

SAMA INSIDER

FEBRUARY 2023

Help stop gender-based violence

SA team devise cost-effective genetic breast and ovarian cancer screening



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MEDICAL ASSOCIATION**

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Diane de Kock
Editor: *SAMA INSIDER*

A new and challenging year

2023 is set to present new and continued challenges for the medical profession. In this issue, SAMA President Dr Risenga Chauke comments that “in the real world, abuse in all its forms is a societal ill witnessed in our communities ... the medical fraternity is not immune to abuse, especially bullying in the workplace.” (page 4). He appeals to doctors to change the prevailing culture and make our working environment conducive for teamwork and patient safety.

Gender-based violence is a widespread problem in SA and one that SAMA is addressing through CPD sessions, which promote awareness among doctors and medical professionals (page 5). We introduce inspiring medical student Mohamed Hoosen Suleman (page 6), and report on the growing measles threat in SA and the immunisation campaign due to start this month (page 7).

The challenge of attracting doctors to rural areas and SA's poorest villages is addressed in Jesse Copelyn's article for Bhekisisa (page 8), while Dr Chris Ellis, a family physician from Pietermaritzburg, unpacks a new discipline called medical humanities (page 10).

Once again, a SA team has made a breakthrough that promises to save money and lives in a collaborative project, which has devised a cost-effective genetic test for breast and ovarian cancer (page 12). Some practical feedback from breast cancer patients on barriers that affect their ability to adhere to breast cancer management should assist doctors in making the cancer journey less daunting, and improve outcomes (page 13).

We look at how HIV treatment is changing in SA (page 14); tips and common pitfalls when writing a clinical report (page 16); unpack notch/grade progression and timeframes (page 18) and the removal of names from and restoring them to the HPCSA register (page 18).

Branch news reflects how busy our branches have been in assisting, representing, thanking, recruiting and rewarding both members and the dedicated staff who so ably represent our association.

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Abuse – a societal ill



Prof. Risenga Chauke, SAMA president

We often think of society merely as the communities in which we live, which is partly true. But there are also other communities that include where we work, learn and play. We expect these communities to constitute people living in harmony and being kind to one another. In the real world, abuse in all its forms is a societal ill witnessed in our communities.

The medical fraternity is not immune to abuse, especially bullying in the workplace. Bullying is defined as intentional physical or emotional cruelty to others, especially those perceived as vulnerable or having less power or privilege. The victims are often too scared to report the perpetrators because of hierarchical issues. Most victims then suffer in silence.

Abuse may take many forms in the workplace, be it verbal, physical, financial, emotional, sexual, etc.

As we begin a new year, I am reminded of the words of Curtis Mayfield when he says "A new world order, a brand new day, a change of mind for the human race".

Bullying and abuse is common among doctors. We need to change the prevailing culture and confront this scourge in order to make our working environment conducive for teamwork and patient safety. The mentality of the old order, in ridiculing the young professionals, should be put to bed. Colleagues, irrespective of their level of seniority, should treat each other with

respect. The respect that we show each other will translate into respect that patients will show to us as doctors. Then patients are able to trust us and believe that they are in good hands, improving outcomes for both doctors and patients.

This does not in any way mean that we should not have differences of opinion in managing each patient. We should, and we should allow ourselves to differ, so that we can bring evidence-based medicine into our discussions to further improve and give better-quality care to our patients. The phenomenon of intentionally making junior or less experienced doctors feel inferior to senior or more experienced doctors should be a thing of the past. Instead, as doctors, we should endeavour to provide feedback to our juniors or less experienced colleagues in a manner that is not demeaning, but respectful.

It is therefore imperative that we recognise and identify the various forms of abuse among us as doctors so we can identify, prevent and address them. The abuse that we are addressing is between doctors, and we as SAMA are here to advocate for such abuse to stop. A mechanism of feedback models at institutions should be adopted to address the problems encountered by doctors in the workplace.

