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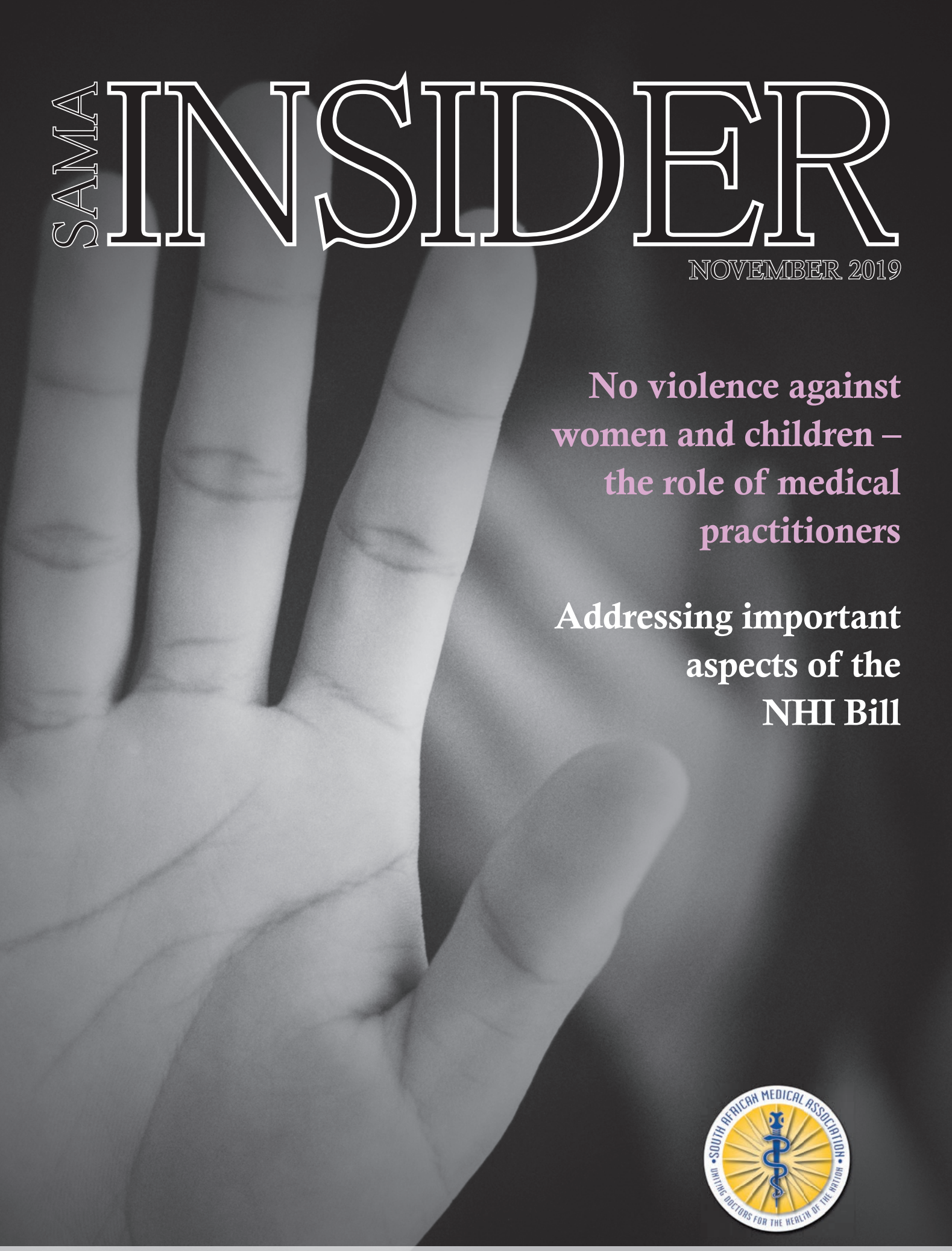

No violence against women and children – the role of medical practitioners

Addressing important aspects of the NHI Bill

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

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CPD

For further information please contact the CPD Officer on

012 481 2000

cpd@samedical.org

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EDITOR'S NOTE NOVEMBER 2019

Diane de Kock
Editor: *SAMA INSIDER*

Step up and show you care

Sixteen Days of Activism for No Violence Against Women and Children runs from 25 November to 10 December, and aims to raise awareness internationally. However, in SA, as recent horrifying events have highlighted, there is a particular need for everyone to "step up and show you care".

In his article on page 5, Brandon Ferlito writes: "Medical practitioners have a vital role to play in protecting women and children who experience violence and/or abuse." He looks at what medical practitioners can do, their role, the dilemma of whether to report or not report, routine screening and protocols, and gives guidance and recommendations to members. Medical practitioners can also often find themselves in challenging ethical and perhaps legal dilemmas, a question that Brandon will address in the December/January issue of *SAMA Insider*.

The recent Private Practice Department (PPD) symposium, held in September, addressed the National Health Insurance (NHI) proposals (page 7) in order to provide members with the opportunity to engage with the National Department of Health, advocacy groups and their peers on the content and implications of the proposals. Issues of quality in healthcare and the proposed NHI Bill were the subject of Prof. Lizo Mazwai's keynote address at the symposium's gala dinner (page 9). "He encouraged SAMA and its members to continue to intensify the conversation about and progress towards universal health coverage, and to co-operate to make the reforms successful," writes Shelley McGee.

As Prof. Mazwai pointed out, the current situation in both the public and private healthcare sectors in SA is unsustainable, and has served to entrench inequities in health. In this light, perhaps it time for us all to step up and show we care – engage, support, give feedback and commit to change.

Join the 16 Days of Activism campaign by wearing a white ribbon during the period. "A white ribbon is a symbol of peace, and symbolises the commitment of the wearer to never commit or condone violence [and abuse] against women and children."

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

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

Senior Designer: Clinton Griffin

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Block F, Castle Walk Corporate Park, Nossob Street
Erasmuskloof Ext. 3, Pretoria

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Landmark UN declaration

On 23 September 2019, world leaders adopted a high-level UN political declaration on universal health coverage (UHC), the most comprehensive set of health commitments ever adopted at this level.

"This declaration represents a landmark for global health and development," said Dr Tedros Adhanom Ghebreyesus, Director-General of the WHO. "The world has 11 years left to make good on its sustainable development goals (SDGs). UHC is key to ensuring that happens." He added, "UHC is a political choice: today, world leaders have signalled their readiness to make that choice. I congratulate them."

The declaration comes a day after the WHO and partners flagged the need to double health coverage between now and 2030, or leave up to 5 billion people unable to access healthcare.

In adopting the declaration, UN member states have committed to advancing towards UHC by investing in four major areas around primary healthcare.

These include mechanisms to ensure that no-one suffers financial hardship because they have had to pay for healthcare out of their own pockets, and implementing high-impact health interventions to combat diseases and protect women's and children's health. In addition, countries must strengthen the health workforce and infrastructure, and reinforce governance capacity. They will report back on their progress to the UN General Assembly in 2023.

"Now that the world has committed to health for all, it is time to get down to the hard work of turning those commitments into results," said Melinda Gates, co-chair of the Bill & Melinda Gates Foundation.

"We all have a role to play. Donors and governments need to move beyond business as usual, to bolster the primary healthcare systems that address the vast majority of people's needs over their lifetimes," said Gates.

Suicide: One person dies every 40 seconds

On World Suicide Prevention Day (10 October), the WHO released the latest data on suicide around the world, showing that close to 800 000 people die by suicide every year. This means that one person dies every 40 seconds. People of all ages and sexes are affected, in every region of the world. Suicide is preventable. Each of us can help to prevent it. Join the WHO's new "40 seconds of action" campaign to raise awareness of the scale of suicide around the world. People are encouraged to:

- increase awareness of the significance of suicide as a global public health problem;
- improve knowledge of what can be done to prevent suicide;
- reduce the stigma associated with suicide;
- let people who are struggling know they are not alone.

The number of countries with national suicide prevention strategies has increased in the 5 years since the publication of the WHO's first global report on suicide, said the organisation in the lead-up to World Suicide Prevention Day. But the total number of countries with strategies, at just 38, is still far too small, and more governments need to commit to establishing such strategies.

"Every death is a tragedy for family, friends and colleagues. Yet suicides are preventable," said WHO Director-General, Dr Tedros Adhanom Ghebreyesus. We call on all countries to incorporate proven suicide-prevention strategies into national health and education programmes in a sustainable way."

Statistics

The global age-standardised suicide rate for 2016 was 10.5 per 100 000. Rates varied widely, however, between countries, from 5 to more than 30 per 100 000. While 79% of the world's suicides occurred in low- and middle-income countries, high-income countries had the highest rate, at 11.5 per 100 000. Nearly three times as many men as women die by suicide in high-income countries, in contrast to low- and middle-income countries, where the rate is more equal.

Suicide was the second leading cause of death among young people aged 15 - 29 years old, after road injury. Among teenagers aged 15 - 19, suicide was the second leading cause of death among girls (after maternal conditions) and the third leading cause of death in boys (after road injury and interpersonal violence).

The most common methods of suicide are hanging, pesticide self-poisoning and firearms. Key interventions that have shown success in reducing suicides are restricting access to means, educating the media on responsible reporting of suicide, implementing programmes among young people to build life skills that enable them to cope with life stresses, and the early identification, management and follow-up of people at risk of suicide.

Put simply, this is an opportunity to show you care.

Urgent action needed to reduce patient harm

Millions of patients are harmed each year due to unsafe healthcare worldwide, resulting in 2.6 million deaths annually in low- and middle-income countries alone. Most of these deaths are avoidable. The personal, social and economic impact of patient harm leads to losses of trillions of US dollars worldwide. The WHO focused global attention on the issue of patient safety and launched a campaign in solidarity with patients on the very first World Patient Safety Day on 17 September.

