

SAMA INSIDER

SEPTEMBER 2019

**Doctors under pressure:
Let's support each other**

**Ethics v. morality:
Same difference?**



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

**SOUTH AFRICAN
MEDICAL ASSOCIATION**

MEMBER BENEFITS



Alexander Forbes

Herman Steyn

012 452 7121 / 083 389 6935 | steynher@forbes.co.za

Offers SAMA members a 20% discount on motor and household insurance premiums.



Automobile Association of South Africa (AA)

AA Customer Care Centre

0861 000 234 | kdeyzel@aasa.co.za

The AA offers a 12.5% discount to SAMA members on the AA Advantage and AA Advantage Plus Membership packages.



APLS

Cindy Maree

021 406 6733 | cindy.maree@uct.ac.za | www.apls.co.za

APLS offers SAMA members a 10% discount on the 2-day Advanced Paediatric Life Support Course.



Barloworld

Tender Smith : External Accounts Manager: EVC

011 052 0182 | tender.smith@bwfm.co.za

Barloworld Retail Digital Channels offers competitive pricing on New vehicles; negotiated pricing on demo and pre-owned vehicles; Trade in's; Test Drives and Vehicle Finance.



BMW

Melissa van Wyk : Corporate Sales Manager

079 523 9043 | melissa.vanwyk1@bmwdealer.co.za

SAMA members qualify for a minimum of 8% discount on selected BMW & MINI models. All Members also receive competitive pricing on Lifestyle items and accessories.



DLT Magazines

Tracey Hack : General Manager

011304 7600 | 076 020 5280 | tracey@dltmmedia.co.za

DLT Magazines offers medical practices current consumer magazines for their patients, to keep them relaxed and occupied while that wait for their service. We work with premium consumer titles from all major publishers in South Africa. SAMA members qualify for a 10% discount off any of our current custom and or preselect magazine packs. We also offer magazine racks at 50% discount for SAMA Members.



Ford/Kia Centurion

Burger Genis : New Vehicle Sales Manager – Ford Centurion

012 678 0000 | burger@laz.co.za

Tyren Long : New vehicle Sales Manager – Kia Centurion

012 678 5220 | tyren.long@kiacenturion.co.za

Lazarus Ford/Kia Centurion, as part of the Lazarus Motor Company group, sells and services the full range of Ford and Kia passenger and commercial vehicles. SAMA Members qualify for agreed minimum discounts on selected Ford and Kia vehicles sourced from Lazarus Ford / Kia Centurion. SAMA members who own a Ford/Kia vehicle also qualify for preferential servicing arrangements. We will structure a transaction to suit your needs.



Hertz Rent a Car

Lorick Barlow

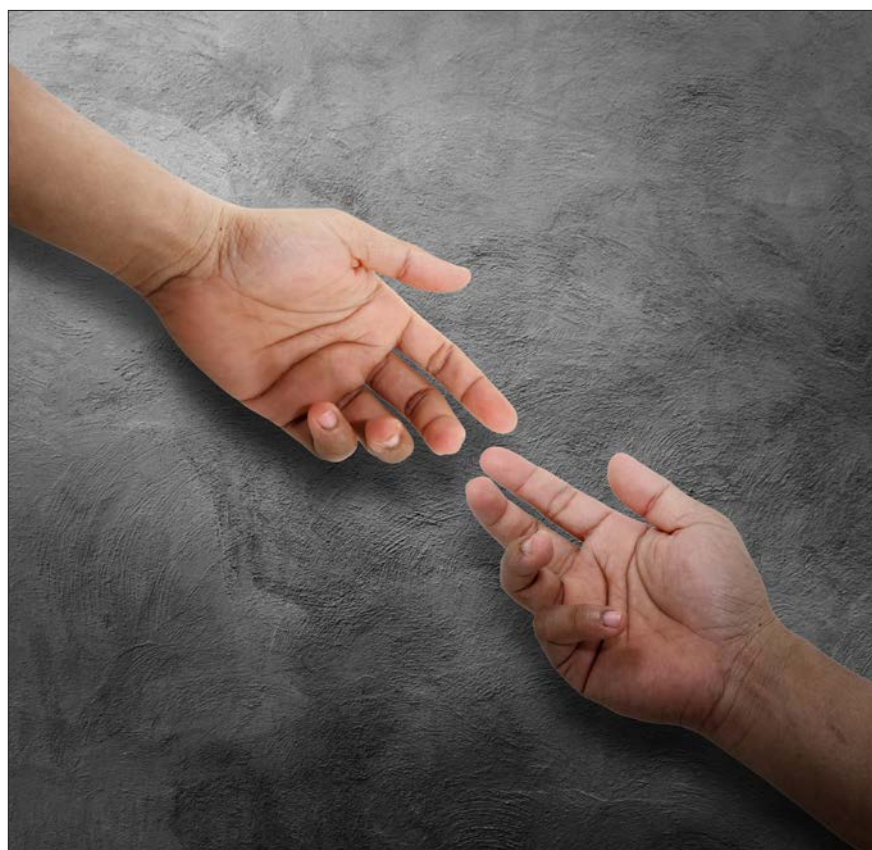
072 308 8516 | lorick@hertz.co.za

Hertz is proud to offer preferential car rental rates to SAMA members. A range of value-add product and service options also available. No cost to register as a Gold Plus Rewards member to enjoy a host of exclusive benefits.



CONTENTS

SEPTEMBER 2019



Source: Shutterstock: I'm Friday

- 3 EDITOR'S NOTE**
Doctors are under pressure
Diane de Kock
- 4 FROM THE PRESIDENT'S DESK**
A personal perspective on NHI in SA
Prof. Hoosen Coovadia
- 5 FEATURES**
Doctors under pressure: Let's support each other
Dr S Nzama
- 6 Gauteng health MEC addresses JUDASA**
SAMA Communications Department
- 7 Ethics v. morality: Same difference?**
Brandon Ferlito
- 8 SAMA's PPD – a voice for doctors in private practice**
SAMA Communications Department
- 10 Whistleblowing in the healthcare sector: Your legal rights**
Hanneke Verwey
- 11 Can you immunise your practice? Using budgets to protect your business**
Portia Phoshoko
- 12 JUDASA elects new leadership at AGM 2019**
SAMA Communications Department
- 12 WHO statement on governance and oversight of human genome editing**
World Health Organization
- 13 SAMA workshop: Bioethics and human rights in healthcare**
Brandon Ferlito
- 14 Harassment in the workplace**
Phumzile Gwala
- 15 Presidential health compact signed at DGMAH**
Tinyiko Maroleng, Mbali Mvelase
- 15 Don't let death or disability destroy your business**
Gert Viljoen
- 16 Doctors struggle under ill-equipped managers**
Lerisa Roberts, Dr G Wolvaardt
- 17 Setting up MM meetings for CPD accreditation**
Lisa Reid
- 17 Anxiety – rattling the "masculinity" cage among men**
South African Society of Psychiatrists
- 19 MEDICINE AND THE LAW**
Close those communication gaps
Medical Protection Society
- 19 BRANCH NEWS**

MEMBER BENEFITS



Inter Africa Bureau De Change



Jaco Brits

072 626 1687 | jaco@interafribdc.co.za

Inter Africa Bureau De Change is a leading provider of foreign exchange. We are licensed by the South African Reserve Bank to operate as an Authorised Dealer in Foreign Currency.

Inter Africa offers a VIP Rate to all SAMA members

Inter Africa Bureau De Change offers a wide variety of products and services, those being: • Cash Passport (a prepaid currency card) • Transport Forex • Travel Forex • Xpress Money • Moneytrans (send and receive money around the world)

Legacy Lifestyle



Allan Mclellan

0861 925 538 / 011 806 6800 | info@legacylifestyle.co.za

SAMA members qualify for complimentary GOLD Legacy Lifestyle membership. Gold membership entitles you to earn rewards at over 250 retail stores as well as preferred rates and privileges at all Legacy Lifestyle partnered hotels and further rewards back on accommodation and extras.

Medical Practice Consulting



Inge Erasmus

012 111 7001 | 074 031 5295 | inge@mpconsulting.co.za

MPC offers SAMA members FREE access to the MPC Online Medical Education platform. SAMA members further have access to Medical Scholarships through MPC for online CPD, CME and Short Courses as well as the attendance of international conferences. For more information, please visit www.mpconsulting.co.za

Mercedes-Benz South Africa (MBSA)



Refilwe Makete

012 673-6608 | refilwe.makete@daimler.com

Mercedes-Benz offers SAMA members a special benefit through their participating dealer network in South Africa. The offer includes a guaranteed discount on brand new Mercedes-Benz vehicles. In addition SAMA members qualify for preferential service bookings and other after market benefits.

SAMA eMDCM | SAMA CCSA



Zandile Dube

012 481 2057 | coding@samedical.org

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



SAMA eMDCM™

CCSA: 50% discount of the first copy of the Complete CPT® for South Africa book.

Tempest Car Hire



Corinne Grobler

083 463 0882 | cgrobler@tempestcarhire.co.za

SAMA members can enjoy discounted car hire rates with Tempest Car Hire.

Thusano Group



Thabiso Makhoana

083 873 1343 | thabiso@thusanogroup.co.za

SAMA members qualify for 30 – 40% discount on all Telkom costs.

Thusano Group offers all doctors NEC Telecommunication products with a 5year warranty at discounted prices. These offers are available for SAMA members with small, medium and large practices. We will structure a solution to suit your business needs.

V Professional Services



Gert Viljoen

012 348 3567 | gert@vprof.co.za

10% discount on medical practice bureau service through V Professional Services.

PROFESSIONAL SERVICES
Medical • Accounting • Taxation • Legal

EDITOR'S NOTE

SEPTEMBER 2019



Diane de Kock
Editor: *SAMA INSIDER*

Doctors are under pressure

The first cover line of this edition, "Doctors under pressure: Let's support each other", reflects the overriding theme of this issue, and this critical time in the history of healthcare in SA.

Doctors are under pressure, and now more than ever before need to stand together as members of their representative association, SAMA.

In August, the NHI Bill was presented to parliament (see pages 4, 6 and 19), a Bill that commits to changing the structure of healthcare in our country. Doctors face ongoing and relentless pressure in the workplace, their safety is often threatened daily and mental wellbeing is a constant struggle. This is reflected in JUDASA's Dr Nzama's article (page 5), which is featured on the cover. "In recent years, the issue of medical practitioners and other healthcare providers' mental health, and their safety, has been highlighted, [but] ... very little has been done to address the issue on a grand scale." She appeals to colleagues to "be more mindful of each other's wellbeing, supporting and acknowledging both the strengths and weaknesses each of us possesses."

