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Presenter Notes:

Good morning, colleagues, partners in healthcare, and friends.
It is a real privilege to address you all today.

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Technical



Clinical



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Presenter Notes:

In the beginning (late 90s) of my career as a Clinical Engineer, I felt alone – Clinical Engineering did not fit in with the Clinical staff, and we also were not part of the Technical departments.

I believe it stems from our human nature to have a sense of belonging, and 3 decades ago, the situation for Clinical engineering practitioners was a bit different. There were very few of us to start with. We did not fit in with the clinical staff, and we were also not part of the technical departments.

At that stage, most Clinical Engineering Practitioners did not stay in the hospital environment for long; eventually, they would find their way to medical device companies or even completely leave and go into sales.

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Through collaboration, beautiful yet functional facilities are developed.



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Presenter Notes:

Through the years, however, things changed. 10 years later, by the time I left the corporate and private hospital group setting, we had mostly integrated Clinical Engineering with the Technical department, and developed clearer career growth paths for those who stayed in the hospital environment.

In the consulting word we were faced with different set problems.

We were often approached by clients where facilities have been completed but standing barren, unable to function because the radiology department was not built to fit the equipment, or the clinical flow of a department or interdepartmental adjacencies just did not work.

It involved rework and redesign, and sometimes having to spend a lot of money, resources and health technology, to fix design or building problems.

But eventually the penny dropped, developers realised these additional costs can be avoided or at least minimised by involving Clinical Engineers/ Health planners from Stage 1 planning.

And then the first government tenders were published, including our discipline as part of the professional teams.

And then the CSIR developed the IUSS guidelines – in collaboration with great minds from the Healthcare, design and engineering industries.

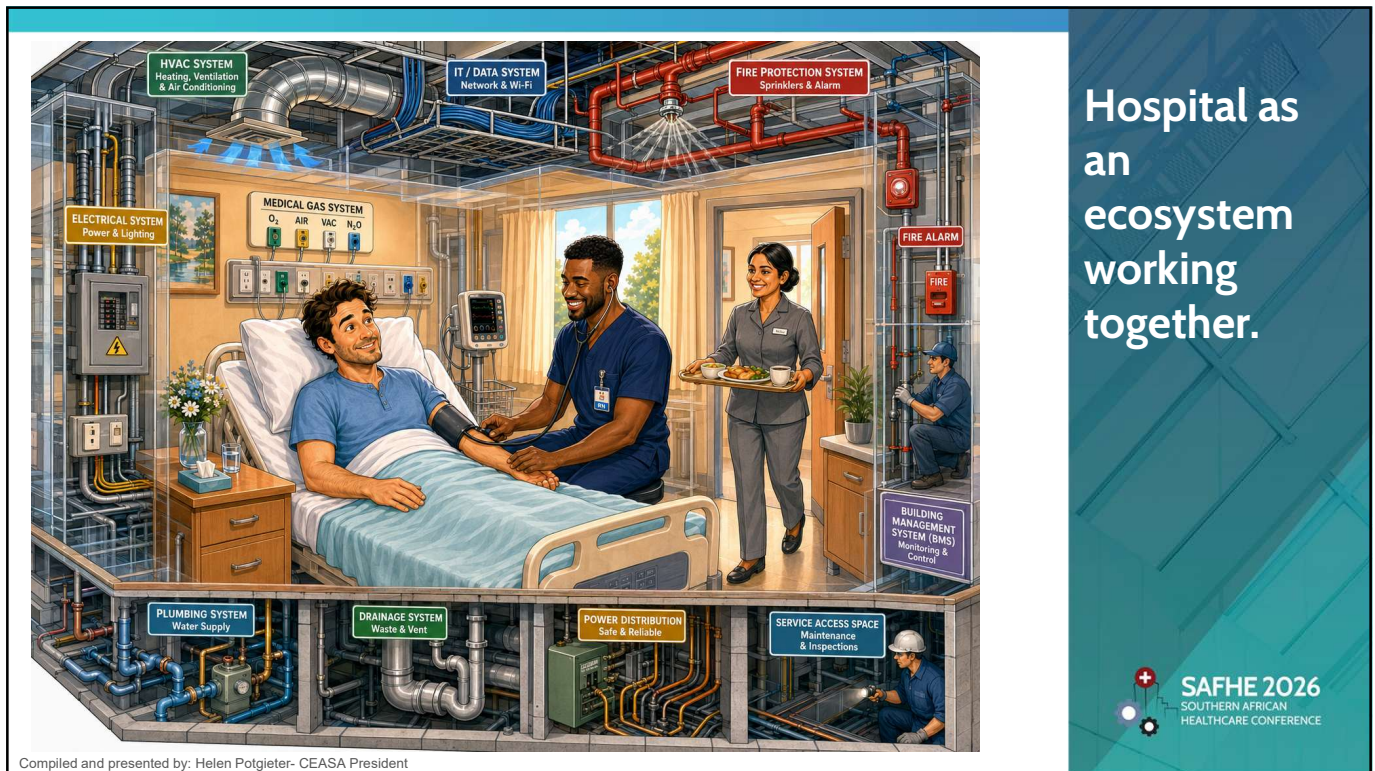
It was quite impressive to see how teams of individuals from such diverse worlds could work together to create not only beautiful but functional facilities.