"No-one should be harmed while receiving healthcare. And yet globally, at least 5 patients die every minute because of unsafe care," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "We need a patient-safety culture that promotes partnership with patients, encourages reporting and learning from errors and creates a blame-free environment where health workers are empowered and trained to reduce errors."

Four out of every 10 patients are harmed during primary and ambulatory healthcare. The most detrimental errors are related to diagnosis, prescription and the use of medicines. Medication errors alone cost an estimated USD42 billion annually. Unsafe surgical care procedures cause complications in up to 25% of patients, resulting in 1 million deaths during or immediately after surgery annually.

Patient harm in healthcare is unacceptable. The WHO is calling for urgent action by countries and partners around the world to reduce this harm. Patient safety and quality of care are essential for delivering effective health services and achieving universal health coverage.

Investment in improving patient safety can lead to significant financial savings. The cost of prevention is far lower than the cost of treatment due to harm.

Greater patient involvement is the key to safer care. Engaging patients can reduce the burden of harm by up to 15%, saving billions of dollars each year.

No violence against women and children – the role of medical practitioners

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

November marks the beginning of the 16 Days of Activism for No Violence Against Women and Children (16 Days of Activism), an international awareness-raising campaign. The campaign takes place every year from 25 November to 10 December. This year's 16 Days of Activism campaign is particularly important, because we commemorate many milestones. The year 2019 marks 65 years since the signing of the Women's Charter, on 17 April 1954, in Johannesburg; 25 years of freedom and democracy in SA; and 20 years of the 16 Days of Activism campaign. However, this year is also proving to be one of the most horrific times for women and children to be alive. The recent violation and murder of 19-year-old UCT student, Uyinene Mrwetyana, the abduction of 6-year-old Amy'Leigh de Jager and the epidemic of other violent acts committed against women and children that have been reported in the media have astonishingly, and unacceptably, become all too commonplace in our society. Sadly, violence against women and children not only either deprives those individuals who have been directly targeted of their lives, or leaves them deeply traumatised and often severely injured, sometimes for life, but its devastating impact also reaches much further, to their families, workplaces and society at large. Violations against women and children, whether physical, emotional or sexual, are a devastating reflection on our society and a lack of moral character that seems to fuel the perpetration of violence.

What can medical practitioners do?

Medical practitioners have a vital role to play in protecting women and children who experience violence and/or abuse. Often, medical practitioners working in the community in health centres and clinics may hear rumours of a woman being assaulted or a child being abused, or see evidence of violence and abuse when women and children seek care for other conditions. Those working in emergency departments in hospitals may be the first to examine a victim of rape or domestic violence. Medical practitioners visiting institutions such as prisons, mental hospitals and retirement homes may be the only source of external assistance to victims of abuse and violence.

Health departments and administrators may also be able to give visibility to the problem of violence against women and children, bearing in mind that in almost every country it is a major cause of ill health and disability. They can ensure that resources are allocated to data collection, the creation of policies to enhance the detection and management of violence and staff sensitisation training. They can also establish a range of responses to the needs of women and children who experience violence.

Violence against women is a major and troubling problem. No easy answers are available. It cannot be fixed by the health sector alone. Still, the sector can start to make a difference with awareness, sensitivity and commitment from medical practitioners.

The role of medical practitioners

Most medical practitioners lack the resources, time or experience to take full responsibility for meeting the needs of women and children who experience violence and abuse. Nevertheless, practitioners can recognise and refer such victims, and provide treatment, where feasible. Additionally, according to the WHO, medical practitioners can, at a minimum:

- First, do no harm, or do not exacerbate the harm that is already being experienced by the victim. Insensitive or victim-blaming behaviours can perpetuate loneliness and self-blame, weaken the victim's self-confidence and make victims less likely to seek help.
- Be mindful and observant of possible symptoms and signs of violence and abuse, and follow up on them.
- Ensure that where possible, as part of normal history-taking, all patients are regularly asked about any violent or abusive encounters.
- Provide appropriate medical care for and note cases of violence and abuse in the victim's medical records, including the perpetrator's information.
- In cases where a child is concerned, report suspicions of violence and abuse to the relevant authorities, as is required by law under the Children's Act No. 38 of 2005, as amended.
- Refer patients to available and accessible community resources.
- Maintain the privacy and confidentiality of the victim's information and records.

To report or not to report

Medical practitioners often encounter injuries and conditions that test their knowledge as to what is considered a violent and/or abusive act, and when to report their suspicions. In SA, with regards to children, the law is clear – any suspicion of violence and/or abuse against a child must be reported to the relevant authorities. Moreover, all medical practitioners have to uphold and abide by an oath or affirmation taken at graduation, i.e. the Declaration of Geneva or the International

Code of Medical Ethics. This ensures that medical practitioners are responsible and accountable to society, and must always act in the best interest of patients. Therefore medical practitioners have both an ethical and a legal obligation to report any suspicion of violence and/or abuse against a child. Mandatory reporting of (sexual) violence and abuse, according to the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007, also applies in the case of individuals who are mentally disabled.

Medical practitioners have a vital role to play

An interesting ethical and perhaps legal dilemma arises in the case of statutory rape. According to the Criminal Law (Sexual Offences and Related Matters) Amendment Act of 2007, the age of consent in SA is 16, regardless of sexual orientation/gender, as specified by sections 15 and 16 of the Act. Section 15 of the Act defines statutory rape as "an act of sexual penetration with a child who is 12 years of age or older, but under the age of 16 years", while section 16 of the Act defines statutory sexual assault as "an act of sexual violation with a child who is 12 years of age or older, but under the age of 16 years." 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 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? This question will be answered in the December edition of *SAMA Insider*.

There are other situations that can also pose an ethical dilemma, and these are not easily resolved, particularly when the victim is neither a child nor mentally disabled. The conflict arises between the medical practitioner's legal and ethical duty to maintain patient privacy and confidentiality, and his or her sense of moral obligation to report any suspicion of violence and abuse, out of concern for the patient. In such an instance, ethics and the law are clear: patient privacy and confidentiality must be maintained, and without the consent of the victim, suspicions of violence and abuse cannot be reported to the relevant authorities by the medical practitioner – a bitter moral and legal pill to swallow.

Nonetheless, this should not discourage medical practitioners from encouraging such victims to speak up and to seek help. According to the WHO, medical practitioners can still take some actions, as described below.

Routine screening and protocols

The importance of screening for violence and abuse as part of normal history-taking cannot be stressed enough. Studies show that with proper training and protocols, medical practitioners can become more attentive and sensitive to issues of violence against women and children.

Nevertheless, it is important to implement such screening with caution. For it to be successful in identifying cases of violence and abuse, adequate practitioner training and development of protocols are required.

Other obstacles can interfere with the maintenance of healthcare standards in resource-poor areas. Sensitive healthcare responses may affect women by decreasing their feelings of isolation or self-blame. Services such as therapy, legal assistance and self-help groups can provide other forms of ongoing support that victims need. However, a lack of such support services may render medical practitioners powerless, because they are restricted in their ability to help victims. Moreover, patient numbers can be high, and the requirement to care for each patient makes it impossible to provide adequate care and treatment beyond a basic level.

Guidance and recommendations

The following is a list of proposed recommendations and guidance by the WHO specifically tailored for the complexities of handling violence and abuse cases in a medical environment.

- Don't be afraid to ask. Contrary to popular belief, many victims are willing to report violence or abuse if approached in a straightforward and non-judgemental way – and actually, many are secretly hoping that someone will ask.
- Allow for a welcoming and non-judgemental rapport. Let the victim tell her story. State clearly that no one deserves to be violated or abused under any circumstance whatsoever.
- Be aware of "red flags". While the best way to detect violence or abuse is to ask directly, multiple injuries "should raise suspicion for abuse:
  - chronic, vague complaints that have no obvious physical cause;
  - injuries that do not match the explanation of how they were sustained;
  - a partner [parent or guardian] who is overly attentive, controlling or unwilling to leave the woman's [or child's] side;
  - physical injury during pregnancy;
  - a history of attempted suicide or suicidal thoughts; and
  - delay between injury and the seeking of treatment."

The list of red flags is non-exhaustive:

- Assess the victim's situation for immediate danger. Establish whether the woman and/or child feels that he or she is in immediate danger. If so, encourage the victim to consider alternative interventions. In the case of a child, mandatory reporting ought to take place.
- Explain to and reassure the victim that they have rights and are protected by the law.
- Be prepared to offer a follow-up appointment or consultation.
- Where possible, display posters and leaflets on domestic violence, rape and sexual abuse, to increase awareness of the issues, and urge victims to document any violence or abuse they may encounter.
- Build and maintain connections with women's and children's groups and other public and non-governmental entities that provide services for victims of violence and abuse.

Violence in our society is often a symptom of deeper social and moral issues. Together, we need to stand up against violence, especially against women and children. The 16 Days of Activism campaign should not only focus on generating increased awareness of the negative impact of violence and abuse on women and children, as well as on greater society, during the 16-day period: it should be a daily campaign, and ought to be ingrained in our daily practices and moral convictions.

References available on request.

Support the campaign by wearing a white ribbon during the 16-day period: "A white ribbon is a symbol of peace, and symbolises the commitment of the wearer to never commit or condone violence [and abuse] against women and children."

PPD symposium addresses important aspects of the NHI Bill

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

On 14 and 15 September 2019, the SAMA Private Practice Department (PPD) organised a symposium on the National Health Insurance (NHI) proposals, to provide members and other stakeholders with the opportunity to engage with the National Department of Health (NDoH), advocacy groups and their peers on the content and implications of the NHI proposals. The symposium follows the call from the Parliamentary Portfolio Committee for Health for stakeholders to submit comments on the NHI Bill, which is before them for consideration.

SAMA has also been conducting CPD sessions with our doctors in the public and private sectors on the contents of the Bill, and took member comments through a written process during September.

The symposium was attended by SAMA doctors in both the public and private sectors, and consisted of a mixed format of content presentations and panel discussions.

