic”. As we move forward to embrace the fourth industrial revolution as a country, it is imperative that we embrace and exploit the utility of technology, and examine and resolve any ethical issues that may arise.

Medical ethics v. public health ethics

Medical ethics is generally individualist in nature, and applies to interactions between a medical practitioner and a patient, whereas public health ethics is typically collective and community-based, and applies to interactions between an agency or institution and a community or population. The four main principles in medical ethics are autonomy, non-maleficence, beneficence and justice. Contrastingly, public health ethics entails principles such as interdependence, community trust, fundamentality and justice.

The conundrum that arises between medical ethics and public health ethics is that medical ethics primarily deals with issues arising from practice in medicine, and is individualistic in nature, while public health ethics deals with public health, which is collective and population-based. Often, the two cannot coexist. Nevertheless, the importance of both medical and public health ethics must be recognised, and coexistence ought to be desired.

In light of the recent Life Esidimeni crisis, it is important to consider public health ethics. Within a resource-constrained setting, policy makers, funders and governments have to face the reality of limited budgets and the need for efficient resource allocation. Public health ethics requires that the allocation of such resources should not cause harm. Without any regulator of public health ethics, our policy makers, medical aid funders and heads of hospitals have the potential to cause great harm, affecting a multitude of patients, if resource allocation is not organised in a manner in which harm is minimised.

There is always a tension between human rights and the allocation of resources. Resources are usually allocated in a manner that benefits the majority. This approach sidelines a significant portion of patients who

suffer from rare and expensive diseases. Usually, their life-saving treatments are unaffordable, and many patients find themselves without adequate healthcare.

HMI findings and recommendations

The Competition Commission of SA established the health market inquiry (HMI) in 2014, which was tasked with probing the dynamics in the private healthcare market to determine whether there are barriers to competition, and to examine the factors driving private healthcare costs. After 4 years of rigorous and comprehensive investigation and numerous stakeholder consultations, the commission released their HMI provisional report on 5 July 2018, and concluded that the private health market is characterised by high and rising costs of healthcare and medical scheme cover, disempowered and uninformed consumers, and ineffective regulation and failures of accountability at many levels. The provisional report noted a number of interesting findings, and made recommendations on (among other issues) the revision of the HPCSA ethical rules, the ethical responsibilities of doctors and the employment of medical doctors in the private health sector.

The HMI recommended that the HPCSA review its ethical rules. The review of these rules may be beneficial to patients and to the healthcare industry in general. For example, the HMI recommended that rules 8 and 8A of the HPCSA ethical rules should be constructed in a manner that allows multidisciplinary practices and partnerships, as this is currently not the case, which limits the potential for holistic healthcare.

Additionally, the HMI has recommended that there be selective employment of doctors in SA. Major hospital groups and administrators have advanced arguments that the selective employment of doctors will save money. However, as seen with Medicare expenditure in the USA, hospital-employed doctors can actually cost medical schemes more. The concern here is that doctors will inevitably be exposed to dual-loyalty conflicts, having to choose between employers’ profit-driven motivations and their patients’ healthcare needs. This is particularly so if government relies on the private sector to employ interns and community service doctors, as many rural areas rely on this junior category of staff for healthcare.

The WMA’s International Code of Medical Ethics, based on the Declaration of Geneva (a modernised version of the Hippocratic Oath), establishes ethical principles and guidelines

for physicians. The code requires the physician, based on his or her duties in general (to patients and to colleagues), to:

- always exercise his or her independent professional judgement, and maintain the highest standards of professional conduct
- not allow his or her judgement to be influenced by personal profit or unfair discrimination
- deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practise unethically or incompetently, or who engage in fraud or deception

- strive to use healthcare resources in ways that best benefit patients and their community
- not receive any financial benefits or other incentives solely for referring patients or prescribing specific products.

Often, there are tensions in the private sector with regard to allocative efficiency, prioritisation and the funding of hospitalisation. Many patients do not have cover for cost-effective and necessary specialist ambulatory care, or for primary healthcare. This creates a dilemma for doctors, as most patients can only access treatment in the advanced stages of disease. The lack of appropriate out-of-hospital

funding therefore results in unnecessary admission, which could have been addressed by efficiently allocating funding to out-of-hospital preventative diagnosis and care. The code requires doctors to use resources in ways that best benefit patients.

On the other hand, the fee-for-service model of reimbursement recommended by the HMI inherently results in overservicing. Alternative reimbursement mechanisms have been recommended, but these are fraught with their own limitations, such as underservicing.

References available on request.

SARA elect new leadership at 2019 AGM

SAMA Communications Department

The SA Registrars Association (SARA) held its elective AGM on 11 and 12 May 2019.

This year's theme was "Leadership and quality in specialist training". Representatives from all the SA training universities attended.

The leadership was elected as follows:

- Chairperson: Dr C Sihlangu
- Vice-chairperson: Dr L Khambule
- Secretary-general: Dr S Selepe
- National co-ordinator: Dr V Mbona
- Treasurer and marketing officer: Dr S Harbor

The SARA university representatives are: Dr N Laher, Wits; Dr A Morodi, SMU; Dr J O'Kennedy, UFS; Dr N Ramsunder, UKZN; Dr I Ntamatamala, UCT; Dr G Maila, UL; and Dr M Liwani, WSU.

The following priorities were identified for the 2019 - 2020 SARA term of office:

MMed: The SARA AGM passed the following resolutions regarding the MMed:

- SARA will compare provincial contracts, and draft a universal contract that includes the MMed document.
- The HPCSA regulations of 2010 required one to have completed an MMed to register as a specialist. This has now been expanded such that the MMed must have been completed and passed, which will be implemented with immediate effect. The SARA newly elected national executive committee (NEC) will approach the SAMA Legal Department to review the new guidelines, and request a grace period of 12 months.

- SARA will approach the SAMA Publishing Department to expand opportunities for MMed publications.

HPCSA and CMSA: It was resolved to request representation on the relevant committee at the HPCSA, in order to explain the challenges that registrars are facing and participate in a multi-stakeholder workshop with the HPCSA, Colleges of Medicine of SA, SA Committee of Medical Deans of SA and National Department of Health.

Cohen method: The SARA AGM resolved to review methods of assessment, by

participation in the SAMA Education, Science and Technology Committee, which will look specifically into the Cohen method as a means of standard-setting.

Registrars' wellbeing: The SARA AGM resolved that the newly elected NEC will compile policies on the following, and distribute them on media platforms:

- implementation of wellness programmes
- occupational health and safety
- maternity
- harassment in the workplace.

SAMA congratulates the SARA leadership.



From left, first row: Dr A Morodi, Dr M Msingapantsi, Dr N Laher, Dr G Maila, Ms G Moseki, Dr T Sadiki. From left, second row: Dr H Mukhihi, Dr E Ati, Dr S Harbor, Dr R Mahlatji, Dr T Naidoo. From left, third row: Dr T Nkadimeng, Dr H Powane, Dr L Lekganyane, Dr K Mathonsi, Dr A Coetzee. From left, fourth row: Dr I Ntamatamala, Dr V Mbona, Dr S More, Dr M Liwani. Last row, from left: Dr C Makgatho, Dr C Sihlangu, Dr L Bango, Dr J O'Kennedy, Dr N Ramsunder, Dr L Khambule, Dr C Liesegang.

