



RURAL HEALTH CONFERENCE

PACASA • RuDASA • RuNurSA • RuReSA

Powered By:
AxessHealth



The world's only Ultrasound-on-Chip Technology

*Limited offer exclusive to Investec Private Banking clients.

Save 20% on the innovative Butterfly iQ+™

ultrasound probe, full POCUS education package, Butterfly Academy™ and extended membership now in a bundled deal.



Scan here for more details

*Subject to the terms and conditions

Investec Private Banking, a division of Investec Bank Limited registration number 1969/004763/06. Investec Private Banking is committed to the Code of Banking Practice as regulated by the Ombudsman for Banking Services. Copies of the Code and the Ombudsman's details are available on request or visit www.investec.com. A registered credit provider registration number NCRCP9

Butterfly iQ+™ is a Class B portable ultrasound system designed for diagnostic imaging by trained healthcare professionals. Carefully read and understand all cautions, warnings and operational instructions prior to use.





RURAL HEALTH CONFERENCE

PACASA • RuDASA • RuNurSA • RuReSA

Special Conference Edition

Published By:



AXESSHEALTH

Block 4 Albury Office Park
Albury Rd, Hyde Park
Johannesburg, RSA

Editorial Contribution:

Chris Bateman

Get your free profile set up now
africa.axesshealth.org



Contents

Finding inspiration –
celebrating rural
doctoring 2

Uncovering the bigger
patient picture – Steve
Reid 6

Clinical Associates
“underpaid and
underrecognized.” 8

Creating a thinking,
feeling environment –
RUDASA workshops. 10

Eastern Cape tackles
medico-legal crisis 12

Finding inspiration – celebrating rural doctoring

Rural doctors, upon whom thousands of impoverished distant communities depend for their health and wellbeing, are too seldom appreciated, and celebrated for the massive difference they make in people's lives.



RUDASA Conference convenor, Dr Madeleine Muller and RUDASA Chairperson, Dr Lungile Hobe

Struggling to do their best amid dire shortages of staff and equipment, power-outages, and bureaucracy, treating complex co-morbidities, fixing generators, and producing innovative solutions daily, they thrive on the collegial intimacy adversity brings.

This was highly visible among the two hundred delegates at this year's Rural Doctors of South Africa, RUDASA, conference held at Chintsa on the Wild Coast of the Eastern Cape from September 14th -17th this year. With the theme, "Celebrating Rural Healthcare," and a particular emphasis on junior doctors, rehabilitation therapists and nurses, delighted shouts of recognition and hugs were the order of the day as provincial and national political leaders, academics and clinicians, old hands and novices, plus several icons of rural healthcare displayed a camaraderie usually only seen among war veterans. To a delegate, everyone present was currently working or had worked in a rural setting, creating an empathy unique to this annual gathering. Opening proceedings, conference convenor, Dr Madeleine Muller, a family physician at Cecilia Makiwane Hospital in Mdantsane and a lecturer at Walter Sisulu University, said Community Service doctors were now the backbone of rural service across disciplines.

"We don't celebrate them enough or remind them of what they do for this country by contributing a year of their lives," she said to loud applause.

Rural doctors came in two categories, many living through both as their careers progressed. They were either 'thriving, inspired and motivated' – or 'holding on by their fingernails.'

"The one thing that contributes to either thriving or surviving is when you feel that what you're doing is your calling, a sense that 'this is my destiny – what I'm meant to be doing. Suddenly that whole year, or a few decades, changes. There are many who settle and educate their kids because they found a calling in rural health," she said.

Muller suggested that three common factors keep people in rural health:

"Doing something you're good at, making people's lives' better – and being appreciated." However, many rural healthcare workers became their own worst enemies, expecting a 'batting average of 100,' or an innate ability to 'do everything 100% right in terms of diagnosis and a treatment plan.

Added Muller; "our own expectations and the weight of having to do it right when faced with severe morbidity and mortality can lead to extraordinary suffering, (ending in burnout), when we get it wrong. Comserves, (across all categories), experience, this quite strongly. There's this belief that with most patients I see, I'll know what to do."