The symposium sessions were expertly moderated by Dr Elton Dorkin, managing director of Dr EP Dorkin & Associates.

Dr Angelique Coetzee, SAMA national chairperson, welcomed the attendees to the symposium, and encouraged the audience to be interactive and to take the opportunity to clarify any queries they have about the NHI. She emphasised the point that healthcare in any form cannot go forward without the input of the medical professions.

Christoff Raath, actuary and joint CEO at Insight Actuaries and Consultants, opened the presentations with a review of the NHI proposals in the international context. Although the NHI Bill is controversial, it does provide a direction, and includes proposals that provide a platform for interrogation.

Globally, there is no single best solution to achieving universal health coverage (UHC), and NHI is just one way to try to realise it. What is clear from the WHO UHC framework is that the NHI journey will never be complete, and these reforms will not be a once-off process. Christoff also stressed that there is no country in the world that has no private health sector at all, although its size often depends on the performance of a publicly funded sector.

The panel, from left: Dr Elton Dorkin, Dr Kgosi Letlape, Prof. Shabir Moosa, Michael Willie, and Dr Bandile Masuku, Gauteng MEC for Health

In all countries, equity, efficiency and sustainability remain challenges. Among middle-income countries, there are very few examples of a single-payer model, as proposed in SA. Countries with the most successful systems tend to decentralise and devolve systems, and there is a myriad of governance structures, delivery models and reimbursement models to facilitate this.

Dr Amit Thakker, chair of the Africa Healthcare Federation, presented a continental perspective on organising doctors for the health of a nation. He said that UHC is a journey and not an event, and one Bill cannot possibly address all the issues. It will take time to achieve a suitable system, and there is a trust deficit between parties at the moment that is hindering discussions.

African countries simply do not have the resources that European countries have to implement healthcare. Human resources, in particular, are straining the system in SA. Dr Thakker encouraged SAMA to set a leadership example in the country and in the health system. If doctors leave the country, leadership will be weakened.

He also made some key recommendations for SAMA on remaining significant and important as part of the health system, in the areas of leadership, quality, regulation, evidence-based advocacy, mentorship, capacity-building and inclusivity.

Two panel discussions then examined the NHI proposals from a multi-stakeholder perspective.

Unpacking the NHI and stakeholder perspective

The first panel was made up by Dr Anban Pillay, deputy director-general, National Health Insurance, NDoH; Dr Angelique Coetzee; Christoff Raath; Dr Dumisani Bomela, CEO of the Hospital Association of SA (HASA); and Mr Nkululeko Conco, attorney at SECTION27.

The panel focused on unpacking some of the areas of uncertainty in the Bill, particularly those that would most affect health professionals.

Dr Pillay responded to a number of concerns, and addressed issues relating to the certification and accreditation of healthcare practitioners to provide services for the fund, as well as issues around NHI benefits and costing of the NHI package. He also addressed some of the specifics in the area of proposed contracting structures for primary care and specialist-level care delivery.

Mr Conco expressed SECTION27's ongoing concerns with the proposed governance structures of the NHI fund, as well as concerns relating to coverage for mental healthcare, and groups such as migrants, under the current proposals.

Dr Bomela spoke to the position of the private hospitals. He agreed that there are many aspects and details that will have to be debated in the future. HASA believes that the government has the prerogative to lead the process of healthcare reform, and

Dr Mvuyisi Mzukwa, Dr Bandile Masuku and Dr Angelique Coetzee

Dr Stephen Grobler presenting on coding issues

the association will collaborate with the government on this to try to achieve the successful implementation of NHI.

Role of provincial government, regulators and funders

The second panel included Dr Bandile Masuku, MEC for Health in Gauteng; Mr Michael Willie, general manager for research and monitoring at the Council for Medical Schemes, Dr Kgosi Letlape, president of the HPCSA; and Dr Amit Thakker.

Dr Thakker spoke to the trust deficit that he had mentioned in his presentation earlier in the day. Trust begins with a dialogue. He recommended that SAMA start a multi-stakeholder forum and have regular meetings, to eventually take this issue to a presidential Round Table. This has resulted in areas of collaboration in other countries.

Dr Masuku discussed issues within the province of Gauteng. His observation was that doctors prefer to act as solitary organisms, and only group together when they are in trouble. It is his hope that the NHI will help us to advance the idea of multidisciplinary practices.

Dr Letlape responded to the ongoing contention that the HPCSA ethical rules and regulations do not support NHI implementation. He emphasised that doctors and other health professions do co-operate. However, the accountability mechanism is such that professionals are accountable individually because of the actions that they take.

There remain a number of grey areas in the Bill for regulators to fill in. Mr Willie confirmed that benefit design will be important for the users of the NHI as well as those purchasing private insurance. At present we don't know what will be in the NHI package and what will be complementary cover.

Dr Letlape confirmed that a key issue is that ethics should not change because of the funding model. He emphasised that the employment of doctors by for-profit companies will remain as is, and that the HPCSA is adamant that they cannot compromise our doctors.

The second day of the symposium provided an opportunity for membership dialogue in the form of three parallel sessions that aimed to address NHI-related issues in general practice, specialist practice and the public sector, specifically.

Common themes that were discussed included quality standards and the role and capacity of the Office of Health Standards Compliance, the proposed payment arrangements, which are generally not well understood, and the lack of clarity on benefits and clinical guidelines and referral expectations. In addition, specific concerns were raised about the situation of junior doctors, and the need for adequate information and training for doctors serving in leadership positions in both public and private sectors.

Dr William Oosthuizen, legal advisor at SAMA, provided an overview of the contents of the 2019 NHI Bill, taking members through the intention behind it, and the proposed structure and operations of the NHI fund that the Bill will enact. There are likely to be several challenges to the proposals in the Bill, which the parliamentary process will be dealing with.

Dr Abdool Cassim and Dr Malapa Modisane, both GPs in private practice and members of the SAMA General Practitioner Private Practice Committee (GPPPC), then presented proposals for a primary healthcare (PHC) benefit produced by general practitioners. Dr Cassim presented a structure and costing model that proposes that the doctor be a CEO and contracted party of the PHC team.

Dr Modisane presented an alternative reimbursement model aimed at addressing the heart of the matter of reimbursement to practitioners under the NHI structures. This model aims to reduce waste, control costs and improve quality. In order to achieve this, we will have to consider infrastructure, human resources and efficient NHI administration.

Dr Stephen Grobler, gastroenterologist in private practice, consultant to the SAMA Coding Department and member of the Specialist Private Practice Committee (SPPC) of SAMA, completed the formal presentations with a review of coding in the NHI. We know very little at this stage about what coding proposals are on the cards for NHI, but this is an opportunity to modernise and adopt appropriate coding for the proposals.

Shelley McGee, health policy analyst at SAMA, summed up the meeting and the main themes to be taken forward by the SAMA structures. These included interrogation of the NHI Bill itself, and the imperative of comments in the parliamentary processes. Additionally, themes to be addressed include the interrogation of governance structures and proposed changes to regulations, how to address quality of care and consideration of the coding structures needed. A lot of work also needs to be done to understand and develop the proposed contracting mechanisms.

SAMA thanked the membership and other stakeholders for their participation, and their contributions to the discussion on the way forward regarding the NHI.

Issues of quality in the healthcare sector and the proposed NHI Bill

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

Prof. Lizo Mazwai, past dean of medicine at Walter Sisulu University's Health Sciences Faculty in Mthatha, and past chairman of the Office of Health Standards Compliance (OHSC), delivered the keynote address at the gala dinner of the SAMA Private Practice Department's National Health Insurance (NHI) symposium on 15 September 2019.

Prof. Mazwai opened by pointing out that the current situation in both the public and private healthcare sectors in SA is unsustainable, and has served to entrench inequities in health. It is clear that something has to be done to make sure that everybody has access to quality healthcare around the country.

The National Department of Health (NDoH) has realised that in order to bring about transformation, reforms are needed in both the structure and operations of healthcare in the country. The NHI is the vehicle by which we can achieve true universal healthcare coverage.

The fact that the competence of the NHI is now located within the Presidency means that the government has seriously committed itself to these reforms.

Primary healthcare is considered the cornerstone of reform of the system, but the structures and training in place have, historically, not promoted this. The re-engineered primary healthcare package is a new package on its own, and the ideal clinic concept has been implemented to try to make reforms in primary care a reality.

Additionally, in outlying areas, such as the Eastern Cape, it remains very difficult for patients to access secondary and tertiary care. Only recently has Mthatha Hospital been upgraded to include much-needed oncology services for patients. This is an example of positive growth that has been accomplished.

There are people who feel very pessimistic about the NHI. Prof. Mazwai conceded there are many problems around the NHI proposals, and that these need to be dealt with. But he said he felt that the government must be commended for the leadership and political will they have shown in making progress with these proposals.

There are three key issues in universal health coverage that the NHI must take cognisance of: access; quality; and affordability. Access should not be taken for granted – it is not as easy as it may seem, in rural areas in particular.

Quality of care is defined by the doctor, public health and the patient, but not always by the same criteria. High quality, to physicians, means that they are able to pursue their trade and deliver appropriate care and treatments where they are needed. High quality to patients may mean that they are seen, and their issues dealt with, without having to stand in long queues.

The burden of disease has an important impact on quality. Under-resourced services, overstretched by the high burden of disease and low ratio of practitioners to patients, cannot adequately cope, let alone deliver quality care. Prof. Mazwai expressed alarm at the high burden of non-communicable diseases and mental illness in his own environment in the Eastern Cape. Mental illness is truly destructive, and our own medical professionals are not immune. Given the national theme of the month of September dealing with gender-based violence, he also encouraged the medical fraternity to pay attention to the burden of gender-based violence and how this translates into health outcomes.

In terms of affordability, the Constitution states that care needs to be defined within the resources available. There is much to do in terms of defining this. The delivery of care "free at the point of service" is important in protecting people against catastrophic financial hardship, but what constitutes financial hardship is different for different individuals.