Another pressure that is faced by doctors daily is reflected in Brandon Ferlito's article (page 7) entitled "Ethics v. morality: Same difference?" The challenge is to do the right and good thing both ethically and morally. "If the two terms are distinguished, morality applies at the individual level, and ethics applies to everyone."

We introduce SAMA's Private Practice Department (page 8), which caters for the needs of doctors in the private sector. Head of department Dr Vusumuzi Nhlapho emphasises that "we do not have a unifying voice right now, and, from SAMA's perspective, this is pivotal for the profession."

Supporting each other may often involve whistleblowing, as was the case in the Life Esidimeni tragedy. In her article on page 10, Hanneke Verwey unpacks your legal rights. "It is essential to reaffirm the need to protect healthcare workers who report criminal and other irregular conduct, and to foster a culture that facilitates responsible whistleblowing."

In SA, anxiety disorders are the most prevalent class of lifetime mental disorders (15.8%). According to the SA Society of Psychiatrists (SASOP; page 17), although one in eight men will have depression, and one in five will experience anxiety, they are less likely than women to seek support. "Share your symptoms with someone you trust," says Dr Westmore.

There is power in numbers: perhaps start on a day-to-day basis, and move, with the support of colleagues, to national matters.

Editor: Diane de Kock
Head of Publishing: Diane Smith
Copyeditor: Kirsten Morreira

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

Senior Designer: Clinton Griffin

Published by the South African Medical Association
Block F, Castle Walk Corporate Park, Nossob Street
Erasmuskloof Ext. 3, Pretoria

Email: publishing@hmpg.co.za | www.samainsider.org.za | Tel. 012 481 2069
Printed by Tandy Print (Pty) Ltd

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

LEGAL ADVICE

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

A personal perspective on NHI in SA



Prof. Hoosen Coovadia, SAMA president

I wish to consider the subject of the National Health Insurance (NHI). So that you understand clearly where I am coming from, let me state at the outset: in the development of my firm belief in the value of democracy as a basic system of governance, the centrality of an NHI has been a sustained feature. For more than 1 500 years, the so-called “natural order of society” has had an autocrat at the head and varying grades among the multitudes below.

My abiding belief in democracy grew from numerous sources, many from the developed world, but also from developing countries such as China and India. My favourite philosopher on the subject is the economics Nobel laureate Amartya Sen, especially in his *Development as Freedom*. A seminar I once attended in Lausanne, Switzerland, attributed a number of aspects of the concept of democracy to European philosophers such as Thomas Hobbes, John Locke on liberalism,

Jean Jacques Rousseau on republicanism and Jürgen Habermas on deliberative theory of democracy.

I was an early convert to the need for social causes and fairness to be included in economic theories, and have written more scholarly articles than this one on the gradual progression of my conceptual understanding. I will not list the papers I have published, as this is more in the nature of a fireside chat among medical colleagues. My writings on political legitimation and the legal framework draw on Hobbes, the idea of human rights from John Locke, the ideas that “man was born free but everywhere is in chains” and of “participation” from Jean Jacques Rousseau, and the idea of “rational deliberation” (much needed in our current deliberations in SA) from Jürgen Habermas.

On the other hand, I read daily the impassioned arguments from the Institute of Race Relations (IRR) about the innumerable reasons for not establishing an NHI under current conditions in the country. They are just plain wrong, as they don't include the principles of universality, equity and democracy: there are many distinguished individuals whose comments I have read, such as the Dean of Public Health at Harvard University, and the previous Minister of Health in Mexico, who make the persuasive argument that some essential functions of society, such as education and health, are public responsibilities, and not for sale like motor cars and Coca-Cola! I sat in some time ago at a meeting of the WMA in Durban where the supporters of NHI battled with its opponents about the issue of funding the entirety of NHI in SA, and there is an extensive piece in

which the erudite writer from the IRR ends by stating that “despite its basic unaffordability, government is pressing ahead with the scheme.” The writer has to learn from other countries that have successfully implemented an NHI: the UK has had one since the Second World War, and many Scandinavian countries and Thailand have national health systems; there is no reason why we cannot begin building the edifice and functions of a SA NHI piece by piece, according to acceptability and affordability, and not be mired in this unjust and costly system.

“There is no reason why we cannot begin building the edifice and functions of a SA NHI piece by piece”

I want to end with a short story about a fine gentleman (and I mean this) who I sat next to at a recent SAMA dinner in Cape Town. He had emigrated from Britain after the Second World War because he couldn't stand the introduction of the UK National Health Service. I asked him how he could leave a democratic country such as the UK to come and settle in apartheid SA, when the country was at its lowest state in terms of justice and fairness. He said it was because of the “long queues” in British health services! He seems quite settled here! QED.

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.



Doctors under pressure: Let's support each other

Dr S Z Nzama, JUDASA NEC vice-chairperson

In recent years, the issue of medical practitioners and other healthcare providers' mental health, and their safety, has been highlighted. However, despite increased awareness of the fact that providing a service in any healthcare environment will take its mental toll at some point or another, very little has been done to address the issue on a grand scale.

Doctors and other healthcare professionals have become increasingly concerned about feeling unsafe in their working environment, and during one-on-one interactions with patients. Over the years, they have reported, on many occasions, events where they have been physically assaulted, verbally abused, threatened or even sexually harassed while executing their civil duties in SA. The number of such incidents witnessed in the past decade highlights the decline of healthcare services in the public sector, partly as a result of burnt-out healthcare professionals. However, while this issue has been in the spotlight, little has been said regarding the gruelling environment and the insurmountable pressures that doctors are forced to work under, resulting in what has been easily termed "poor service delivery". Little improvement has been seen in the workspace despite aims to provide noticeable change for the holistic betterment of healthcare professionals in their efforts to serve the citizens of the republic.

In 2010, a doctor was raped while on duty in a Bloemfontein hospital. In 2011, a junior doctor in Mpumalanga tragically lost his life at the hands of a patient, after being stabbed in the chest. In 2016, the safe-working-hours campaign was started by the Junior Doctors Association of SA (JUDASA) following the death of an exhausted "post-call" medical intern in the Western Cape. Yet to date, doctors across the country still report alarming working hours of up to 120 per week. Since the campaign began, ever-increasing numbers of dangerous and even life-threatening situations have been documented, incidents involving heinous crimes against doctors across the country. In 2018, three public-servant junior doctors were attacked at their off-site hospital residence in Limpopo, with a second series of attacks occurring just days afterwards in a different hospital in the same province.

The year 2019, regrettably, brings us back to the Free State, where a junior doctor had to defend herself against a vicious attack by a patient in an attempted rape. Less than 72 hours later, another doctor was the victim of an attempted hijacking in the hospital parking lot at the same facility. In other provinces, cases have been reported of armed gang-related violence in hospitals, where security service personnel have either fled the scene, leaving patients and healthcare professionals to fend for themselves, or else cowered together with the healthcare workers, leaving patients helpless. One question that comes to mind is whether doctors are no longer valued in our society in the way they previously were; or have economic circumstances become so dire that criminals merely see hospitals as easy targets?

[Are] doctors no longer valued in our society in the way they previously were?

Section 8 of the Occupational Health and Safety Amendment Act No. 181 of 1993 constitutionally compels employers to "provide and maintain, as far as reasonably practicable, a working environment that is safe and without risk to the health of his employees". Questions raised by the lack of staff safety in the vast majority of state facilities include:

- Does the responsibility for security in government-owned facilities lie with the executive of each facility, the provincial government or the national authorities?
- Are the sourced security companies experienced in and capable of handling the multi-factored high-stress environment of a healthcare facility? Or is the safety of its employees not a priority for the Ministry of Health?

The mental health of medical professionals remains widely overlooked. Medical staff on the ground are continually subjected to various forms of abuse by patients and/or their families, and sometimes even by other

members of staff, but physicians are expected to "de-escalate" and "manage" each situation they encounter – and then to proceed with daily activities as though they are unaffected by the cases they have dealt with in their attempts to preserve human life. Comments from clients that they as tax contributors pay doctors' salaries, or that doctors should be grateful for their jobs, have been heard one too many times in public service. When asked to describe their working environment and their current outlook on their profession, junior doctors have described their experiences thus far as "demoralising, dangerous and exhausting". Unbeknownst to many in the field, medical professionals may act within their Constitutional rights by refusing to treat patients who are verbally or physically abusive, or who harass the professional in a sexual manner, with the exception of the *non compos mentis* patient (section 20, chapter 2 of the National Health Act No. 61 of 2003).

It should no longer be surprising that doctors are at high risk of a host of mental instabilities following years of practising their profession in what can be described as a hostile environment. Breaking bad news, counselling family members on the loss of loved ones and being viewed as a symbol of potentially devastating news are just some of the burdens that healthcare practitioners carry on their shoulders when entering their working environment daily. So far, there seems to be no national guideline or protocol that seeks to debrief healthcare practitioners on the traumatic situations they encounter during their practice. The expectation, it appears, is for healthcare workers to pick themselves up and carry on. Some facilities, as reported by a group of community service officers, do not have occupational health personnel on site, or policies/avenues for staff members to access these necessary services for their own mental healthcare benefit. Long working hours, with breaks viewed as luxuries one is lucky to have, constant criticism, without guidance, support or interest from senior staff, and snarky remarks when trying to refer patients to higher facilities of care are just some examples of the "minor" challenges the junior doctor must face in the arena. Does this then not explain the high substance abuse and other self-harm statistics reported in various journals and studies over the years?

Is this not an indicator that doctors are not coping? Does this not also explain the blunted affects that doctors are repeatedly cautioned not to develop?

When asked, "How does it feel being a doctor?" one junior doctor replied: "It's not worth it! There is no amount of money that can bring back the pieces of myself that I lose every time I watch someone die, or the time I've lost with my loved ones in their times of celebration or mourning because I'm on call, or the sleep I've lost only for patients and their families to abuse me, even though I have been at work for over 24 hours and have had no time to eat, rest or even use the bathroom to relieve myself peacefully." This doctor further added, "My weekends are spent

We can be more mindful of each other's wellbeing

either working, or sleeping in an attempt to recover from the week past and ready myself for the week coming. Yes, I chose this, but I didn't think I would have to sacrifice the rest of my life to a career where my safety, mental and physical health is compromised and constantly under threat. Forgive me if I don't stay very long in clinical medicine."

We should notice that some, although not all, of the challenges mentioned above

are those that we as healthcare professionals inflict on one other. Yes, it goes without saying that the nature of our work is stressful, and that cannot be corrected immediately, but the way we treat each other as colleagues can be. We can be more mindful of each other's wellbeing, supporting and acknowledging both the strengths and weaknesses each of us possesses.