In the real world, abuse in all its forms is a societal ill witnessed in our communities

Doctors experience various forms of abuse perpetrated by colleagues in the form of emotional, sexual, verbal and bullying acts, some of which go unreported. Bullying and abuse in the workplace, especially that related to competence and training, needs to change, and the cycle to be disrupted. How and where feedback is provided is paramount, and this must be exercised with responsibility. Learning is a lifelong journey and errors are inevitable, but lack of competence cannot be ignored. Medicine

is a profession practised by human beings who are fallible and need a safe culture to facilitate learning from their mistakes.

There are various models of providing feedback, and one such model is the SPIKES framework developed by Walter Baile:

A proper setting should be provided for such feedback to be given. It cannot be anywhere, in front of everybody, including patients and other staff in the working environment.

We need to change the prevailing culture and confront this scourge in order to make our working environment conducive for teamwork and patient safety

- Check your colleague's perception of the situation that they find themselves in.
- Determine the amount of information that is known or to be shared.
- Know the facts and their implications before the conversation is started.
- Emotions raised during the interview or discussion should be explored.
- Respond with empathy.
- Summarise the discussion and devise a strategy for support.

In this way, the subordinate feels safe, confident and empowered to continue in their journey as a doctor.

It is also important to encourage doctors who are abused sexually and emotionally to report cases to their seniors without the risk of being victimised.

In cases where the seniors or leaders are the perpetrators themselves, doctors are encouraged to report such cases to their unions or associations such as SAMA, where these matters can be dealt with.

We should endeavour to make 2023 and beyond an abuse-free period.

Help stop gender-based violence

SAMA Communications

Gender-based violence (GBV) is a profound and widespread problem in SA, impacting on almost every aspect of life. GBV, which disproportionately affects women and girls, is systemic, and deeply entrenched in institutions, cultures and traditions.

There are many different definitions of GBV, but it can be broadly defined as “the general term used to capture violence that occurs as a result of the normative role expectations associated with each gender, along with the unequal power relationships between genders within the context of a specific society”.

Addressing GBV is a complex issue requiring multifaceted responses and commitment from all stakeholders, including government, civil society and other citizens. There is growing recognition in SA of the magnitude and impact of GBV and of the need to strengthen the response across sectors.

GBV is systemic, and deeply entrenched in institutions, cultures and traditions

In December, the SAMA KwaZulu-Natal (KZN) Midlands branch hosted an informative CPD allocated session at the Pietermaritzburg Mediclinic to make other doctors and medical professionals aware of the circumstances of GBV and the prevalence of HIV in society. An in-depth explanation of the medicolegal J88 form was presented and Dr Ellesh Soni, SAMA KZN Midlands branch chairperson, gave a brief overview of one of his cases.

The J88 form is a document generated by the Department of Justice, which is utilised in the SA courts as the preferred method of evidence in criminal matters. The form is in regard to an injury the complainant sustained, and serves as a crucial piece of evidence in cases where interpersonal violence has taken place, for example, rape, assault or attempted murder cases. For more



Back row (left to right): Thobile Majola (Lifeline social worker), Dr Ellesh Soni, Sister Gumede (Northdale Hospital Crisis Centre), Mandy Hattingh (SAMA KZN branch secretary); front row seated (left to right): Patricia Jele (Lifeline social worker), Sister Maharaj (Northdale Hospital Crisis Centre)

information on GBV and the J88 form, see the PowerPoint presentation (<https://www.samedical.org/file/1961>).

Dr Soni is also a sessional medical officer for the Northdale Hospital Crisis Centre. The

Pledge to end violence against women and children

- Change begins with me, and I can motivate others to end violence against women and children.
- I pledge to help break the culture of silence that accompanies violence and abuse.
- I pledge not to commit violence, and to act when I see violence against women and children.
- I pledge to teach those in my care the values of human dignity, equality and respect.

centre has a multidisciplinary approach to all gender-based victims, when they are brought in for a medical assessment and the completion of all medical forms required by the Department of Justice. The department also has psychologists and Lifeline social workers who are always available to deal with any situation on hand. The team completes 1-, 3- or 6-month reviews depending on the individual case. The other presenters were Sister Maharaj and Sister Gumede, senior sisters at the crisis centre, who assist Dr Soni with all examinations, and social workers Thobile Majola and Patricia Jele, who assist with counselling the victims.