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Hospital as
an
ecosystem
working
together.

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Presenter Notes:

If there is one thing that I've learned from the healthcare industry, it is that nothing important happens in isolation.

When a patient comes in for a procedure at the hospital, they interact with their nurse, their doctor, and the highlight of their day- their food But long before the patient experiences care, an entire invisible ecosystem is already at work....

Years, if not decades, before an architect ensured that there was a wheelchair ramp and enough natural light to create a healing environment.

A structural engineer ensured that there was sufficient support for the X-Ray machine,
The mechanical engineer ensured that the 93-degree water from the Autoclave was safely disposed of, and the electrical engineer ensured that there was back-up power when loadshedding hit.
The technical department ensured the bulk oxygen tank was filled on time.
CSSD ensured the sterility of the procedure to prevent infection.
Patient data and imaging is available when and where the clinician needs it because the ITC system works.
The pharmacy ensured that the theatre was stocked.
The Clinical Engineer serviced the Anaesthetic machine this week so that it is safe and available for use.
In the patient's most vulnerable state, the linen is clean and crisp, and the Security systems keep them safe.

And so we have a whole ecosystem working together.



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Align Priorities





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It is important to understand, however, that those who make these ecosystems work are individuals, usually highly intelligent, with very different viewpoints.

For instance:

The word "URGENT" can have completely different definitions...

For a clinician, URGENT means NOW.

For engineers, URGENT means, before it becomes dangerous.

For procurement, it means after 3 signatures and a good motivation letter.

For Finance, it means by our next quarterly financial report.

And for IT, URGENT begins with "Have you logged a ticket ?"

Unfortunately, when our definitions, priorities, and timelines are disconnected, patient care feels the impact.

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Health Technology central to patient care

Essential to a functioning Health system:
Prevention, Diagnosis, Treatment and Rehabilitation

Important to be included in procurement processes

What do we do ?

- Ensure care is safe
- Usable equipment
- Services continue
- Risks are managed
- Manage scarce resources

**Part of the
Health workforce.**

This is how **we** provide patient care



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The WHO puts it plainly: health technologies are essential to a functioning health system, and medical devices are central to prevention, diagnosis, treatment and rehabilitation, further emphasising the importance of HTM involvement in procurement processes.

This can be extended to include all hospital engineering services

– we form part of the health workforce.

However, many of the professions represented in rooms like this one, would describe themselves as “support services,” and although there is nothing wrong with the term, it somehow creates the illusion that the service stand outside the real work of care.

Work that determines whether care is safe, whether equipment is usable, whether services continue, whether risks are managed, and whether scarce resources create value or waste.

This is not peripheral work.

This is patient care by another route.

And perhaps that is part of our challenge. Many of us work in the background.

If we do our jobs well, there is no applause. If we do our jobs badly, everyone notices.

It is a humbling profession.