It may not be a giant step, but a step forward we can take, in our attempts to improve our own mental health and that of our colleagues.

I would like to acknowledge Dr M Maseko and Dr I Bloemstein, community service medical officers, for their contributions to this article.

Gauteng health MEC addresses JUDASA

SAMA Communications Department

The theme of the Junior Doctors Association of SA (JUDASA) AGM held in Pretoria on 4 August was "Young leaders in healthcare – reimagining a safe, healthy and inclusive work environment within the public health system of SA".

In his address, the MEC for Health in Gauteng, Dr Bongani Masuku, explained that medical professionals are confronted with a number of issues in healthcare. These include transformation, medical practitioner unity and patient-centred health. Staff morale is directly linked to patient experience in public sector facilities, where resources are required to ensure quality health systems. Patient experience involves the look and feel of hospitals, and maintenance and security issues, which are being addressed.

Dr Masuku went on to state that "national health insurance (NHI) is a reality, but it needs to be understood that it is a funding model for a health system, and not a health system in itself." He explained that NHI will provide the opportunities and resources required for an improved healthcare system. It will also educate the public, as health literacy is very low.

He urged all doctors in SA to become members of SAMA, and to remain united and focused, as well as to always remember why they became doctors, while also taking care of each other.



Dr Rhulani Ngwenya, Dr Angelique Coetzee, Dr Bongani Masuku (Gauteng MEC for Health) and Dr Terry Mwesigwa (outgoing JUDASA chair)

The delegates were also addressed by Dr Rhulani Ngwenya, SAMA board member and Trade Union Task Team convenor. He stated that public sector doctors have specific issues that need to be addressed, but also have the profession to uphold when addressing those issues, which should therefore be done with decorum, and according to the standards of ethical conduct.

Dr Angelique Coetzee, the SAMA board chairperson, in her address, emphasised the importance of mentorship, and of staying true to oneself while showing compassion and following ethical guidelines.

She went on to state that "medicine is an art," and urged the junior doctors to obtain experience in primary healthcare before specialising.

Ethics v. morality: Same difference?

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

We all encounter ethical issues and moral dilemmas in our day-to-day lives. The terms “ethics” and “morality” are often used as synonyms, and although it is claimed that there is a difference between the two, in a philosophical sense there is generally no recognised difference. Both are used to refer to what is good or bad, right or wrong. Philosophers who study ethics/morality often do not make a distinction between the two, and use the terms interchangeably.

However, there are many people (including some members of KMRED) who believe that there is a difference between ethics and morality. Divergent views on topics such as abortion and euthanasia are examples of where morality and ethics often conflict. Much of the confusion between these two terms can be traced back to their roots. The word “ethics” comes from the Greek word *ethikos*, itself derived from Greek *ethos* (custom, or character). “Morality” is derived from the Latin *moralis* (appropriate behaviour and manners in society). It is easy to see why there is confusion when the two are so similar in their origins.

In comparison

When people make a distinction between ethics and morality, ethics is usually considered the standard of what is right or wrong, good or bad, imposed by an external force such as a professional or regulatory body (e.g. the HPCSA). Ethics is concerned with conduct, or how one ought to behave, based on what

that particular external force says is right or wrong. By way of illustration, the HPCSA expects all its registered members to conduct themselves in an ethical manner, that is, in a way that is good and right, and to refrain from bad/wrong behaviour, or from any conduct that would result in harm. This is evident from the HPCSA's General Ethical Guidelines for the Healthcare Professions. In a broader context, societies also impose standards of right or wrong, and good or bad – for example, certain societies, countries or cultures believe that abortion is wrong, bad and/or harmful, and impose this standard on everyone within that society, country or culture.

Examples of ethical behaviour/conduct may include truthfulness, loyalty, respect and integrity, while unethical behaviour/conduct includes dishonesty, deceitfulness and disrespect. On the other side of the coin, morality is usually seen as concerned with one's own personal belief system (religious, cultural and/or social), and not imposed by any external force. Morality therefore has to do with what one personally thinks is right or wrong. Examples of moral behaviour can include not cheating, being loyal and always telling the truth, and immorality, therefore, cheating, being disloyal and telling lies.

It is easy to see why ethics and morality are often thought to be the same thing. However, the two can conflict. Ethics (society, culture) might say you should do one thing, but your

morality says you should do another, and “follow your moral compass.”

In summary, “morals are concerned with principles of right and wrong, and ethics are related to right and wrong conduct of an individual in a particular situation.” Diffen.com have created a comparison chart (see below) showing the difference between ethics and morality.

Abortion and euthanasia are examples of where morality and ethics often conflict

It is important to note that in practice, most individuals generally do not distinguish between ethics and morality, and are usually referring to what is right or wrong, good or bad when they use either term. It is also important to realise that ethics/morality is at times dependent on what a society or a culture thinks is right or wrong, good or bad (relativism/emotivism).

If the two terms are distinguished, morality applies at the individual level, and ethics applies to everyone.

References available on request.

Ethics v. morals		
	Ethics	Morals
What are they?	Rules of conduct recognised with respect to a particular class of human actions, or a particular group or culture	Principles or habits with respect to right or wrong behaviour: while morals also prescribe dos and don'ts, morality is ultimately a personal compass of right and wrong
Where do they come from?	Social system – external	Individual – internal
Why we do the right/wrong thing?	Because society says it is right or wrong	Because we believe something to be right or wrong
Flexibility	Dependent on others for definition; ethics tend to be consistent within a certain context, but can vary between contexts	Usually consistent, although can change if an individual's beliefs change
The “grey areas”	A person strictly following ethical principles may not have any morals at all; likewise, one could violate ethical principles within a given system of rules in order to maintain moral integrity	A moral person, although perhaps bound by a higher covenant, may choose to follow a code of ethics as it would apply to a system, and “make it fit”
Origin	Greek word <i>ethos</i> , meaning character	Latin word <i>mos</i> , meaning custom
Acceptability	Governed by professional and legal guidelines within a particular time and place	Transcend cultural norms

SAMA's PPD – a voice for doctors in private practice

SAMA Communications Department

The SAMA Private Practice Department (PPD) caters for the needs of doctors in the private sector. The PPD operates within the highly competitive and complicated private healthcare environment, and covers family/general practitioners as well as specialists.

"There are close to 9 000 doctors in the private sector in SA, and there are important operational and strategic issues that they face on a daily basis. PPD is here to assist doctors to navigate their way around the myriad issues they are confronted with," explains Dr Vusumuzi Nhlapho, acting general manager of SAMA and HOD: PPD.

The PPD derives its mandate from the two private practice committees within SAMA: the General Practitioners' Private Practice Committee (GPPPC), headed by Dr Norman Mabasa, and the Specialists' Private Practice Committee (SPPC), headed by Dr Malikah van der Schyff.

"From the input we receive from these two committees, we are able to identify key areas that need attention, and we plan and allocate resources accordingly. This is an extremely well-structured environment where our goal is to provide exceptional service to doctors, to enable them to function better. I believe we fulfil an important role for private doctors. It's a task we undertake very seriously," says Dr Nhlapho.

One of the critical functions of the PPD is medical coding, and the publishing of material for doctors to use.

"Medical coding is the basis on which the private sector actually functions, in recording the clinical interactions between doctors and patients; it therefore provides a conduit of communication between the doctor and the funder – the medical scheme. This is a vital cog in the wheel of how doctors manage their clinical and professional activities in a formal manner, and forms the basis of remuneration in the private sector," explains Dr Nhlapho.

He says that because of the importance of medical coding in the private practice environment, it is vital to get it right. The PPD publishes two books: the *Medical Doctors' Coding Manual (MDCM)*, an annual publication, and the electronic *eMDCM*, which is updated on a regular basis whenever information needs to be amended. They further publish the *Complete CPT for South Africa (CCSA)* every 2 years.

"These publications are usually the first port of call for all medical coding-related queries in the private sector, so their importance cannot be overstated. Not only are they used locally in SA, but they are also consulted widely in the region, and so the reach is immense," notes Dr Nhlapho.

Dr Nhlapho has especially high praise for Glenda de Beer, who is responsible for the medical coding processes. Glenda has nearly 30 years' professional experience at SAMA, and assists in all matters relating to medical coding – what codes should be added, which codes should be amended and those which must be discontinued.

"We work closely with a number of associations and organisations linked to the SPPC, and also consult many different stakeholders to ensure that the processes are fair, and the outcomes of the deliberations on medical coding are fair and serve the industry as a whole. There are ongoing conversations regarding the role of medical coding, particularly in the era of national health insurance (NHI). SAMA, through the PPD, is actively involved in these discussions, and periodic communications will be issued in this regard," says Dr Nhlapho.

"The gap between the private and public health sector is wide, and there is a need for processes to bring the two sectors together. In the envisaged world of NHI, coding will even become critical for all stakeholders.

Uniting doctors in private healthcare

In addition to the medical coding activities performed by the PPD, the department is actively involved in efforts to unite the private medical sector, a task Dr Nhlapho says is of critical importance.

"We are of the view that among other factors, doctors have not been able to negotiate more favourable outcomes in their engagements with funders because they are not united as a profession. One recent success is that SAMA, the Independent Practitioner Association Foundation (IPAF), the Dispensing Family Practitioners' Association (DFPA) and the Society for General/Family Practitioners (SGFP) have signed a memorandum of understanding establishing the Unity Forum for Family Practitioners (UFFP), which will be referred to as 'the Unity Forum'," says Dr Nhlapho.



Dr Vusumuzi Nhlapho

Dr Vusumuzi Nhlapho is the Acting General Manager of SAMA, and head of department of the PPD. In 1990 he graduated with a BA, majoring in molecular biology and political science, from the Wesleyan University in Middletown, USA. In 1993 he returned to SA, where he attained an MSc from the University of the Witwatersrand, and in 1997 he completed an MB BCH, Bachelor of Surgery, from the same institution.

Dr Nhlapho has since completed several more diplomas and degrees, and is currently studying towards an MBA. He has professional experience working in SA, the UK and Canada, and for several multinational organisations such as Rio Tinto and De Beers Consolidated Mines.

In June, Dr Nhlapho received the Discovery Emerging Leader Award at the KZN DHC Conference.

On receiving the award, Dr Nhlapho says, "It was humbling, as it was completely unexpected. I am passionate about the work I do, and have a sense of purpose about contributing to the wellbeing of all South Africans, and the SA healthcare environment in particular."

Dr Nhlapho is a strong believer in family. He has 3 beautiful daughters, who are the light of his life.