The NDoH introduced national core standards some time ago, and this led to the establishment of the OHSC, tasked with assessing adherence to these standards. There has been a misconception that these standards exist only for public institutions, when in fact they apply to both public and private facilities. The NDoH also set up the Office of the Health Ombud, which has responded to such issues as the Life Esidimeni crisis and the Tower Hospital claims. This is the first ombud of its kind in the country.

The nine national pilot sites for NHI experienced problems, but rather than dismissing them as failures, Prof. Mazwai suggested that we should look to these experiences as learning opportunities.

There are four key issues that need to be addressed in terms of quality of care, based on the professor's experience with the core standards. Firstly, we need to better our understanding of and attempts to adequately address the burden of disease. Secondly, the human resources of the health system, from specialist level right through to the cleaners, must be specially trained, and understand how they affect the health of other people. Thirdly, the facilities themselves, including equipment and the maintenance of equipment, need adequate and competent management. Lastly, all the hospitals that performed poorly in the assessments by the OHSC had poor leadership, governance and management, and the success of these facilities depends on strengthening all of these.

Prof. Lizo Mazwai

Quality also involves engaging patients, to encourage them to take care of their own health and manage their own conditions, so that we have a patient-centred care approach. Patient-centred and community-centred care are key to operationalising all of these quality issues. Bringing patients forward and empowering them to manage their own care and contribute to the care that they receive will be imperative.

Prof. Mazwai concluded with the famous quote from former President Nelson Mandela: "It always seems impossible until it's done." The reforms may seem impossible now, but it falls on a generation to be great, and he encouraged the audience to be that generation. As South Africans, we can do this, with a positive attitude.

He encouraged SAMA and its members to continue to intensify the conversation about and progress towards universal health coverage, and to co-operate to make the reforms successful.

SAMA Finance Department – the heart of the organisation

SAMA Communications Department

SAMA's Finance Department is there to provide "cutting-edge support to all stakeholders of the organisation". This is the view of Mr Richard Matambo, who was appointed to the position of finance manager in mid-September 2019. He says that other departments and branches within SAMA rely on the Finance Department for quick and efficient support, and it is important that it fulfils this mandate.

"Other departments, branches, individual doctors, the SAMA board and outside stakeholders all rely on us, and it is absolutely essential that we provide an outstanding service that they can trust and depend on. We want the Finance Department to be recognised for their service as a strategic partner in each and every initiative SAMA undertakes," says Richard.

Richard – a member of the Association of Certified Chartered Accountants – is also a member of the Institute of Directors. In addition, he holds a Master's in Business Administration, achieved through his studies at Regenesys Business School. Richard started his career at Ernst & Young Chartered Accountants in 2006, where he rose through the ranks from audit assistant to audit senior.

Richard joined SAMA from the Human Sciences Research Council (HSRC) where, as finance director, he was responsible for the overall financial function of the HSRC, and reported to the chief financial officer.

"A key achievement for me while at the HSRC was that our finance team achieved seven unqualified audits, with five of these outcomes being clean audit opinions. The HSRC received a trophy for these achievements, and I'm extremely proud to have been a part of that, more so given the number of regulatory requirements that public entities have to follow in compliance with the Public Finance Management Act (No. 1 of 1999) and National Treasury regulations," he explains.

Richard Matambo

Veronica Lilford

Tintswalo Ndlovu

Baldwin Diale

Eustacia Nel

Tshepiso Mokoena

Cyrildean Hobbs

Lebogang Sekonya

Makhadzi Mulaudzi

It is this same commitment to excellence that Richard wants to continue at SAMA.

"My vision for the department is that the finance team will ensure that all contributions are used efficiently and properly, so that our members receive maximum benefit from their payments. SAMA offers value to its members, and it is important that each of our members derives the best value from being SAMA members. The Finance Department is central to making this happen," he says.

He adds that SAMA has identified a number of key strategies, and that the service provided by the Finance Department is essential in making these strategies a reality.

"These strategies need to be spearheaded by the Finance Department; it's important therefore that the strategies are driven by sound financial practices to ensure that they materialise and that outcomes are achieved," he says.

Richard's vision for the Finance Department is that it stands at the forefront of innovation and technology adoption and utilisation, the implementation of key governance practices and SAMA's long-term sustainability. He says the department must make this happen through key strategic partnerships and initiatives.

Another area he would like to see grow is that of the SAMA properties, in Pretoria and in the regions.

"We want to explore how we can make these properties work better for us, and increase the visibility of the branches. This may include having some of our practising members use parts of

SAMA properties as practices, and the use of such properties by junior doctors in their early years is also something we are considering in delivering value to our members," he says.

Roles and responsibilities

The Finance Department's current role includes the day-to-day payment of operational expenses, invoicing of all revenue streams, management of the organisation's financial resources and branch accounting, among other key functions.

"It's been pretty hectic since I started here, but at the same time it's interesting to see the work SAMA does; it's very enlightening. The work of the Finance Department could not be done without an exceptional team, and I'm fortunate that the people who work in this department are skilled and driven, which makes achieving or attaining goals a lot easier," he says.

The people who work in the Finance Department come from diverse professional backgrounds, and many of them are furthering their studies in different financial fields.

Baldwin Diale is the acting accountant and his responsibilities include payroll, cash book and creditors' control within the Finance Department. He joined SAMA in January 2014. Since then, Baldwin has acquired knowledge in the field of financial accounting and is currently pursuing postgraduate studies in accounting and taxation at the University of Pretoria.

Cyrildean Hobbs is SAMA's senior bookkeeper. She joined SAMA in May 2013. Her roles include the management of the debtors, accounts and bookkeeping to balance sheet.

Veronica Lilford is SAMA's bookkeeper, and one of the longest-serving members of the Finance Department and SAMA, having joined 27 years ago. Veronica's role entails reconciling the Medical Protection Society's account monthly, and processing all of the organisation's payments.

Eustacia Nel is the Finance Department's finance administrator, and also serves as the personal assistant to the finance manager. Eustacia joined the Finance Department in September 2017, and her role includes the processing of the cash-book transactions, and general administration of the finance department. Eustacia is currently furthering her studies in accountancy.

Lebogang Sekonya serves as an assistant bookkeeper in the department. He joined the Finance Department in 2015 as a finance intern, and was subsequently offered a permanent contract as an assistant bookkeeper. His role includes branch accounting and bookkeeping for SAMA Property Holdings, one of SAMA's subsidiaries. Lebogang is also furthering his studies in accountancy.

Tintswalo Ndlovu is a finance intern who joined SAMA in late 2018. She assists with the bookkeeping for SAMA Property Holdings, and is also currently pursuing her postgraduate studies in accounting (CTA) through the University of SA.

Tshepiso Mokoena is an administrative and finance assistant within the department. She joined the Health & Medical Publishing Group (HMPG) in March 2015, and subsequently joined the SAMA Finance Department in January 2019. Her role includes the processing of creditors' invoices and reconciliations.

Makhadzi Mulaudzi is a junior administrator in the Finance Department, who joined HMPG in July 2015 as an intern. She was subsequently offered a permanent contract in July 2016 as a junior administrator, and joined the Finance Department in January. Makhadzi processes debtors' invoices and also does general administration in the department.

"SAMA is a big organisation, and implementing new strategies and initiatives requires buy-in from everyone. I'm excited to be here working with a great team, and I'm looking forward to undertaking some exciting programmes going forward. My approach is always to work with people to find solutions that benefit everyone," concludes Richard.

Burnout: Are doctors immune to working long hours and stress?

Jolene Hattingh, *SAMA Knowledge Management, Research and Ethics Department*

Many people do not realise the extent to which doctors push themselves on a daily basis. The hours are long and the burden is heavy, and doctors too experience exhaustion and fatigue, and are not exempt from falling prey to the creeping side-effects of burnout.

But what exactly is it? "Burnout" is a psychological term used to describe the result of long-term exhaustion and occupational stress, with a diminished interest in work. Recognised in the *DSM-5*, burnout is closely related to disorders such as brain fag syndrome, chronic fatigue, anxiety and other depressive disorders, and should therefore not be taken lightly or simply brushed off. According to the WHO, workers in the health services have an increased risk of suicide.

Burnout, listed under life-management difficulty, falls within the ICD-10 codes (Z73) as a "state of vital exhaustion". The symptoms are similar to those of clinical depression, and include:

- **emotional exhaustion:** People suffering from burnout feel drained and exhausted, angry, overloaded, constantly tired and low in energy. You may feel like what you are doing does not matter that much anymore, or you may be disillusioned with everything. You might notice that you feel more generally pessimistic than you used to. While everybody experiences some negative emotions from time to time, it is important to notice when these become unusually common for you.
- **physical exhaustion:** Physical problems include stomach pains and digestion problems, insomnia, chronic fatigue and weight loss or gain.
- **reduced performance:** Burnout affects everyday tasks at work, at home or when caring for family members. People with burnout find it hard to concentrate, are listless and lack creativity. You may experience a lack of motivation, and find it difficult to drag yourself to work every day. You might even find yourself avoiding work-related activities.

Some risk factors that are specific to doctors include:

- occupational risk factors:
  - emotional demands that are part of the job, including patients' fears and frustrations, dealing with death and breaking the news of a loved one lost
  - extended working hours and staff shortages, leading to sleep deprivation
  - tension and lack of support among colleagues
  - easy access to prescription medications, which could lead to habitual use or misuse of these substances
- individual risk factors: Most doctors are strong, driven Type A personalities who strive for perfection. This personality can lead them to be obsessive-compulsive and overly controlling of their work environments. Type A individuals are described as being outgoing, ambitious, rigidly organised, highly status-conscious, sensitive, impatient, anxious, proactive, concerned with time management, high-achieving and "workaholics". They push themselves towards deadlines, and experience more job-related stress than satisfaction.

