

SAMA INSIDER

DECEMBER/JANUARY 2020

**Dr Coetzee reflects
on a challenging year**

**To report or not to report?
Mandatory reporting of
sexual offences**



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

**SOUTH AFRICAN
MEDICAL ASSOCIATION**



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gems

Government Employees
Medical Scheme

WHAT'S NEW FOR GEMS MEMBERS IN 2020!

Public service employees and their families can look forward to receiving enhanced healthcare coverage in 2020 as the Government Employees Medical Scheme (GEMS) has reinvested close to a billion rand towards benefits enhancement. For the second year in a row, GEMS has kept its contribution increase one of the lowest in the industry.

The South Africa's largest restricted medical Scheme has announced a weighted average contribution increase of 7.69% across all its benefit options. The Scheme also announced a change in name of the Sapphire option which will now be called **Tanzanite One** with bigger, better and richer benefits.

"The Scheme endeavors to keep annual increases to a minimum without compromising members' access to quality healthcare as we continue to prioritize the healthcare needs of over 720 000 principal members and over 1.8 million beneficiaries entrusted to us, said Dr Stan Moloabi, GEMS Chief Operations Officer.

GEMS continues to make a significant contribution to providing access to quality healthcare to South Africans. As South Africa's largest restricted Scheme, GEMS has the lowest non healthcare expenditure which means more benefits for members and their beneficiaries.

"The enhanced benefits on **Tanzanite One** symbolize an evolution towards the Basic Benefit Package and transformation which forms part of our business strategy that seeks to ensure more value for our members", says Dr Moloabi.

Summary of key benefit enhancements on specific benefit options for 2020:

Tanzanite One:

GEMS is excited to announce that the Sapphire option has been renamed **Tanzanite One** with better, bigger and richer benefits for our members who will now have access to a network of healthcare providers by nominating a general practitioner of their choice to coordinate their healthcare needs. From 2020, members on the **Tanzanite One** option will have access to private hospitals, subject to utilizing the GEMS private hospital network.

Emerald and Emerald Value options:

Members on the **Emerald Value** Option will experience the lowest monthly contributions increase of all our options, which makes sense for members on **EVO** to stay on this option. Both **EVO** and **Emerald** benefit options offer the same level of healthcare cover, however **EVO** is more affordable because members make use of a network of healthcare providers having nominated a general practitioner of their choice to coordinate their healthcare needs. Members on **Emerald** who switch to **EVO** can experience around R600's worth of savings on their monthly contribution that could be R7200 money back in their pockets per annum.

Benefits enhancement across all options

Each year medical scheme members are encouraged to review their healthcare needs and make the decision of whether they wish to remain on their current benefit option or choose to move to a different option. GEMS invites all members of the Scheme and prospective members of the public service who qualify to join GEMS to consider their family's healthcare needs for the year ahead and choose the cover they are likely to need. More importantly, we would like to encourage public service employees on employment levels one to five to take advantage of the enhanced **Tanzanite One** option as they may qualify for a 100% subsidy which could cover their contributions.

Each year medical scheme members are encouraged to review their healthcare cover and make the decision of whether they wish to remain on their current benefit option or choose to move to a different option.

For more information on the benefit enhancement for 2020, contact GEMS using one of the followings communication channels:

Call centre: **0860 00 4367**
email: enquiries@gems.go.za or visit:
www.gems.gov.za.





Diane de Kock
Editor: *SAMA INSIDER*

Ending the year

Welcome to the final issue of *SAMA Insider* for 2019. We round off the year by interviewing Dr Angelique Coetzee, chairperson of SAMA, on her first year, its challenges and being a woman in leadership (page 9).

Brandon Ferlito continues his discussion on the challenges faced by medical practitioners when managing sexual offences (page 5), and Shelley McGee unpacks the recently published Competition Commission's Health Market Inquiry report into the private healthcare sector (page 7). "SAMA has been involved throughout the processes of the HMI," says Shelley, "and our inputs were taken into account in many areas of the final report. We continue to engage with the recommendations and their implications for our membership, in a bid to ensure that the proposed recommendations are implemented in such a way as to have a truly positive impact on the private sector environment."

SAMA appeals for urgent intervention at the HPCSA (page 6) and expresses outrage at the situation regarding safety and security, especially in public hospitals (page 8): "The situation is unacceptable and can simply not continue."

Positive news includes the historic announcement by the WHO that wild poliovirus type 3 has been eradicated worldwide (page 16), the successful implementation of a SAMA industrial relations advisory service in the Western Cape (page 16) and the many activities at our branches recently (pages 19 - 21).

A sobering reflection by SAMA President, Prof. Coovadia (page 4), on the shattering of the world order, provides food for thought as we reflect on 2019. "Some of the key reasons for this changing climate in human relations and social discourse ... include the looming and untrammelled power of dangerous and reckless leaders scattered throughout the world's nations." Prof. Coovadia appeals to us to stay focused on the essential tasks "for preventing instability and disaster, and constructing a new order based on fairness in society, equity in wealth, mutual respect for all people and creating safe societies through public programmes based on justice and community engagement."

We wish our readers a safe, peaceful and restful end to 2019.

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The world order is being shattered



Prof. Hoosen Coovadia, SAMA president

This, without doubt, is a time in the world of mounting troubles, as the drumbeats of open hostility and increasing aggression between nations get louder and more insistent. It is a perilous period as seen from these African shores, when twitchy leaders from rich and poor nations alike reach for their guns and tanks, rather than for the tools and compacts of negotiation and peace. Some of the key reasons for this changing climate in human relations and social discourse, and brinkmanship teetering at the edges and shifting margins of war, include the looming and untrammelled power of dangerous and reckless leaders scattered throughout the world's nations.

As an aside, we had our own example of denialism in SA, when Thabo Mbeki denied scientific evidence of the cause of HIV/AIDS, and concocted his own version of half-truths. I chaired the International AIDS Conference in 2000, and we were assailed by President Mbeki's pseudo-science. During the last few days at the closing of the conference, this is what I wrote: "Intellectuals and practitioners rose to assert in quiet dignity the centuries-old foundations of the scientific method. Five thousand responded to the call, which

became known as the Durban Declaration. It is a singularly important document attesting to the scientific method for arriving at the truth, and as a lasting expression of the unity of scientists amidst their diversity throughout the world." The Durban Declaration has left an indelible memory in the collective mind of HIV scientists and health workers.

We also have had our own imitation mini-Trump, such as ex-President Jacob Zuma, who, through the machinations of his local cohorts and his partners-in-crime such as the notorious and nauseating Guptas, has almost bankrupted our country. And there are many more in the world: Jair Bolsonaro in Brazil; the egregious Narendra Modi in India, with his cringe-worthy public familiarities with Trump; Rodrigo Duterte in the Philippines, with his "death squads" and vile threats: "Forget the laws on human rights. You drug pushers, hold-up men and do-nothings, you better get out, because I'll kill you," he said at his final campaign rally. "I'll dump all of you into Manila Bay, and fatten all the fish there."

Primus inter pares of those who run fast and loose with evidence is the President of the United States, Donald Trump. Simply because of the global dominance of the USA in many interdigitating fields of the globalised world, not least the economic and political dimensions, Trump has become an exceptionally influential individual. The paradox is that he is the least equipped personally to handle this responsibility with the intelligence, perception and probity needed to address the inequities and suffering of the multitudes from east to west, and from the Arctic wastes to Ushuaia. The current betrayal of the Syrian Kurds – who led the battle to control the devastation caused by ISIS – through the withdrawal of US troops' support is the most flagrant example of being an untrustworthy ally. But the examples of Trump's sheer incompetence in whatever

he does are legion. We are still awaiting the denuclearisation benefits of his romance with the North Korean leader, which have vanished in the dust! Despite the evidence of experts that undertaking a battle employing increasing tariffs on imported goods into the USA is unwinnable and endangers the world economic order, he has gone ahead, with predictable outcomes. But Trump requires an entire volume to record adequately his massive errors in international diplomacy and in advancing the cause of global peace.

It is clear that the world finds itself in a precarious and menacing period, almost as if we are in an intervening space in time on the cusp of plunging into an abyss, or advancing to global safety and progress; these disquieting years can divert us for years to come, away from essential tasks for preventing instability and disaster, and constructing a new order based on fairness in society, equity in wealth, mutual respect for all people and creating safe societies through public programmes based on justice and community engagement. In SA, we have a long way to go before we attain these goals. We have regressed rapidly since those evanescent days of the Mandela years, and we need to ask what our present role is in achieving health, welfare and a stable and just society. What has helped me in avoiding the urge to attempt to implement grand schemes for human happiness is to be involved in issues at my door: engagement in the social, political and economic struggles of ordinary people; and building an effective and affordable healthcare system. I must add I have long been a firm believer in a national health system, partly because the elements of such a system satisfy my basic democratic instincts, and partly also because I lived in the UK for 2 years, became familiar with similar systems in Europe and was repelled by the mercenary health system in the USA.

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@samedical.org.



To report or not to report? Mandatory reporting of sexual offences

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



In the November issue of *SAMA Insider*, an ethical dilemma was presented in the article entitled: “No violence against women and children – the role of medical practitioners”.

This ethical dilemma read as follows:

“By way of illustration: a 15-year-old pregnant girl presents to a medical practitioner, requesting an abortion. The medical practitioner is informed by the girl that the father of the baby is 18 years old. By law, the medical practitioner ought to mandatorily report the matter to the relevant authorities, as this is a clear case of statutory rape. However, the medical practitioner is further informed by the girl that the father of the baby is the financial provider for both her family and herself, and as a result, the girl’s family accepts the sexual relationship. The medical practitioner is aware that reporting could result in disastrous financial complications for the girl and her family. In this case, what should the medical practitioner do?”