Dr Norman Mabasa, chairperson of the GPPPC at SAMA, was elected chairperson of the Unity Forum.

One of the aims of the Unity Forum is to provide a platform where family practitioners' organisations can discuss, at a high level, issues that affect the world of family/general practitioners, and take positions that advance the role of the family/general practitioner as a co-ordinator of care.

Dr Nhlapo says that the vision is for the Unity Forum to eventually become the forum with which anyone needing to consult or engage with general practitioners on policy or other pertinent matters must engage.

The forum does not accept individual members; instead, it brings together a number of different associations in what is effectively a federation of organisations. This is key, as it provides the forum the benefit of strength in numbers, a critical tool when engaging strategic partners.

“We do not have a unifying voice right now ... this is pivotal for the profession”

“It took the PPD a long time to get to where we are now with the Unity Forum. We are exploring possibilities to replicate this process for specialists. Unity is critical in engaging different strategic partners in matters relating to healthcare policy in SA. The Unity Forum, and hopefully the specialist forum, will serve as important bodies in mitigating the adverse outcomes of disunity in the profession. We do not have a unifying voice right now and, from SAMA's perspective, this is pivotal for the profession,” says Dr Nhlapo.

Dr Nhlapo is, however, quick to point out that the Unity Forum does not supersede the role of SAMA: this is certainly not the case. The Unity Forum does not detract from the *raison d'être* of PPD and SAMA.

“I regard the work of the Unity Forum as complementary to what the PPD does, specifically, and SAMA in general,” Dr Nhlapo explains.

The PPD also does other significant work for doctors in the private sector, including providing assistance with advice relating



Private Practice Department. Seated, left to right: Dr Rosanna Naidoo (principal business officer), Leanne Barends (PA to the HOD), Zandile Dube (senior medical coding consultant), Glenda de Beer (medical coding team leader). Standing, left to right: Tebogo Sanyane (private practice membership liaison officer), Rendani Tendane (medical coding consultant), Dr Vusumuzi Nhlapo (head of department), Caccius Nkosi (administrative assistant), Anton van Schalkwyk (medical coding specialist).

to establishing practices and the relevant processes, assisting doctors with representation at medical funders' engagements (in association with the legal department), and scanning and communicating policy changes in the private healthcare industry (in association with the Knowledge Management, Research and Ethics Department).

The department has ongoing engagements with a number of strategic partners, including the National Department of Health, funders, the Council for Medical Schemes (CMS) and the HPCSA, where issues of concern to SAMA members are raised.

The PPD has initiated discussions with the CMS to review the annual payment for a practice number with the Board of Healthcare Funders. The Government Employees Medical Scheme (GEMS) and Discovery have been engaged with regard to issues related to benefit design and formularies, and these discussions are ongoing.

SAMA is opposed to the direct payment of members by funders, and the CMS has been robustly engaged in this regard. The PPD awaits the findings of the section investigation, and will explore alternative resolution mechanisms if this issue is not adequately addressed.

Dr Rosanna Naidoo, principal business officer, is spearheading the opportunities for private/public partnerships and the positioning of SAMA as a commercial partner for initiatives that would support doctors in the private sector.

The PPD will be hosting an NHI Symposium on 14 - 15 September 2019 to engage robustly on all aspects of the Bill.

Office of the Medical Ombud

Dr Nhlapo says that in addition to their current work, a process has begun to establish a mediation division within the PPD, which will include an Office of the Medical Ombud dealing directly with patient/doctor issues.

“In general, patients want to be heard in cases of medical disputes, and the mediation division will be able to facilitate communication between aggrieved patients and doctors. We believe that the office of the medical ombud will assist in finding solutions to some of the problems, thus avoiding the need for further stressful escalations,” says Dr Nhlapo.

“The office of the ombud will focus on resolving complaints from a variety of sources against doctors. The ombud will focus on the merits of individual cases and attempt to resolve these through mediation, among other measures of dispute resolutions. The division will deal with cases expeditiously, and have a swift turnaround,” he concludes.

It is clear, given the scope of the work performed by the PPD, that this department fulfils a unique and important role within the medical profession. It's a role Dr Nhlapo says he and the PPD team perform with commitment and, above all, with doctors' needs foremost in their minds.

Whistleblowing in the healthcare sector: Your legal rights

Hanneke Verwey, legal advisor, SAMA Governance and Legal Unit

Several high-profile instances of grave irregular conduct on the part of organs of state and private bodies within the SA healthcare sector, including large-scale human rights abuses, have been reported in the media in recent years. One of the most notable, the Life Esidimeni tragedy, involved the deaths of at least 144 mental health patients. These patients, who represented some of the most vulnerable members of our society, succumbed to starvation and neglect after being placed in unlicensed state psychiatric facilities and non-governmental organisations.

Very often, these abuses are only exposed by virtue of whistleblowers who are willing to come forward in the interests of society. Whistleblowers play a pivotal role in exposing illegal and irregular conduct, including corruption, safety violations, mismanagement, negligence, human rights violations and the waste of resources. Healthcare workers in particular have a special ethical duty to act as advocates for their patients, to protect patients and to improve quality of care.

Regrettably, whistleblowers often face hostility, and fear being punished for their whistleblowing in the form of retributive action, including professional and reputational harm. Given the recent history of gross human rights violations and mismanagement in the healthcare sector, it is therefore essential to reaffirm the need to protect healthcare workers who report criminal and other irregular conduct, and to foster a culture that facilitates responsible whistleblowing. It is also important that healthcare workers are familiar with the relevant legislative and ethical frameworks that regulate whistleblowing in the healthcare sector.

Recognising both the potential vulnerability of whistleblowers and the need to promote the eradication of criminal and other irregular conduct in organs of state and private bodies, the SA government enacted the Protected Disclosures Act No. 26 of 2000. By virtue of this Act, whistleblowers who act in accordance with the procedures provided for enjoy broad protection against reprisals or victimisation as a result of their disclosures.

The Act applies to both “employees” and “workers” who make a “protected disclosure”,

as defined in the Act. “Disclosure” is defined as any information that shows or tends to show that: a criminal offence has been committed; a person has failed, is failing or is likely to fail to comply with any legal obligation; a miscarriage of justice has occurred, is occurring or is likely to occur; or the health or safety of an individual has been, is being or is likely to be endangered.

In order to enjoy protection under the Act, the disclosure must be made via one of the four avenues provided for in the Act: (i) disclosure to a legal advisor; (ii) disclosure to an employer; (iii) regulatory disclosures; or (iv) general protected disclosures. Any one of these four may be used to report impropriety, provided that the prescribed requirements are complied with.

Healthcare workers have a special ethical duty to act as advocates for their patients

Avenue 1: Protected disclosure to a legal adviser (section 5). Any disclosure made to a legal practitioner is protected, provided that the disclosure was made with the object of and in the course of obtaining legal advice.

Avenue 2: Internal disclosures (section 6). A disclosure to an employer will enjoy protection under the Act if it is made in good faith and substantially in accordance with the procedure, if any, authorised by the employer. In terms of the “Practical guidelines for employees” issued in terms of the Act, a whistleblower will be deemed to have acted in good faith if he or she acted in a responsible and honest manner, and with no intention to gain personal advantage. In the healthcare context, internal reporting mechanisms include the complaints procedures available within the National Department of Health, or in a private facility. Healthcare workers should consider first reporting conduct via the available internal mechanisms or procedures at facility level, failing which the district or

provincial Department of Health can be approached. If the matter cannot be resolved at district or provincial level, a complaint can be lodged with the Office of Health Standards Compliance. Various other internal reporting mechanisms may be available. For example, internal morbidity and mortality meetings could, in certain circumstances, provide a useful internal platform for disclosing and addressing instances of clinical mismanagement.

Avenue 3: Regulatory disclosures (section 8). Any disclosure made in good faith to the Public Protector or Auditor-General will be protected, subject to certain requirements. The whistleblower must be able to show that he or she reasonably believed that the relevant impropriety fell within the jurisdiction of the person or body concerned. Furthermore, the whistleblower must have reasonably believed that the information disclosed, and any allegation, was substantially true.

Avenue 4: Wider disclosures (section 9). Section 9 of the Act provides for protection in respect of certain wider disclosures. This includes disclosures made outside of the three avenues discussed above. This could include disclosures to the press and the SA Police Service.

In order to qualify as a general protected disclosure, the whistleblower must have reasonably believed that the information and allegations were substantially true. Disclosures may not be made for purposes of personal gain. Furthermore, one or more of four conditions set out in subsection 9(2) must apply, and it must have been reasonable to make the disclosure.

These conditions are that: (i) the whistleblower has reason to believe that he or she will be subjected to an occupational detriment if the disclosure is made to the employer; (ii) in a case where no person or body is prescribed for the purposes of section 8 in relation to the impropriety, the whistleblower has reason to believe that it is likely that evidence relating to the impropriety will be concealed or destroyed if he or she makes the disclosure to his or her employer; (iii) the whistleblower has previously made a disclosure of substantially the same information and no action has been taken within a reasonable period; or (iv) the impropriety is of an exceptionally serious nature.

In determining whether it is reasonable for the whistleblower to make the disclosure, consideration will be given to, among other factors, the seriousness of the impropriety, whether the impropriety is ongoing or likely to occur in the future, and the public interest.

What protection does the Act afford?

Whistleblowers are protected from occupational detriment as well as civil or criminal liability. Any contract that conflicts with the Act, such as a confidentiality clause prohibiting whistleblowing, is invalid, and an employer will therefore not be able to allege that the whistleblower has committed breach of contract.

Any whistleblower who has made a protected disclosure and who reasonably believes that he or she may be adversely affected may also request to be transferred from his or her current post or position to another in the same or another division of his or her employer. The terms and conditions of the new employment may, furthermore, not be less favourable.

Whistleblowers may also pursue any other processes allowed or prescribed by

any law for appropriate relief: the Act does not prevent whistleblowers from exercising legal remedies provided for in other statutes. This could, for example, include a claim for damages in circumstances where a whistleblower suffers reputational harm as a result of any retaliatory action pursuant to blowing the whistle. Therefore in addition to the protection afforded in terms of this Act, the remedies provided for in, among others, the Intimidation Act No. 72 of 1982 and the Protection from Harassment Act No. 17 of 2011 are also available to whistleblowers who are harassed or fear for their own safety on account of their whistleblowing.