HMI seminars and industry responses

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

During April, the Competition Commission's health market inquiry (HMI) held three seminars to focus on issues identified in its 2018 provisional report, namely funder concentration, facility concentration and supply-induced demand (SID). Following the presentations at these seminars, stakeholders were asked to submit additional comments. All presentations and comments have now been published on the HMI webpage for consideration.

SAMA has made extensive submissions and presentation on the SID aspect in particular, as we feel the HMI has not succeeded in demonstrating that this phenomenon even exists, let alone that it is a cost driver. We discussed this in the April 2019 edition of *SAMA Insider*.

At the April seminars, there was a good deal of discussion around funder and facility concentration, and whether this indeed exists, and is contributing to increases in costs.

These three elements are considered major contributors to cost escalations for private healthcare.

The HMI provisional report had undertaken very detailed analysis of claims and hospital databases to try to prove the existence of suspected market failures.

The specifics of the methods used by the HMI to examine concentration in the funder and hospital environments, as well as the SID aspect, received some quite heavy criticism. In contrast, many of the recommendations made by the HMI for dealing with these issues received support from stakeholders least likely to be negatively affected by them.

Funder concentration

Funder concentration relates to the countervailing power of funders (medical schemes and administrators), largely based on the market shares of these entities.

In its provisional report, the HMI considered that the structure of the funders' markets is concentrated. In the open medical scheme market, Discovery Health Medical Scheme alone has a market share of approximately 55%. Similarly, in the restricted medical schemes market, the Government Employees Medical Scheme has a share of 47%, and the SA Police Service Medical Scheme is the next largest, with 13%.

In the administrator market, the patterns were similar. Depending on the definition applied, the three larger administrators (Discovery Health (Pty) Ltd, Medscheme Holdings (Pty) Ltd (Medscheme) and Metropolitan Health Corporate (Pty) Ltd (Metropolitan Health)) constitute around 80% of the market, with Discovery Health alone having a market share of 40%.

Many more findings emerged from the HMI's analysis that were worthy of exploring at the April seminars.

The HMI concluded that funders, in their role of procuring services, are not performing optimally. The panel considered that the current negotiations between funders and service providers are largely limited to prices and terms and conditions of designated service provider (DSP) inclusion (which also largely focus on price). There is little focus on the overall value of services purchased.

Risk transfer arrangements, such as alternative reimbursement models (ARMs), are still in their infancy in SA, despite the number of contracts claiming notional ARM arrangements. These ARM contracts typically have large carve-outs that prevent effective risk transfer.

The HMI also found that trustees and principal officers of medical schemes do not have sufficient incentives to act as agents for members of their schemes. Members are additionally unable to hold contracting parties (administrators and managed care organisations (MCOs)) to account. The Council for Medical Schemes (CMS), the funder industries' regulator, while reportedly understaffed, has been unable to make up for this flaw in the governance structure.

The HMI also felt that the somewhat artificial delineation in SA of medical schemes as non-profit organisations and medical scheme administrators/MCOs as for-profit partners is problematic.

The HMI expressed concern that the financial interests of shareholders and of the financial groups that medical scheme administrators are accountable to appear to trump the interests of beneficiaries under administration.

At the Funder Concentration Seminar on 10 April, medical schemes, administrators and hospital groups all contributed to the

discussions. Unfortunately, SAMA believes, the discussions were quickly turned from the primary issue of funder concentration towards other issues, such as tariffs and supply-side interventions to impact practitioners and hospital groups.

Medical schemes and administrators argued that the schemes market is not concentrated, and that in the open medical schemes market, membership churn still takes place, and is indicative that there is competition between medical schemes.

Schemes and administrators maintain that large and strong medical schemes are a positive function of the market, as this enables them to negotiate good tariffs for their members and protect against tariff increases imposed by hospital groups and practitioners over time.

Discovery Health urged the HMI not to neglect quality of service when it comes to administration fees. They maintain that their managed care interventions save their schemes considerable amounts of money by avoiding unnecessary expenditure.

Several stakeholders urged the HMI to make recommendations on a review of the HPCSA's ethical rules, which they believe are responsible for delaying innovation in funding models and multidisciplinary practice models to enhance the quality and continuity of healthcare delivery.

There was general acknowledgement that monitoring of quality healthcare and outcomes was insufficient, and that innovative payment arrangements could assist in improving this.

Schemes largely supported the introduction of a single base benefit package, with option to supplement, although there was no support for a proposal by the CMS to limit the number of option packages that each scheme might make available to its members. The funder environment is also in support of the introduction of low-cost benefit options, as has been proposed by the CMS in the past (2015), and recently again in a circular in March 2019. Essentially, the aim should be to increase medical scheme membership, rather than to curtail the market shares of existing medical scheme structures.

Schemes and administrators also countered the HMI findings regarding misaligned interests between medical

schemes and trustees. Discovery in particular disagreed with the HMI's view that governance failures are prevalent in the funder market. Discovery defended its trustees as having upheld their fiduciary duty, and being indeed accountable to members.

Schemes and administrators have also generally disagreed that there is a lack of transparency and accountability to members.

Schemes and administrators that submitted after the seminar argued for the strengthening of DSP arrangements and contracts with hospital groups, given the savings that can be realised through these mechanisms. According to funders, there is still limited (although growing) evidence that well-structured DSP arrangements may also improve the quality of care their members receive.

Facility concentration

Hospital groups presented in defence of the HMI's findings that the facilities market exhibits substantial levels of concentration at both national and local levels. The observed concentration in the hospital industry is partly a result of acquisitions of independent hospitals by the three large groups, Netcare, Mediclinic and Life Healthcare.

The HMI was of the opinion that the national concentration levels provide a significant strategic advantage to the three largest facility groups – both individually and as a collective – in the national bilateral negotiations with medical schemes. The findings included the fact that schemes/

administrators that operate nationally cannot avoid contracting any of the three big hospital groups. These hospital groups, to a significant degree, are a must-have.

While the HMI's analysis was subject to a lot of criticism by hospital groups and their consultants, there is little doubt that the three large groups do support a significant proportion of private hospital beds and privately hospitalised patients in SA.

At the seminars, hospital groups argued that hospitalisation services were not overly concentrated, and that the increasing consolidation in the funder market was providing funders with stronger power to put pressure on hospital groups for better tariffs, ARMs and hospital network terms and conditions.

Funders argued that actual hospital admission rates have continuously outstripped expected rates in the long term, and that new hospitals in particular pushed up admission rates in an area dramatically.

The HMI's proposals for improvements to the licensing framework for hospitals, and the introduction of the certificate of need, to ensure better country-wide distribution of facilities, were supported by funders, but not by hospital groups.

Ultimately, hospital groups felt that there are sufficient competitive alternatives in the hospital market for funders to engage with, and that there are no insurmountable barriers to entry in the facilities sector. There was good evidence of network engagement by funders in the hospital market, and choice between hospital groups in most instances.

Implications for health professionals

Despite the intended focus of the seminars being on facility and funder concentration, and possible remedies for this, SAMA's experience of the discussions and the submissions thereafter has been that many of the proposed and supported regulatory interventions are likely to impact health practitioners directly.

The hospital and funder groupings managed to shift conversations towards the proposed interventions on the supply side, namely revision of the HPCSA ethical rules, in order to make hospital and even funder employment of practitioners acceptable, and interventions to address the SID that is supposedly incentivised by the fee-for-service environment in the private sector.