It is also a deeply meaningful one.

Behind every nurse call system is a frightened patient hoping someone will come.

Behind every oxygen outlet is a life that may depend on whether a system was installed properly, maintained properly, and treated as essential.

This is how we provide patient care.



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Silo culture

Silos form gradually.

- Protect your turf.
- Become a specialist and exclude others.
- Wait to be told.
- "That is not my scope"
- Gather evidence
- Waste Resources
- Frustration



Presenter Notes:

When we forget the human being at the end of the chain, silos begin to grow.
 Silos are interesting things. Nobody usually sets out to create them. – They form gradually.
 The Clinical Engineer is not included in the procurement conversation until the equipment is being delivered.
 The Facilities Manager finds out about the ward expansion when the building contractor is appointed.
 The IT department operates in its own little world, whilst every medical device, imaging, and lab report system is now connected to a network.
 -Departments get busy.
 -Meetings become optional.
 -Everyone becomes a specialist.

In silo cultures, people protect themselves.
 -They copy the right people into emails.
 -They wait to be told.
 -They gather evidence.
 -They become experts at saying, "That was not in my scope."

Everyone is now working harder, wasting resources, frustrated and burned- out professionals who are fighting a system, more than they are fixing it.
 And in the end, it cost us care.

Collaborative Culture

Synergy changes the emotional climate.

- Ask more
- Listen more
- Escalate risk early.
- Prioritise protecting the system



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Presenter Notes:

Synergy changes the emotional climate of an organisation.

In collaborative cultures, people still care about accountability, but the energy is different. They ask and they listen more.

They escalate risks before they become failures.

They understand that protecting the system is more important than protecting one's turf.

Silos are comfortable, **but Synergy is powerful.**

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Synergy in Action

The rescue of the 33 Chilean miners in 2010 is considered one of the greatest examples of multidisciplinary collaboration under pressure.

The rescue capsule — called the *Fénix* — was designed in 33 days, involved engineers from Chile, the US, and Germany, and was tested only once before it was used. All 33 miners came home alive.



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In 2010, 33 miners were trapped 700 metres underground in the San José mine in Chile. They were there for 69 days.

And to get them out, the rescue operation required: mining engineers. Medical professionals. NASA psychologists. Drilling specialists from three countries. Nutritionists. Telecommunications experts. A custom-built rescue capsule. And a network of international volunteers who had never met each other before — all working toward one shared goal.

All 33 miners came home.
Because no one said: that's not my department.

That is what we are building here. Not a rescue operation for miners — but a resilient, sustainable, people-centred healthcare system for 60 million South Africans.

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Sustainability

Health-care facilities face growing risks from climate shocks and infrastructure vulnerabilities. WHO recommends facilities that use resources more efficiently, reduce emissions, manage waste properly, and apply sustainable procurement principles.

It also includes :

- Financial
- Technical
- Organisational
- Educational
- Operational



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Presenter Notes:

When we talk about “sustainability,” most immediately think about environmental sustainability. Once again, the WHO notes that health-care facilities face growing risks from climate shocks and infrastructure vulnerabilities, and recommends facilities that use resources more efficiently, reduce emissions, manage waste properly, and apply sustainable procurement principles.

Those are serious realities, and I am glad to see that there are several talks during this conference on waste management , water security and green designs.

But sustainability in our context means even more than that.....

Sustainability is also financial.

Can we afford to operate what we procure?

It is technical. -Can we maintain it and keep it safe?

It is organisational. -Have we designed systems that survive staff turnover?

Is it educational? Are we developing the next generation with the right skills?

And it is operational. -Can the hospital keep delivering care when conditions are difficult?

The buildings we design, the equipment we procure, the energy systems we install — these decisions have a clinical impact. It should be a Healthcare system that can still function next month, next year, and during the next crisis.

And that is why our engineering practitioners belong at the strategy table, and not only the support service in the workshop and the plant room.

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Future collaborations

1-The Internet of Medical Things (IoMT)

Every device in your hospital is becoming smart. They are all generating data. They are all connected — or trying to be connected — to networks.