Friedman suggested that dangerous Type A behaviour is expressed through three major symptoms: (*i*) free-floating hostility, which can be triggered by even minor incidents; (*ii*) time urgency and impatience, which causes irritation and exasperation, usually described as being "short fused"; and (*iii*) a competitive drive, which causes stress and an achievement-driven mentality. The first of these symptoms is believed to be covert, and therefore less observable than the other two.

Stress and resulting burnout does not go away on its own – it will get worse unless you address the underlying issues causing it. If you ignore it, it will only cause you further harm as time goes by. It is important to know that the healing process takes time, and that it is not something that can be rushed. Not everyone will recover at the same pace, and not all strategies work equally well for everyone. The recovery strategies outlined below are all useful in different situations, so one should try to find a balance between them, and use those that work best and that feel right for you. If you believe that something is not working, do not be afraid to try something new.

Recovery strategies

Exercise. It is important to realise that your body may be in need of attention if you have experienced burnout. Studies have shown that exercise has both physical and mental benefits; not only does regular exercise help to reduce stress, but it also boosts your mood, improves your overall health and enhances your quality of life.

Rest and self-care. Make sure that you are getting enough sleep, eating well and drinking plenty of water throughout the day. These sound obvious, but busy professionals often ignore their most basic needs, while taking care of others. Often, call schedules result in erratic sleep patterns and busy doctors can go for many days without adequate sleep.

Take a vacation or leave of absence. Time away from work gives you the distance you need to relax and de-stress. Though your stress and problems at work may still be waiting for you when you return, taking time off is essential for getting the rest you need and coming up with long-term solutions to burnout. Taking time off to prepare for exams does not count as rest, unfortunately.

Reassess your goals. Take some time to reassess your personal goals. Burnout can occur when your work is out of alignment with your values, or when it is not contributing to your long-term goals. You may also experience frustration and burnout if you have no idea what your goals are. Self-analysis will give you a deeper understanding of what you find most important, and will show you which elements, if any, are missing from your life or work.

Avoid taking on any new responsibilities or commitments while you are recovering from burnout, if possible. Say "no" politely: doctors should be aware of their inherent sense of responsibility, which makes it really difficult to say no.

Practise positive thinking. Burnout can cause you to slip into a cycle of negative thinking. This negative thinking often worsens over time. Affirmations can also help you visualise and believe in what you are doing. It can be a challenge to develop the habit of positive thinking. This is why it is important to start small. Try thinking of something positive before you get out of bed each morning. Alternatively, at the end of the day, think back to one great thing that you did at work or at home.

Celebrate small accomplishments. These celebrations can help you rediscover joy and meaning in your work again.

Random acts of kindness. You can also bring more positivity into your life by practising random acts of kindness at work. A basic part of our human nature is to help others. Being kind to others not only helps spread positivity in the workplace, but it also feels great.

Conclusion

Stress is a strong contributor to burnout. Stress can cause severe health problems and, in extreme cases, death. While stress management techniques have been shown to have a positive effect on reducing stress, they are for guidance only, and readers should take the advice of suitably qualified health professionals if they have any concerns over stress-related illnesses, or if stress is causing significant or persistent unhappiness. Health professionals should also be consulted before any major changes in diet or levels of exercise.

References available on request.

Registrar burnout at Wits far exceeds international norms

More than that 80% of registrars at the University of the Witwatersrand's School of Clinical Medicine suffer from burnout, a response to prolonged stress, with "extremely high" levels of depersonalisation that affect professional response to patients, a survey published in the *South African Medical Journal* found.

In a 2014 US study, 60% of registrars were found to be suffering from burnout.

Researcher Cathelijn Zeijlemaker said in a *Times Select* report that she was particularly worried by the "extremely high" levels of depersonalisation felt that she uncovered among 170 registrars at Wits who completed an online questionnaire. This detachment from work, which resulted in unfeeling and impersonal responses to patients, "is associated with negative effects on professionalism", she said.

The report says the publication of Zeijlemaker's research, which she presented at the SA Association of Family Physicians conference in Midrand, coincides with a WHO bulletin in which a Cape Town doctor describes how he quit as an emergency physician after feeling an overwhelming sense of futility. Many of the responses indicated that registrars were suffering under both categories, but depersonalisation was the bigger problem area.

Richard Heron, co-chair of the International Occupational Medicine Society Collaborative, said that patients would ultimately suffer as a result. "The compassionate, caring environment is harder to maintain, and mistakes are more likely," he is quoted in the report as saying. "Burnout is not just linked to the health of the doctor: it also affects the safety of the patient."

Source: *Medical Brief*, 25 September 2019.

Suicide risk needs to be better managed in SA

SAMA Communications Department

Suicide is preventable, but gaps in SA's healthcare system, in both the public and private sectors, need to be closed if the country is to reduce the risk of self-harm, which kills an estimated 18 people every day.

Death by suicide has lasting effects on families, workplaces and communities, and the SA Society of Psychiatrists (SASOP) urges healthcare providers to better manage follow-up care for those at risk of suicide, rather than focusing only on one-off interventions at a crisis point.

SA's estimated suicide rate of 13.4 people per 100 000 is approximately four times the global rate of 3.6 per 100 000, but "if strategies are in place to identify and manage the risk in the early stages", most of these deaths could be averted, says Dr Kobus Roux, a psychiatrist and SASOP member.

Suicide prevention was the focus of this year's World Mental Health Day on 10 October, with the WHO estimating that one person in the world dies by suicide every 40 seconds, a tragic statistic that has led to their campaign for "40 seconds of action" to prevent suicide.

In SA, Dr Roux said, the private and public healthcare sectors "grossly fail" their users by not providing for follow-ups and ongoing treatment for high-risk patients who have attempted or threatened suicide, although this phase of treatment is considered critical in most healthcare systems for reducing suicide rates.

"Ongoing therapeutic contact with high-risk patients is a very important strategy in suicide prevention. It needs to be implemented in the SA healthcare system and in the proposals for National Health Insurance (NHI)," Dr Roux said.

He highlighted Denmark and South Australia as regions that had achieved significant reductions in suicide rates by implementing strategies that included continuing outpatient treatment after episodes of suicidal behaviour.

"People who have had a previous episode of serious suicidal ideation or behaviour are at greater risk of the events recurring, and they need follow-up and management for an extended period after the threat of suicide has been averted – but it is exactly that part which is neglected in SA," Dr Roux said.

Even more concerning, he said, was that the proposed NHI does not make provision for outpatient psychiatric care – psychiatric services are included only for inpatient care for chronic and severe mental disorders such as mania or psychotic disorders.

He said that the first phase of suicide prevention and treatment was "defusing and preventing acute suicidal behaviour", and that this was managed effectively by the healthcare system and volunteer organisations such as the SA Depression and Anxiety Group (SADAG) and LifeLine.

"The second phase, of follow-up on people with suicidal behaviour and depression – which is the leading cause of suicide – is where our system fails.

"Depression and suicidality are not included on the chronic disease list in private healthcare, and only acute treatment at the point of crisis, in averting a suicide, is covered by medical aids. Ongoing outpatient treatment is not supported by most medical aids.

"In the public sector, once the suicidal crisis is averted, there is nowhere to refer a patient

for follow-up care. Public sector psychiatric services have capacity to treat only those patients with chronic serious mental disorders, such as psychotic disorders, or after acute suicide attempts," Dr Roux said.

The third phase of managing suicide risk is for healthcare providers to be more vigilant in looking for signs of depression in patients with other long-standing chronic illnesses, both physical and mental, as there is a widely confirmed link between chronic illness and depression, and these patients are at higher risk of suicidal thoughts and behaviour.

"SASOP urges healthcare administrators and providers to make an effort to manage suicide risk and promote suicide prevention in their patients in all three of these distinct phases of risk, and particularly in urgently finding ways to provide ongoing care after a suicidal episode to prevent re-occurrence," Dr Roux said.

The SA Depression and Anxiety Group (SADAG) operates the country's only dedicated suicide helpline, open 24 hours every day of the year – call them on 0800 567 567 if you or someone you know needs help.

For assistance from LifeLine, contact 0861 322 322.

Medical scheme forensic audits – what you need to know

Wendy Massaingaie, *legal advisor, SAMA Legal Department*

In recent years, many medical practitioners have been bombarded with forensic audits carried out on their practices, with direct payments suspended and the medical schemes "clawing back" unproven amounts, under the guise of section 59(3) of the Medical Schemes Act No. 131 of 1998. The outcry from our SAMA members has not fallen on deaf ears.

The usual process is for medical scheme administrators to contact the medical practitioner, after conducting a desk audit, with their suspicions regarding misconduct, fraud, billing errors, corruption and practice structure, among other potential problems. This is then followed by a request for the submission of patient files for verification purposes.

Legal basis

Section 59(3) of the Act provides as follows:

"59. Charges by suppliers of service

(3) Notwithstanding anything to the contrary contained in any other law, a medical scheme may, in the case of –

(a) any amount that has been paid *bona fide* in accordance with the provisions of this Act to which a member or a supplier of health service **is not entitled**; or

(b) any loss that has been sustained by the medical scheme through **theft, fraud, negligence or any misconduct** that comes to the notice of the medical scheme, **deduct such amount** from any benefit payable to such a member or supplier of health service" (emphasis added).

One must bear in mind that the Act requires that medical schemes effect payments of all genuine claims within 30 days of receipt of the account, to either the service provider or the member. However, in the case of "clawbacks", medical schemes must indicate under which of the grounds listed in section 59(3)(b) the claimed amounts are not due to the medical practitioner. The medical schemes therefore bear the onus of proving that they are owed money by the medical practitioner, and must provide justification for their findings.