Mandatory reporting: Legislation explored

SA is known for its liberal legal framework, which ensures that children from the age of 12 have a right to access a variety of sexual and reproductive health services, including contraceptives and termination of pregnancy. Consensual but underage sex, however, was until recently a criminal offence, and had to be reported to the police. These conflicting approaches between the different branches of law would place those working with adolescents, such as medical practitioners, in an unpleasant position where they were

obliged to provide sexual and reproductive services to adolescents, but were also required to report all sexual acts (including consensual sexual acts).

These and other issues came to the Constitutional Court in the ground-breaking *Teddy Bear Clinic* case. The court deliberated whether criminalising consensual, underage sex and sexual behaviour violated children’s constitutional rights. The apex court held that adolescents are entitled to participate in healthy sexual activity, and that such actions form part of the normal progression from puberty to adulthood. The Constitutional Court also held that the criminalisation of consensual sex or sexual activity between adolescents between the ages of 12 and 15 breached their constitutional rights to privacy, physical integrity and dignity – and the criminalisation of “such behaviour was also not in the best interests of the affected children”.

The Constitutional Court ordered Parliament to amend the law and conform to the Constitution. Parliament passed the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 5 of 2015. The Act amends sections 15 and 16 of the Sexual Offences Act, which are the sections dealing with the consensual sexual activity of a minor.

The Amendment Act of 2015

With regard to statutory rape, the Act states in section 15 that:

“(1) A person (“A”) who commits an act of sexual penetration with a child (“B”) who is 12 years of age or older but under the age of 16 years is, despite the consent of B to the commission of such an act, guilty of the offence of having committed an act of consensual sexual penetration with a child, unless A, at the time of the alleged commission of such an act, was –

- (a) 12 years of age or older but under the age of 16 years; or
- (b) either 16 or 17 years of age and the age difference between A and B was not more than 2 years.”

As a result, it is no longer a criminal offence for adolescents aged 12 – 15 to engage in consensual sex. Additionally, if one child is between the ages of 12 and 15 and the other is 16 or 17, it will not be a criminal offence as

long as there is no more than a difference of 2 years between the parties.

With regard to statutory sexual assault, the Act states in section 16 that:

“(1) A person (“A”) who commits an act of sexual violation with a child (“B”) who is 12 years of age or older but under the age of 16 years is, despite the consent of B to the commission of such an act, guilty of the offence of having committed an act of consensual sexual violation with a child, unless A, at the time of the alleged commission of such an act, was –

- (a) 12 years of age or older but under the age of 16 years; or
- (b) either 16 or 17 years of age and the age difference between A and B was not more than 2 years.”

Section 1 of the Act states that most forms of sexual expression and experimentation, including kissing and mutual masturbation, or touching genital organs, breasts or any part of the body that results in sexual stimulation, are considered to be a form of sexual violation. However, they are no longer a criminal offence, provided that both adolescents are between the ages of 12 and 15 years or one adolescent is aged between 12 and 15 and the other is 16 or 17, and there is no more than a 2-year age gap between them.

Ethical and legal implications

Although the Act does not amend the mandatory reporting provisions, it limits the previously criminalised activities that medical practitioners must report. This means medical practitioners do not need to report such activity unless:

- One of the parties was under the age of 12.
- The activity was non-consensual.
- The younger participant was 12 – 15 years old, and the older participant 16 – 17, and the age difference between them was more than 2 years at the time of the act.
- The younger participant was 12 – 15 years old and their partner was an adult.

However, as illustrated in the case above, the changes to the law do not fully address the ethical issues that medical practitioners may face. With regard to termination of pregnancy, the Choice on Termination of Pregnancy Act

No. 92 of 1996 clearly states that a woman of any age can choose to terminate her pregnancy, and this includes, under the Act's definition, a girl under the age of 12, provided that she has sufficient capacity to make such a decision. Nevertheless, in our case study in which a 15-year-old girl is requesting an abortion, which she is legally allowed to do, her consent to sex with the 18-year-old man is not legally valid according to the 2015 Criminal Law (Sexual Offences and Related Matters) Amendment Act, and must be reported. However, given that the girl and her family are financially dependent on the man, a medical practitioner may find him- or herself in a difficult position, as reporting in this instance may result in disastrous financial complications for the girl and her family. Furthermore, other girls in similar situations may opt to have a back-street abortion instead, as a way of avoiding their partners being charged with a criminal offence, out of fear that the medical practitioner will report the sexual offence.

The “good faith” principle

The principle of “good faith” is a common-law duty to act honestly, openly and with conscientious impartiality. It is intrinsically embedded in, and finds its meaning within, the context of the law of contract. Within the parameters of mandatory reporting legislation, the medical practitioner must report any wrongdoing without any malicious

intent. Common-law duty to act in good faith involves preventing a disruption of the trust relationship between the parties involved in the partnership, and a conflict can arise when the victim does not want the wrongdoing to be reported. Nonetheless, with regard to our case study, the law is clear: “the primary objective, which supersedes all other considerations, is the safety and protection of the [girl] involved.” The good faith standard is objectively measured against community standards of decency and fairness (in this case represented by professionals and professional organisations), and not against the subjective beliefs of the individual.

Who must report, and when?

The Sexual Offences and Related Matters Act No. 32 of 2007 (the Sexual Offences Act) compels all SA citizens who are aware of a sexual offence to report the offence to the police. According to section 54(1)(a) of the Act, the reporting of a sexual offence must be done immediately. “Immediately” can be interpreted as on becoming aware of the sexual abuse, or when there is a reasonable suspicion of abuse of a sexual nature. Reporting the offence, when done in good faith, will not result in any claims of liability.

Accountability

Medical practitioners can be held accountable for not reporting sexual offences

under the conditions described above, as they have taken an oath to keep all those in their care from harm and injustice. The HPCSA guidelines advise members to report any unethical or illegal conduct. Under the Health Professions Act No. 56 of 1974, the HPCSA can order a fine or a suspension, or remove a member's name from the register, in the case of a guilty finding. Furthermore, in terms of section 54(b) of the Sexual Offences Act, failure to report sexual abuse or exploitation of children and mentally handicapped persons is deemed an offence, and is punishable with a fine or imprisonment of up to 5 years, or both, if the person is found guilty.

Conclusion

Mandatory reporting is just one of the challenges faced by medical practitioners when it comes to managing sexual offences. If medical practitioners are unsure about what to do when faced with a similar situation, they may contact SAMA on:

Switchboard: +27 (0) 12 481 2000
Knowledge Management, Research and Ethics Department: Brandon Ferlito (brandonf@samedical.org)
Legal Department: Karlien Pienaar karlienp@samedical.org).

References available on request.

Urgent intervention needed at HPCSA

SAMA Communications Department

Recent reports of poor and inadequate administration at the HPCSA have again highlighted the need for urgent intervention at the council. This is the view of SAMA, which says problems identified at the HPCSA 4 years ago remain a stumbling block for both practitioners and the public.

In 2015, the late Prof. Bongani Mayosi led a ministerial task team that investigated allegations of administrative irregularities and poor governance at the HPCSA. In the report that followed, the task team noted that “the HPCSA is in a state of multi-system organisational dysfunction that is resulting in the failure of the organisation to deliver effectively and efficiently on its primary

objects and functions in terms of the Health Professions Act [No. 56 of 1974]”.

SAMA says the continued lack of proper administration is an indictment on the HPCSA and its inability to institute the recommendations made by Prof. Mayosi and his team. The association says the HPCSA remains an inefficient and ineffective organisation.

“It is outrageous that the same problems identified 4 years ago remain unresolved today. Poor communication to members of the public and practitioners, unfair processes in professional conduct inquiries and undue and unnecessary delays in processing applications continue. It really is a sad state of affairs,” says Dr Angelique Coetzee, chairperson of SAMA.

Dr Coetzee says a raft of recommendations for the HPCSA's turnaround were made by the ministerial task team 4 years ago, among them a full organisational review and a proposal for new governance and administrative structures.

“These recommendations need to be revisited and implemented wholly. The proper functioning of the HPCSA is vital to practitioners and the public, and we cannot allow such an important body to fall further into decline when practical and effective measures for its turnaround have already been identified. We endorse a separate Medical and Dental Council, as per the recommendations in the Mayosi report,” concludes Dr Coetzee.

Competition Commission HMI publishes final report

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



The Competition Commission Health Market Inquiry (HMI) into the private healthcare sector, which commenced in 2014, released its final report on 30 September 2019.

The HMI was charged with identifying features of the private healthcare sector which, alone or in combination, can prevent, restrict or distort competition. SAMA participated in a number of submissions, workshops and meetings as the process unfolded, and we hope that some of the results will translate into positive improvements for the health sector.

Summary of findings and HMI recommendations

The HMI identified multiple market failings and challenges in the private sector. These extend from market fragmentation and governance failures to lack of transparency and damaging regulatory structures. Most of these were identified in relation to the facilities, practitioners and funders markets.

Healthcare facilities

The HMI found that competition has largely failed in the facilities market. The three major hospital groups dominate the facilities market, and are thus able to secure steady and significant profits every year. Independent hospitals' ability to compete has been hindered by a number of factors, including lack of bargaining power in tariff and network negotiations with medical schemes, and an inability to attract specialists to their facilities.

Existing regulations for facility licensing and allowances for "creeping mergers" has allowed the concentration to become entrenched.

In response to this situation and their findings with regard to practitioners, the HMI has recommended that a new regulatory body be established – the supply-side regulator for health (SSRH).

One of the SSRH's duties will be the formulation and implementation of a new needs-based system of licensing for facilities, which will be applied across all provinces and which will serve to ensure that licences are only issued where facilities are needed, to prevent concentration of capacity.