In our submission, following the seminars, SAMA openly cautioned the HMI about the difficulties of dual loyalty that will be generated by employment arrangements of doctors with for-profit hospital groups and funders, as well as the pitfalls of encouraging ARMs through contracts where the powers of the funders and hospital groups so staggeringly outbalance the fragmented practitioner arena.

SAMA maintains that focus on quality of care and clinician autonomy needs to be considered ahead of what have become unilateral attempts to curtail costs.

All the seminar details, presentations and subsequent submissions can be accessed on the HMI's webpage at <http://www.compcom.co.za/healthcare-inquiry/>.

Limitations on the right to strike in public and essential services

Bertha Shabangu, *legal advisor: labour relations, SAMA Trade Union Department*

A strike or industrial action is defined by the Labour Relations Act No. 66 of 1995 (LRA) in section 213 as "the partial or complete concerted refusal to work, or the retardation or obstruction of work, by persons who are or have been employed by the same employer or by different employers, for the purpose of remedying a grievance or resolving a dispute in respect of any matter

of mutual interest between employer and employee, and every reference to 'work' in this definition includes overtime work, whether it is voluntary or compulsory."

It is the Constitutional right of every employee to strike, as provided for in terms of section 23(2)(c) of the Constitution of the Republic of SA. However, the LRA does place restrictions on the right to strike in respect

of those employees who are engaged in essential services. Examples of essential services designations are:

- blood transfusion services
- court services
- fire-fighting
- municipal health
- nursing
- medical and paramedical services

- public health services
- emergency health services and the provision of emergency health facilities to the community
- forensics.

A service or industry or any part thereof may be designated as an essential service by the Essential Services Committee established in terms of section 70 of the LRA.

To understand the restrictions set by the LRA with regard to the right to strike, it is necessary to understand what these limitations are. The International Labour Organization (ILO)'s definition of essential services helps to clarify in this regard. The ILO defines essential services as "services, by whomever rendered, and whether rendered to the government or to any other person, the interruption of which would endanger the life, health or personal

safety of the whole or part of the population". In layman's terms, there is no place for a strike if it would directly and seriously threaten human life, health or security or the environment, or hinder the prevention of elementary damage.

Trade unions have in the past argued that it is unconstitutional to designate a service as essential, since this denies the Constitutional rights of employees in that industry to strike. However, although it is the case that section 74(1) of the LRA states that employees working in a designated essential service may not strike, the provisions are not absolute, as the LRA also provides mechanisms to counter the apparent blanket restriction on striking.

Section 72 of the LRA makes provision for parties in designated essential services to enter into a collective agreement that can be used to regulate the minimum services to be provided by the workers in the event of a strike.

In light of the above, the statutory provisions do restrict employees delivering essential services in terms of strike action. These restrictions should not, however, be misconstrued as a contravention of the right to strike as provided for in the Constitution. In fact, the essential services limitation on the right to strike in the LRA has thus far not been subjected to Constitutional challenge. The reason for this is that it is patently justified, and properly kept within bounds in its scope.

The Constitution does permit rights in the Bill of Rights to be limited in terms of laws of general application, to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. The limitation is provided for in section 36(1) of the Constitution.

A just transition to tackling climate change

Jolene Hattingh, Dr Selaelo Mametja, *SAMA Knowledge, Management, Research and Ethics Department*

A just transition, in terms of tackling climate change, which affects both the community and environmental health, means making a positive transition part of our response – a metamorphosis, as such. The term, once foreign to us, has now become of great importance, especially in SA, where the need to tackle both climate change and unemployment is great. The UN Framework Convention on Climate Change (UNFCCC) states that a just transition includes the creation of "decent work and quality jobs", without which the transition process will not be just. SAMA, as part of the association's response towards climate change, attended a just transition workshop and round table discussion, which took place on 16 and 17 May 2019. The workshop was hosted by COSATU, and focused on the following principles:

- Capitalist accumulation has been the underlying cause of excessive greenhouse gas emissions, and therefore of global warming and climate change.
- A new low-carbon development path is needed that addresses the need for decent jobs and the elimination of unemployment.
- Food insecurity must be urgently addressed.
- All South Africans have the right to clean, safe and affordable energy.
- All South Africans have the right to clean water.
- We need a massive ramping up of public transport in SA.
- The impacts of climate change on health must be understood and dealt with in the context of the demand for universal access to healthcare.
- A just transition to a low-carbon and climate-resilient economy is required.
- We need a carbon budget for SA.
- African solidarity is imperative.
- An ambitious legally binding international agreement designed to limit temperature increases to a maximum of 1.5 degrees is essential as an outcome of the UNFCCC process. COSATU rejects market mechanisms to reduce carbon emissions.
- Developed countries must pay for their climate debt, and the Green Climate Fund must be accountable.
- We need investment in technology, and technology transfers to developing countries must not be fettered by intellectual property rights.
- The SA government's position in the UNFCCC processes must properly represent the interests of the people.

The example used to illustrate the need for the above principles was the outcome of the almost complete closure of the Optimum Mine in Hendrina, in an attempt to start the process of weaning SA off coal mining. This closure had various effects, including abandoning their homes and reallocation to new areas, and the loss of productivity for surrounding businesses. With no plans put into place to replace the jobs that were lost, the concern was that the staffing of the wind power stations replacing the coal mine consisted of only four operators and one overseer, the latter of whom is not even situated within the country.

Become educated as to the health effects of climate change

In 2015, the International Labour Organization (ILO), a union body that brings together unions, workers and their representatives, and employers to develop global labour standards, developed guidelines on the Just Transition based on human rights, social dialogue and eliminating and reducing poverty. These guidelines also include the

social and financial (e.g. healthcare, income/ pension support, free training and retraining of vocational education) protection of workers in the transitioning phase.

The impacts of climate change on health that were highlighted included drought, flooding, seasonal change and rising temperatures, all of which could give rise to multiple diseases. The educational focus should be on being proactive instead of reactive about issues affecting climate change, health and the community, and should be included from a primary education level. Projects need to be properly monitored and evaluated, and there needs to be continued engagement with the multiple stakeholders on ways to provide input on relevant legislation. Community engagement will give communities a sense of both inclusion and ownership: projects run at ground level have greater impact, since the community can witness the impacts that their actions have first-hand.

Lawyer, activist and director of the Just Transition Centre (JTC), Samantha Smith, gave a presentation on the just transition initiative. The JTC is an organisation that assists the affiliates of the international trade union confederation, representing over 200 million organised workers and 162 countries, to create a just transition plan. This plan needs to include organised labour, and focuses on three things: (i) information and education; (ii) formulating demands; and (iii) assisting with a social dialogue with a real outcome. The JTC works with the regional centres in the union movement to bring about engagement between trade unionists in different countries to discuss a just transition, and assist these unions in developing successful plans to make sure that the transition processes they go through will, in fact, be just. (with a focus on fossil fuel workers).

Tasneem Essop of the National Planning Commission (NPC), and also head of strategy and advocacy for the International World Wide Fund for Nature (WWF)'s Global Climate and Energy Initiative, presented on the National Development Plan (NDP)'s role in a just transition. The focus in the roundtable discussion was on how labour will be affected by the just transition, as per the NDP – specifically chapter 5, on ensuring environmental sustainability and equitable transition to a low-carbon economy by engaging with relevant stakeholders. These dialogues must include building a consensus on a vision for an equitable and sustainable country by the year 2050. The NPC hosted a concluding conference on 29 May 2019.