"Fortunately, it gets better with experience, but you'll never get to that point where you know everything. Medicine's a chancy affair. Patients can be extraordinarily complex with co-morbidities – there's no way you'll be able to know everything in terms of managing the patient in front of you. But collectively in this room, we know everything. The trick in terms of being a rural physician is to have everyone on your cell phone, use this network of supportive, generous people. Build relationships. With social media we have all the links we need. It's possible to become exceptionally good at what you do. "

Besides having trusted, knowledgeable veteran colleagues on hand, making people's lives better depended on having an intrinsic motivation or transcendental purpose, she said.

"The reality is that every single day we make a difference where illness is derailing or disrupting lives. For patients who don't have many resources, even a little thing can complicate life extraordinarily. The challenge is that we forget the difference we make, how many lives we touched today. You can do extraordinary work and make a massive difference, but if nobody reminds you of that, you get exhausted and burn out. We need to see and appreciate one another, celebrate what we bring to people's lives – that helps us to find our calling in rural health," she said to loud cheers.

Deputy Minister Dr Sibongiseni Dlomo, himself a former rural doctor, singled out several "heroes and trailblazers," in the gathering, saying they had inspired newcomers to carry the baton through their work, resilience, and innovation.

He singled out Dr Victor Fredlund, former medical manager at Mseleni Hospital in northern Kwa Zulu Natal and founder of numerous community upliftment projects during his 43-year tenure. Fredlund co-discovered and surgically treated Mseleni Joint Disease and taught scores of doctors.

"You should tap on his window of resilience of what kept him in rural health for so long, to the disadvantage of his family life but to the advantage of all our citizens in that space," Dlomo advised younger delegates.

CONTINUED ON THE NEXT PAGE

Another was Professor Steve Reid, now Head of Family Medicine at UCT but a veteran of KZN rural medicine and co-founder of RUDASA.

"He's introduced rural health to many young doctors and inspired them – and has a wealth of wisdom in supporting them."

Dlomo said the lived reality of rural life inspired many young medical students.

"I asked one young medical student 'why medicine' and she said her mother had suffered an asthma attack at home. Nobody in the house knew what to do and the ambo arrived too late. Her mother died. She was grateful for the opportunity to go into medicine because she didn't want others around her to land in the same predicament," he said.

Stories of pregnant women dying at home because they had no money to go to the clinic were legion. These memories were engrained in the minds of young students, and they often returned to their own communities to make a difference, with several NGOs like the Umthombo Youth Development Foundation, set up to fund their medical education.

Dlomo commended RUDASA for adding the rural rehabilitation association and the rural nurses' association to this year's conference, saying it was a dream of his to have an advanced midwife on every shift at every district hospital.

"Don't keep ten of them in a big hospital," he urged.

On inadequate preventative care, he cited a project in Durban some years ago when thousands of women were collected from surrounding townships and given pap smears and mammograms – under one roof in one day.

"KZN had a particularly good head of obs/gynae. They did two thousand pap smears in one day, of which 110 women had some lesion in their cervix – which was dealt with at once. Some 1800 were advised to return for an examination in three years.

"This is the kind of intervention you should be thinking of, because rural women would rather spend the little that they have on food for their children. They won't spend the R200 in their pocket on travel, or miss work," he added.

Professor Khaya Mfenyana, former vice chancellor and principal of Walter Sisulu University, hailed the success of multi-disciplinary rural teams and the intersectoral model of community engagement, which his department initiated.

Urging delegates to 'refer whenever in doubt,' he tearfully cited his own experience at his family home in Queenstown where his sister died of Stage Four cancer after an extended period of misdiagnoses.

"We buried her two weeks ago. They kept saying they were unsure of what's going on and she was eventually diagnosed at Stage Four. You can undermine people coming from the rural areas. You must take them seriously and investigate them like any other person. When in doubt consult someone," he urged.

Mfenyana said WSU was now teaching in thirty hospitals and leading the country in community-engaged scholarship.