Practitioners

The final report has acknowledged that the 2004 Competition Commission ruling that prohibited collective negotiation for tariff determination created a "price vacuum" in which tariffs are stand-alone for practices. The HMI felt this has also contributed to an outdated coding system and unilateral changes to coding, with no forum to agree on these.

The HMI also found that there is currently no standard way to measure and report on quality and health outcomes, and that there are few mechanisms in place to allow for choosing practitioners based on value for money.

They also found evidence of excessive utilisation of health services, which they attributed to supplier-induced demand (SID). SID refers to a situation where the utilisation of healthcare services is unnecessarily promoted by suppliers of services who stand to profit off this activity. The HMI believes that several incentives in the market have promoted overservicing by medical practitioners, which includes increased admission to hospitals, increased length of stay, and higher levels of care and use of more expensive care than can be explained by the disease burden of the population.

Additionally, the HMI found that the HPCSA ethical guidelines in respect of fee-sharing and multidisciplinary group practices should be reviewed, as these serve to inhibit innovative models of care in the private sector environment.

Problems with the structures of existing practitioner associations were also identified. Associations that serve to advise on professional and business matters were seen to be potentially acting anti-competitively, particularly where they are participating in the negotiations of tariffs for their membership with medical schemes.

Overall, the HMI has recommended a move away from fee-for-service structures as soon as possible. In response to the challenges, the SSRH to be established will also provide a platform for multistakeholder negotiation of practitioner tariffs, which will set a maximum tariff for prescribed minimum benefit-related services, and a benchmark tariff for other services. The multilateral negotiations will not exclude the potential for bilateral negotiations between practitioners and schemes, for designated service provider arrangements, networks and contracts, however, and there will still be room to negotiate further.

The HMI has also recommended the establishment of an outcomes monitoring and reporting organisation as a platform for providers, patients and other stakeholders to generate robust information on the outcomes generated by healthcare provision.

Funders

The HMI also found that the funder administrator environment is highly concentrated, with just two administrators owning the majority of the market of medical schemes.

It also found that medical scheme members do not understand their benefits, and have trouble comparing the offerings of different medical schemes, and hence cannot make informed choices about their cover. Schemes are currently competing on attracting healthier members, and not on making their offerings more affordable.

The HMI found that most scheme members do not derive value from their brokers, and that there is little incentive to align brokers' interests with those of medical scheme members.

Medical scheme governance and the roles of scheme trustees also came under scrutiny, with the HMI finding that the roles of scheme trustees need to be enhanced, and that principal officers and trustees need to be incentivised to ensure that they receive value for money for members, both from their administrators and healthcare providers.

To address some of these issues, the HMI has recommended that a single standardised benefit package is introduced as mandatory for all scheme options to cover. Schemes can then offer supplementary packages on top of this. This should allow members to compare options more easily, and enhance competition in the industry.

In addition, the HMI emphasised that a risk-adjustment mechanism needs to be put in place. This mechanism will make financial adjustments across schemes to mitigate risk-profiling and schemes' attempts to attract healthier membership with their benefit design.

Key implications of the HMI findings

Supply-side regulator for health

The HMI recommends that an independent supply-side regulator be established to oversee and manage functions related to "healthcare capacity planning, economic value assessments, health services monitoring and health services pricing".

The SSRH will have multiple powers and responsibilities, including clinical coding, negotiation of tariffs and issuing of licences, and even will own the practice code numbering system (PCNS – currently hosted by the Board of Healthcare Funders (BHF) on behalf of the Council for Medical Schemes).

According to the HMI, locating these functions within a single supply-side regulator will ensure coherence in policy development and implementation.

It will take some years to set up such a regulatory body, and the HMI has also made

recommendations about interim solutions for licensing and practice code numbering, which will involve the presidential appointment of a working group to develop a licensing framework. In the interim, the BHF will continue to administer the PCNS system.

Tariffs

Most of our private sector doctors have experienced the frustration of the tariff vacuum left by a Competition Tribunal ruling against SAMA, the BHF and the Hospital Association of SA in 2004, and the subsequent failure of the National Health Reference Price List process. This often leaves patients financially exposed to co-payments and balanced billing.

The multilateral tariff negotiations proposed for funders and practitioners will take place under the SSRH, so it seems it may be some time before we see these negotiations actually materialise. In the interim, practitioner groups such as SAMA may need to consider how strong they will be in such a forum against powerful medical schemes and administrators, and how fee determination can be done fairly.

Practitioner payment models

The HMI recommendations are strongly in favour of a move away from the

fee-for-service models to alternative reimbursement options. Alongside this, various recommendations have been made, which include the recommendation that schemes report on what they have done to promote value-based contracting, address supply-induced demand and contain non-healthcare expenditure.

There is also a recommendation for a review of the HPCSA ethical rules to allow for multidisciplinary practices and global fees, and mechanisms for the encouragement of geographically based new entrants into the market to serve underserved areas.

These changes could significantly impact on the delivery models for care, and health practitioners will have to actively engage to ensure that funding interests do not trump medical ethics in how the ethical rules are eventually structured.

SAMA has been involved throughout the processes of the HMI, and our inputs were taken into account in many areas of the final HMI report. We continue to engage with the recommendations and their implications for our membership, in a bid to ensure that the proposed recommendations are implemented in such a way as to have a truly positive impact on the private sector environment.

SAMA calls for immediate action on safety

Dr Angelique Coetzee, SAMA chairperson

SAMA is outraged and demands that government acts decisively in making hospitals safe places for patients to receive care and for healthcare workers to deliver that essential care.

The situation with regard to safety and security, particularly in public hospitals, has reached crisis levels. Patients are being brutally killed in hospitals while doctors and nurses are treating them. This situation is unacceptable and can simply **not** continue.

At the SAMA Chairperson's Forum meeting held in Pretoria on 16 November, the chairpersons of SAMA branches from across the country, and the Board of Directors, took a decision to address the brutal killings of patients by criminals in hospital wards. SAMA views this as a threat to the very dream of universal healthcare coverage.

On the evening of the same day that this decision was taken, SAMA received news

that yet another patient had been shot and killed in an orthopaedic ward in Witbank, Mpumalanga Province. The information at our disposal is that the patient was admitted on Wednesday 13 November and shot at 20h00 on Saturday 16 November, and subsequently died hours later.

This comes just a week after a patient was brutally stabbed to death while doctors and nurses were attending to him in the Eastern Cape.

In KwaZulu-Natal, thieves broke into a community health centre and took off with computers.

SAMA is calling on the Ministers of Health and Police to stop this scourge immediately. It is completely unacceptable that patients and healthcare workers are exposed to this kind of danger. Community and traditional leaders must provide leadership in this regard. Crime is a societal issue that cannot be allowed to

spill over into our hospitals. SAMA has set up a task team that will be meeting with the Minister of Health to present a plan to deal with this scourge.

It remains the view of the association that the primary responsibility of our members is to their patients, and a safe environment is a necessary condition to discharge that responsibility. The association is firm in its position that unless improvements or security upgrades are put in place, especially in hotspot areas, there will be no other option but to withdraw both patients and healthcare workers from these unsafe hospitals, and redirect them to safer communities.

SAMA is acutely aware of the difficulties in access this would create for communities; however, patient safety and the safety of healthcare workers must be regarded as sacrosanct.

Dr Coetzee reflects on a challenging year

SAMA Communications Department

Dr Angelique Coetzee, elected a year ago as chairperson of SAMA, is only the second woman to hold this position (Prof. Denise White was acting chairperson in 2008/2009). A Pretoria-based GP, Dr Coetzee is a long-serving member of SAMA, at both branch and executive level. We caught up with her to reflect on the year.

Congratulations on being the second female chairperson of SAMA. A year into your position, please tell us about some of your challenges?

It's unbelievable how quickly time passes. I can't believe it has already been 12 months. This has been a very challenging year. Although I knew that the job would not be easy, I didn't expect just how difficult it would turn out to be. At management and senior level, two employees, one a departmental head and one a senior employee, were headhunted by their previous firms; another head of department emigrated; and the general manager and previous company secretary both left the association. Understanding the legal aspects around the SAMA NPC [non-profit company] and SAMA TU [trade union], the MOI [memorandum of incorporation] and rules, and the TU constitution proved to be a challenge of its own. As a very young and inexperienced BOD [board of directors], we managed to find our way under difficult circumstances, with plenty of laughter and tears along the way. I lost three dear BOD members due to unforeseen circumstances, which led to deep introspection on whether these situations could have been handled differently. The current placement of the SAMA TU under administration is also a challenge. To find a balance between SAMA, my family and my practice is no easy task.

We are definitely making a difference

Is SAMA moving in the right direction?

I am very proud to say that SAMA is regaining its rightful position as leader of the medical profession. In the international arena, we have built an excellent relationship with the

WMA – I am current chair of the Advocacy and Communication Panel, and Dr Lwando Maki was again elected as part of the Junior Doctors Network leadership. On the African continent, SAMA is part of the coalition of national medical associations, a role I took over from Dr Mzukisi Grootboom. Locally, SAMA is a partner of the Health Federation of SA, and we have united the different GP doctor groupings under one banner, the Unity Forum of Family Practitioners, with the aim of becoming a powerful voice in the primary healthcare space. SAMA signed an MOU [memorandum of understanding] with the Council for Medical Schemes to enhance our working relationship. SAMA is also part of the joint technical monitoring and evaluation compact of the Presidential Health Summit. I am glad to say that SAMA has a good relationship with the Minister of Health and other senior management in the department. We are definitely making a difference.

Has being a woman proved to be an advantage in uniting SAMA?

This is a difficult question, as a very small group of colleagues feel that there is no space for a white Afrikaans female in the leadership. However, the majority of colleagues and members do not judge me on my race or gender, or on my horrendous English verbs and tenses! Perceptions and unfounded opinions can make unity a challenge. I've realised that "unity" is a term that can be used in many different ways, and for ulterior motives.