SAMA attended a just transition workshop and round table discussion hosted by COSATU

Transitioning to a sustainable and resilient economy and society will require both systemic and structural changes. These should see the use of SA's natural resources, including water and energy, resulting in appropriate economic and social development that addresses our country's triple challenges of inequality, poverty and unemployment. The NPC's work is now in its second phase, and intends to ensure the implementation of chapter 5 of the NDP regarding the transition to a low-carbon economy. The NPC has designed a process to facilitate a series of dialogues culminating in a social compact – an agreement on what the best pathway for a just transition to a sustainable society would be, as well as agreements on the modalities for implementation.

President Cyril Ramaphosa, in the State of the Nation Address 2018, highlighted the need for South Africans to work together "by getting social partners in our country to collaborate in building a social compact on which we will create drivers of economic recovery". He further stated: "Our country has entered a period of change. While change can produce uncertainty, even anxiety, it also offers great opportunities for renewal and revitalisation, and for progress."

The WMA Declaration of Delhi on Health and Climate Change recognises that climate change interacts with social determinants of health (SDHs) through exposure to the factors that people are born into and grow up, live and work in. Usually the countries least able to adapt to climate change are those that suffer the poorest health and the lowest life expectancy. The WMA makes the following recommendations for national medical associations and their physician members:

- Advocate for sustainable, environmentally responsible low-carbon practices across the health sector to reduce the

environmental impact of healthcare facilities and practices.

- Prepare for the infrastructure disruptions that accompany health emergencies, in particular by planning in advance for the delivery of services and increased patient care demands during these crisis situations.
- Encourage and support advocacy for environmental protection and greenhouse gas emissions reductions, including through emissions trading systems and/or carbon taxes.
- Become educated as to the health effects of climate change, and be prepared to treat and manage them in individual patients.
- Promote medical research into improved use of antibiotherapy to be able to respond, in the future, to new infectious diseases linked to climate change.
- Seek to build professional and public awareness of the importance of the environment and climate change to personal, community and societal health.
- Collaborate with the WHO and other stakeholders, as appropriate, to produce educational and advocacy materials on climate change for national medical associations, physicians and other health professionals, as well as the general public.
- Have climate change as a priority issue on the agenda, and actively participate in the creation of policies and initiatives that mitigate the effects of climate change on health.
- Work with healthcare institutions and individual physicians to adopt climate policies and act as role models by reducing their carbon emissions.
- Recognise environmental factors as key social determinants of health (SDH), and encourage governments to foster collaboration between the health and non-health sectors in addressing these determinants.

References available on request.

How sure are you that written consent is informed consent?

Adri van der Walt, Dr Selaelo Mametja, *SAMA Knowledge Management, Research and Ethics Department*



Obtaining informed consent requires that sufficient information has been provided to the patient to make an informed decision, and that the patient not only understands the information but also grasps the implications of acting on it.

Informed consent relates to sections 10 and 17 of the SA Constitution, which protect the rights to human dignity, autonomy and privacy. Patient autonomy is a fundamental ethical principle in healthcare. It is the right of the patient to make decisions on his or her own health issues, including how health information ought to be shared. Individuals therefore have the right to decide what information about themselves is disclosed, and to whom.

Informed consent requirements in the SA health system are codified in the National Health Act (NHA) No. 61 of 2003, under section 14 (disclosing medical information to a third party), sections 11 and 16 (research) and sections 6, 7 and 8 (diagnosis, treatment and care). The Protection of Personal Information (POPI) Act No. 13 of 2004 seeks to give effect to the Constitutional right to privacy by safeguarding personal information, and to regulate the manner in which personal information may be processed. The POPI Act makes provisions for personal processing of data provided that the subject has voluntarily given consent for such processing. According to section 2 of the POPI Act, the responsible party bears the burden of proof for the data subject's or competent person's consent.

On a daily basis, users of the healthcare system and the general public are confronted with issues of consent. For example, while digitalisation brings with it efficiency, its unintended consequence is less human interaction for informed consent. Patients may use the system without fully comprehending what they are consenting to, and may not be given a user-friendly opportunity to ask questions.

According to the HPCSA's general ethical rules (booklet 9), "the SA courts have held that legally, for proper informed consent, the patient must have knowledge of the nature or extent of the harm or risks, and have appreciated and understood the nature of the harm or risk and consented to the harm or assumed the risk, and the consent must have been comprehensive (i.e. extended to the entire transaction, inclusive of its consequences)."

Section 2 of the NHA requires that the healthcare provider concerned must, where possible, inform the user in a language that the user understands, and in a manner that takes into account the user's level of literacy.

As the HPCSA rules make clear, "obtaining informed consent cannot be an isolated event," and it involves a continuing dialogue between healthcare practitioners and their patients that keeps practitioners abreast of changes in the condition of patients, and patients of the treatment or investigation the practitioner proposes. Whenever possible, the healthcare practitioner should discuss treatment options at a time when the patient is best able to understand and retain the information.

Informed consent: Ethical principles

Properly informed consent requires "disclosure of all necessary information that a reasonable person would use in making an informed decision, in a format that is readily understandable to the individual, and without coercion influencing choice". For an individual to give valid informed consent, three components must be present: disclosure, capacity and voluntariness.

Disclosure refers to the need for the patient/participant to be provided with

the information necessary to make an autonomous decision, and for it to be ensured that he or she adequately understands this information. This latter requirement implies that a written consent form is written in lay language suited for the comprehension skills of the participant/patient, and that his or her level of understanding is assessed through conversation. The information should include the benefits and harms of participation or treatment.

Capacity pertains to the ability of the participant/patient to both understand the information provided and form a reasonable judgement based on the potential consequences of his or her decision.

Voluntariness refers to the participant/patient's right to freely exercise his or her decision-making without being subjected to external pressure such as coercion, manipulation or undue influence.

Is written consent informed consent?

Legally speaking, what is informed consent? Can we safely assume that once we have obtained written consent, it is in fact informed consent?

Often, without any verbal communication, it is presumed that patients have read and understood consent forms. Considering section 2 of the NHA, the high illiteracy rates among elderly South Africans and SA's diverse language groups, it is prudent that all health professionals, researchers, medical schemes, administrators and all parties involved consider seriously the limitation of written consent forms that are not in the user's language. Even among English speakers, users might be confused by technical English terminology. Without human interaction, it can be difficult to be sure that a patient has understood the information given to him or her and had an opportunity to obtain clarity, if needed.

Healthcare professionals obtaining informed consent also have a responsibility to ensure that all information provided is accurate, relevant and up to date.

There is also often an assumption that patients consent to a procedure voluntarily. Let us, for example, take a procedure in which

there are two possible interventions, such as appendectomy. Often, there is a choice between open and laparoscopic appendectomy, with the latter being considered safer, but not accessible due to the costs of laparoscopic equipment. As the principles of consent require disclosure of all information to the patient, it is imperative that the doctor provides all information related to evidence-based medicine, as well as the limitations to accessing such a treatment, such as cost-effectiveness, affordability and availability. This will, in future, protect doctors in cases where they have been unable to provide care due to limitations imposed by managed healthcare interventions, scheme rules and gaps in prescribed minimum benefits. Also, where the state has not adequately allocated necessary healthcare, it can be demonstrated that doctors had advised the patients correctly.