When conducting a forensic audit, medical schemes often state that they are entitled to confidential patient records from the medical practitioner. In this respect, regulation 15J(2)(c) of the Act states:

"15J. General provisions

(2) Notwithstanding anything to the contrary in these regulations –

(c) subject to the provisions of any other legislation, a **medical scheme is entitled to access any treatment record held by a managed healthcare organisation or healthcare provider** and other information pertaining to the diagnosis, treatment and health status of the beneficiary in terms of a contract entered into pursuant to regulation 15A, but **such information may not be disclosed to any other person without the express consent of the beneficiary**" (own emphasis).

Consequently, and in line with the medical profession's own ethical rules, confidential information cannot be disclosed to third parties without the medical practitioner having received consent, preferably in writing, from the patient. Disclosing this information without the required consent is in contravention of the ethical rules, the Health Professions Act No. 56 of 1974, the National Health Act No. 61 of 2003 and the Constitution, subject to the applicable exceptions.

What to be cognisant of

In order to navigate the field of forensic audits, medical practitioners should always ensure that they keep proper patient records, use the correct billing codes, keep purchase-order records for any medications acquired and/or prescribed, avoid any misconduct, uphold the ethical rules and legislation and insist on peer review where necessary. Furthermore, in the event of a medical practitioner meeting with a medical scheme for any discussion concerning forensic audits, it is advisable to make a record of the meeting.

Aggressive approach

There have been varying reports of the methods applied by medical schemes in soliciting information from medical practitioners, such as using threatening language and assuming that the medical practitioner is guilty of misconduct. Such bullying tactics usually result in medical practitioners feeling overwhelmed, and making payments to the medical scheme as a means of avoiding a protracted investigation. In some cases, medical schemes elect to withhold payments to medical practitioners pending finalisation of the investigation, or to impose the "clawbacks" immediately – or both.

What you are permitted to request

Ideally, the forensic audits should be finalised within 30 days of commencement, provided that the medical practitioners co-operate with the investigation, where legally possible. Upon receipt of the intention to conduct a forensic audit, medical practitioners may ask for clarity on any vague assertions made by the medical schemes; request a time extension, so as to obtain legal advice; query the basis and quantification of any amounts alleged to be owed to the medical scheme; and enquire as to how the audit will be conducted, and by whom.

In light of the above, when approached by any medical aid scheme regarding a forensic audit, we urge our members to refrain from conceding to any wrongdoing and signing an Acknowledgement of Debt agreement. They should rather contact SAMA immediately for assistance. Once there is clarity on the nature of the audit, and on which patient files are required, and for what purpose, and if patient consent has been obtained, the files may be provided to the medical scheme. Should there be a quantum provided by the medical scheme, this may be disputed, and the medical scheme has to provide evidence of any such amounts allegedly owed to it. It is also worth noting that the findings of the medical scheme may be appealed, either internally or with the Council for Medical Schemes.

Health and safety concerns in the workplace

Ruan Vlok, *employee relations advisor, SAMA Industrial Relations Department*

One of the biggest issues faced by medical practitioners, and all other personnel working in the public health sector, is their own health and safety while they are ensuring that of patients. In some instances this can result in adverse effects on their mental health, due to the violent element of the crimes that can take place in health establishments. All employees are entitled to work in a safe environment without hazards, and this is regulated by legislation and case law. This article will discuss and provide details of the applicable legislative framework and case law regarding the rights of employees to health and safety.

What does the legislation say?

The Occupational Health and Safety Act No. 85 of 1993 came into effect in 1994, and serves as primary law with reference to health and safety in the workplace. Section 8(1) of the Act states that every employer shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of employees. Subsection 2 states that the duties of the employer are to:

- provide and maintain of systems of work that are safe and without risk to health;
- take steps to eliminate or mitigate any hazard or potential hazard to the health and safety of employees, before resorting to personal protective equipment;
- ensure the safety and absence of risks to health in connection with the production, processing, use, handling, storage or transport of articles or substances;
- establish what hazards to the health and safety of persons are attached to any work that is performed and further establish what precautionary measures should be taken with respect to such work in order to protect the health and safety of persons;
- provide information, instructions, training and supervision to ensure the health and safety of employees;
- not permit employees to do any work unless the abovementioned precautionary measures have been taken;
- take all necessary measures to ensure that the requirements of this Act are complied with;
- enforce such measures as may be necessary in the interests of health and safety;
- ensure that work is performed under the general supervision of a person trained to understand the hazards associated with it, and who has the authority to ensure that precautionary measures are implemented; and
- cause all employees to be informed regarding the scope of their authority.

The National Health Act No. 61 of 2003 specifically refers to employees in a health establishment, and section 20(3)(a) thereof states that every health establishment must implement measures to minimise injury or damage to the person and property of healthcare personnel working in that establishment. The Act goes further and requires all health establishments to be in possession of a certificate of need, and states in section 36(6)(c) that the Director-General of the National Department of Health may withdraw a certificate of need if the establishment is unable or unwilling to comply with minimum operational norms and standards necessary for the health and safety of users.

What does case law say?

In Media 24 Ltd and another v Grobler (2005) 7 BALLR 649 (SCA), the court found that there is a common law duty on employers to take reasonable care of employee safety.

In Odayar v Compensation Commissioner (2006) 27 ILJ 1477 (N), the court came to the conclusion that an employee can claim compensation for post-traumatic stress

disorder in terms of the Compensation for Occupational Injuries and Diseases Act No. 130 of 1993, and does not have to prove exposure to an extreme traumatic event or stressor. Section 65 of the Act only requires the employee to prove that the disease arose out of the course of employment.

What steps to take?

Taking all of the above into consideration one sees that there is a clear responsibility for the employer to ensure the safety of its employees, and to safeguard them against violent acts by members of the public in healthcare facilities. In a media release (12 September 2019), SAMA encouraged all of its members to report instances of non-compliance with occupational health and safety standards to the association.

Medical personnel reporting such non-compliance will enjoy the protection of the Occupational Health and Safety Act, since section 26 of the Act forbids victimisation, and states that no employer shall dismiss an employee, or reduce his or her rate of remuneration, or alter the terms or conditions of employment to any less favourable, or alter his or her position relative to other employees employed by that employer to his or her disadvantage, by reason of the fact, or because it believes that the employee has given information to the now Minister of Employment and Labour or to any other person charged with the administration of a provision of this Act that in terms of this Act he or she is required to give.

Opportunities and challenges ahead for digital healthcare

Foundation for Professional Development

Digital technologies have great potential for solving various complexities in healthcare. This article will take a look at some of these areas of impact.

Such technologies can augment the capacity of healthcare providers, by automating diagnosis based on advanced image-recognition algorithms, in areas such as blood, urine and cheek swab tests and laboratory images. Technologies also allow remote consultation, overcoming barriers of distance.

Digital technologies can also improve the capability of healthcare providers; the use of tools such as virtual/augmented/mixed reality can provide better training to doctors, nurses and paramedics on techniques and medical advancements. Robotic surgeries and 3D-printed prostheses will also increase our capabilities.

Smart devices to monitor blood pressure, pulse or glucose levels, for example, will allow healthcare providers to pre-empt incidents in patients suffering from chronic conditions such as diabetes or heart problems. Apps, games and other digital tools can also motivate such patients to lead a healthy lifestyle and take medication regularly and on time, thereby maintaining their quality of life.

Technologies can also reduce the cost of care – smart devices in hospitals can improve asset utilisation and maintenance, and allow the automation of functions such as monitoring conditions in ICU after operations. Costs can also be reduced through the use of better costing mechanisms in hospitals that allow them to optimise their processes, and cut waste.

Better population health management becomes possible with the digitalisation of patient records, allowing better pricing of insurance and more insurance coverage, and incentivising preventative measures. Such information can also be fed into algorithms to predict disease outbreaks in sensitive regions. Improving the traceability of medicines from factory to pharmacy can prevent wastage, and ensure the authenticity of medication.

Many of the above technologies are currently being used, but what is missing is harmonised system-wide data interconnection, which would create more intelligence. In many developing countries, the adoption of digital technologies has been very high in urban populations in regard to certain aspects of healthcare. However, there is a gap when it comes to rural and peri-urban areas. There is much more that we can do to increase digital adoption. This will require addressing specific challenges.

The digital compliance-related behaviour of individuals needs to improve: very few doctors outside branded hospital chains are using a computer or tablet to record prescriptions. Similarly, patients at risk or suffering from chronic conditions might not be using apps or smart devices rigorously to record readings and share them with their doctors.

The design of the user interface of technologies could improve this situation: imagine a senior citizen who has had diabetes for 20 years – they might be a smartphone user, but the apps meant for better diabetes management do not have an interface in the patient's mother tongue, which would make them easier for such a patient to adopt. Also, many apps do not build in workflows and features to include family members who are known to have a positive influence in ensuring adherence to certain lifestyles.

Doctors also need to be co-opted in getting patients to adopt technology – they are yet to start prescribing apps in addition to medicines. This is probably because clinical evidence to show that apps have positive health outcomes for patients is not yet available.

End-to-end health coverage would mean that the consolidation of spends in the wallets of an employer or insurer could bring about compliance at the hospital or the individual doctor/patient level, because capturing data would become a key need, to ensure transparency.

Better collaboration between entities is needed. For example, pharmaceutical companies could pool data to determine combined drug sales in an area, or pharmacies might collaborate with manufacturers and distributors to trace drug shipments across the supply chain. Also, many hospitals and clinics in an area could share data to see if there is a disease that is on the rise.

Technologies today allow the sharing of such data in a secure manner, but the alignment of incentives and setting up of the right data security laws is needed.

So what is the prognosis for digital healthcare? One ecosystem-level development in the USA promises to usher in change that will propel the adoption of digital technology in healthcare. The concept of digital therapeutics is emerging, under which apps might be treated like drugs by regulators – app-makers could be expected to conduct clinical trial-like studies to prove their claims, so that doctors can start prescribing their apps like drugs.