Just after your appointment, you said: "We tend to forget that doctors are people first, with needs and dreams. They have loved ones who, most of the time, will be second to the needs of the patient, unconsciously putting a lot of strain on the doctor as a real person." As a woman, do you feel you have more empathy? And how have you juggled the roles of wife and mother with the demands of your job?

Empathy is part of being a woman, and I am no exception. I am extremely lucky that all my children are grown up, and very supportive. My husband and mother, neither of whom is medically fit, depend on me as the breadwinner and carer. This can sometimes be emotionally stressful, but each of us is



coping in our own way. I am slightly worried about my surgery of 30 years, as I am quite frequently unavailable due to SAMA business.

Stepping into a position traditionally held by men must have had its challenges. Have you found this to be the case? And, if so, please share some of your experiences.

Apart from a handful of colleagues, as mentioned before, I have not experienced any real problems. I have a very supportive vice-chair and some caring BOD members who sense when I am going to become emotional, and immediately step in and get me out of trouble. As females we sometimes want to empathetically "mother" situations, as the "helicopter mom". I still need to practise a bit around that.

Do you have any advice for women in similar positions?

You need to develop a very thick skin, and I mean a *very* thick skin ... Have a few trusted colleagues with whom you can vent, or who you can ask for advice. Always try to keep your head held high and your eye on the ball. Remember that it is not possible for everyone to like you – nor should they, and that is okay.

To quote Rosalynn Carter (a former US first lady), "A leader takes people where they want to go. A great leader takes people where they don't necessarily want to go, but ought to be."

Ethics For All 2019 – rise to the challenges

SAMA Communications Department

On 17 October, the Medical Protection Society (MPS) held the Cape Town Ethics For All event, an evening of presentations by expert speakers from around the world on topics covering the major ethical risks and challenges facing medical and dental practitioners today.

Held at the Cape Town International Convention Centre, the event began with refreshments and networking opportunities for the attendees over the registration period, before moving into the auditorium for the talks. Dr Graham Howarth, head of medical services in southern Africa for MPS, welcomed the members, before Simon Kayll, chief executive of MPS, spoke on the society's history and functions, emphasising its length and breadth of experience in protecting doctors from the risks involved in clinical practice. MPS has been established in SA for over 60 years, and during that time has demonstrated the benefits of strength in numbers, and having a broad base of medicolegal experts to defend doctors against claims of negligence.

Prof. Jonathan Jansen, author, thought leader and education specialist, gave an insightful and also highly entertaining presentation on "A letter to my doctor", based on the responses of his Twitter followers to the question: "What is the one thing you expect from your doctor?" He explained that ethics, to him, was about "doing the right thing", and the themes that emerged from the responses should alert doctors to the ways in which they could treat patients ethically, ensuring that they are satisfied with the care they receive.

Primary among the concerns mentioned by the commenters was that the doctor should treat the patient with humanity and empathy, as a whole person deserving of attention and concern. "Engage me as a person, not a body part," as one commenter put it, and another, "I'm a person before I am a patient."

Part of treating patients as people is keeping to the appointment time: many people complained about the disrespect they felt doctors showed patients by not being on time. "It is the right thing to do to respect people's time" in any profession, Prof. Jansen stated, and not doing so gives the impression that the doctor's time is more valuable than the patient's. Doctors should also take the time to genuinely listen, and not rush consultations, or ignore patients' worries: "Listen to me and take

me seriously. It's my body, I might know a little something." A good doctor, said Prof. Jansen, is somebody who takes her time. Several commenters also mentioned that they would like their doctors to show continuing concern by following up on them, for instance, after a specialist consultation.

Closely related to this theme of treating patients with respect and consideration, Prof. Jansen discussed the often-mentioned experience of hearing from an older, often poorly educated relative that "the doctor didn't say" what their diagnosis was, and merely prescribed medication without explanation. Doctors should take care to treat all patients equally, regardless of their background, and "include them in the discussion" about their illness – using simple language laymen can understand.

Most importantly, doctors should think of their role as being to give patients a sense of hope and comfort – that things will get better.

Prof. Jansen ended on a lighter note with some of the more tongue-in-cheek comments, such as that doctors should have "fresh minty breath" and that their diagnoses should not vary too much from the patient's Google search results. But above all, he encouraged doctors to take seriously the real concerns that these ordinary patients had raised about the differences between what they expect, and how they perceive the care they are given.

Prof. Jansen was followed by Dr Pallavi Bradshaw, a medicolegal consultant for MPS, who spoke about the doctor-patient relationship from the other perspective: burnout in the medical and dental professions. This was the third time MPS has organised a presentation on burnout, as it is a real concern not just for doctors themselves, but also for patient safety, opening the door to medicolegal risk.

Dr Bradshaw explained that burnout occurs when people's resilience is stretched beyond the point of their coping mechanisms. Healthcare professionals are particularly vulnerable, because of their vocation: as passionate and committed people, when their values are breached by chronic workplace problems and stresses that prevent them from providing high-quality care, their risk of burnout increases. According to a recent MPS survey, the biggest risk factor for SA health professionals is patient expectations. Burnout



Prof. Jonathan Jansen engages the audience

itself, however, is a key risk factor for patient complaints, as a result of the depersonalisation it causes, where doctors become less empathic towards patients, communication is poorer and the doctor-patient relationship lacks trust.

Doctors, said Dr Bradshaw, should try to "say no for safety", rather than forcing themselves to work when they are sick or feeling burned out – as hard as this is for a profession in which the patient's needs always come first. They can also learn to "live with less than perfect", and take time to recover and do things that re-energise them outside of work.

Although these are steps that doctors can take as individuals and at the practice level to improve their resilience, organisational intervention at the unit, hospital and policy-making levels has been shown to have the greatest effect in decreasing rates of burnout, and MPS is available to help with this, if doctors approach the society to tell them what is needed. MPS will also be rolling out workshops on burnout and resilience soon, and Dr Bradshaw encouraged the members to attend.

Dr Tony Behrman, a medical business consultant for MPS, spoke next on the topic of loadshedding from the perspective of health professionals, particularly in relation to hospitals. With the backup systems that major hospitals have in place to prevent downtime during power outages, a surgeon in theatre may not even notice that an outage has begun, but data from the three biggest hospital groups and Western Cape Department of Health show that 60% of major incidents occur at these times. In order for a doctor to safely carry out

procedures during an outage, (s)he needs to understand the backup system available at the facility, and be absolutely certain that every element, from the UPS to the critical generator to the baseline generator to the diesel delivery system, is being regularly maintained, as well as have done practice runs with the whole team, to make sure that the backup power lasts the 24 hours it is supposed to.

The final speaker, Dr Izak Loftus, gave a presentation on the issue of culpable homicide charges for SA medical professionals, and in

particular, the “sword of Damocles” hanging over them: the risk of serving a custodial sentence if a patient dies as a result of medical negligence. Unlike in the UK, where in order to be charged, a doctor must have been grossly negligent, in SA only negligence itself has to be proven. It is the degree of negligence that affects the sentence, however, and lesser instances may only lead to a fine or a suspended sentence. Extreme recklessness leading to a patient’s death, as measured against the actions a reasonable medical

professional would have taken, can lead to jail time, and several SA doctors are currently in prison. With this risk hanging over their heads, SA health professionals need to ensure they have indemnity and protection in place.

Dr Alastair McKelvie, head of Dental Services – Southern Africa for Dental Protection, closed the evening by thanking the organisers, and reminded the audience that buying indemnity is a bit like buying a parachute: if it doesn’t open correctly the first time, you’re probably not going to need it again.

JUDASA Western Cape appoint provincial executive committee

JUDASA Western Cape

The Junior Doctors Association of SA (JUDASA) Western Cape provincial executive committee (PEC) is a JUDASA special-interest group, under the guidance of the SAMA Cape Western and Boland District branches. Our membership of junior doctors comprises SAMA members in the Western Cape Province in their first 4 years of practice.

The current PEC was constituted in June 2019, after many attempts to host provincial elections for the committee throughout the province. The vibrant individuals who now form the PEC structure share a common vision of representing and advocating for junior doctors at various levels of their practice throughout the province, from Caledon to Muizenberg to the Cape Town city bowl.

Taking the reins of an outgoing PEC structure that required active resuscitation and intensive care from the previous leadership, the PEC of 2019/2020 identified the fact that among many other challenges, there was a severe shortage of site-specific representatives (facility reps) of JUDASA in the hospitals across the province. Together with this, we

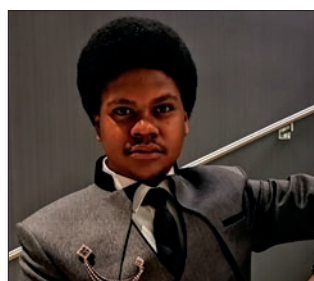
realised that junior doctors were largely unaware of the presence of JUDASA as an entity of SAMA, and of the structure in general.

These two challenges have created the two main goals of the PEC during their term – to:

- establish functioning facility representatives in every hospital that accommodates interns and community service officers
- make JUDASA more visible and accessible throughout the province.

A major challenge faced by JUDASA, which is not specific to our province, is the apathy of junior doctors in terms of joining the organisation during their early years of practice. This makes it extremely difficult for JUDASA to keep its hands on the pulse when it comes to the challenges and concerns experienced by junior doctors in individual facilities across the province.