In the clinical setting, it is often easier for doctors to assess the patient's capacity to give consent, as face-to-face interaction enables one to pick up non-verbal communication. In the clinical research setting, in keeping with the requirement for disclosure, clients are instead provided with long written

documents (sometimes of 20-odd pages). This document will, at times, contain intimidating medical terminology that is foreign to the patient. This information could in fact be conveyed in layman's terms, but the document might then become so long as to be impractical. We are fortunate enough to have ethics committees to review these documents for patient-friendliness.

In the clinical setting too, our consent documents may contain medical jargon that may distract patients from their real underlying medical issues (who among us has not had to extensively explain the word "porphyria" to a patient, as this is a common high-risk condition found on many consent forms?).

For medical schemes and administrators, in terms of informed consent, the emphasis is often on complying with laws and regulations rather than ensuring that the patient understands the information and its implications.

Lack of voluntariness in providing informed consent occurs when a scheme requires that the patient uses one form to obtain authorisation for access to benefits, research and for accessing and sharing of medical

information. This is sometimes called umbrella consent. Within a practical setting, obtaining informed consent is a real challenge. We have large volumes of patients and limited time to provide extensive explanations of what is being done. We are continuously walking the line between overloading the patient with information, and not providing enough information, while at the same time keeping up with a growing culture of knowledge, and keeping in mind the cultural and language barriers that are unique to our country.

Conclusion

Considering all the factors affecting informed consent, it is clear that obtaining consent is not as clear-cut as we had thought it to be. Nonetheless, the onus remains on healthcare professionals to ensure that all reasonable measures are taken to ensure that consent taken is in fact informed consent. This does, however, open the door to questions on how we determine if we have indeed obtained informed consent. Is informed consent really objective and scientifically measurable, or is it simply subjective?

References available on request.

Obesity – changing the conversation

Dr Mantha Makume

Obesity and overweight have together now been officially designated a chronic disease, requiring a lifetime of management. It is no doubt a leading cause of death, as people with obesity perish from several comorbidities. The aetiology of obesity is far more complex than we had previously believed, and therefore exploring its causality and treatment options requires that we embark on a paradigm shift when it comes to dealing with overweight and obese individuals.

The stigma of "laziness" and "lack of self-discipline", and the "eat less-move more" lectures from healthcare professionals should finally be changed to questions of "Why are you overweight? What does it mean to be overweight? And how can we assist in alleviating the health complications of obesity?" It is time to change the conversation.

Statistics

There is an abundance of data and statistics on the prevalence of overweight and obese people, showing that over 600 billion people are estimated to be overweight or obese. Population studies report a 30% increase in adult obesity and a 33% increase in obesity among children since 1999. We are now faced with the reality that the current generation's life expectancy is calculated to be lower than that of their parents.

Equally ubiquitous are trends highlighting the popularity of weight-loss strategies, where various mechanisms are punted to the afflicted audience.

Now that we have firmly established the worrisome fact that we are getting fatter as a race, it is also a known fact that being overweight comes with a whole host of comorbidities – over 195 and counting. The healthcare system is also feeling the effects of

overweight and obesity: we are now allocating a significant portion of the healthcare budget toward the treatment of comorbidities associated with an increased body mass index (BMI). The USA alone calculated the economic impact of obesity in 2015 at USD2.0 trillion, with USD427.8 billion direct medical spend on obesity.

Causes

Overweight and obesity is precisely defined as "an abnormal accumulation of fat, leading to impaired health", or in a concise physiological definition: "an imbalance between energy intake and expenditure that impairs health".

The current standard of diagnosing overweight and obesity is the use of BMI measurements in conjunction with waist circumference (WC), where a BMI of $\geq 25 - 29.9 \text{ kg/m}^2$ places an individual in the overweight category, and a BMI of >30 classes one as obese. The obese category

itself is subdivided into classes: class I is 30 - 34.9 kg/m², class II 35.0 - 39.9 kg/m² and class III ≥40 kg/m².

WC measurement can be viewed as a “practical measure of visceral abdominal fat”. Visceral fat accumulation has been associated with several disease states, in studies that have linked BMI status to declining health and increased risk of comorbid complications. Apart from the economic impacts of obesity, the healthcare costs related to increasing BMI are equally staggering, and more than 80% of deaths from complications of obesity and overweight were reported in patients with a BMI of at least 30 kg/m².

Obesity and overweight declared a chronic disease

As research into the state of fat accumulation expands, it has become evident that there are many different types of overweight and obesity, such as hypertrophic obesity, an increase in the size of adipocytes, and hypercellular obesity, an increase in the number of fat cells. The former type has been linked to an increase in metabolic complications such as diabetes, cardiovascular disease and hypertension. It is now not uncommon to view adipocytes as part of the endocrine system, as research has shown that hypertrophic cells do in fact produce leptin (a hormone that triggers the hunger signals in the brain). On the other spectrum, hypercellular obesity is typically found among patients with a BMI of >40 kg/m², and this type also has its own complications.

Despite the statistics and our knowledge of how to prevent weight loss, the science of obesity has largely been relegated to physiology laboratories, evidenced by the fact that very few weight-loss medications

have been approved by the various agencies worldwide.

The exact mechanisms of weight gain, and the accompanying challenges in losing the weight, are a lot more complex than previously thought. Scientific evidence shows that the simple definition of “imbalance between energy intake and expenditure” is simplistic, as genetics, the neuroendocrine system and the environment play major roles in weight gain. The two components, energy intake and expenditure, are each carefully regulated by the brain and the environment, resulting in the behavioural outcomes that eventually lead to the imbalance.

The science of obesity

The brain is a key player in the maintenance of energy homeostasis, and studies have shown that numerous genes associated with obesity are expressed in the central nervous system (CNS). The entire body has indeed evolved over centuries to carefully and accurately maintain a regulatory system such that energy stores are used or conserved based on periods of high activity or fasting, possibly to account for famines and migrations. The endocrine system within the gastrointestinal tract (GI), in conjunction with the hypothalamus, plays a pivotal role in how much the body needs and how it dispenses with the ingested nutrients, as the body is intricately designed to conserve energy. This, in addition to behavioural cues, has far-reaching implications for the rates and extent of weight-loss, including weight cycling. Whereas our human ancestors would rely on the CNS and GI hormones to remain alive during lean times, the same body has unfortunately not evolved for the current obesogenic environment, where one does not even have to leave the couch in order to get food. One could even reach a tentative conclusion that humans have survived so well that more people on earth are dying from too much food rather than from undernourishment.

The human element

Outside the mechanisms of weight gain, there is the ever-present notion that those afflicted with obesity are either “lazy, overly indulgent, or over eat”. This is compounded by the fact that such patients often delay in accessing treatment, as the conversation surrounding their weight is often met with a lackadaisical approach from healthcare professionals (HCPs). A recent study, “Awareness, care and treatment in obesity management – an international observation” (ACTION-IO), revealed that an average of 3 - 6 years of weight maintenance struggles elapsed before patients felt that they could initiate a conversation with their HCPs, and that 81% of the patients assumed that their weight issues were their own responsibility, which invariably creates a barrier to treatment. However, various medical associations (such as the American Medical Association and the American Association of Clinical Endocrinologists) have, over recent years, classified overweight and obesity as a chronic disease, requiring a comprehensive and multidisciplinary approach to its management. The basis of such a classification is that obesity: (i) impairs normal functioning of some aspects of the body; (ii) has characteristic symptoms; and (iii) increases morbidity. It is now imperative to acknowledge that losing weight is a lot more complex than simply adjusting portion size and increasing physical activity.