Courtesy of Door of Hope & Hannah Thompson



Therapist Support

- Product Training on Shonaquip devices
- New to Seating: introduction to seating skills
- Remote support via email or video



Let's Talk Disability

- Community dialogue to shift perceptions about disability



Ndinogona

- Inclusive Play & Learning training for ECD practitioners



Parent Network

- WhatsApp-based peer support & training for parents of children with disabilities

Product Range: Paediatric 24hour Posture Support Devices



Shonaquip Social Enterprise produces a range of posture support and mobility devices, as well as wheelchair cushions and therapy equipment for use by children and adults with mobility impairments. We manufacture options for 24 hour positioning for the user, which enable participation in daily activities such as playing, learning, socialising or resting.



**SHONAQUIP
SOCIAL ENTERPRISE**
Enabling inclusion

Cape Town Head Office: +27 21 797 8239 JHB Office: +27 74 729 1717
info@ShonaquipSE.org.za | www.ShonaquipSE.org.za



Uncovering the bigger patient picture – Steve Reid

Context often teaches a medical student a far more powerful lesson than the content of a particular subject or discipline, enabling them to see the bigger picture – and may play a significant role in their resilience and commitment later in their careers.

This was said by Professor Steve Reid, Head of Family Medicine at UCT and a founder member of the Rural Doctors' Association of South Africa, (RUDASA), at the eponymous annual conference at Chintsa near East London in mid- September.

Addressing a session entitled, 'Integrating clinical practice and population health – the advantages of teaching and learning in the rural context,' Reid said a rural context avoided the 'clutter and complexity,' of city life and helped integrate individual care with a population perspective to give one the bigger picture."

"In rural KwaZulu Natal we had a tenth of the resources; why did we not burnout? he asked. "It's because we were connected to the bigger picture."



A RUDASA plenary session gets going

Henry Giroux, the influential Canadian American educationist, talked about getting away from training doctors and other healthcare professionals 'to be simply efficient technicians and practitioners.'

Instead, Giroux put forward a new vision of what constituted medical leadership, "so we can educate doctors to think critically, locate ourselves in our own histories, and exercise moral and public responsibility in our role as engaged critics and transformative intellectuals."

An occupational therapist in Reid's audience added, "teachers get 'very excited when young doctors get to that point because, a lot of the people are unwilling to see the bigger picture –it's too overwhelming.

Your training doesn't prepare you to do anything about it. It's too much emotionally, as evidenced by our dear leaders. When the word 'rehab' comes up they go into a bit of a stupor. It's vital to see people in context."

Reid concurred, adding that early career health care professionals told themselves, “I can’t handle all this general stuff – I’ll just go into ophthalmology – it’s a common response, but the opportunity is also there. It’s a huge motivator once you get that.”

He said that a decade ago, he and a group of fellow educators in Canada and Australia put together a rural medicine education guidebook which received a varied reception in different contexts and in affluent and poor countries.

“It’s the iceberg phenomenon. We spend a lot of time on what we can see and react to these things.

But under the water we anticipate patterns, like drunkenness on a Friday night, not taking pills, the social determinants of health, political and cultural – the underlying structures in rural areas that drive patterns, enabling us to make decisions.

He gave the example of diabetes which could be reversed through nutrition enabling patients to stop taking tablets or injecting insulin.

“It challenges the Old-World view that diabetes is life-long. Some colleagues are still teaching that, based on a whole set of assumptions.”

He lauded a course that colleagues Ben Gaunt and Karl le Roux, formerly both Zithulele District Hospital doctors near Mthatha, gave at UCT, showing the contextual difference between population and individual healthcare and the value of asking the simple revelatory question of “u-velaphi? (Where are you from?).

“This is critical consciousness. Why did this happen, what are our assumptions, why is this persisting? For example, TB is a seemingly intractable problem and it’s worsening.

We’ve got on top of HIV, but TB won’t go away. We must see what’s driving it at a deeper level. It’s critical for health literacy, to understand that iceberg.

Reid proposed that teaching and assessment integrate individual and collective perspectives on health.

“It’s no use having a little slide show called public or community health that doesn’t influence the way we practice! We need case studies, home visits, referrals, photovoice, debriefing, reflection and ‘sense making- how do we make sense of having gone out (on a home visit)?”

The most basic questions pertained, he said.

“So what? Why? and what next? – what sense are you making of this patient presentation with a home visit.