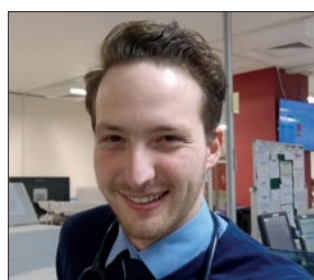
Thankfully, with the presence, guidance and support of the SAMA Cape Western and Boland District branches, the Western Cape JUDASA PEC has been able to formulate ideas and plans to activate and mobilise junior doctors in our current term of office.



Dr Sazi Nzama: chairperson (Caledon Hospital)



Dr Ziyaad Limalia: secretary general (Tygerberg Hospital)



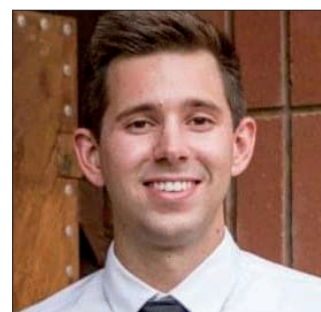
Dr Jarryd Lunn: student liaison officer (Groote Schuur Hospital)



Dr Muhammed Sheik: public relations (2 Military Hospital)



Dr Maleeka Abrahams: executive member



Dr Cornel Vermaak: executive member (Groote Schuur Hospital)

Employees have lion's share of labour rights

Bertha Shabangu, legal advisor: labour relations, SAMA Employee Relations Department



According to the recent third-quarter report for 2019 released by Statistics SA (StatsSA), the country's unemployment rate has skyrocketed to an alarming 29.1%. This, StatsSA says, is the highest unemployment rate since the body started measuring unemployment using the Quarterly Labour Force Survey, in 2008.

There are also, according to Trading Economics, about 10 172 000 people employed in SA at the moment. The sad reality, however, is that a large number of those who are employed are not familiar with the legal rights they enjoy as employees, and this renders them vulnerable. One hypothesis is that it is possible that the unemployment rate is affected by, among other things, the fact that the labour rights of employees are often infringed upon by employers, and the employees often do not know where to run for protection against such infringement. This article is intended to remind employees that they have a plethora of legal rights, not only provided for but protected by legislation.

These include:

- the right to procedural and substantive fairness at disciplinary hearings
- the right to a fair reason for dismissal
- overtime pay
- protection against demotion
- protection from unfair discrimination
- the right to lodge a grievance
- the right to a safe working environment
- the right to strike (subject to limitations)
- the right to representation at bargaining councils or the Commission for Conciliation, Mediation and Arbitration (CCMA) by a suitable representative
- the right not to be victimised, and to be treated with dignity and respect

- the right to leave benefits, as provided for in the Basic Conditions of Employment Act No. 75 of 1977 and the public service regulations.

The list is not exhaustive. Some of these rights are discussed in more detail below.

Legislative framework

The supreme law of the land, the SA Constitution, encapsulates in its Bill of Rights the rights of all South Africans. The following are some of the Constitutional rights meant to be enjoyed by employees.

Section 18: The right to freedom of association

Section 23: Labour rights. In terms of this section:

- (1) Every worker has the right to fair labour practices.
- (2) Every worker has the right–
 - (a) to form and join a trade union;
 - (b) to participate in the activities and programmes of a trade union; and
 - (c) to strike.

Section 36 of the Constitution sets some limitations on these rights. The Labour Relations Act No. 66 of 1995 (LRA) also limits the right to strike in those working within essential services.

The purpose of the LRA includes giving effect to and regulating the fundamental rights conferred by section 23 of the Constitution. The LRA does indeed regulate these rights, as seen in, for instance, section 5, which makes provision for the protection of employees and persons seeking employment. Section 185 provides that every employee has the rights not to be (a) unfairly dismissed, and (b) subjected to unfair labour practices.

Other important legislative protections are provided for by the Employment Equity Act No. 55 of 1998, which in its 65 sections and regulations aims to achieve equity in the workplace by promoting equal opportunity and fair treatment in employment, through the elimination of unfair discrimination, and implementing affirmative action measures to redress the disadvantages in employment experienced by designated groups. The Occupational Health and Safety Act No. 85 of 1993 also gives effect to the rights of workers, by ensuring that there is provision for the health and safety of persons at work and

persons in connection with the use of plant and machinery, and that there is protection of persons other than those at work against hazards to health and safety arising out of or in connection with the activities of persons at work. It also established an advisory council for occupational health and safety to provide for matters connected therewith. In light of recent incidents at public institutions emanating from unsafe working conditions, it appears that the Department of Health fails dismally in adhering to the provisions of this Act.

Protection in the eyes of the courts

Having highlighted some of the legal rights provided for by the legislation, it is also important to note that judicial precedent, including judicial decisions and arbitration awards, also offers protection to vulnerable employees. If there is any infringement of the abovementioned rights, one can lodge an internal grievance, or approach the Commission for Conciliation, Mediation and Arbitration or the Bargaining Council, or the courts. In *Media 24 Ltd & another v Grobler* [2005] 7 BALLR 649 (SCA), an employee had been sexually harassed by a junior manager over a period of 5 months. At the time that the alleged sexual harassment took place, the complainant was a 33-year-old secretary employed by the employer. The accused was at that time a trainee manager employed by the employer. The complainant maintained that she never at any stage received protection from her employer, despite her reporting the incidents. The court's main view in this case was that an employer has a common law duty to its employees to take reasonable care for their safety, and also found that this duty cannot be confined to an obligation to take reasonable steps to protect employees only from physical harm caused by what may be called physical hazards.

In *Gordon v Department of Health KZN* [2008] ZASCA 99, the court held that the employer's failure to promote the complainant, for equity reasons, was unfair as there was no affirmative action policy or plan in place. This ruling by the court upholds an employee's right not to be unfairly treated and discriminated against.

With regard to the right not to be unfairly dismissed, a number of cases have been dealt

with by the courts over the years. In the case of *CWIU & others v Algorax (Pty) Ltd* [2003] 11 BLLR 1081 (LAC), the court stated that “where a dismissal compels the employee to agree to the employer’s demand to change terms and conditions of employment, it will be automatically unfair.”

Most employees fear victimisation in the event that they lodge a grievance, but in

Mackay v Absa Group & another [1999] 12 BLLR 1317 (LC), the court ruled that “victimisation in the form of dismissal resulting from an employee filing a grievance will constitute an automatically unfair dismissal.”

Conclusion

It is imperative that employees are aware of their legal rights. We are nearing the end

of 2019, and some will be starting new employment in the new year. Knowing some of these rights and the protection they confer gives one peace of mind. For any advice and/or assistance on labour-related matters, members are encouraged to get in touch with SAMA’s Employed Doctors Department at labour@samedical.org or on 012 481 2000.

Businesses: Think strategically when cost-cutting

Gert Viljoen, *VPROF*

V Professional 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.

If your business has to reduce its expenses, you are far from alone. In these tough times, companies across the board are cutting costs not just to boost profits, but increasingly as a matter of survival.

Be careful, however – a cost-cutting exercise could become counterproductive if you don’t plan for it strategically. The last thing you need now is a drop in either productivity or staff morale.

We share some tips on how to go about limiting cost to best effect, and with as little risk as possible of leaving your business worse even off than it was before.

We all know times are tough, and many companies are embarking on cost-cutting exercises. This is, unfortunately, a necessary procedure, but think of the impact on staff morale and the potential loss of productivity when undertaking cost reduction. You don’t want to end up leaving your business worse off.

A few tips

Communicate effectively: Cost-cutting is not a pleasant experience, so be open with staff – why it is necessary, how much you plan to save and how this exercise will make the business more sustainable.

Be fair: If you plan to stop business class travel for some employees, but keep it for senior executives, think of the possibility of staff resentment and the potential for an “us v. them” situation to develop.

Keep perspective: A company recently stopped funding junior staff’s cell phones. Not only did this cause widespread anger, but the actual saving was too small to have a real impact on reducing expenses.

Think it through holistically: In another example, a business made significant cuts to travel expenses and used video conferencing for team members to communicate with each other. This reduced team ethos and effectiveness, and productivity was lost.

Think of the side-effects: In another travel cost-cutting scheme, staff were not allowed to use taxis. This, in effect, stopped travel after hours, as staff then opted to travel during business hours. The company lost up to 2 working days a week when staff undertook business trips.

Don’t skimp on contractors: This includes refusing to let them use your canteen. They do important work for your company, so don’t put this at risk by treating them badly.

Use common sense as your guide when you undertake cost-cutting.

Cut your electricity bills

As the cost of electricity mounts and as the spectre of loadshedding once more looms threateningly over both our businesses and our homes, the need for us all to limit our consumption increases exponentially.

The internet is full of ideas on how to go about achieving that, and for your convenience we’ve summarised six ideas that we hope will help you choose those strategies best suited to your particular circumstances.

You will of course be lowering your expenses and limiting your exposure to the business disruption and inconvenience that power cuts always bring with them. Perhaps even most importantly, if we all took these

six steps to heart, we would greatly reduce the risk of Eskom plunging us into darkness in the first place!

Electricity has become a major concern in our lives – not only does it increase in price by double digits each year, but we also face the ongoing possibility (perhaps probability) of loadshedding.

But we can be proactive, as there are many ways to cut costs and, with some research and a good plan, you can cut electricity costs by 40%, by taking certain steps. For example:

- There are several things you can do with your geyser. Turning the thermostat down can save 150 kwh per month, while putting in a timer can save even more (although it does cost up to ZAR1 250 to install), while putting on an energy blanket also saves money. A heat pump can reduce 60% of the geyser’s energy consumption, but they are expensive (up to ZAR16 000), and noisy. Solar geysers are slightly more expensive than heat pumps, and are quiet and operate well (assuming your area has plenty of sunlight). Remember that a geyser makes up 40% of your monthly electricity bill.
- Switch off unnecessary lights, as these costs add up. Get into the habit of turning off lights you aren’t using.
- LED lights are big savers – it’s common sense that moving from 40 watt to 3 watt bulbs will drive power costs down – by up to 2000 kwh per month. Prices for LED bulbs have also dropped rapidly, and you can purchase them for ZAR20. Don’t forget downlights and outside lights when

- considering LED, as these latter two use 40- to 45-watt bulbs.
- Washing in cold water also yields savings, as do new fridges, which can save up to 150 kWh per month but only cost from ZAR7 000 upwards.
 - Using gas for cooking saves money, as a

9-kg gas cylinder only costs ZAR200 for up to 6 months.