Top honours for UKZN medical student 2 years in a row

SAMA Communications

He has been described by the University of KwaZulu-Natal (UKZN) as someone who embodies excellence and one who advances the institution's motto of "inspiring greatness". He is widely known among his colleagues as one who displays high levels of respect, integrity and intellectual prowess. His name is Mohamed Hoosen Suleman, a 5th-year medical student at UKZN's Nelson R. Mandela School of Medicine in Durban, and he has been awarded the "best student researcher" and "best student innovator" accolades by the university's College of Health Sciences for the second consecutive year. Suleman received these awards at the Tea with the Deans event, reserved for top achievers, which takes place annually at the university. The UKZN deans of the Schools of Laboratory Medicine and Medical Sciences and Clinical Medicine, Profs Musa Mabandla and Ncoza Dlova, congratulated Suleman on the double award and wished him well during his time as an undergraduate medical student.

Suleman is known for his selfless contributions to science and medicine

The "best student researcher" award is granted to a student who is productive and active in research, with the "best student innovator" award bestowed on a student who displays innovation in harnessing ideas and solutions to pre-existing health challenges. This includes bringing about ideas that are assessed for their novelty, feasibility and sustainability in tackling important health challenges, both locally and abroad.

Suleman boasts a history of academic excellence at the institution, with multiple awards and accolades already beside his name. His works in academia have also been rewarded by the WHO, having been invited to their headquarters in Geneva and also being awarded the prestigious Changemaker Scholarship Award, making him one of only three medical students globally to receive



Mohamed Hoosen Suleman

this incredible honour. Counted among SA's Top 200 South Africans under the age of 35 by the *Mail and Guardian*, he is one of two SA editorial board members among a team of 40 academics and experts globally who undertake peer review of scientific articles submitted to the *International Journal of Medical Students*. Suleman is also a research placement intern at the Centre for the AIDS Programme of Research in South Africa (CAPRISA), which looks at research into HIV/AIDS.

Under the supervision of the dean of the medical school at UKZN, Prof. Ncoza Dlova, one of his current research projects involves investigating hair loss in women of African ethnicity. He also leads a host of research projects, one of which examines the knowledge, attitudes and practices of final-year nursing students regarding vaccines.

During the peak waves of the COVID-19 pandemic in SA, Suleman was regularly invited by radio and TV stations to share a youth's perspective on the evolving novel coronavirus and the instrumental role that science and innovation play in managing the ravaging effects of the pandemic. He has also been lauded for his advocacy efforts and leadership skills in combating COVID-19 vaccine hesitancy, and tackling fake news and misinformation about science.

He was chosen by the International Federation of Medical Students' Associations to form part of the official youth delegation

to the WHO African Regional Meeting in Togo in August 2022, alongside two other medical students, one from Cameroon and another from the Gambia, and was involved in drafting five statements to the WHO-Afro Regional Committee and the heads of African member states present. These covered a range of topics that included universal health coverage, mental health, human resources for health, health insecurities, and environmental determinants of health. The youth delegation was also tasked with analysing and making contributions to the current healthcare policies that African countries have in place.

He has been described by UKZN as someone who embodies excellence and one who advances the institution's motto of "inspiring greatness"

Suleman, who will undertake clinical rotations in the City of Pietermaritzburg this year, is known for his selfless contributions to science and medicine. As an undergraduate student, he hopes to create a SA wherein healthcare for all is genuinely recognised. His social work includes fostering social cohesion and the adoption of togetherness with the spirit of ubuntu, where he is regularly invited to address youth gatherings. He also volunteers at the Childhood Cancer Foundation of South Africa (CHOC), a non-profit organisation that supports the wellbeing of children and teenagers diagnosed with cancer or life-threatening disorders. He has led many projects with CHOC, both in his personal capacity and as president of the Golden Key International Honour Society medical school branch. SAMA believes that the country needs more medical students like Suleman.