It’s potentially transformative education. The light can turn on. It depends upon turning the ice-berg upside down, understanding the context of that presentation,” he stressed.

Clinical Associates “underpaid and underrecognized.”

Clinical Associates, (CA's), a category of healthcare workers created to help address the rural healthcare delivery crisis are doing just that – but are poorly paid and underrecognized. Roundly applauded for their contributions over the last 13 years by delegates to the Rural Doctors of South Africa, RUDASA, conference at Chintsa, near East London, last week, (14th to 16th September), the CA's extracted a promise from guest speaker, Deputy Health Minister, Dr Sibongiseni Dlomo, to probe their grievances.

Professional Association of Clinical Associates of SA, (PACASA), executive member, Nomsa Ndaba, said 93 CA students, initially at Walter Sisulu University in Mthatha and later at the University of Pretoria and Wits University graduated in 2012, rising to 1500 graduates by 2021. The three-year training today sees them in both healthcare sectors performing a variety of tasks, but always under the supervision of a doctor. Ndaba said the founding assumption that CAs would want to work in rural areas had been proven correct via a 2014 study that showed 68% of first year students and 92,1% of third years fell into this category. By comparison, just 4,8% of medical students wanted to work in rural practice.

She said one example of their efficacy was that over 90% of circumcisions- a powerful HIV prevention tool – in 2014/15 were shown to have been done by CA's. Clinical associates provided comprehensive healthcare to a wide variety of patients and contributed greatly to task sharing, be it in theatre, the outpatients' department, or casualty. A 2018 study in Tshwane had shown that when a healthcare team included a CA, their colleagues could spend more time with patients', and they helped reduced the patient overload significantly.

There were four main areas where CAs came into their own in preventing unnecessary referrals and closing gaps when doctors were busy with emergencies or in theatre. These were HIV and opportunistic infections, NCD's, TB injuries, and trauma. A colleague from the floor said during question time that while CAs did most of the things a doctor could do, when it came to salary scale, they were pegged below nurses although they were doing procedures “way above” nurses who were preferred over CAs for managerial posts.

Ndaba appealed to Deputy Minister of Health Sibongiseni Dlomo to probe their lack of career progression while another CA colleague said the late former Health Minister, Dr Manto Tshabalala-Msimang had introduced the CA category and championed their cause, but the national health department had done very little subsequently. “We need to create a culture of inclusivity for CA's –and foreign qualified doctors,” she added. Dlomo promised to set up a meeting with PACASA to thrash out their issues to give them more parity and recognition.

Dr Madeleine Muller, a family physician at Cecilia Makiwane hospital and lecturer at Walter Sisulu University, said her university was developing a post graduate diploma in infectious diseases for CA's and wanted to use it as a precedent for more graduate diplomas for CA's. “There's also a regulation with the Colleges of Medicine which has created a possible gap to enable CAs to write some of their exams,” she revealed.

SAMA AD

Creating a thinking, feeling environment – RUDASA workshops.

What do poetry, balls of string, masks and smarties have to do with healthcare? Everything, if you attended two potentially transformative Rural Doctors of South Africa, RUDASA, conference workshops at Chintsa on the Wild Coast in mid-September where they were used as learning tools.

Held for the first time as a collaborative conference embracing all allied rural healthcare professions, (rehabilitation workers in the main), nurses, clinicians and their associates, the 200 delegates reveled in learning opportunities provided by veteran colleagues. Professor Elma de Vries, a family physician and lecturer based at the new Nelson Mandela University in Gqeberha, (and former chairperson of Rudasa), had doctors, clinical associates, nurses and rehabilitation therapists counting smarties and throwing balls of string in human circles.

Her workshop title? Interprofessional education and collaborative practice; strategies for teamwork.

After pooling their smarties on a plate, each participant picked out a color and refilled their box, some with far less than others. Participants immediately twigged to the analogy of not having all the necessary members of an inter-disciplinary team – or far fewer members of one crucial healthcare discipline than another.

Intoned de Vries, “we need all the colors for it to look like smarties,” before breaking participants up into discussion groups – with an instruction to each come up with an interprofessional interaction that ‘did not go well.’ Groups then put on a skit, role playing their experiences before the larger audience.