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Presenter Notes:

I am only going to highlight 2 trends

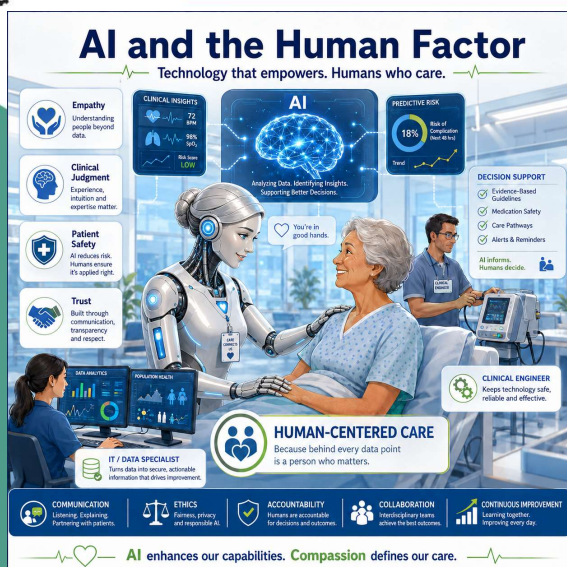
Trend 1: The Internet of Medical Things

Every device in your hospital is becoming smart. Infusion pumps. Ventilators. Patient monitors. Imaging equipment.

They are all generating data. They are all connected — or trying to be connected — to networks.

This means clinical engineers and IT professionals are no longer in adjacent corridors. They are in the same conversation. The same risk framework. The same responsibility.

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Future collaborations

2- AI and the Human Factor

AI will not replace healthcare teams. But healthcare teams that use AI collaboratively will outperform those who do not — and those who ignore it entirely.

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Presenter Notes:

Trend 2: AI and the Human Factor

Artificial intelligence is entering healthcare at speed.

Diagnostic imaging. Predictive maintenance tools. Clinical decision support. Drug interaction alerts.

And here is the thing nobody tells you in the press releases: AI does not implement itself. It needs engineers who understand the technology. It needs clinicians who trust and can interrogate the outputs. It needs facility and IT infrastructure that can support it. It needs human oversight, governance, and ethics frameworks.

AI will not replace healthcare teams. But healthcare teams that use AI collaboratively will outperform those who do not — and those who ignore it entirely.

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What do we do next?

1. Start naming your wins as shared wins



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Presenter Notes:

What do we do next ?

I want to challenge you to do 2 things.

1- Start naming your wins as shared wins- and build a culture of Synergy.

When a piece of equipment runs reliably.

When a procurement decision saves money and improves patient outcomes.

When a ward upgrade goes smoothly, do not let those be invisible.

Tell the story. Include the people who helped make it happen. Make synergy visible, because invisible wins do not build culture.

I am going to take the first step and highlight a major win we've had recently...

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ECSA discipline specific registration of : Biomedical and Clinical Technicians, Technologists and Engineers.



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For the past 3 decades, there have been many attempts to address the professionalisation of Clinical Engineering.

If we want to register with ECSA, we have to register under the electrical engineering discipline, which was always a struggle because when it comes to submitting evidence of competency, electrical engineering is not what we do, and candidates are often rejected by panels that do not understand our discipline.

But finally, mid-last year, we received the fantastic news that a sub-category for Biomedical and Clinical Engineering practitioners will be created.

The documentation for the registration is currently in the final stages of development and we are in the process of commenting on the draft document.

And this was, of course, achieved by the collaboration of ECSA, NDoH, CEASA, BESSA, Academic institutions and leaders in our industry.



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What do we do next?

1. Start naming your wins as shared wins



2. Champion the next generation.



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Presenter Notes:

Second challenge

2- Champion the next generation.

We need young clinical and hospital engineers who see themselves as system thinkers. Not just equipment specialists. Not just maintenance teams. But people who sit at the table where healthcare strategy is decided.

CEASA, SAFHE, and every association in this room have a role to play in making that happen — through mentorship, through advocacy, through education, and through making our professions visible to the people who need to value them.