Tips

The Rural Health Advocacy Project (RHAP) has published *A Healthcare Provider's Guide to Reporting Healthcare Challenges: Principles, Tools & Strategies*, a useful guide for healthcare workers regarding whistleblowing within the healthcare sector. The guide, among other things, provides healthcare workers with tips on reporting illegal and unethical conduct. The guide confirms that the correct approach when it comes to whistleblowing depends on the surrounding circumstances, including

the urgency and seriousness of the matter. The protection of patients' best interests should be the overriding consideration. RHAP recommends that whistleblowers should:

- report misconduct sooner rather than later
- attempt to gather the key information
- if possible, organise themselves and blow the whistle as a group of professionals
- where appropriate, exhaust internal mechanisms at facility level when reporting illegal and unethical conduct
- insofar as possible, keep a written record of all communication related to the matter
- where appropriate, liaise with patients and advise patients to use the available complaints mechanisms
- ensure that they use one of the four avenues provided for in the Act when reporting illegal or unethical conduct.

Healthcare workers are encouraged to seek advice in order to determine whether they should blow the whistle and, if so, to obtain information on the available reporting mechanisms. In addition to contacting SAMA for guidance on the available avenues, SAMA is able to refer members to a number of organisations that assist whistleblowers.

Can you immunise your practice? Using budgets to protect your business

Portia Phoshoko, *FinancialFlow Accountancy and Advisory*

Both vaccines and budgets have sparked vigorous debates about their benefits, in terms of managing health and businesses, respectively. While vaccines are a complex topic, I hope to use them as an analogy, to give a better understanding of budgets to those in the medical field.

On their website, the WHO states that "immunisation is the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine."

Plans and budgets are the tools we use in business to become "resistant" to failure. They chart out the financial roadmap a business will take in the future, and seek to predict the financial impact of planned business activities.

In budgeting, we anticipate all costs and revenues by gauging likely future

performance, to limit the possibility of being caught off guard.

How budgets and immunisations are alike

Purpose: Both immunisation and budgets are protective tools. They aim to prepare the body or a practice to deal with adverse situations in the future. As a practice formulates its future actions in financial terms, the practice owner is able to assess the impact that these actions will have on profitability well in advance. Where an adverse effect is detected, appropriate measures can be put in place ahead of time to prevent or curb the losses.

Budgets require clear goals, and so the process channels practice owners into focusing on what they want.

Effectiveness: Like vaccines, where a weakened substance is used to stimulate the

immune system, budgets and plans are based on past results, assumptions and goals. These are weakened substances – past performance is not always an accurate predictor of future performance, since unexpected events happen, and assumptions might also be incorrect. Although no-one can predict the future with absolute accuracy, the use of budgets and vaccines improves the chances of success.

In making a decision, the practice owner should regularly refer to the budget, and make decisions in line with it. This helps the owner to stay focused on their goals.

Frequency and timing: Some vaccines are administered once in a lifetime, and some have to be given more frequently. Moreover, immunisation is best done before encountering the disease. Accordingly, overall practice budgets should be prepared annually before the financial year begins.

However, they can be reviewed more frequently, depending on your needs/goals. To get the most out of the budget, i.e. to ensure that the practice is running according to plan, actual performance must be compared to the budget periodically. Practices are advised to perform this on a monthly basis.

Side-effects

A practice that periodically compares its actual results to the budget becomes more mindful of its goals, and makes decisions in support of them, but the habit of constantly referring to the budget is seen by some as cumbersome. Budgets are fixed in nature, and so can be seen as inspiring rigid behaviour that does not take into account the changes that occur in a practice.

To answer this, projections can be done that take into account significant changes in circumstances. These projections will always be built on the budget. Basing your decisions on the budget and subsequent projections ensures that your decisions support the achievement of your practice goals.

Setting up and reviewing the budget requires a time commitment. Time is always in competition with other practice tasks.

The chances are that there will be variances between the reality of how things turn out and the budget. These may include favourable and unfavourable results. Possible reasons for these variances should be explored, to determine which activities need to be adjusted in order to keep on track with your practice goals.

Last words

Budgets improve a practice's defence mechanisms just as immunisation improves the body's. The practice owner is provided with an overview of likely future performance, enabling him or her to continue with profitable activities while curbing financial harmful choices. The owner becomes aware of the financial impact of his or her habits and activities through the periodic comparison of reality against the budget. When you know the consequences of your actions and are prepared for all eventualities, you can spend your time implementing profitable actions – rather than being reactive and spending it putting out fires. Your practice's chance of success is better with a plan than without.

JUDASA elects new leadership at AGM 2019

SAMA Communications Department

SAMA congratulates the new JUDASA leadership, who were elected at the AGM on 3 - 4 August 2019 as follows:

- Chairperson: Dr Bridged Tshutshu
- Vice-chairperson: Dr Tshepile Tlali
- Secretary-general: Dr Siyabonga Mbatha
- Deputy secretary: Dr Bonginkosi Mnguni
- Treasurer: Dr Rebonethato Lesupi
- Public relations officer: Dr Muhammed Sheik
- Student liaison officer: Dr Jarryd Lunn
- International relations officer: Dr Lerato Masenya
- Additional member: Dr Patricia Zondo.



Back, left to right: Dr Bonginkosi Mnguni, Dr Tshepile Tlali, Dr Siyabonga Mbatha, Dr Lerato Masenya, Dr Bridged Tshutshu, Dr Patricia Zondo, Dr Jarryd Lunn, Dr Muhammed Sheik, Dr Rebonethato Lesupi. Front: Girly Moseki, Dr Vusumuzi Nhlapho

WHO statement on governance and oversight of human genome editing

World Health Organization

The WHO expert advisory committee on governance and oversight of human genome editing convened on 18 - 19 March 2019. At this meeting, in an interim recommendation to the WHO Director-General, the committee stated

that "it would be irresponsible at this time for anyone to proceed with clinical applications of human germline genome editing."

The WHO supports this interim recommendation, and advises regulatory or ethics

authorities to refrain from issuing approvals concerning requests for clinical applications for work that involves human germline genome editing.

"Human germline genome editing poses unique and unprecedented ethical and

technical challenges,” said WHO Director-General Dr Tedros Adhanom Ghebreyesus. “I have accepted the interim recommendations of the WHO’s Expert Advisory Committee that regulatory authorities in all countries

should not allow any further work in this area until its implications have been properly considered.”

The WHO’s Expert Advisory Committee continues its consideration of this matter, and

will, at its forthcoming meeting in Geneva on 26 - 28 August 2019, evaluate, *inter alia*, effective governance instruments to deter and prevent irresponsible and unacceptable uses of genome-edited embryos to initiate human pregnancies.

SAMA workshop: Bioethics and human rights in healthcare

Brandon Ferlito, *bioethics researcher, SAMA Knowledge Management, Research and Ethics Department*

On Friday 2 August 2019, SAMA held its very first “Bioethics and human rights in healthcare” workshop, which took place at SAMA headquarters in Pretoria. The workshop was presented by Prof. Ames Dhai, director of the Steve Biko Centre for Bioethics at the University of the Witwatersrand, Johannesburg and a member of the Human Rights, Law and Ethics (HRLE) Committee. The workshop, designed and delivered by Prof. Dhai, was aimed at equipping practitioners and people with an interest in bioethics and human rights in healthcare with ethical and human rights norms and standards that will be of practical use to them in the practice of healthcare. The attendees included medical doctors, SAMA researchers and staff and members of the various SAMA committees.

The 4-hour workshop was divided into two parts. The first part provided an introduction to bioethics, covering topics such as the basic types of ethical enquiry, morality, principles, theories and indigenous African values, and finished with a case study. The second dealt with specific topics on professionalism in healthcare, including the moral contract, core foundational values, professionalism (practice and challenges), healthcare as a human right, the doctor-patient relationship, dual loyalty, the moral authority of codes and how to approach an ethical analysis. Part two also finished with a case study.

Prof. Dhai kept the attendees on their toes by asking them to apply the content they were learning to the ever-contentious topic of euthanasia and doctor-assisted suicide. This proved to be both challenging and exciting – attendees found a new respect for bioethics, acknowledging that it is not simply a matter of “right or wrong, good



Front row, left to right: Dr Mark Human, Abigail Mkhonza, Prof. Ames Dhai, Dr Angelique Coetzee. Second row, left to right: Dr Daniel Mokumo, Dr Mawunyo Ati, Dr Simthandile Toni, Dr Aziza van der Schyff, Jolene Hattingh. Third row, left to right: Dr Malikh van der Schyff, Dr Selaelo Mametja, Brandon Ferlito, Hanneke Verwey. Fourth row, left to right: Shelley McGee, Prof. Christoffel Grobler, Dr Maurice Goodman. Missing: Modisane Lelaka.

or bad”. Additionally, the case study “Good old Dr Thusi” proved to be just as mentally stimulating. The case study, divided into two parts, was based on a real-life scenario filled with ethical dilemmas and legal challenges, to which the attendees had to apply themselves using all that they had learned during the workshop.

At the end of the workshop, attendees completed an assessment in the form of

multiple choice questions, to qualify for a SAMA Certificate of Attendance and 4 CPD points in ethics. All attendees successfully completed the workshop – not a surprise, given Prof. Dhai’s effortless and engaging style of teaching.

Special thanks to Prof. Ames Dhai and the Steve Biko Centre for Bioethics, SAMA and the HRLE Committee, Karlien Pienaar and Tebogo Dithung.

Harassment in the workplace

Phumzile Gwala, *Employee Relations advisor, SAMA Trade Union Department*

Labour law can assist you if you are being harassed at work. Harassment of any kind is in no-one's interest, and should not be tolerated in the workplace. Everyone should be treated with dignity and respect at work. Harassment is recognised as unfair discrimination, and the right to be free of it in the workplace is protected by law.

What constitutes harassment in the workplace?

Harassment in the workplace may arise out of an incident or series thereof that have affected an individual at work that are unwelcome, unwanted and have a destructive effect. In terms of the labour law, examples of harassment are:

- bullying
- spreading malicious rumours, or insulting someone, particularly on gender, race or disability grounds
- ridiculing or degrading someone – picking on them, or setting them up to fail
- exclusion or victimisation
- unfair treatment, for example based on race, gender, sexual orientation, pregnancy, age, disability, religion or HIV status (this type of harassment/discrimination is prohibited in terms of the Employment Equity Act (EEA) No. 55 of 1998)
- overbearing supervision or other misuse of power or position
- unwelcome sexual advances – touching, standing too close and displaying of offensive material
- making threats/comments about job security without foundation
- deliberately undermining a competent worker by overloading and constant criticism
- preventing an individual's progress by intentionally blocking promotion or training opportunities.

Employer good practice

Employers have a duty to protect their workers from harassment, and to inform and educate them about the issues. Employers are encouraged to develop a code of conduct on harassment. This should be done in consultation with both employees and employee representatives, if applicable.