Some were painfully experiential. Like the nurse roundly berated in front of her ward colleagues by a consultant for questioning his, (contra-indicated), antibiotic patient prescription. Or a physiotherapist finding a crying baby with a swollen knee missed by the doctor who prescribed Panado after eliminating lack of immunization and fever. The doctor then reluctantly booked the child in for an X ray.

De Vries’s ‘spider-web’ exercise had participants throwing an unravelling ball of string to one another in a circle, creating a ‘web of care’ which responded to any movement by any team member.

“Communication, listening, getting the context and appreciating what everybody does, respect, humility, appreciation, especially for innovation. Expressing appreciation gives them safe space to do more of these things. We’re not focusing on our profession, but on the outcome for that patient – that’s the common goal, she said.

She urged participants to educate themselves about their colleague’s profession. One physiotherapist summed up group sentiment with a rapidly adopted expression; “differences make a difference.”

She added, "This took us outside our comfort zones. We have to think of the other, something we can practice in our institutions for better quality healthcare."

De Vries concluded, "I love that we can laugh at ourselves like true South Africans and in so doing see the holes of what needs to be fixed – and do it with an open heart." Another participant, Dr Colin Pfaff, no stranger to medico-political struggles during the HIV/AIDS denialism years, quipped, "that was too close to reality. I think I need some de-briefing."

In another breakaway room, rural healthcare professionals were writing poetry under the guidance of the Ukwanda Centre for Rural Health's, Dr Francois Coetzee, whose mantra was, "our preferred future is rooted in our positive past".

Both facilitators had their participatory audiences rivetted, laughing or in tears as they shared their unique teaching methods aimed at building patient empathy or encouraging inter-professional collaboration.

Coetzee's poetry writing exercise was aimed at describing the felt experience of what inspired participants – as against events that demotivated them when their faults were, (often harshly), pointed out.

"Describe your best experience of working in a rural environment in 55 words," he challenged them.

He read one poem by Dr Mia Diedericks a medical officer at the remote Zithulele Hospital on the coast, 100kms from Mthata, in which she imagines a disabled patient's experience.

"More than just distance.

So close yet so far; I can see the hospital from home.

Peeking through my rondavel's window, looking down at legs not working
I stumble over rocks with hope to be seen before returning.

The valley is more than just measured distance, the crutches beneath my arms more than just needed assistance."

As many participants confessed to having teared up, Venter said deep reflection was a way of connecting, 'how we are transformed and allowed to transform, that's why we're so vulnerable. The best thing is to be connected."



Eastern Cape tackles medico-legal crisis

Accrued medico-legal suits against the Eastern Cape Department of Health stand at R5,62 billion – or 20% of their total budget (R28,1 billion), leaving the province unable to replace staff, freezing unfilled posts and juggling funding allocations.

This comes on top of National Treasury austerity measures across provinces, with a reduced and shrinking equitable share contribution, aggravated in the Eastern Cape by a population reduced by work seekers migrating to other provinces.

Several Eastern Cape doctors and at least one provincial official attending the annual Rural Doctors of South Africa, (RUDASA), conference at Chintsa near East London last week described the medico-legal predicament as, “like trying to bail water from a sinking ship.”

The crisis – which is being addressed with a turnaround strategy led by multiple award-winning Eastern Cape Head of Department, Dr Rolene Wagner – is in large part due to the juniorisation and shortage of posts, illegible or poorly kept records of medical procedures gone wrong and a woefully inadequate emergency transport system.

This has kept the delivery of avoidably cerebrally palsied infants – which forms the bulk of legal suits – stacking up year upon year.

Tragically, most of the victims are low-income, often rurally resident mothers, who end up with cerebrally palsied, (CP), children, 2812 of whom are officially recorded, and “about 1000” of whom



(Left to right); Dr Mzu Nodikida, Director of Clinical Services for the Eastern Cape, his Director General, Dr Rolene Wagner and Dr Luvuyo Bayeni, recently appointed Deputy Human Resources Director, National Health Department.

are receiving provincial rehabilitation services at hospitals. The remainder, discouraged by the recent Covid pandemic, are gradually being tracked down by community health workers.