Nelson Mandela Children's Hospital – 2 years on

Dr Nonkululeko Boikhutso, *clinical director, Nelson Mandela Children's Hospital*

The need for specialised tertiary and quaternary medical care for children cannot be overstated. While primary healthcare services in SA have significantly improved access to healthcare for many children, there has been a gap in the provision of specialised tertiary services in the country and on the continent. Currently, children who rely on public hospital services often wait for several months, sometimes years, to receive treatment in hospitals that are often strained by the demands on their services.

Initiated by the Nelson Mandela Children's Fund, in line with its vision to change the way society treats its children and youth, the Nelson Mandela Children's Hospital (NMCH) was born out of Madiba's vision to meet this challenge and to improve access to quality healthcare for the children of southern Africa. Built through a global fundraising campaign by the Nelson Mandela Children's Hospital Trust, NMCH is a 200-bed state-of-the-art referral facility in Johannesburg, and now the second dedicated paediatric hospital in the southern African region. The institution has begun to make significant strides in improving health outcomes for children in Gauteng.

The radiology unit, which was the first unit to become operational in June 2017, has significantly reduced waiting lists for MRI services within the network of referring hospitals. In March 2018, the hospital rolled out additional services, which include a critical care complex (neonatal and paediatric intensive care units), renal services, cardiology, cardiothoracic surgery, neurosurgery and general surgery, supported by anaesthesia and allied health services.

The vision of the hospital is "to give every child a chance to live and thrive", with a focus on providing family-centred care through a multidisciplinary approach. This is achieved through collaborative partnerships from a strategic and socioeconomic perspective. Although the hospital is located within Gauteng, it remains of service to children in the southern African region in general. As a result, NMCH has already begun to treat patients from Limpopo, North West and Mpumalanga, and has provided services to children of migrant families from our neighbouring countries.

We remain grateful to the national government for its support for the operations of the facility, and for the training of nurses and doctors through the National Skills Fund. Skills development remains a strategic priority for the hospital, as the region faces a shortage of paediatric specialists and intensivists. International partnerships with renowned hospitals such as SickKids International in Toronto, Canada, and Johns Hopkins in the USA, have also supported training opportunities for healthcare workers at NMCH and those within the hospital's network.

NMCH has incorporated interprofessional practice into its daily operations. This collaborative approach to patient care is not common practice in the SA setting, for various reasons. Some of the benefits of this approach are in providing an understanding that all healthcare providers contribute and are important members of the team. Interprofessional practice also builds trust among team members, which leads to better care and better outcomes. The family-centred care provided at NMCH has created a platform of inclusivity for families to be involved in the care of their children, which has led to better understanding of their child's medical condition by caregivers.

We recognise that a child's health outcome and his or her ability to thrive are dependent on the family's participation in the management of the child's illness. We therefore look forward to many more partnerships in advancing this optimal care in collaboration, in service of many parents of children who otherwise would not be able to access this care.

Becoming a ''doctor without borders'' brings different perspective on medicine

SAMA Communications Department

SA's Dr Stefan Kruger, a member of the Médecins Sans Frontières (Doctors Without Borders; MSF) board of directors, found working with MSF personally and professionally rewarding – and hard to leave behind.

"Usually we would receive no warning of the imminent arrival of bomb-blast victims. They normally arrived in a cloud of panic: chaotic screaming would ensue, and staff members run to man their posts. But this time we were prepared," Dr Stefan Kruger, an experienced medical humanitarian, says of one experience.

In 2012, he joined MSF for his first assignment in Afghanistan, working in the restive Kunduz Province. Before the UCT medical school graduate took the leap with MSF, he had completed his internship in Nelspruit, and worked at Frere Hospital in East London and as a resident medical officer in the UK, experiences that would prepare him for his time with MSF.

"In Kunduz, from the time of the phone call, it would be 20 minutes before the blast-injured patients arrived. Not much time to ready the emergency room, but I was surprised at how much got done. We cleared the resuscitation room and triage area, we prepared IV bags and bandages and then we prepared a queue of stretchers outside," Dr Kruger says.

"From what we'd heard, it was a small improvised explosive device, and there should have been six victims only. We knew we should manage without problems, but there was still a sense of added urgency to everything we did. Colleagues from the inpatient and outpatient departments temporarily left their stations, and within 2 minutes there was a small platoon of doctors and nurses tending the wounded."

After completing his assignment in Afghanistan, he accepted a second assignment with MSF in South Sudan, before returning home to SA.

In 2014, Dr Kruger was working in private practice in SA. When a major Ebola epidemic broke out in West Africa, he joined MSF teams responding to the crisis in Sierra Leone, and later, Liberia.

"When I entered the isolation unit for the first time, I saw that my first patient was

Dr Stefan Kruger in the field with a colleague ©PK Lee/MSF

a nurse from a nearby clinic. He had been seeing many patients, some suspected to have Ebola. He had now fallen ill himself. We collected his blood sample for testing. This is quite a process as well: the sample container is decontaminated with chlorine; it is placed in a plastic bag, which again is decontaminated; and upon our exit is placed in another bag and decontaminated again," Dr Kruger recalls.

"We got into a routine of admitting between 10 and 20 new patients per day. We became accustomed to families being broken up because of discordant blood test results, and entire households being erased from their family trees – one by one."

"Of course, not all patients exited the treatment centre through the mortuary. Many suspected cases were discharged when their admission blood tests were negative. There was also a cure rate of approximately 40%. The truth is that we didn't know whether we truly cured them – perhaps we only provided the final straw their immune systems needed to break the Ebola camel's back. A small service we were more than happy to provide."

After returning from West Africa, Dr Kruger worked at Chris Hani Baragwanath Academic Hospital in Johannesburg, before moving to Cape Town, where he currently works as a registrar in neurosurgery. He also serves as

Dr Stefan Kruger ©MSF

a volunteer member on the Doctors Without Borders (MSF) Southern Africa board of directors, using his experiences and skills to help guide the work of MSF in southern Africa and beyond.

"Working with MSF has afforded me the opportunity to experience a different facet of medicine, and in different contexts, with immense job satisfaction. I don't think it is something one can ever let go of completely," Dr Kruger says.

Traditional healers play a significant role in mental health

SAMA Communications Department

With one-third of South Africans experiencing a mental disorder in their lifetime, and limited access to psychiatric treatment in the public health sector, traditional healers can play an important role in the frontline of treatment for depression, anxiety and substance abuse.

Specialist psychiatrist Dr Lerato Dikobe-Kalane, a member of the SA Society of Psychiatrists (SASOP), has called for greater co-operation between conventional Western medicine and traditional health practitioners, to improve access to mental healthcare.

SA currently has 915 practising psychiatrists, the majority in the private sector and in urban areas, and 75% of people in SA with mental health disorders do not receive the treatment they need, she said.

"We have an estimated 200 000 traditional healers in SA – they have intimate knowledge of traditional medicine and cultural and spiritual practices and beliefs. They are respected in the community and their advice is sought and respected, and they are able to offer culturally appropriate treatment.

"There is evidence that the psychosocial role of traditional healers – informal counselling and support in improving family, community or work relationships – can help to relieve distress and mild symptoms of common mental disorders such as depression and anxiety. Given our limited public sector psychiatric facilities, traditional healers can play an important role in assisting people with mental health issues at a primary healthcare level," Dr Dikobe-Kalane said.

Traditional healers play an influential role in providing health information in both rural and urban settings, and greater collaboration between conventional, Western health practitioners and traditional healers could educate traditional healers on common mental disorders and treatment options, and when to refer people for more specialist treatment, she said.

The SA Stress and Health Study in 2009, the first nationally-representative research into mental disorders, showed that alternative, or traditional, medicine is widely used by South Africans, and that those suffering from anxiety or a substance abuse disorder were likely to consult traditional healers.

Dr Dikobe-Kalane said the wide use of traditional medicine suggested that educating traditional healers on common mental disorders and treatment options could have a significant impact for people living with untreated mental health problems.

"There is little evidence that traditional healers have an impact on treatment for severe mental illnesses such as bipolar and psychotic disorders. This is why collaboration between traditional and Western practitioners is needed – to ensure that they understand each other's roles and cultures, and are able to refer treatment-resistant patients to alternative modes," she said.

References available on request.

African Traditional Medicine Day 2019

African Traditional Medicine Day is a WHO initiative as part of their advocacy of recognition of traditional health practitioners and the integration of traditional medicine into national health systems. Commemoration of African Traditional Medicine Day coincides with the date, 31 August 2000, on which the ministers of health adopted the relevant resolution at the 50th session of the WHO Regional Committee for Africa in Ouagadougou, Burkina Faso.

Traditional African medicine is a holistic discipline involving the use of indigenous herbalism combined with aspects of African spirituality.

According to the SA Department of Health (DoH), "about 80% of Africa's population relies on traditional medicine for their basic health needs. In some cases, traditional medicine is the only healthcare service available, accessible and affordable to many people on the continent. In this case the significant contribution of traditional medicine as a major provider of healthcare services in Africa cannot be underestimated … [we have] taken steps towards the official recognition and institutionalisation of African traditional medicine by establishing a directorate of traditional medicine within the National DoH, as well as enacting the Traditional Health Practitioners Act (No. 22 of 2007), which established the Interim Traditional Health Practitioners Council."

SAMA Trade Union – administration clarity

SAMA Communications Department

SAMA has always endeavoured to serve the interests and needs of its members in all healthcare-related matters.

SAMA's membership is unique, and includes practitioners in both the private and public sectors. This diversity has been its strength, and has enabled SAMA to provide a more powerful unified voice on matters affecting doctors and the healthcare system in general.

SAMA is constantly looking for opportunities to serve its members better, and provide value to them.

One such initiative has been the registration of a SAMA Trade Union. Through its Industrial Relations Department, SAMA has ably assisted members in various employment matters, and has been actively involved in collective bargaining to protect and advance the interests of employed members.