- Finally, there is solar, which is expensive (costs vary depending on requirements and scale). If your local authority allows you to sell back your excess solar power to them, then solar becomes an attractive

investment. Solar power is getting cheaper and more sophisticated, and offers you the possibility of reducing or eliminating your exposure to load shedding.

There are many ways to save on electricity – why not start now?

Gender-based violence – too little but not too late!

Dr Margot Uys, Head: FPD School of Health Sciences

A society is still reeling from the latest spate of acts of violence against women, which shocked both South Africans and the world: a young student wanting to post a parcel raped and bludgeoned to death by a government employee, a promising woman boxer shot by her ex-boyfriend, girls abducted, raped and left for dead. These are occurrences that happen daily at all levels of our society, sparing no one. It is alleged that SA has one of the highest gender-based violence (GBV) rates in the world, and is becoming an increasingly unsafe place to live. At least 55 rape complaints against police officers were investigated in the 6 months between April and September 2018, with the highest rape rate by police officers recorded in the Eastern Cape.

Worldwide, GBV affects 1 in 3 women in their lifetime, who will experience physical and/or sexual intimate partner violence or non-partner sexual violence; 7% of women will be sexually assaulted by someone other than a partner; intimate partners are involved in 38% of murder cases; and more than 200 million women have experienced female genital mutilation/cutting according to the World Bank.

In SA, the Thuthuzela (a Xhosa word for “comfort”) Care Centre project (with approximately one centre per district) was launched in 1999 by the National Prosecuting Authority (NPA) to provide a one-stop service for survivors of sexual assault. The project aims to create a therapeutic environment that is supportive, empathetic and promotes the

collection of irrefutable evidence to be used in courts of law towards the conviction of the perpetrators of sexual violence. From 2014 to 2018, FPD supported the Thuthuzela project through technical assistance, and by establishing four new centres. As happened in the national AIDS response, there is now a need to expand service provision to survivors of sexual assault from centralised centres of excellence to primary care level. For this to be realised, the services should become part of the clinical care cascade. Extensive training in the care and management of such clients will be needed for all healthcare provider staff.

Ms Phumzile Mlambo-Ngcuka, as the executive director of UN Women, identified 10 key essential principles for addressing GBV during a speech in 2017:

- Laws must address violence against women in private and public spaces.
- Equal rights must be provided for women in marriage, divorce, property and child custody.
- National action plans with clear benchmarks, timelines and allocated resources are needed.
- Access must be provided for all survivors of violence for immediate protection, including medical treatment, police interventions, social, psychological and legal assistance and safe accommodation.
- All service providers, especially police, lawyers, judges, social workers and health personnel, need systematic training.

- Preventive interventions via awareness raising, mobilisation, and the engagement of men and boys, and of custodians of culture and customs, are needed.
- Systematic data collection and analysis of the causes and consequences of violence against women must be carried out.
- There must be monitoring and evaluation of the impact of laws and policies.
- Adequate resources must be allocated.
- Actions to end violence against women must be integrated into broader policies such as poverty reduction, education, gender-responsive planning and development.

During the parliamentary Women’s Day debate on 4 September 2019, it was pointed out that official statistics confirm that only a small percentage of cases of violence and crime against women make it to court. However, once in court, the success rate for conviction, as confirmed by NPA statistics, is very high.

In view of the desperate need for heightened awareness and training of healthcare staff, FPD has recently updated all its GBV material, and increased its online portfolio on this topic. In addition, the foundation is providing an in-depth discussion and video on how to fill in the J88 form to ensure compliance with medicolegal requirements. Please visit the FPD website <https://www.foundation.co.za/clinical-courses> to access these products and/or for more information on these and other related products.

References available on request.



Forensic Medical Aspects of Gender Based Violence

WHO SHOULD ENROL?

All medical practitioners that come into contact with victims of sexual assault

MODE: Contact Tuition

Be equipped with the knowledge to understand the causes of sexual violence, and the strategies for recognizing and preventing violence in their workplace and families, and be equipped with the resources to support victims of violence

Prevention is better than cancer cure – protecting the lungs of the next generation

Dr L Maki and the National Council Against Smoking

Tobacco is the second leading cause of death and disability in the world, resulting in 6 million deaths a year.

Smokers, and non-smokers exposed to second-hand smoke, are at risk for developing chronic diseases, including various types of cancer. Globally, smoking is the cause of approximately 22% of cancer deaths. Based on the most recent SA National Cancer Registry data, 3 in 5 patients with lung cancer die, and it is now the second-most common cancer in men, and the sixth-most common among women. Cancer is a complex disease that places a significant burden on individuals, families and society. In low-resource settings, the additional burden of expenses for prolonged treatment, and the loss of income from earners, often force families into poverty. Therefore, the use of tobacco products remains a public health threat to all.

Since the implementation of the Tobacco Control Act No. 83 of 1993, SA has had success in reducing cigarette consumption and smoking prevalence through strong tobacco control policies and health education programmes. However, over the past few years, the number of deaths attributed to lung cancer in SA has steadily increased. This is possibly due to the long latency period of lung cancer, which means that it is difficult to detect this type of cancer in its early stages; it is usually detected when the disease has advanced for many years. Consequently, it may be that individuals who began smoking or were exposed to second-hand smoke decades ago are showing signs and symptoms of lung cancer today.

Despite this growing burden, cancer treatment continues to receive a relatively low public health priority in SA. Overall, the country has 38 radiation oncologists working in public hospitals, compared with 147 in the private sector. Following a decision by the KwaZulu-Natal (KZN) provincial government to cut costs and stop recruiting or replacing doctors, hundreds of patients have died in the region over the past 3 years, as cancer services have been under acute pressure. According to the Human Rights Commission, patients at publicly funded hospitals in KZN waited between 5 months and a year to see an oncologist, and another 8 months for radiotherapy or chemotherapy. Moreover, patient treatment is severely compromised due to the unavailability



of equipment. Delaying treatment results in patients moving from stage 1 to stage 2 of cancer, reducing their rate of survival, and negatively affecting the quality of life of those who survive. In light of the cancer treatment crisis facing SA, it is imperative to focus more strongly on cancer prevention, where possible.

Given that smoking is by far the most important preventable cause of cancer, it is worrying that a large proportion of adolescent and adult South Africans continue to use tobacco. Studies have shown that smoking cessation leads to instant benefits, such as a decrease in blood pressure and improved lung circulation. The long-term benefits include reducing the risk of cancer, heart and lung disease and other conditions related to smoking. Moreover, adults who stop smoking between the ages of 25 and 34, 35 and 44, or 45 and 54 years of age gain about 10, 9 and 6 years of life, respectively, compared with those who continue to smoke. It is therefore logical and cost-effective to promote action within the SA population to prevent or reduce tobacco use, and ultimately, lower the risks of cancer and other tobacco-related diseases.

SA is part of the WHO Framework Convention on Tobacco Control (FCTC), which ensures the highest standards of health by setting evidence-based measures to protect all South Africans from the harms caused by tobacco. In line with the FCTC, the current draft Tobacco Bill is intended to replace the 1993 Tobacco Control Act, as it introduces tighter tobacco regulations and introduces the regulation of electronic cigarettes.

The areas that the Bill addresses include:

- The regulation of electronic devices (e-cigarettes): Emerging and growing

evidence suggests that the use of electronic devices is associated with major health threats for smokers and non-smokers. Therefore, electronic devices will fall under the same regulations as tobacco products.

- Smoke-free public areas: Evidence has shown that there is no safe level of exposure to second-hand smoke, which remains a threat to non-smokers. The draft Bill aims to protect non-smokers by making enclosed public areas and certain public outdoor areas 100% smoke-free.
- Prohibition of smoking in cars with children under 18 years old: Research has found that children are more vulnerable to the negative health effects of second-hand smoke and the risk of developing chronic diseases. The draft Bill aims to further protect children from the harms of second-hand smoke in confined spaces by preventing smoking in cars that they are in.
- Plain packaging of tobacco products: Plain packaging introduced in other countries has been shown to reduce the appeal of tobacco products to consumers, increase the effectiveness of health warnings and prevent consumers from being misled about the harmful effects of tobacco use.

The National Council Against Smoking and SAMA therefore urge all South Africans who are smokers to reduce or stop smoking, and encourage all non-smokers not to take up any form of smoking or tobacco. These steps will reduce your cancer risk and improve your quality of life, as well as save you thousands of rands over your lifetime.

Two out of three wild poliovirus strains eradicated

World Health Organization

In a historic announcement on World Polio Day, an independent commission of experts concluded that wild poliovirus type 3 (WPV3) has been eradicated worldwide. Following the eradication of smallpox and wild poliovirus type 2 (WPV2), this news represents a historic achievement for humanity.

"The achievement of polio eradication will be a milestone for global health. Commitment from partners and countries, coupled with innovation, means that of the three wild polio serotypes, only type one remains," said Dr Tedros Adhanom Ghebreyesus, director-general of the WHO and chair of the Global Polio Eradication Initiative (GPEI) polio oversight board. "We remain fully committed to ensuring that all necessary resources are made available to eradicate all poliovirus strains. We urge all our other stakeholders and partners to also stay the course until final success is achieved," he added.