Problems caused by harassment

Harassment is not only unacceptable on moral grounds, but may create problems for an organisation. It needs to be addressed, as it may:

- constitute a violation of human rights
- lead to poor employee morale
- lead to poor employer/employee or employee/employee relations
- threaten the physical and psychological health of employees
- affect the productivity and performance of employees
- lead to other unfortunate symptoms in the workplace, including unexplained absenteeism, lateness and poor concentration, which leads to unnecessary mistakes
- create a hostile, intimidating and offensive work environment
- lead to losses in workplace effectiveness and productivity
- lead to resignations of competent employees.

What to do if harassed at work

- Keep a record of all incidents, taking notes of dates and times, potential witnesses and details of what took place. Even if it feels unimportant at the time, the details will help to build a systematic case.
- Keep all offending emails and correspondence. This evidence will help you when you take action against the perpetrator.
- Most cases of perceived bullying may be nothing more than an abrupt management style. Bringing unacceptable behaviour to managers' attention may help solve the issues.
- When you do confront the person, make clear and direct requests, stay calm and stand firm. Do not confront him or her on your own – take someone with you to the meeting.
- If this does not rectify the situation, you can lodge a formal grievance in line with Resolution No. 14 of 2002 (Grievance Rules for the Public Service).
- Report the matter to SAMA, to get representation during the grievance hearing.

Also note that once a case has been reported, the employer should investigate the matter.

Usually, there will be a disciplinary inquiry to establish the facts. This will give the chairperson the opportunity to hear both sides of the story and decide on the appropriate disciplinary measures for the harasser.

Case law

In the case of *Mkhize and Dube Transport (2019) 40 ILJ 929 (CCMA)*, in which the employee referred a complaint for bullying to the Commission for Conciliation, Mediation and Arbitration (CCMA) as an unfair dismissal claim, the CCMA exercised its discretion to assess the real reason for the employee's referral, and determined that although the employee had referred a dispute for unfair dismissal, the true complaint was about victimisation in the workplace. The employee had alleged that the human resource (HR) manager of the employer was bullying and victimising her, both inside and outside of the workplace, and that although she had ultimately been dismissed for medical incapacity, the employer had actually sought to use this as a convenient method to get rid of her after she had lodged a grievance about the bullying allegations. Although the CCMA did not have to contend with the facts of the matter, it confirmed that where an employee has a dispute about bullying, victimisation or harassment, although the CCMA can always conciliate the dispute, if the parties fails to agree on a resolution, the next step (arbitration) must be taken at the Labour Court: the dismissal then is an automatically unfair dismissal, which the Labour Court has exclusive jurisdiction to determine. This approach, that bullying is a form of harassment, and to be dealt with in terms of the EEA as unfair discrimination, was also recently confirmed in *Private Sector Workers Trade Union on behalf of Opperman and Gerrie Ebersohn Attorneys (2019) 40 ILJ 1159 (CCMA)*.

If an employee has not been dismissed and remains employed, the appropriate referral would be for unfair discrimination in terms of the EEA; if the employee has been dismissed, the appropriate referral would be for automatically unfair dismissal (based on unfair discrimination). In the case of *Simmadari v Absa Bank Ltd (2018) 39 ILJ 1819 (LC)*, the Labour Court found that these two referrals are not mutually exclusive, and a dismissed employee may refer both claims simultaneously.

As such, employers should be aware that instances of workplace bullying should be

dealt with quickly and decisively, and that it should not be tolerated in the workplace: a failure to deal with bullying may expose the

employer to up to 24 months' remuneration if the employee is found to have been dismissed due to bullying, and to unlimited

compensation claims if the employee is found to have been the victim of unfair discrimination due to the bullying.

Presidential health compact signed at DGMAH

Tinyiko Maroleng, Mbali Mvelase, *DGMAH Marketing and Communications Department*

SA President Cyril Ramaphosa held a press conference at Dr George Mukhari Academic Hospital (DGMAH) on 25 July, where he signed the Presidential Health Compact. The aim of the press conference was to tackle a number of challenges faced by the public healthcare system in providing universal healthcare for all.

President Ramaphosa said the signing of the Presidential Health Compact was a step closer to improving the quality of the SA healthcare system. The aim of this compact is to reform healthcare in SA while trying to make it better suited to encompass the needs of the growing population. Ramaphosa was escorted on a guided tour of the hospital, where he visited the various units. "By working in a collaborative way, we will be able to reach our goals faster and implement them efficiently and with the best use of resources. In fixing what is wrong with the public healthcare system, we are mindful of the impact of our past," said the president.

SAMA chairperson Dr Angelique Coetzee said the Presidential Health Compact will pave the way for the roll-out of universal healthcare. Dr Coetzee emphasised that the health

compact has been informed by an outcry from SA medical practitioners and civil society, who had jointly expressed their concern about the current situation in healthcare, especially in the public sector.

"It opens up the door for proper universal coverage for all our members and our SA people. It is the way forward, because currently the system in the private sector is going to become unaffordable as we move forward," says Coetzee.

Dr Zweli Mkhize, Minister of Health, detailed the nine pillars supporting the presidential compact, which will include among other things ensuring that patients no longer have to wait in long queues, and that poor treatment by staff will no longer be tolerated in public health facilities.

President Ramaphosa said a healthy nation was the bedrock of the economy.

"Under one health system, all our hospitals, clinics and doctors' rooms [will be] appropriately staffed and resourced, there [will be] enough medicines, equipment and supplies. Infrastructure [will be] suitable for the services to be provided," President Ramaphosa said.



President Cyril Ramaphosa delivering his speech



Dr Angelique Coetzee, SAMA chairperson

Don't let death or disability destroy your business

Gert Viljoen, *VPROF*

Your business could be in serious trouble if a shareholder dies suddenly, or if a key player dies or is disabled. How can you manage these risks?

A good start is to take out the correct insurance cover upfront. Appropriate policies can both reduce the risks to the business and provide financial assistance to an affected shareholder's family. In this article we discuss what buy/sell insurance is, and what its benefits are, then look at key person insurance.

The greatest need in many small businesses is for cash flow. Picture this

scenario: Three people start a business, and after a few years it is beginning to make profit – in a year, it will go cash-positive. One of the shareholders is killed (or disabled) in an accident, leaving the spouse and children desperate, as neither the company nor the remaining shareholders can afford to buy the dead shareholder's equity. The family put his or her shares up for sale. The other two shareholders now face the prospect of a new shareholder who may not agree with their strategies. The outlook for the business is suddenly very uncertain.

Buy/sell policies

Had the shareholders put in place a buy/sell policy when they started the company, the death would not have threatened the business. The policy on the death (or disability) of the shareholder means that the remaining shareholders acquire the shares, and the proceeds of the policy go to the family of the dead shareholder. In this way, the remaining shareholders keep control of the business, and the family of the dead shareholder receives a payout, which will lessen the financial uncertainty they face.

Generally, buy/sell policies are governed in terms of a shareholders' agreement. If the shareholders have loans, then make sure that these are covered in the agreement – they will need to be dealt with anyway on the death or disability of a shareholder.

Also ensure that the agreement is aligned with your memorandum of incorporation (MOI), as the MOI takes preference over a shareholder agreement.

Key person insurance

If you have shareholders who are active in your

company, or a key manager(s), and the loss of any of these people would have a detrimental impact on the business, then the company can take out insurance on these key people. Proceeds from key person insurance flow into the company.

Suppose, for example, that you recruit a marketing executive who substantially grows your business. Should this executive be killed or disabled, it will lead to a material loss in sales. Taking out key person insurance will give your company the financial space to recruit and train a new marketing manager,

and will give you time to make up the lost sales.

Many companies have failed by not providing for the loss of a shareholder or key manager.

Take expert advice when taking out either of these policies, as there are legal, potential tax and or death duty exposures.

VProfessional Services (VPROF) is a medical practice administrator, medical bureau and professional accounting firm dedicated to supporting the business activities and patient care of independent medical practices around SA.

Doctors struggle under ill-equipped managers

Lerisa Roberts, Dr G Wolvaardt

In early 2019, Tshilidzini Hospital in Vhembe was in crisis. The Limpopo facility, which had been declared a National Health Insurance pilot hospital, had been earmarked for demolition, with a new state of the art facility intended to be erected in its place by 2019. For locals who had suffered under the chaos of Tshilidzini's previous administration, the upgraded facility promised to usher in a new era for healthcare in the province.

However, when Limpopo Health MEC Dr Phophi Ramathuba visited Tshilidzini in February 2019, she found that the dilapidated structure stood untouched, with no sign of the promised rejuvenation taking place.

Patients complained to Ramathuba of overcrowding, long waiting hours and doctors unsure of what was required of them. To patients, it appeared as if staff shortages were at the root of the problem, resulting in anyone who visited the hospital waiting hours to see one of the busy doctors.

However, on taking a closer look at the hospital's operations, Ramathuba realised that there were, in fact, no staff shortages, and the hospital staff's disarray could be linked back to the poor management structures in place at the facility.

Maladministration in the healthcare sector has been at the forefront of SA news since 2017, when the tragedy and horror of the Life Esidimeni scandal became public knowledge. The South African Health Review 2018 looked

further into maladministration at health institutes around the country, and uncovered alarming statistics.

According to the report, "SA ranks among the top five countries in the African region in terms of density of physicians and nursing and midwifery personnel per 1 000 population." Yet reports of healthcare facilities suffering staff shortages as a result of maladministration persist.

In Vhembe, Dr Ramathuba acted quickly to remove Tshilidzini's management staff, and introduced a new management team, which was required to run under administration for at least 100 days.

Although swift action took place at Tshilidzini, the situation spotlighted the urgent need for qualified managers at SA's healthcare facilities.

In SA, it is clear that healthcare facilities require a unique type of manager: someone who is able to efficiently and effectively manage the facility while understanding the day-to-day needs of both the medical professionals they employ, and the patients who come to them for treatment.

In other words, medical facilities require managers with both medical and managerial competence. But finding such managers can be quite a task, and it is showing.

In the USA, several studies have linked the growing number of cases of physician burnout to one key factor: the massive disconnect between the needs of upper management in healthcare facilities, and the needs of the doctors working beneath them.

According to Medscape's 2019 National Physicians Burnout & Depression Report, more than 40% of physicians in the USA are suffering from burnout; for doctors in specialist fields, that number is even higher, at nearly 50%.

In the USA, the management staff of healthcare facilities are largely from business backgrounds, with little to no medical knowledge. While this puts them in an excellent position to run an average white-collar business, managing a medical facility comes with unique challenges, and requires managers with both clinical insight and managerial skills, who will appreciate the needs of medical personnel. A mad scramble to equip hospitals and other medical facilities with this new breed of manager has ensued.