The current standards advocate initial therapeutic lifestyle intervention, which includes cognitive-behavioural modifications. Should this initial step fail, pharmacotherapy has been recommended as a second-line treatment, and finally, as the last option, surgery. Ultimately, the role of the HCP is likely to become pivotal, as training and disease awareness intensify. It is indeed time for a different conversation surrounding obesity, with the patient at the centre of it.

2019 Government Gazette: COID

Zandile Dube, senior medical coding consultant, SAMA Private Practice Department

The scale of fees for medical aid, as published by the Department of Labour in respect of the Occupational Injuries and Diseases Act No. 130 of 1993 (also known as injury on duty), was published on 29 March 2019 in the *Government Gazette* no. 42354.

These compensation for occupational injuries and diseases (COID) fees are applicable from 1 April 2019.

Please go to the SAMA website (<https://www.samedical.org/private-health/coid>) to download the complete *Government Gazette*.

Please note that the amounts published in the gazette are VAT exclusive.

The medical tariffs increase for 2019 is 6.4%. The new unit values for the various groups and sections are shown in the Table below.

New unit values

Section	Symbol	Description	VAT inclusive, ZAR	VAT exclusive, ZAR
1a	V	Section 1: Consultative services: items 0173 - 0175, 0177 - 0179, 0190 - 0193, 0109, 0129, 0151 - 0153, 0130 - 0136, 0199 (please note item 0136 has a fixed amount)	29.29	25.47
1b	VC	Consultation services codes 0181 - 0186, 0151 (COVID only)	29.84	25.95
2	CL	Clinical procedures	29.29	25.47
3	A	Anaesthetics performed	136.87	119.02
4a	RA	Section 19: Radiology	30.64	26.64
4b	MR	Section 19.15: Magnetic resonance imaging	30.64	26.64
5a	RO	Section 20: Radiation oncology	32.22	28.02
5b	ROTC	Section 20: Radiation oncology: technical component	32.22	28.02
6	U	Section 19.11: Ultrasound	28.95	25.17
7	CT	Section 19.9: Computed tomography	29.44	25.60
8	CP	Section 21: Clinical pathology	30.49	26.51
9a	AC	Section 22.1: Anatomical pathology: cytology (items 4561 - 4566)	30.08	26.16
9a	AH	Section 22.2: Anatomical pathology: histology (items 4567 - 4595)	30.08	26.16
10		5 digit radiology (specialist radiologists)	199.79	173.73

Changes in the rules, codes, descriptions and units

These changes have been identified between the 2018/2019 and 2019/2020 COID gazettes, applicable from 1 April 2019:

- Item 0136: Please note that for this item there is now a fixed amount of ZAR3 724.00 applicable. The unit value is now ZAR127.14.
- Item 2918: This has been discontinued and the descriptions changed.
- Item 2058: This has been discontinued and the descriptions changed.

The office of the Compensation Fund has confirmed that for the rehabilitation codes item 2918 and item 2058, which have been discontinued in the latest *Government Gazette*, medical doctors may now use item 0109 for non-operative supervision of head/brain injuries, spinal injuries (including paraplegics) or burns, even if this exceeds 20 visits within a period of 4 calendar months, if the patient is in a hospital or step-down facility.

Contact SAMA Coding Division, Private Practice Department for more information: Tel. 012 481 2073 or email coding@samedical.org

Academy of Family Physicians supports a new national diploma in family medicine

Prof. Bob Mash, *Faculty of Medicine and Health Sciences, Stellenbosch University*

Strengthening primary care is a major priority for SA in terms of improving health outcomes and enabling access for all to quality primary care under national health insurance (NHI). Primary care doctors, whether GPs or medical officers, work as medical generalists and are essential to strategies aimed at achieving these goals. The Ideal Clinic project expects every primary care clinic to have access to a doctor, and for this to be a norm for practice accreditation under NHI.

The future role of primary care doctors as key members of primary care teams has been defined nationally as more than just that of a competent clinician. Primary care doctors should be change agents who help lead improvement in the quality of care, capability builders who help develop other team members, critical thinkers who help the team make sense of evidence and health information and advocates of community-

orientated primary care, who have a collaborative approach to working in a team.

The majority of primary care doctors in SA have no postgraduate training in family medicine or primary care, while in many countries this is the norm, or even a requirement of practice. At the same time, many primary care doctors are established in their practices, and unlikely to return for training as family physicians, which would require them to take up a registrar post in a training complex for 4 years. It is also clear, however, that primary care doctors in both the public and private sectors have learning needs that should be addressed.

In order to address this situation, the SA Academy of Family Physicians has supported the development of a 2-year Postgraduate Diploma in Family Medicine. The educational design and learning outcomes have been agreed on through a national consultative

process, and currently four universities are offering the diploma: Stellenbosch University and the Universities of Cape Town, Pretoria and KwaZulu-Natal. The College of Family Physicians has also created a national diploma-level examination. The Universities of the Free State and the Witwatersrand are in the process of approving the new diploma.

We hope that many medical officers and GPs will take advantage of this opportunity. In some provinces incentives have been created for medical officers who complete the diploma, and some have been supported by provincial training funds. There is also a discussion on how the remuneration of practices under NHI can recognise such postgraduate training.

For further information on the Postgraduate Diploma in Family Medicine, please contact the SA Academy of Family Physicians at info@saafp.org.

References available on request.

The teaching initiative: Facilitating improves student learning and success

Dr C J Henley-Smith, Dr Gustaaf Wolvaardt, FPD School of Education

"Academics are appointed primarily for their disciplinary expertise and research capacity, and it is not reasonable to assume that they will automatically be well-equipped to carry out this task [of having a scholarly and professional approach to teaching]."

In November 2018, the Minister of Higher Education and Training, Naledi Pandor, made the above statement in a foreword to the National Framework for Enhancing Academics as University Teachers. This framework was released in a collaboration between the Department of Higher Education and Training and the University Capacity Development Programme.

Its aim is to ensure that lecturers receive training on how to facilitate, which not every current lecturer has received. This applies to all facilitators, from emerging scholars and early career academics to established academics and even management. The hope is that this framework will help to improve student learning and success.

The framework hopes to enhance the seven roles of an educator, and cultivate the 21st century skills not just of students, but lecturers too. Evaluations, surveys and reflections through student, self and peer review will help to develop the role of a lecturer.

One way to drive the framework is to introduce CPD points to lecturing. This will enable a lecturer to take control of their own professional development and record their skills development, as well as stay in touch with developments in a changing workplace.

Health professions and other professions such as accounting, law and engineering have already implemented CPD points. The framework may even implement a version of the CPD for educators too, by incorporating seminars, workshops and symposia.

The idea is to incorporate professional development activities into a lecturer's workload

This CPD practice may also contribute to balancing out teaching and research, as more recognition and even resources are currently awarded to research than teaching at universities. Alternatively, universities could encourage more research projects on teaching and learning. Communities of practice both within and between universities may collaborate and benefit from researching education.