There are three individual and immunologically-distinct wild poliovirus strains: wild poliovirus type 1 (WPV1), WPV2 and WPV3. Symptomatically, all three strains are identical, in that they cause irreversible paralysis or even death. But there are genetic and virological differences that make these strains three

separate viruses that must each be eradicated individually.

WPV3 is the second strain of the poliovirus to be wiped out, following the certification of the eradication of WPV2 in 2015. The last case of WPV3 was detected in northern Nigeria in 2012. Since then, the strength and reach of the eradication programme's global surveillance system has been critical in verifying that this strain is truly gone. Investments in skilled workers, innovative tools and a global network of laboratories have helped determine that no WPV3 exists anywhere in the world, apart from specimens locked in secure containment.

At a celebration event at the headquarters of the WHO in Geneva, Switzerland, Prof. David Salisbury, chair of the independent Global Commission for the Certification of Poliomyelitis Eradication, presented the official certificate of WPV3 eradication to Dr Adhanom Ghebreyesus. "Wild poliovirus type 3 is globally eradicated," said Prof. Salisbury. "This is a significant achievement that should reinvigorate the eradication process, and it provides motivation for the final step – the eradication of WPV1. This virus remains in circulation in just two countries: Afghanistan and Pakistan. We cannot stop our efforts now: we must eradicate all remaining

strains of all polioviruses. We do have good news from Africa: no WPV1 has been detected anywhere on the continent since 2016, in the face of ever-improving surveillance. Although the region is affected by circulating vaccine-derived polioviruses, which must urgently be stopped, it does appear as if the continent is free of all wild polioviruses – a tremendous achievement."

Eradicating WPV3 proves that a polio-free world is achievable. Key to success will be the ongoing commitment of the international development community. The GPEI 2019 - 2023 Investment Case lays out the impact of investing in polio eradication. The polio eradication efforts have saved the world more than USD27 billion in health costs since 1988. A sustained polio-free world will generate a further USD14 billion in savings by 2050, compared with the cost countries would incur for controlling the virus indefinitely.

The GPEI is a public-private global effort made up of national governments, partners including the WHO, Rotary International, the US Centers for Disease Control and Prevention, UNICEF, the Bill & Melinda Gates Foundation and a broad range of long-term supporters.

IR assistance for public sector doctors

SAMA Communications Department

In April this year, the SAMA Industrial Relations Department welcomed Ruan Vlok as an employee relations advisor launching an advisory service in the Western Cape. "I assist all doctors employed in the public sector with any employee relations and/or labour law issues," explains Ruan.

The position was created this year in order to provide doctors in the Western Cape with direct contact with SAMA when facing any issues in the workplace. "I have a passion for labour law, and saw this as an opportunity to broaden my career, assist doctors facing employment issues and provide them with the assurance of fair labour practices," says Ruan. His services have been in high demand,

and well received. A few examples include the payment of commuted overtime that had been halted, prevention of unfair disciplinary action being taken, and pay and grade progression being implemented.

"I grew up in Upington in the Northern Cape, and completed my LLB degree at the University of the Free State in Bloemfontein. After completing my articles in 2015, I was admitted as an attorney of the High Court of SA in April 2015, after which I started my career in labour law," he says. Ruan is a tennis fanatic who hits the courts whenever he has a chance.

You can contact Ruan at RuanV@samedical.org or on 021 531 1177.



Ruan Vlok

Burnout is impacting patient care, says MPS

SAMA Communications Department

Over a third of both doctors and dentists suspect that emotional exhaustion has contributed to a clinical error, according to a Medical Protection Society (MPS) survey.

MPS's survey findings were revealed at its Ethics For All conference – one of the biggest events for healthcare professionals to explore the issues facing the profession. The survey of over 450 doctors and 147 dentists found:

- 60% of doctors, and 61% of dentists, experience a decreasing sense of personal wellbeing.
- 37% of doctors suspect that emotional exhaustion has at some point contributed to an irreversible clinical error, with 60% saying this was related to a lack of concentration.
- 31% of dentists suspect that emotional exhaustion has at some point contributed to an irreversible clinical error, with 43% saying this was related to a lack of concentration.
- 47% of doctors, and 44% of dentists, often or always start the working day feeling tired.

As the world's leading medical protection organisation, MPS sees first-hand the consequences when things have gone too far, and when its members can no longer cope – potentially leading to complaints or a negligence claim, leaving clinicians even more vulnerable to burnout.

To support healthcare professionals, MPS will be launching a burnout workshop across SA in 2020 for both doctors and dentists.

Members attending the workshop can enhance their understanding of resilience, burnout and associated risk, recognise the key signs of burnout and learn how to develop coping strategies to recover.

Dr Graham Howarth, head of medical services, SA, said: "Medicine is a brilliant career – there are few other professions with so many possibilities to improve people's lives. However, the increasing level of burnout I hear of from colleagues is particularly worrying. When doctors feel burnt out it is not only concerning for them, but for patients and the wider team. Doctors who are happy and engaged will find it easier to be compassionate, and provide safer patient care.

"As a mutual organisation, it is vital that we listen to and care for members – part of the solution is introducing the burnout workshop across SA in 2020 for both doctors and dentists.



60% of doctors experience a decreasing sense of personal wellbeing

However, we recognise that more needs to be done, and we want to go further by using our international insight and experience to call for concrete solutions to help improve the work environment of doctors and dentists."

Dr Alasdair McKelvie, head of dental services, SA, said: "A career in dentistry can be hugely rewarding, as dentists often have a strong sense of mission and purpose to help people have a better quality of life. But dentists can spend so much time and energy worrying about their patients that their own wellbeing can often be put on the back burner, which over time could affect patient care. I am all too aware of the increasing levels of burnout dentists are facing – it is vital that action is taken to ensure that we do not let the environment we work in reduce the sense of value that we get from being a dentist.

"Our insight and international perspective allow for efforts to be directed towards practical solutions, such as rolling out our burnout workshop – but we must also work alongside other organisations and government to truly tackle the endemic problem of burnout in healthcare."

About MPS

The Medical Protection Society Limited (MPS) is the world's leading protection organisation for doctors, dentists and healthcare professionals. We protect and support the professional interests of more than 300 000 members around the world. Membership provides access to expert advice and support, and can also provide, depending on the type of membership required, the right to request indemnity for any complaints or claims arising from professional practice. Our in-house experts assist with the wide range of legal and ethical problems that arise from professional practice. These can include clinical negligence claims, complaints, medical and dental council inquiries, legal and ethical dilemmas, disciplinary procedures, inquests and fatal accident inquiries.

Our philosophy is to support safe practice in medicine and dentistry by helping to avert problems in the first place. We do this by promoting risk management through our workshops, e-learning, clinical risk assessments, publications, conferences, lectures and presentations.

MPS is not an insurance company. All the benefits of membership of MPS are discretionary, as set out in the memorandum and articles of association.

A rare diagnosis that seemed common

The Medical Protection Society shares a case report from their files

Mrs K, a 42-year-old insurance clerk, had a history of dysmenorrhoea, for which she took the combined oral contraceptive pill (OCP).

She visited her GP practice and consulted with Dr F, saying that she had experienced heavy bleeding with clots that morning, despite the OCP, and had suffered from gripping abdominal pains the evening before, which had now settled. Dr F suggested a trial of tranexamic acid to take as needed when Mrs K's periods were heavy, and advised her to book an appointment for a pelvic examination.

Mrs K attended the surgery for another face-to-face appointment some 4 weeks later, complaining of ongoing heavy periods and abdominal pain, and was reviewed by Dr A. Pelvic examination was found to be difficult due to Mrs K's obesity and heavy bleeding, and Dr A referred her for a pelvic ultrasound scan, as well as requesting a range of blood tests, including a full blood count and CA125. The blood tests revealed Mrs K to be slightly anaemic, which was attributed to the heavy menstrual bleeding.

The ultrasound scan took place 2 weeks later, and revealed two large fibroids. A referral to gynaecology was recommended. Dr F discussed the results with Mrs K over the telephone, and established that Mrs K was experiencing bloating after eating, with intermittent abdominal pain, and that she wished to be referred to gynaecology for consideration of surgery. A referral to gynaecology was duly made.

A further 2 weeks passed, and Mrs K contacted the surgery again, undertaking a telephone consultation with Dr F in which she described an episode of severe abdominal pain throughout the night, which had now settled. This was considered to be due to the fibroids, and mefenamic acid was prescribed.

One week after this, Mrs K undertook a further telephone consultation with Dr F, complaining of ongoing abdominal bloating, and three episodes of vomiting the previous day. It was noted that Mrs K tended to vomit when her period was due, and she was prescribed codeine and paracetamol, as she was finding mefenamic acid to be ineffective. Her gynaecology appointment was noted to be due in 2 weeks' time.

The gynaecologist repeated the pelvic ultrasound and, due to poor views, requested

an MRI scan for better imaging of the fibroids. This revealed a very large fibroid, and Mrs K was counselled for laparoscopic hysterectomy, although she was advised that she needed to lose weight before this could take place.

Over the next few months, Mrs K continued to present to the GP practice complaining of spasmodic upper abdominal pain, vomiting and bloating. A diagnosis of biliary colic was considered, and she was referred firstly for an ultrasound scan to assess for the presence of gallstones, and then to a specialist gastroenterologist. Although the ultrasound scan did not demonstrate gallstones, both the gastroenterologist and the GPs continued to consider biliary colic to be the most likely cause for her ongoing but intermittent symptoms.

Mrs K was ultimately admitted to hospital with severe abdominal pain and a raised temperature, suspected to be caused by ascending cholangitis. However, investigations revealed a small bowel stricture, and she underwent an emergency laparotomy and small bowel resection. Histology demonstrated a small bowel adenocarcinoma. She was advised to undergo adjuvant chemotherapy.