Nearly 40 million children susceptible to growing measles threat

World Health Organization

Measles vaccination coverage has steadily declined since the beginning of the COVID-19 pandemic. In 2021, a record high of nearly 40 million children missed a measles vaccine dose: 25 million children missed their first dose and an additional 14.7 million missed their second dose, a joint publication by the WHO and the US Centers for Disease Control and Prevention (CDC) reports. This decline is a significant setback in global progress towards achieving and maintaining measles elimination and leaves millions of children susceptible to infection.

In 2021, there were an estimated 9 million cases and 128 000 deaths from measles worldwide. Twenty-two countries experienced large and disruptive outbreaks. Declines in vaccine coverage, weakened measles surveillance and continued interruptions and delays in immunisation activities due to COVID-19, as well as persistent large outbreaks in 2022, mean that measles is an imminent threat in every region of the world.

"The paradox of the pandemic is that while vaccines against COVID-19 were developed in record time and deployed in the largest vaccination campaign in history, routine immunisation programmes were badly disrupted, and millions of kids missed out on life-saving vaccinations against deadly diseases like measles," said WHO Director-General Dr Tedros Adhanom Ghebreyesus. "Getting immunisation programmes back on track is absolutely critical. Behind every statistic in this report is a child at risk of a preventable disease."

The situation is grave: measles is one of the most contagious human viruses, but is almost entirely preventable through vaccination. Coverage of 95% or greater of two doses of measles-containing vaccine is needed to create herd immunity in order to protect communities and achieve and maintain measles elimination. The world is well under that, with only 81% of children receiving their first measles-containing vaccine dose, and only 71% of children receiving their second measles-containing vaccine dose. These are the lowest global coverage rates of the first dose of measles vaccination since 2008, although coverage varies by country.

SA measles immunisation campaign to start in February as cases spread

On 14 December 2022, *Medical Brief* reported that health minister Dr Joe Phaahla announced that a national measles immunisation campaign would kick off nationally – but only in February 2023. Measles outbreaks have now spread to five provinces, with a total of 305 laboratory-confirmed cases reported by the National Institute for Communicable Diseases (NICD).

An outbreak was first declared in Limpopo on 11 October, with Mpumalanga announcing an outbreak on 11 November, as well as North West on 2 December, where three cases were reported. On 5 December 2022, three cases were reported in Gauteng, where an outbreak has since been declared.

News24 reported that the NICD said the age of cases countrywide ranged from 2 months to 42 years old, the dominant category being the 5 to 9-year-old group.

In Limpopo, which currently has an immunisation campaign on the go, most cases were in the Greater Sekhukhune and Mopani districts.

The outbreak in North West was declared after three cases were reported in Ngaka Modiri Molema district.

In Gauteng, three laboratory-confirmed cases were reported at a single health facility in Ekurhuleni.

In January 2023, laboratory-confirmed measles cases were reported in Limpopo (131 cases), Mpumalanga (69 cases), North West (80 cases), Gauteng (14 cases), and Free State (11 cases), says the National Institute for Communicable Diseases (NICD).

Of those who have been infected, less than one-third had a vaccination record. And of those with a record, 61% had not had the measles vaccine.

The most affected age group was five to nine years old, (41%), followed by 28% in the one-to-four age group and % in the 10-to-14 age group. The worst-hit province is Limpopo.

Urgent global action needed

Measles anywhere is a threat everywhere, as the virus can quickly spread to multiple communities and across international borders. No WHO region has achieved and sustained measles elimination. Since 2016, 10 countries that had previously eliminated measles experienced outbreaks and re-established transmission.

"The record number of children under-immunised and susceptible to measles shows the profound damage immunisation systems have sustained during the COVID-19 pandemic," said CDC Director Dr Rochelle P. Walensky. "Measles outbreaks illustrate weaknesses in immunisation programmes, but public health officials can use outbreak response to identify communities at risk, understand causes of under-vaccination, and help deliver locally tailored solutions to ensure vaccinations are available to all."