Wagner, who was appointed to the post in mid-2021, told delegates that the province’s gross liability of nearly R5,7 billion, (including a bank overdraft of R1,046 billion), represents 75% of her goods and services budget of R7,5 billion.

“In one year, we paid out R750 million. We should have closed hospitals, but we couldn’t, so the debt accumulated. We couldn’t replace people in posts, and staff shortages accumulated until our turnaround strategy started. It’s not surprising we’re having problems with quality of care,” she said. Now, there’s a focus on going back to basics. One example is the prioritization of maintenance of facilities, with the allocation going from 21% of budget in 2020/21 to 47% currently – but there’s a massive backlog.

Were it not for a court judgement in Bisho early this year, the province would be in deeper trouble.

Judge Robert Griffiths allowed for the common law to be developed to enable the state to offer rehabilitation and other care services for children with cerebral palsy instead of paying the private sector to do so – and not merely granting lump sum payments.

The ruling will free up a significant amount of cash because future medical expenses for treatment in the private sector made up the bulk of most medico-legal damage claims for infants who suffered birth injuries in state hospitals.

Mr Gift Tshaka, Clinical Support Manager at the Nelson Mandela Academic Hospital, NMAH, in Mthatha, where the first of eight Cerebral Palsy ‘Centres of Excellence’ will be completed by the end of this year, told delegates that his rehabilitation unit will deal with all permanent disorders of development and movement, “or anything causing activity-limitation.”

“We’ll assess the validity of the claim with our multi-disciplinary team before it’s made, provide ongoing care, and make sure court orders are carried out. It’s case management.”

He said there will be ten consulting rooms, four gyms and ten offices with a boardroom and a ‘relaxation area,” at NMAH.

“If we’re negligent in managing these cases we can be held in contempt of court. But there are so many that it’s like we’re in a ship with a big hole underneath and lots of water coming in. We’re using buckets to bail but the pressure is so much the ship can sink,” he added.

The plan is to complete one CP Centre of Excellence for each of the eight provincial health districts within three years, with hospitals supported by the NMAC unit from next year.

Dr Ben Gaunt, the newly appointed clinical medico-legal manager for the province said he was currently working with 140 claims, as well as reviewing 372 others, some dating back to the early 1990’s. Of these 80% were maternity related and about three quarters of those were CP cases.

“In addition to the numbers of claims, we’re seeing big increases in the amounts claimed. As recently as 2015/16 claims were on average about R12 to R15 million each. More recently, I’ve been doing some that are R30 to R40 million. Usually, the issue is about how did we record the monitoring during labor.

So, it’s a combination of (the procedure), not being done properly and not being documented properly – or sometimes simply that it has faded.

We just didn’t see this coming. We’re dealing with cases from 10 to 15 years ago, and often the cardiotocograph, (aka an electronic fetal monitor) heat-sensitive paper has faded.”

“Often though, it’s just a function of claims being grossly inflated. We refer the dodgier ones to the Special Investigation Unit, things like MRI’s submitted for the wrong child. We only want legitimate, and defensible, cases to get to court.

There’s also a lot of work happening with provincial treasury and the department of health to use mechanisms in the Public Finances Management Act to recoup some of the money back into the Dept of Health.”

CONTINUED ON THE NEXT PAGE

Gaunt said the legal costs, when added to the court settlements, were crippling.

"All of these accumulate over time. With accruals at over R5 billion, it means that at the beginning of the year, as the HOD said, some institutions have already got up to 73% of their budget spoken for.

That percentage is getting worse over time, so I understand the metaphor of bailing a sinking ship," he added.

Asked what the other major drivers of CP were, Gaunt, a veteran rural doctor who helped transform Zithulele Hospital near Mthatha into an award-winning, globally admired district facility, said there were 'times where we've been understaffed or had junior staff trying to manage cases. It's difficult to tease out how much that was the case, because you don't know who was on duty that long ago."

Pressed on the main drivers of the CP burden, he answered, "definitely midwives not always recording what they do during labor, but sometimes it's clinicians or midwives misinterpreting CTGs, or at other times just doing their best to be as efficient as possible in terms of how they act during emergencies."