But, as one article recently asked: how many doctors, who have studied for years to gain their qualifications, now have the time and energy to tackle the world of management, and study further?

However, there is hope.

Recently, more and more medical professionals are making the time to enter the management field. As the South African Health Review 2018 points out, SA has some way to go in terms of true human resource understanding in the healthcare sector, but with a small group of people dedicated to improving the system, change is on the way.

References available on request.

MANCHESTER
1824

The University of Manchester
Alliance Manchester Business School

International Advanced Management Programme

"Build Resilience in a VUCA World"
with the Advanced Management Programme



FPD
BUSINESS
SCHOOL

Setting up MM meetings for CPD accreditation

Lisa Reid, CPD officer, Knowledge Management, Research and Ethics Department

Mortality and morbidity (MM) CPD accreditation meetings aim to provide a routine, structured forum for the open examination and review of cases that have led to complications or the death of a patient, in order to collectively learn from these events and improve patient management and quality of care, and to provide continuing professional development.

Guidelines and set-up

An MM CPD accreditation meeting is a regular, organisationally convened meeting, predominantly involving medical practitioners (but becoming increasingly multidisciplinary) who gather to discuss selected cases for the purposes of clarifying medical management, and to provide a forum for teaching and learning, focusing on patient safety and quality improvement, including the identification and reporting of errors.

The roles and responsibilities of participants should be clearly defined, and accreditation obtained from SAMA (cpd@samedical.org).

Each MM meeting should have a chair and secretariat to be responsible for co-ordinating the meeting. All members should be encouraged to contribute their views.

The goals of the meeting are to:

- identify key events resulting in adverse patient outcomes
- foster open and honest discussion of those events
- identify and disseminate information and insights about patient care that are drawn from individual and collective experience
- reinforce system-level and individual accountability for providing high-quality care
- create a forum that supports open and honest discussion through the provision of a just, patient-centred culture
- contribute to clinical governance processes.

Meeting content

MM meetings should occur on site. They must be chaired by a senior doctor, who takes responsibility for the process, and has an ability to engage with clinical colleagues and to facilitate change by improving processes of patient care. This may be the medical director, unit/department head or a delegate. Where possible, MMs should be regularly scheduled, to maximise participation.

Members of other clinical disciplines, such as nurses, pharmacists, physiotherapists and junior medical staff, should attend. Cases for discussion should be identified by senior doctors raising specific cases, or by referral from other MM meetings.

In order to provide sufficient time for adequate discussion, no more than two cases should be discussed per hour, although aggregating cases with similar issues into a "block" discussion may be appropriate.

Doctors and other clinicians actively involved in the care of the patient to be discussed must be made aware of the intention to discuss the case at least 72 hours prior to the meeting, and of its date, time and place. If they are unable or unwilling to attend the meeting where the case is to be discussed, the case should be referred to the appropriate medical lead for further investigation or action. Cases must never be discussed in the absence of the senior doctors with primary responsibility for care of the patient.

Cases should be presented in verbal format in a de-identified fashion, describing only the facts of the case. The major issues should be identified during the presentation, with the chair providing further clarification if required.

The chair should ensure that following the presentation, the key discussion points are agreed. These should always include:

- What went wrong (or right)?
- How did it go wrong (or right)?

- Why did it go wrong (or right)?
- What could we do differently in future?
- What are the key lessons for the organisation?

A consistent approach to problem-solving should be used to discuss the case.

The chair should ensure that any discussion relates to the facts of the case, and not to personal issues. This is not a meeting to attack or openly criticise individuals who have contributed to patient care – doing so impedes the development of a "just" culture.

If major performance issues relating to an individual senior doctor become apparent at any stage during the discussion, the chair should immediately halt the discussion and refer the issue to the relevant medical lead (medical director, unit head or equivalent), who should then initiate the organisation's usual performance development processes. Discussion around other matters pertaining to the case may continue.

At the completion of the discussion, action points should be agreed and prioritised by all present in the meeting. Responses to these issues should be presented at subsequent meetings.

Minutes should be kept, with patient and doctor details de-identified.

An action list and appropriate accountabilities should be generated and circulated to all participants and to appropriate organisation-level clinical governance structures, as evidence-based guidance to correct or prevent future incidents.

For further information on CPD accreditation, please contact Lisa Reid on 012 481 2082 or cpd@samedical.org.

The minutes of meetings must be sent through every 6 months to your accreditor for auditing purposes.

Please note that medical professionals whose job descriptions involve hosting MM meetings may should not accumulate CPD points for attendance or hosting.

Anxiety – rattling the “masculinity” cage among men

South African Society of Psychiatrists

Anxiety disorders are ranked as the sixth largest contributor to life-long health concerns worldwide, with an

estimated 3.6% of the global population (264 million people) living with anxiety. It affects nearly one in five adults in the USA,

and in SA, the South African Stress and Health (SASH) study, which investigated the lifetime prevalence of common mental disorders,

anxiety disorders were found to be the most prevalent class of lifetime mental disorders, at 15.8%.

On average, one in eight men will have depression, and one in five men will experience anxiety at some stage of their lives.

And even though statistics point towards women being twice as likely as men to suffer from anxiety disorders, the reason for this finding might be more social than scientific.

Dr Ian Westmore of the SA Society of Psychiatrists (SASOP) says that the stigma associated with anxiety disorders labels the condition as “unmanly” and a sign of weakness. He says that “this is the very reason that men are less likely to talk about their anxiety, and instead drown their anxiety with poor coping behaviours, increasing their risk of the anxiety or depression going unrecognised and untreated.”

Dr Westmore says men are far less likely to seek support: this behaviour is more commonly seen in women, who are more eager to speak out and seek help, as opposed to the macho male social stereotype, which expects men to “man up” and adopt a “boys don’t cry” mentality.

“It’s this attitude of portraying men as brave and fearless that leads to men seeing themselves in a negative light if they suffer from anxiety. And for this very reason, they see seeking help as putting themselves in a vulnerable position.”

Dr Westmore emphasises that it is a given that everyone feels anxious from time to time, and not every anxious episode should be seen as representing a disorder.

“It’s okay to worry about things and life’s many challenges. The difference is when that worry is difficult to control or shake long after a certain experience or event, and it starts interfering with your day-to-day activities or changes the way that you used to approach life – affecting aspects such as going out with your friends, being productive at work, taking part in team sports, bantering with colleagues and so forth. It severely affects relationships in that the coping mechanisms applied often affect those close to you, through alcohol, abusive behaviour and frequently depression.”

“Society expects a lot from men. They’re expected to be seen as confident, in control, decision-makers and decisive voices of reason and rationality. They are often portrayed as the rock with a steady hand and mind in times of trouble or uncertainty. They are stereotyped as the provider and protector, dependable, confident and fearless.”

“However, these very traits that society has labelled men with could lead men to feel inadequate and emasculated. It’s not realistic to expect men to be the stronger sex who always live by society’s version of ‘what makes a man,’ and to simply find a way to ‘pull yourself together.’”

Dr Westmore says that if left untreated, anxiety can present itself in many forms.

“Men who don’t speak out find inappropriate coping strategies that might very well dull the anxiety temporarily, but could develop into a dependency that eventually spins out of control, aggravating the anxiety disorder.”

“Abuse, gambling, drugs (including alcohol) and reckless behaviour are some of the confidence-gaining and coping mechanisms embraced by men. However, since they enable men to avoid their anxieties instead of facing them, these very coping mechanisms could aggravate the disorder.”

“Anxiety can trigger anger in men, with violence, outbursts, bullying, abusiveness and explosive quick temper bursts as a result. Irritability – being edgy, touchy, cranky or impatient – becomes the normal reaction to everyday frustrations, large and small. In addition, anxiety drives avoidance, which in turn constricts lives. The result is a sense of having an empty life, which turns to depression, with feelings of hopelessness and helplessness.”

Dr Westmore says a range of factors can contribute to, or even trigger the development of an anxiety disorder. These could be a genetic predisposition, as well as physical factors such as an imbalance of hormones and chemical messengers in the brain. But it can also be affected by environmental factors such as excessive stress in a relationship or a job/at school, financial predicaments and traumatic life events. Medical factors such as the side-effects of some medications, and symptoms or stress relating to an illness, may also lead to an anxiety disorder.

What are the tell-tale signs?

“Anxiety is more than just a bit of stress, sweaty palms or a sense of butterflies in the stomach. The symptoms are far more severe and include continuous feelings of worry, fear and impending doom that are so severe they interfere with your ability to work, to live a healthy life, to maintain relationships and to sleep.”

Dr Westmore points out the following signs of anxiety:

Physical

- pounding or racing heart
- excessive sweating
- muscle tension or aches
- restlessness or agitation
- dizziness or vertigo
- shortness of breath or sensation of choking
- insomnia
- panic attacks
- fatigue
- nausea, diarrhoea or irritable bowel syndrome.

Emotional

- constant worry about what could go wrong
- perceiving situations and events as threatening when they are not
- indecisiveness and fear of making the wrong decision
- difficulty concentrating
- feelings of dread
- concentration problems
- avoidance
- catastrophic thinking
- irritability and edginess
- nightmares or intrusive thoughts in which traumatic scenes are replayed in the mind
- mood swings
- being overly vigilant towards danger
- absentmindedness
- fear of losing control.

In addition, persistent sadness, apathy or loss of hope or suicidal thoughts could show that the anxiety has morphed into depression, a condition commonly seen together with anxiety disorders.

Dr Westmore says it is important to share your symptoms with someone you trust. Start with a family member or friend, but always find your way to a healthcare professional, who will be able to help you manage the symptoms. He says that treatments include cognitive behavioural therapy, counselling and, in some instances, medication, depending on the type of anxiety present.

“It is important to note that you need to develop your own action plan that includes lifestyle changes, which are as much a part of the recovery process as seeking medical attention. Engage in regular exercise to release your anxious energy and happy endorphins, get enough sleep, socialise with supportive friends and family, manage stress through meditation, music or art, follow a healthy diet, cut down on alcohol and avoid drugs and other stimulants.”

Close those communication gaps

The Medical Protection Society shares a case report from their files

Mrs X gave birth to J, a healthy baby boy. J was discharged with a note in the records stating he was a “normal healthy infant”; a further note stated that, on eye examination, a bilateral red reflex was present.

At 4 weeks, the baby clinic’s notes showed that J’s parents were concerned that his left eye was smaller than the right, and the nurse referred the baby to a specialist paediatrician. A couple of weeks later, though, the nurse documented the left eye as being more open, and the referral was cancelled.