Another principle included in the framework is a recognition and reward system for performance and teaching quality. Being recognised and rewarded, for example, by a high-profile national teaching awards programme may encourage lecturers to improve on their personal and professional development. This may be further encour-

aged if promotion within universities were to take teaching quality into account.

It is essential that developmental structures, resources (such as national grants and open education resources) and support are in place to enable lecturers to engage in developing their facilitation skills through established teaching and learning centres. As time is an issue for everyone these days, the idea is to incorporate professional development activities into a lecturer's workload.

Academic leadership is vital to the framework, and encouraged through the Teaching Advancement at Universities Fellowship Programme. Lecturers who have been recognised for their teaching success will provide leadership within their own and other universities. HoDs will also need to provide administrative leadership to lecturers.

So, you may wonder what impact the National Framework for Enhancing Academics as University Teachers will have on you as a health professional. Imagine that you are called on to guest lecture or present a module. Would you feel confident in doing so? Have you had suitable educational training for this purpose? Fortunately, there are options available. For example, the FPD Postgraduate Diploma in Health Professions Education and Leadership is designed to develop world class education in the health sciences, with the required skills to lead health professions education in the 21st century.

References available on request.



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Amitabh Mitra, surgeon, artist, poet

Congratulations to Dr Amitabh Mitra, a member of our Border Coastal branch, who recently received the 2018 Provincial Eastern Cape Minister of Arts and Culture's Special Award in the category of Fine Arts for his continued dedication to the arts in SA. His work has been exhibited worldwide, on the covers of the *SA Medical Journal* and the *Journal of Psychiatry*.

Dr Mitra completed his postgraduate studies in orthopaedic surgery in India, before studying aerospace medicine and family medicine at the University of Pretoria. A practitioner of orthopaedic surgery and trauma surgery, he currently works at the accident and emergency unit of Cecilia Makiwane Hospital,

Mdantsane, SA. He has published five volumes of poetry, and exhibited his poetry and art internationally. Dr Mitra also represented SA at the World Literary Festival in Oslo in 2008.

His present art is about Mdantsane, and he has published a book, *Mdantsane Breathing*, on the art and poetry of Mdantsane. His art and poetry on the area was exhibited at the 2011 International Symposium for Poetry and Medicine, and at the Hippocrates Prize for Poetry and Medicine Awards. *Splinters of a Mirage Dawn, an Anthology of Migrant Poetry of South Africa* (co-edited with Naomi Nkealah) was short-listed for the National Humanities and Social Sciences Award, SA, 2016.



Dr Mitra (left) hands over a charcoal portrait of Dr Neil Aggett to a representative from Kingswood College, at the memorial lecture for Dr Aggett in Grahamstown this year

Goldfields branch donates to local hospice

Dr Flip Nieuwoudt, chairperson of Goldfields branch in Welkom, recently donated ZAR10 000 to Marli Young, general manager of the Goldfields Hospice Association.

The Goldfields branch may be one of the smaller branches, but they are very active and involved in all medical issues in SA, and continuously keep their members

updated. "We here in the Goldfields have a rich and long history," said Dr Nieuwoudt during the presentation. "This branch was founded due to the unique circumstances in the then rich and developing Goldfields area of old. They had to deal with a lot of matters in the mining sector, which was totally different from the Free State branch, situated in Bloemfontein.

"We hold CPD events, in co-operation with Mediclinic and St Helena Private Hospital, to keep doctors up to date with the latest developments in the medical world.

"Our geographical area and job opportunities allow for only so many doctors to be employed in the private and public sectors, but the Goldfields branch is going strong, with the majority of doctors as members."

Griqualand West hand over life membership awards

The Griqualand West branch recently hosted a CPD meeting on 14 May 2019 at the Protea Hotel, Big Hole, in Kimberley. The branch invited their life members in celebration of their long commitment to SAMA, and to making the branch the active entity it is today.

Dr M J Ngundu, chairperson of the Griqualand West branch, in his opening address, enlightened the attendees on the objectives of the event, pinpointing the most significant as countering the generational barrier that exists between the senior or retired medical practitioners and the current generation, in order to allow senior practitioners to impart their knowledge to the current medical practitioners.

Dr B D Janse van Rensburg and Dr H J Spangenberg were awarded SAMA Life



Dr M J Ngundu (right) handing over the SAMA Life Membership Award to Dr B D Janse van Rensburg and his wife, Margo

Membership Awards, in recognition of their long service to the association.

In closure, Dr M J Ngundu encouraged the life members to continue their support of the



Dr M J Ngundu (right) presents the SAMA Life Membership Award to Dr H J Spangenberg and his wife, Christine

association and the branch. The CPD event was a good social encounter for the attendees to meet their colleagues and to indulge in shared memories.

EP branch hold successful first trail run

The first annual SAMA Eastern Province (EP) Trail Run was held at Crossways Farm Village on Sunday 5 May.

SAMA has more than 600 members in the Eastern Cape, and represents the interests of both public and private medical doctors. Branch chairperson, Dr Farhaad Khan, said: "SAMA has noted the high burden of burnout and stress-related health issues among its members, and launched the annual SAMA EP Trail Run in an effort to promote a healthy and active lifestyle." It was also an opportunity for medical doctors to socialise in a non-work environment.

The trail run was extremely well attended by medical doctors and their companions, with many travelling from as far afield as Somerset East and Graaff Reinet. The 6 km race provided ample opportunity for the more relaxed members to work up a sweat, while the 12 km race was a true test for the more adventurous.

The beautiful landscape at Crossways was a perfect backdrop for family and friends to relax on picnic blankets after the race and enjoy the breakfast on offer. The top finishers in both races were well rewarded with generous prizes.

The event was generously sponsored by Investec Private Bank. The proceeds of the event, totalling ZAR10 000, was donated to the Association for Babies in Crisis in partnership with the Missionvale Care Centre. This local NGO has made an invaluable contribution to the care of abandoned and neglected children. The Missionvale Care Centre is currently expanding its services to provide "baby safes", which will provide a safe alternative for mothers unable to care for their babies. The Baby Safes project will provide a location for unwanted babies to be taken to, and aims to eliminate babies being dumped.

SAMA extends its gratitude to its members for their support and to the main sponsor,



Dr Janita Saayman (left) and Thea Vermaak from Andries Vosloo Hospital

Investec, together with all our other sponsors, for making the first annual SAMA EP Trail Run a huge success that can only go from strength to strength.

Busy young doctors take time out

Young doctors from Karl Bremer and Tygerberg Hospitals recently took time out from their tremendous workload to attend the Tygerberg branch annual social function at Nitida Wine Farm. All expressed their appreciation for the invitation, and enjoyed hearing the different views on national health insurance.



Young doctors from Karl Bremer Hospital



A group of 10 young doctors from Tygerberg Hospital enjoyed the evening



Dr Jay Punwasi (chairperson) and Shelley McGee

West Rand branch AGM a success

West Rand branch recently held a successful AGM on 24 April at their offices, in the form of a cocktail function and CPD presentation.

Shelly McGee did an ethical presentation on "Recent developments in NHI and Presidential Health summit".

The branch would like to thank all members who attended the event.

Gauteng North hold ethics CPD

An ethics CPD was held at SAMA head office by the Gauteng North Branch on 15 May. The evening meeting was opened by Dr Andre Marais, assisted by Dr Julius Kunzmann. It was a well-attended and highly successful CPD.