"I mean in SA we've always been under resourced, and we've done a remarkable job of sticking it out. What changes it is this kind of medico-legal pressure – and that makes people fearful and practice defensive medicine. Junior people are then scared to do something and would rather do nothing – ironically with the same result."

Gaunt added, 'the more we think of healthcare as a commodity with a 100% outcome, the worse we make it. It's impossible for it to be like that.

There must be a measure of saying we'll hold you accountable, but people also must realize that we can't expect a 100% product. And that's not an excuse, it's just a reality. So, it's that kind of balance."

The most telling intervention for CP and other infant maladies would come from a high-risk pregnancy and infant early identification and monitoring program using parent facilitators paid with a stipend by NGO's.



*E Cape Medico Legal Clinical Advisor,
Dr Ben Gaunt (left)*

They're in the community, attend community meetings and do random home visits. If you make it a doctor's problem, you lose your kids. Or you end up 18 years later with people who fell out of the system. That, and transport are two key mitigators," he said. He was asked to compare his current job with his 20 years at Zithulele Hospital which he and his doctor wife Taryn, left 14 months ago amid political turmoil after a new nurse-trained CEO was appointed and a multi-million-rand extension was announced.

He observed, "Ja, I think it's been a year of change, but I remain passionate about trying to make a difference. We've embraced the reality that this is life, and this is where we are in our current season. At a conference like this, you get all fired up. Patient care remains my passion – and I loved one-on-one contact with patients – but I can also help make systems better, so this is a chance to do that."



AXESSHEALTH

WHAT KIND OF HCP ARE YOU?

AxessHealth HCPs are CONNECTED, ORGANISED, INFORMED, RELAXED, BALANCED, IN CONTROL & ENABLED masters of their trade and their practice, with happier patients.

Become an "AxessHealth HCP" today !

Join now for FREE



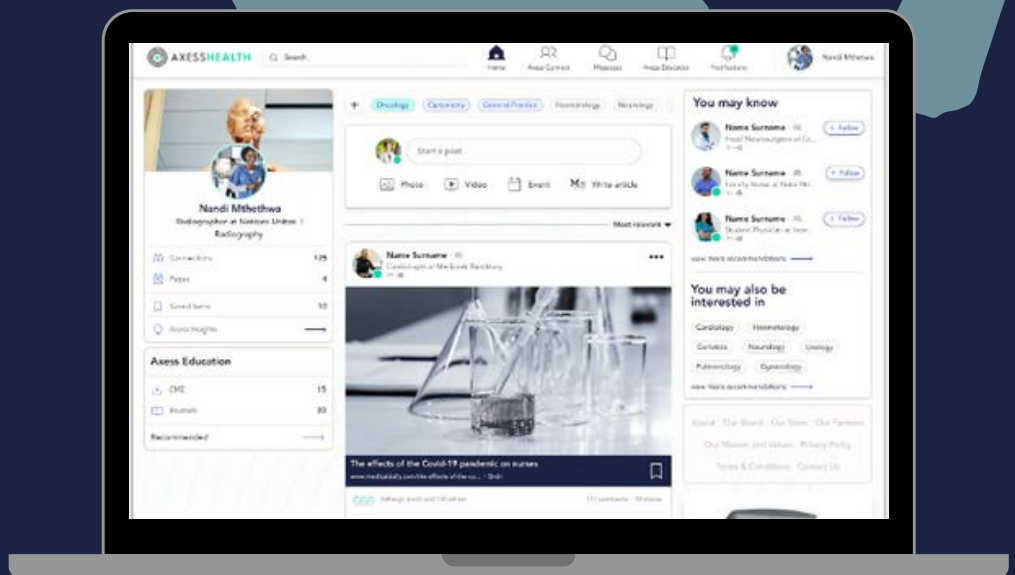
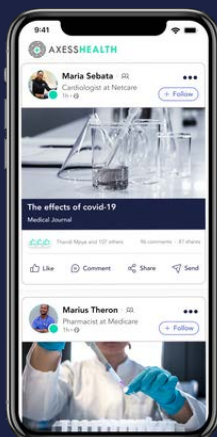
CPD

Latest medical market news

Digital tools

Peer-to-Peer networking

Private or group messaging



africa.axesshealth.org