However, it has been difficult to reconcile the uniqueness of SAMA with the rigidity of the Labour Relations Act No. 66 of 1995. Doctors, due to their highly skilled and professional

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Fatal condition

The Medical Protection Society shares a case report from their files

Mrs J, a 62-year-old housewife, did not visit her GP's surgery often. However, she consulted Dr D with a 2-week history of coryzal symptoms. Other than hypothyroidism, she was generally fit and well, but she reported lethargy, body aches and a cough, productive of green sputum, for the previous fortnight. Dr D recorded a temperature of 40°C, with a pulse of 102, respiratory rate of 24 and oxygen saturation levels of 95%. Despite a lack of chest signs on auscultation, he commenced treatment for a lower respiratory tract infection, prescribing co-amoxiclav and clarithromycin, which the patient had taken in the past without problems.

The following day Mrs J felt worse rather than better, and her husband requested a visit at home. This time she was seen by Dr A, who found that her fever continued and she now had a sore throat and a rash. Her husband mentioned that she had been confused throughout the night and had been hallucinating. Dr A measured her temperature at 40.5°C, and found her throat to be red and swollen with bilateral exudates. He documented a blanching rash on her chest and back, which appeared to be erythema multiforme. He also noted bilateral conjunctivitis, for which he started chloramphenicol.

Since she also complained of thrush, Dr A added Canesten to his script and advised Mrs J to give the antibiotics longer to work, and to take paracetamol, ibuprofen and fluids to control her fever.

Mrs J continued to deteriorate and the following morning she called the surgery again. She spoke to Dr C, explaining that she was unable to swallow any medication due to her sore throat. The rash and fever were ongoing. Dr C converted the paracetamol and antibiotics to a dispersible form and advised her to crush the clarithromycin. She advised the patient to seek medical attention if the fever persisted once she had managed to swallow her medications.

Later that day, Mrs J deteriorated further, and her husband called the surgery, this time speaking to Dr B. The patient was now unable to swallow fluids at all. Dr B advised that she would need intravenous treatment and told them to go urgently to the emergency department (ED). The ambulance transferred them to hospital within 30 minutes.

On arrival in the ED, a temperature of 39°C was recorded. Mrs J was noted to have macules and papules with urticarial plaques and bullous erythema multiforme over her face, scalp, neck and trunk (30% of her body). Oral ulceration and conjunctivitis were present.

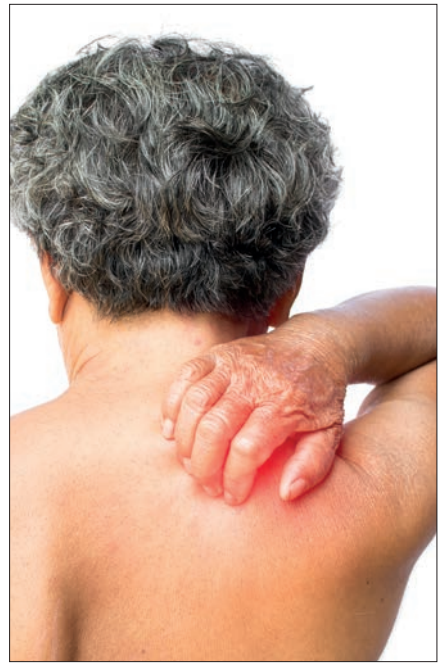
A diagnosis of Stevens-Johnson syndrome was made, presumed secondary to penicillin or to mycoplasma pneumonia, and she was transferred to the ICU, where she remained for over a month. Chest X-ray showed a left lower zone consolidation, and skin swabs detected herpes simplex virus, which was treated with acyclovir. By the time of Mrs J's discharge from ICU her skin had greatly improved, but she became colonised with *Pseudomonas* and suffered from recurrent chest infections. She had significant muscle loss, which required intensive physiotherapy. Another month after being discharged to the ward, Mrs J's breathing began to deteriorate, and she was transferred back to ICU with severe type 2 respiratory failure attributed to toxic epidermal necrosis and associated bronchiolitis obliterans. She was intubated, ventilated and treated with methylprednisolone, cyclophosphamide and IV immunoglobulin. Despite this, Mrs J continued to deteriorate, and died.

Expert opinion

Experts reviewing the case were critical of Dr A, and considered that she had breached her duty of care in this case. When she had visited Mrs J, there was a clear deterioration in her condition. She was febrile, hallucinating and had a widespread rash. Dr A maintained that she had been concerned about the patient but felt that hospital admission would not have changed the patient's treatment at this point.

It was unclear whether the Stevens-Johnson syndrome was drug-induced, and expert opinion agreed that it was reasonable for Dr D to have commenced antibiotics in a patient with no history of drug allergy who had been given both of the medications in the past without problems. It proved difficult to speculate on whether or not earlier withdrawal of these medications would have affected Mrs J's outcome.

The Medical Protection Society served a detailed letter of response, defending the claim on a causation basis. As a result, the case was discontinued.



Learning points

- Stevens-Johnson syndrome is a rare but potentially fatal condition, usually triggered by drugs or infection. Useful summaries and images of the condition can be accessed at www.patient.co.uk/doctor/stevensjohnson-syndrome, and http://dermnetnz.org/reactions/sjs-ten.html.
- Take care to revisit the earlier diagnosis of another doctor, especially if the condition has changed. Treatment does take time to work, but in this case, a more careful assessment was needed in light of the changes in the patient's condition. Expert opinion agreed hospital admission should have been initiated earlier for Mrs J, but was unlikely to have made a difference to the overall outcome.
- The decision as to whether to admit patients to hospital is often very difficult – documentation of observations is important so that if there is any uncertainty later regarding a hospital admission, someone reading your notes can be clear as to how the patient was at the time, and why you agreed on the course of action.

CPD meeting at Tembisa Hospital

Sarah Molefe, *SAMA junior marketing officer*

SAMA hosted a successful CPD meeting sponsored by Sanlam on 20 September at Tembisa Provincial Hospital. A total of 74 doctors attended the meeting.

Brandon Ferlito presented on the ethical code of conduct for doctors, covering topics such as the basic types of ethical enquiry, morality, principles, foundational and modern-day theories and indigenous African values (Ubuntu). The presentation also focused on topics such as professionalism in healthcare, including moral conduct, core foundational values, professionalism (practice and challenges), healthcare as a human right, the doctor-patient relationship, dual loyalty, the moral authority of codes and how to approach an ethical analysis.

Brandon Ferlito delivering his presentation to the Tembisa doctors

Discussing diabetes, and the NHI Bill

The Griqualand West branch hosted a CPD meeting on Thursday 22 August 2019 at the Flamingo Casino, Sun International, in Kimberley. The topics discussed at the meeting, presented by Dr Mbesi Joseph Ngundu and Dr Selaelo Mametja, were "Diabetes management in resource-limited settings" and "The NHI Bill".

Dr Ngundu graduated from the University of Kinshasa in the Democratic Republic of Congo as a medical doctor in 1989, and went on to qualify as a specialist in family medicine at the University of Pretoria. He is currently the Head of Clinical Unit in Family Medicine in Frances Baard Health District in the district clinical specialist team, with special emphasis on government priority programmes (maternal and child health, TB/HIV and non-communicable diseases).

Dr Ngundu has particular interests in research, diabetes management, HIV/AIDS and drug-resistant TB. He is a member of the provincial health research and ethics committee, and the provincial clinical review committee dealing with drug-resistant TB and HIV-complicated cases. Dr Ngundu is also a master trainer in essential steps in the management of obstetric emergencies, and CPR for professionals, under the Resuscitation Council of Southern Africa. He is also the current chairperson of the Griqualand West branch, having first been elected in 2017, and was the co-principal investigator in the published article "Factors contributing to the emergence of drug-resistant tuberculosis in the Northern Cape".

Dr Mametja, head of the SAMA Knowledge Management, Research and Ethics Department, is a public health medicine specialist with experience in health economics and financing, health policy, management and the medical aid industry. She is passionate about access to quality healthcare, and a long, disability-free life for all South Africans. Her qualifications include a medical degree, a MMed in public health medicine, a Fellowship of the College of Public Health Medicine of SA, a postgraduate diploma in health management and a postgraduate certificate in business management. Dr Mametja is also a member of the minister-appointed tertiary/quaternary essential medicines list committee, the clinical advisory board at Health Quality Assessment (HQA) and the minister-appointed pricing committee (2011 - 2013), which is involved in the regulation of medicine prices, in accordance with the Medicines and Related Substances Act No. 101 of 1965.

The meeting was well attended, and the presentations were excellent – a very informative session.

SAMA Trade Union – administration clarity (continued from page 19)

occupation, do not fit neatly into the traditional trade union mould, and do not have the time to engage actively in shop steward roles.

This means that the normal leadership structures required by the Act, and the SAMA Trade Union's own adopted Constitution, could not be constituted properly. SAMA welcomes the clarity provided by the Registrar of Labour and the Labour Court that there is currently no valid leadership structure within the trade union.

However, to ensure the continued proper functioning of the trade union, SAMA has reached an agreement with the Registrar of Labour to have it placed under administration in terms of section 103A of the Act. While the legislative compliance issues are being addressed, SAMA will continue offering employed members the excellent labour-related services they have come to expect.

The greater SAMA non-profit company is not affected by these matters, and membership contributions will continue to be used for the benefit of SAMA members.

SAMA RESEARCH ETHICS COMMITTEE

WHAT ARE WE ABOUT

Evaluating the ethics of research protocols developed for clinical trials conducted in the private healthcare sector. Ensuring the protection and respect of rights, safety and well-being of participants involved in clinical trials and to provide public assurance of the protection by reviewing, approving and providing comment on clinical trial protocols, the suitability of investigators, facilities, methods and procedures used to obtain informed consent.

SERVICES AVAILABLE

- South African Medical Association Research Ethics Committee - SAMAREC

- **Our Mission**
  - Empowering Doctors to bring health to the nation
  - Excellent Service
  - Quick Turnaround
  - Efficiency

For further information please contact the SAMAREC Secretariat on

012 481 2046

samarec@samedical.org