J was then seen by the family’s GP, Dr A, for a 6-week check-up; his vision and hearing were recorded as being “satisfactory”. At 3 months, Dr A referred J to the ophthalmology department after noticing a squint in his left eye; the left pupil was also smaller than the right. Six weeks later – before the ophthalmology consultation took place – J was admitted to hospital as an emergency via Dr A, with coryza, vomiting and poor feeding. He was transferred to the paediatric department, but there was no record from this admission of any examination of his eyes.

At 6 months, J’s ophthalmology appointment took place. He saw a specialist ophthalmologist, Dr H, who noted that she

could not detect any visual acuity in the left eye, and that the eye was microphthalmic. She also noted a central cataract on the left side. J eventually became blind in his left eye.

His parents made a claim against Dr A and the hospital for the delay in the diagnosis of the congenital cataract.

Expert opinion

Expert GP opinion on breach of duty stated that Dr A had not been diligent when initially examining J’s eyes at the time of the 6-week check. By that time the nurse had listed initial concerns about the size of the eyes, which should have prompted Dr A to be meticulous in his examination of the eyes; had the red reflex been absent, referral to a specialist

should have occurred immediately. Prompt and appropriate referral would have led to a 20% chance of restoring J’s visual acuity to a level adequate for driving.

Another expert report, provided by a specialist ophthalmologist, also stated this examination was inadequate, as an abnormal red reflex would almost certainly have been present; this would have allowed for appropriate surgical intervention of the cataract that was later diagnosed.

This report also criticised the hospital paediatric department for failing to communicate the concerns in J’s records about his eye size to the appropriate colleagues. The case was settled for a substantial sum.

Learning points

- Poor communication results in poor treatment. In this case there was poor communication at various stages, including between GP and hospital and within the hospital itself.
- Congenital cataract has a finite time period in which surgical intervention is beneficial.
- J was not seen by a specialist ophthalmologist until he was 6 months old; this delay highlights failings at both ends. Dr A’s referral letter did not make the urgency of the appointment clear, but also, the recognised association of microphthalmia with congenital cataract should have prompted an urgent outpatient appointment.

SAMA KZN Coastal branch responds to provincial health budget

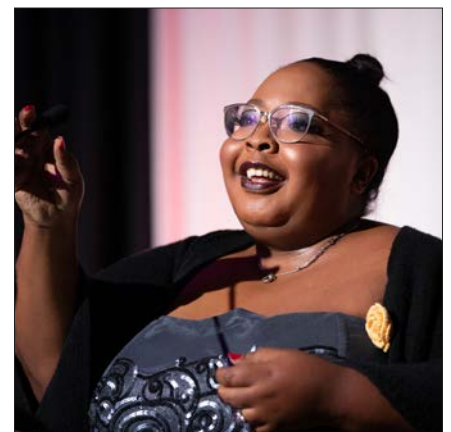
SAMA Communications Department

SAMA KwaZulu-Natal Coastal Branch says that the health budget recently delivered by KwaZulu-Natal Health MEC Ms Nomagugu Simelane-Zulu is comprehensive and balanced, but some areas remain a concern.

“Several key areas were addressed well, including infrastructure development, staffing, emergency medical services and health programmes. The emphasis on primary healthcare, in alignment with the national health insurance (NHI), is also welcomed, as is the establishment of a medicolegal unit that will help address the litigation crisis currently facing the department,” says Dr Zanele

Bikitsha, branch chair of KZN Coastal branch. However, Dr Bikitsha says some areas need more attention. These include the province’s HIV programme, supply chain management, nursing issues, staff wellness and the problem of vacant posts within the health sector in the province.

“The HIV programme, for instance, is largely supported by NGOs, and this leads to skewed statistics. There is also a concern that some of these organisations are withdrawing from institutions while the capacity of the health department has not yet been fully established there, particularly in relation to administrative abilities,” notes Dr Bikitsha.



Dr Zanele Bikitsha

She says that while KZN Coastal branch welcomes the promise to tighten supply chain management processes, the fact that many vendors who do not meet their obligations continue to be given business, despite non-delivery, remains a problem.

Regarding nursing, Dr Bikitsha says there is a concern over the large number of unemployed nurses in the province, especially as nurses are pivotal to the roll-out of primary healthcare, which will be the cornerstone of NHI. She says more nurses are still being produced without a plan for their retention, a situation that needs to be addressed immediately.

"In addition, we also call for all vacant posts within the health sector in the province to be filled urgently, to alleviate the severe staffing crisis that is leading to increased medicolegal cases, and which is also leading to the poor quality of service provision in KwaZulu-Natal," she says.

Dr Bikitsha says that more emphasis should have been placed on the issue of staff safety and wellness in Ms Simelane-Zulu's address.

"We would have liked to hear of a commitment to physical security measures, the upgrading of institutions currently not deemed safe, and of measures to deal with

psychiatric patients in our institutions. This, we believe, needed more focus from the MEC," says Dr Bikitsha.

While Dr Bikitsha says there are still areas of worry for SAMA KZN Coastal branch, progress in other areas is encouraging.

"We applaud, for instance, the announcement that the Dr Pixley Ka Isaka Seme Memorial Hospital north of Durban is 95% complete, and is expected to be operational before the new financial year. This is certainly good news for everyone in the province, and we congratulate the provincial department of health on this achievement," concludes Dr Bikitsha.

Griqualand West host successful CPD meeting

Dr Maria Giaquinto-Cilliers gave a presentation on 27 June at the Kalahari Lodge in Kimberley. The topic discussed at this CPD meeting was "Game of dressings: Strategies for wound care and use of advanced dressings".

Dr Giaquinto-Cilliers qualified as a doctor at the School of Medicine of the Federal University of Pernambuco in Brazil, and went on to qualify as a specialist plastic and reconstructive surgeon at Pedro Ernesto State of Rio de Janeiro University. She currently works full-time in the public health sector in Kimberley, SA. She is the head of unit of the Department of Plastic and Reconstructive Surgery at Robert Mangaliso Sobukwe Hospital. Alongside a number of colleagues,

she has researched and published on dermatofibrosarcoma protuberans of the head and the neck. She is also the chair of the Northern Cape chapter for the Wound Healing Association of the Southern Africa (WHASA).

Dr Giaquinto-Cilliers has participated in various health collaboration initiatives relating to health system strengthening, and has been invited to speak on behalf of these initiatives at international conferences such as the ISBI (International Society for Burn Injuries) congress in Brazil. Her clinical interests include burns prevention and wound healing.

Griqualand West branch hosted the event, which was attended by 48 people and well received.



Dr Maria Giaquinto delivered a presentation on wound care

Tygerberg strengthens relationship with young doctors

The Tygerberg-Boland branch sponsored a lunch at the annual Financial Day for final-year medical students, held on 11 May on the Tygerberg medical campus, Stellenbosch University.

Some 180 students attended the event, and 120 of these joined SAMA as members. Sandra Ferrone was in attendance at a stall offering SAMA literature and advertising material. The branch awarded their annual bursary to Asavele Botheka, a fourth-year medical student.

Ruan Vlok, SAMA Western Cape industrial relations advisor, explained to the students how SAMA can assist them when they commence their community service in the public sector next year. This resulted in positive interaction with the SAMA representatives during lunch.

"It was to our benefit to be part of the programme as only a limited number of companies could be accommodated because of the time frame. This type of involvement with medical students strengthens our relationship with the young doctors of the future," Sandra Ferrone says.



Asavele Botheka received the bursary cheque from the branch chairperson, Dr Wynand Goosen



PROFESSIONAL SERVICES

Medical • Accounting • Taxation • Legal

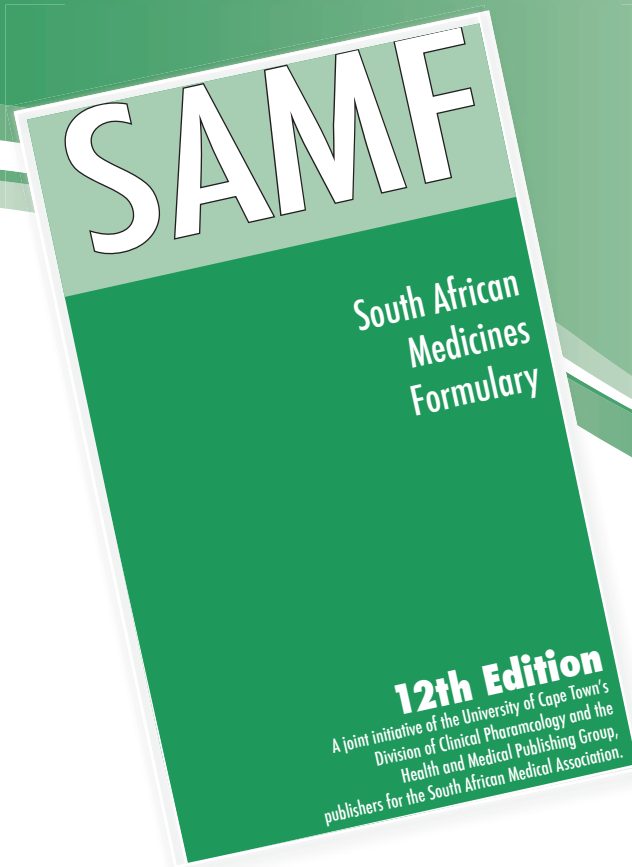
- + Simply Grow Your Practice
- + Medical Claim Bureau
- + Specialised IT Support
- + Remittance Reconciliation Services
- + Debt Collection Bureau
- + Practice Management Application & Support
- + 95% Plus Recovery Rate on Medical Claim Recoveries
- + Currently running a promotion for all Specialists and GP's

We offer pharmaceutical distribution and sales of scheduled medicine and surgical items at discounted rates

For more information and advice:

Telephone: 012 348 3567 / 087 550 2115

Fax: 012 548 0562



The ESSENTIAL MEDICAL REFERENCE for every healthcare professional!

The convenient pocket-sized design enables you to fit it comfortably into your hospital bag or coat pocket, so it can always be at hand for ready reference. South African Medicines Formulary (SAMF), a joint initiative of the University of Cape Town's Division of Clinical Pharmacology and the Health and Medical Publishing Group, Department of the South African Medical Association, provides easy access to the latest, scientifically accurate information, including full drug profiles, clinical notes and special prescriber's points. The thoroughly updated 12th edition of SAMF is your essential reference to the rational, cost-effective and safe use of medicines.

Contact: Diane Smith

Tel: 012 481 2069

Email: dianes@hmpg.co.za

Tax invoice to be posted on dispatch of order