Mrs K subsequently brought a claim against Dr F, alleging that she had been experiencing severe pain at the time of the initial telephone consultation, and should have been advised to attend the practice the same day for a face-to-face appointment.

It was also alleged that subsequent to Mrs K's reporting an episode of severe abdominal pain that had lasted throughout the night, Dr F should have arranged a face-to-face same-day appointment for examination and review, and again at the time that Mrs K reported vomiting.

Had she been reviewed in person on these occasions, it was alleged that she would have been referred to specialist care earlier, and the tumour would have been identified at an earlier time point, therefore preventing several months of unpleasant symptoms, and allowing surgery to be performed in an elective manner.

Further allegations were made against other clinicians who had reviewed Mrs K during this time.

Outcome

The case was considered by the Medical Protection Society (MPS)'s medical and legal team, and Dr F was considered to have acted appropriately. The team also felt that it was

Learning points

- Comprehensive and unambiguous documentation of the patient's symptoms at the time of a telephone consultation is vital should the history obtained ever be challenged at a later date.
- The need for a face-to-face appointment should always be considered, especially if the patient is a poor historian, or there is doubt about the nature or severity of the symptoms.
- If a patient is repeatedly contacting the surgery for telephone consultations about the same symptoms, it may be prudent to offer a face-to-face appointment to discuss the symptoms further and perform any appropriate examination or investigations.
- In the event that a patient's symptoms do not settle, it may be advisable to reconsider the working diagnosis in light of the information available, and weigh up whether an alternative, perhaps rarer, diagnosis may be the cause.
- Clinicians should be mindful that a patient may have more than one pathology contributing to their symptoms.

unlikely that, even had Mrs K been seen face-to-face on any of these occasions, or referred sooner to specialist care, the tumour would have been identified significantly earlier than it was.

A GP expert was instructed. The expert was clear that, on the basis of the medical records and Dr F's comments, it was not mandatory to offer a face-to-face appointment on the same day at any of her telephone consultations.

The expert did, however, comment that had symptoms been ongoing at the time of the consultations, then Dr F should have established the severity of the pain or vomiting, and probably offered a same-day appointment for review and examination.

On receipt of the expert report, the case was again fully reviewed by MPS's medical and legal team, and it was agreed that a letter of response defending the actions of Dr F should be drafted, and that the offer of early settlement by Mrs K's solicitors should be rejected.

Following receipt of the letter of response, Mrs K's solicitors discontinued the claim against Dr F.

Gauteng North's jubilant celebration

SAMA Gauteng North branch (GNB) held its annual year-end dinner on 12 October 2019. It was a jubilant celebratory event for all attendees. Dr Lindi Shange, vice-chairperson, gave the welcoming speech and presented the 2019 year report. Dr Julius Kunzmann, honorary secretary, was the master of ceremonies for the evening.

Dr Chandra Balie and Dr Lindiwe Shange presented awards to the following recipients for outstanding work in their respective fields:

- Dr Tshomoko Reuben Mahlare: outstanding work in the field of community service general practitioner
- Dr Deodat Mare: outstanding work in the field of orthopaedics
- Dr Keneilwe Letebele-Hartnell: outstanding work in the field of public medicine
- Prof. Mashudu Tshifularo: outstanding work in the field of ENT otorhinolaryngology
- Prof. Gboyega Ogunbanjo: posthumously awarded for outstanding work in the field of family medicine.

The dinner was a fancy-dress occasion, with a cowboy theme. Games were played, including "wheel the barrow" and "tie up the sheriff". Prizes were given for the best-dressed couple, fastest barrow run and unfasten-the-sheriff games. Professional dancers entertained the guests with line-dancing to country songs. A live band played late into the evening.

Gifts of appreciation were given to the support staff at SAMA head office who had assisted the branch during the year with various assignments and projects, and to the branch administrator for contributions to the branch beyond the scope of her duties.



Dr Tshomoko Reuben Mahlare with his award



Dr Deodat Mare receiving his award



Prof. Mashudu Tshifularo receives his award from Dr Chandra Balie and Dr Lindiwe Shange



Dr J Kunzmann (honorary secretary, GNB branch council)

An eventful year for Border Coastal Branch

Border Coastal branch have had an eventful year, which has included three trade union issues ably solved by Simon Buthelezi at head office, and four CPD events.

CPD events provide a membership recruitment opportunity, and were held in the Life St Dominic's Hospital conference room.

The branch, situated in prosthetist and orthoptist Dr Roland Toogood's rooms in Marks Road, Southernwood, is chaired by Dr Mzulungile Nodikida, and the vice-chair is Dr Anastasia Rossouw.



Dr Mzulungile Nodikida



Border Coastal offices

KZN host annual CME conference

KZN Midlands branch hosted their 48th annual CME conference on 15 September at the ANEW Hotel Hilton. Dr Mohamed Bhayat, chairperson of the organising committee, ably assisted by Prof. Mohammed Cassimjee and Dr Surendra Sirkar, must be commended for organising a conference with excellent speakers and interesting topics. The conference was officially opened by Prof. Hoosen Coovadia, whose talk was factual, inspiring and entertaining.

All the talks were of a high standard, but the delegates found the talks by Dr Zubie Hameed on "Recognising HIV skin disorders for the family practitioner" and Dr Amit Kalpee's talk on "An update to the management of benign prostatic hyperplasia including holmium laser enucleation" to be most inspiring and informative. A conference of this nature can only be successful with



Prof. Hoosen Coovadia (SAMA president) and his wife Dr Zubeida Hamed, dermatologist



Prof. Hoosen Coovadia, Dr Amit Kalpee, Dr Mario Haines, Dr Selaelo Mamejja

sponsorships, and there were almost 20 sponsors, including most of the hospitals in the Pietermaritzburg area. The delegates had a very good day meeting old friends, visiting

the sponsors' stands and listening to excellent speakers. Thanks to Mandy Hattingh, branch secretary, for all her hard work in arranging this conference.

Life membership awards presented at high tea

The Gauteng North branch held its annual high tea for branch life members on 11 September. At this event, Life Membership Awards were awarded to Prof. Ida van Biljon and Dr Abdul Carim. This year the awards were presented by Dr Pam Mathebula, branch council member, who holds the events portfolio for the branch.

The morning event was thoroughly enjoyed by all attendees. Thanks to all who attended and made this event memorable.



Prof. Ida Van Biljon



Dr Abdul Carim



Eastern Highveld round off busy year

Eastern Highveld branch has had a busy last 4 months of the year. On 26 August, they held their usual council meeting at the branch office in the Northmead Mall in Benoni. As August was Women's Month, the branch had decided to arrange an event to celebrate the month. Several suggestions were put forward, but the most popular came from Dr Mtshali, who suggested we hold a family fun run/walk.

However, after researching several sports clubs in the area, it became apparent that

arranging a run on public roads was more difficult than anticipated.

The best option seemed to be to join a park run. Having explored this possibility, and eventually agreed on a central location with pleasant surroundings, Gillooly's Farm in Bedfordview was selected, a beautiful spot on a beautiful August morning. However, Saturday morning is apparently not the best time for branch members, as only three brave souls participated. From these small beginnings, it has been suggested that the

branch considers holding a similar event in the future, at a more suitable date and time.

The last CPD meeting of the year was held on 30 October at the Holiday Inn in Boksburg, a central venue accessible from all directions on the highways. The SAMA General Manager, Dr Vusumuzi Nhlapho, attended and addressed the members, who enjoyed welcoming him to the function.

A last branch council meeting will be held in early December, and then it will be Christmas, and soon time to start again in the new year.

Griqualand West's successful CPD meeting

Griqualand West branch hosted a presentation by Mr Hendrik Heystek on 10 October at the Flamingo Casino, Sun International in Kimberley. The topic discussed at the meeting was "Ethics in modern society".

Mr Heystek was born in Pretoria in 1962, and grew up in Pietersburg (now Polokwane), where he matriculated at Hoërskool Pietersburg in 1980. He studied law at the Rand Afrikaans University, where he obtained a BProc degree in 1984, and an LLB in 1987. He

started his career at the Department of Justice as a public prosecutor in 1984, and interrupted this for national service obligations in 1988. As part of his national service, he served as legal advisor to the then-chief of the army, General Kat Liebenberg.

After completion of his national service, Mr Heystek resumed his duties with the Department of Justice, and joined the Office of the State Attorney in 1990. He later left the state attorney and joined the private sector as

a practising attorney. Mr Heystek left private practice for the business world in 1997.

Mr Heystek is a keen student of risk management and risk financing models, and his expertise in this field is well sought after. It is his expert knowledge of the medicolegal field, in which he has been actively involved since 2013, that led to his passion for risk management and training models in this field, in SA as well as abroad.

The event was well attended.

Goldfields give back to the community

Goldfields branch have had a busy year. The last few months have included visiting Wits University to discuss the HIV/TB programme supported by the Department of Health, a Mediclinic video broadcast, a Sanofi presentation on the myths and facts around diabetes control and CPD functions on emergency management of severe burns, and breast cancer.

On 14 October, 28 needy people from the Goldfields community received free cataract operations at Welkom Medical Centre as part of the "Right to See" campaign, in co-operation with the private sector and other interested parties. The services of the nursing personnel and the theatres were made available for free by Mediclinic. The operations were done by Dr Steve Steyn (ophthalmologist) and Dr Simanga Vuthela (anaesthetist). The lenses for the implants were donated by the firm Bausch & Lomb.

There is a very long waiting list for cataract operations in the Goldfields area, and the doctors, other participants and the Welkom Medical Centre considered this a way of giving back to the community, as the operations drastically change the lives of the people involved.



Dr Steve Steyn and Dr Simanga Vuthela with their assistants and two patients



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