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Synergy is Powerful

The future for healthcare in South Africa will be built when people, systems, technology and purpose are aligned.



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Presenter Notes:

The future for healthcare in SA will not be built by technology alone.
It will not be built by infrastructure alone.
It will not be built by policy or any one profession.

It will be built WHEN people, systems, technology, and purpose are aligned.

I'll say it again: **Synergy is Powerful.**

Let this conference be the place where we choose to be powerful.

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SYNERGY
IN ACTION: SHAPING THE FUTURE OF
HEALTHCARE TOGETHER

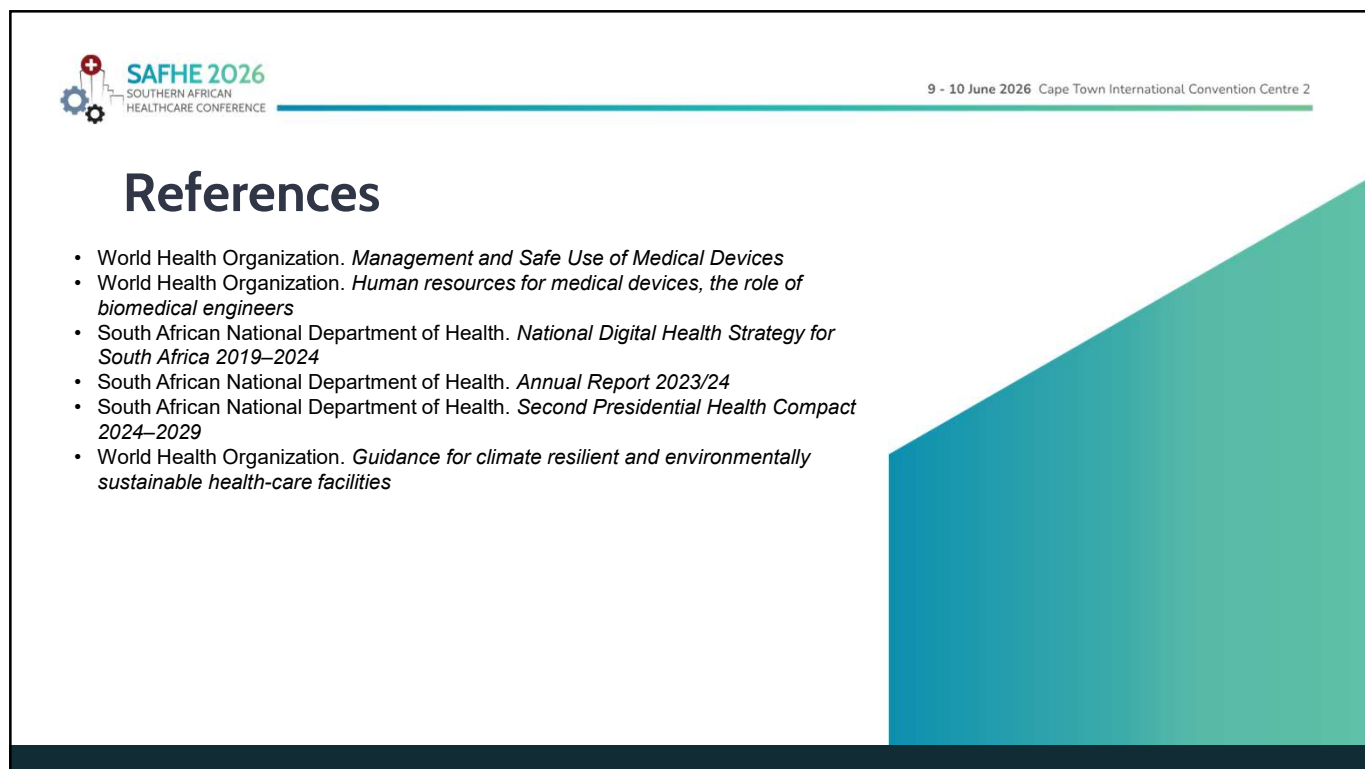
Thank you

**Keynote Speaker
ANNOUNCEMENT**

Helen Potgieter
President of CEASA



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