Topics covered were:

Cell and gene therapy: New medicines on the horizon – Prof. M S Pepper

Telemedicine – Dr Selaelo Mametja

Cannabis – Shelley McGee.

A big thank you to Dr Marais, who holds the CPD events portfolio on the Gauteng North branch council, for a well-organised event.

Griqualand West host informative CPD meeting

The Griqualand West branch hosted a CPD meeting on 14 May 2019 in Kimberley. The topics discussed at the meeting, which were presented by Ms A Boonzaier, Dr P Wessels and Dr K Bezuidenhout, were “Informed consent”, “Blood transfusions, ethical and legal considerations” and “Thrombotic microangiopathies in pregnancy”.

Alene Boonzaier is an accredited financial adviser at Sanlam, specialising in estate planning and practice management for graduate professionals. She obtained her BCom (Law) and LLB degrees from the University of the Free State, and practised as an admitted attorney before joining Sanlam in 2015. She is an HPCSA-accredited presenter, with a specific interest in ethics and standards of professional conduct.

Dr P Wessels qualified as a doctor at the University of the Free State, and went on to qualify as a transfusion medical specialist, among other postgraduate qualifications,

completing a Diploma in Transfusion Medicine. She currently works as a lead consultant in patient blood management for the SA National Blood Service in Bloemfontein. Her clinical interests include blood transfusions.

Dr K Bezuidenhout qualified as a doctor at the University of Cape Town, and went on to qualify as a specialist physician and nephrologist at Stellenbosch University. She currently works full-time in the public health sector in Kimberley. She is a consultant physician and nephrologist in the Robert Mangaliso Sobukwe Hospital Department of Medicine. Her clinical interests include chronic kidney disease and HIV management. Alongside a number of colleagues, she has researched and published on salivary creatinine as a diagnostic tool for evaluating patients with chronic kidney disease.

The meeting was well attended, and the very informative presentations and case studies elicited much discussion.



Dr K Bezuidenhout receiving a gift from SAMA Griqualand West vice-chairperson, Dr I N Blanche

SAMA participates in atherosclerosis CPD

Bokang Motlhaga, junior marketing officer, SAMA Marketing Department

SAMA recently attended an atherosclerosis CPD session held at Botshilu Private Hospital. As a means of taking quality healthcare to remote areas and bridging the gap that exists between health facilities in urban areas and those in rural areas, Botshilu Private Hospital is located in Soshanguve, a township situated approximately 30 km north of the Pretoria central business district.

The CPD session was focused on topical issues around the cardiovascular disease atherosclerosis, including stroke, vascular disease, erectile dysfunction and biomarkers of atherosclerosis. The presentations were delivered by experienced medical practitioners and included Dr M Mayayise (cardiologist), Dr N Mashaba (physician), Dr M Mufamadi (general surgeon), Dr C Mamitele (urologist) and Dr B Phiri (pathologist), and covered recent developments and cases that medical practitioners need to be made aware of.

Atherosclerosis is the major cause of morbidity and mortality globally. It is the most

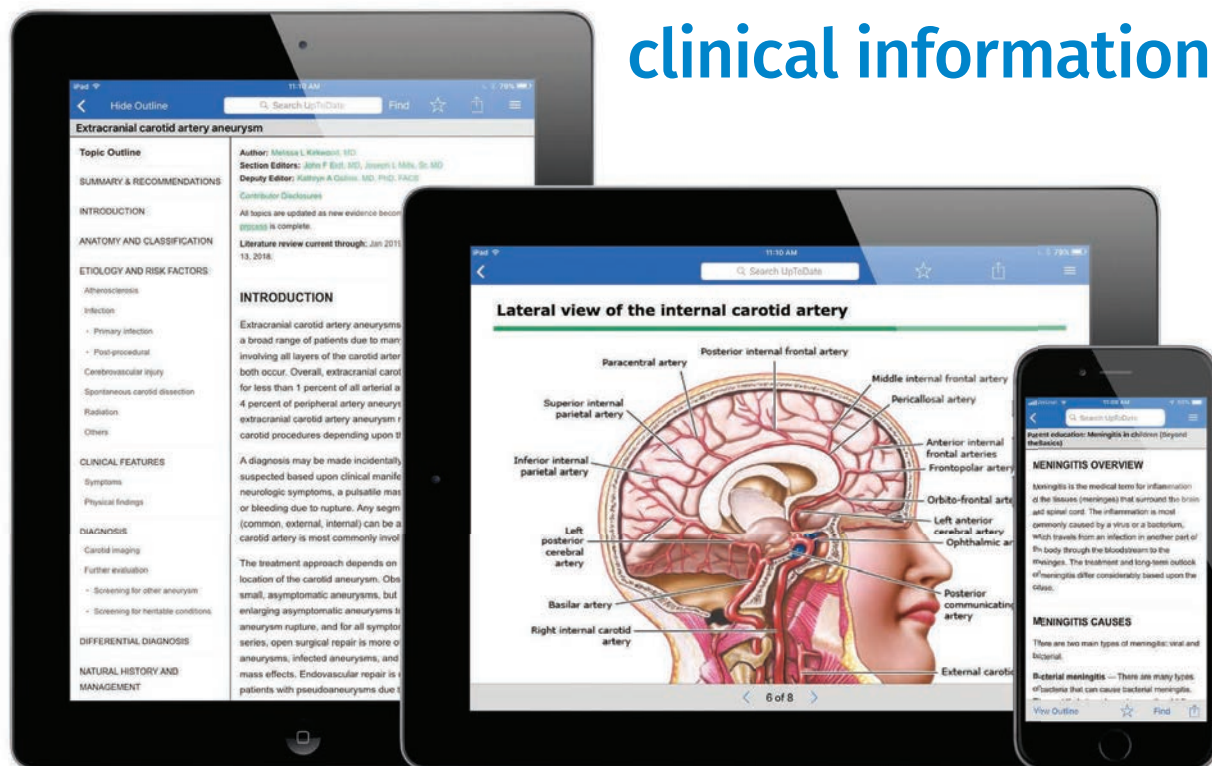
common underlying cause of cardiovascular diseases. The atherosclerosis process is initiated by a macrophage-mediated immune response to lipoprotein and cholesterol accumulation in arterial walls, which results in plaque formation. Total cholesterol and low density lipoprotein cholesterol (LDL-C) are the most robust traditional markers used for cardiovascular risk estimation, based on research evidence and clinical drug trials. Other markers that have been reported to be useful include the apoB/apoA ratio, small dense LDL, oxidised LDL, lipoprotein (a) and high-sensitivity C-reactive protein.

Ms Tamara Ncanywa, the marketing manager at Botshilu Private Hospital, said that the hospital prides itself on delivering impeccable healthcare services to the greater Soshanguve community and the surrounding townships. She explained that Botshilu is aiming for greater heights in terms of service delivery, hence the need for continuing medical education to ensure that medical practitioners are well informed about current developments.



The drivers behind the successful atherosclerosis CPD (from left): Dr Mamitele (urologist), Dr Mayayise (cardiologist), Dr Phiri (clinical pathologist), Ms Ncanywa (marketing manager and organiser), Mr Mnyandi (cardiac technologist) and Dr Mufamadi (general surgeon)

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