In 2021, nearly 61 million measles vaccine doses were postponed or missed due to COVID-19-related delays in immunisation

campaigns in 18 countries. Delays increase the risk of measles outbreaks, so the time for public health officials to accelerate vaccination efforts and strengthen surveillance is now. The CDC and WHO urge co-ordinated and collaborative action from all partners at global, regional, national and local levels to prioritise efforts to find and immunise all unprotected children, including those who were missed during the last 2 years.

Measles outbreaks illustrate weaknesses in immunisation programmes and other essential health services. To mitigate risk of outbreaks, countries and global stakeholders must invest in robust surveillance systems. Under the Immunization Agenda 2030 global immunisation strategy, global immunisation partners remain committed to supporting investments in strengthening surveillance as a means to detect outbreaks quickly, respond with urgency and immunise all children who are not yet protected from vaccine-preventable diseases.

Why these health workers are spending their lives in SA's poorest villages

Jesse Copelyn, for *Bhekisisa*

Nomkhosi Mkhwanazi, 35, is sitting in her office at Hlabisa Hospital in the small rural settlement in KwaZulu-Natal that this district healthcare facility is named for, about 3 hours' drive north of Durban.

She's a dietician, and the hospital's only one.

Mkhwanazi grew up in Hlabisa and has spent most of her life here.

She's also one of around 500 health workers whom the [Umthombo Youth Development Foundation](#) has helped to study health science since 1999. Like Mkhwanazi, the students are from poor, rural backgrounds and get funded and mentored during their studies.

In return, they're expected to work at the hospitals in (or near) the towns or villages they grew up in after graduating, for the same number of years that the foundation supported them.

Mkhwanazi was contractually compelled to work in the Hlabisa area for 4 years, but she's stayed for far longer. This month, she would have worked here for 9 years.

In fact, her desire to help people in her community is what drove her to become a dietician in the first place.

"I always wanted to come back and work here," Mkhwanazi says. "Before I became a dietician, I was a student nurse here at the hospital. I noticed that many patients didn't gain weight due to their illnesses or because they struggled to afford food."

Dieticians provide such patients with [evidence-based advice](#) on what kinds of foods they should eat. "If patients are too ill to keep food down, dieticians prescribe the appropriate nutritional supplements," Mkhwanazi adds.

If the patients that Mkhwanazi was seeing lived in cities such as Cape Town or Durban, they would likely have had a choice of dieticians to consult at public hospitals.

But here in Hlabisa, things are different.

"There wasn't a single permanent dietician at the hospital until I started working here in 2013," Mkhwanazi says. "So I decided to study dietetics and then come back to serve my community."

When doctors were raised in rural areas, they're more likely to work there

Mkhwanazi's story reveals why Umthombo was set up.

People who grew up in rural towns are far more likely than their urban counterparts to take up jobs in rural clinics and hospitals, where they're [desperately needed](#).

A 2019 study that tracked medical students from the University of the Witwatersrand (Wits), for instance, showed that 5 years after graduating, doctors who were raised in rural areas were almost five times more likely to be working in rural hospitals than those who hailed from cities.

Research from other South African medical schools has found similar results.

So what about Umthombo's own data?

A 2015 study showed that almost 95% of the 185 health science students who had graduated by 2013 had honoured their contracts and worked back the full period they were supported for at a rural health centre, or were in the process of doing so. And of those who had completed their obligations, 71% stayed on in these areas afterwards.

The foundation's graduates take skills that rural hospitals and clinics struggle to attract or retain to those facilities, a 2021 study, published in *BMC Health Services Research*, found.

A health department report from 2011 shows that of the 1 200 medical students who graduated per year, only 3% ended up working in rural areas 10 - 20 years later. There's no new health department data, but a 2019 study that tracked doctors who graduated at Wits between 2007 and 2011 found that only 7% were working in rural areas.

This contributes to the huge mismatch in how easily people in far-flung districts can get healthcare compared with those in the country's metropolises.

But why do people who grew up in rural areas and who now have the means to live anywhere in the country (or even emigrate) choose to work in small SA settlements – and often in under-resourced facilities?



Nomkhosi Mkhwanazi, 35, is the only dietician at Hlabisa Hospital in Hlabisa, a small rural settlement in KwaZulu-Natal, about 3 hours' drive north from Durban (Dylan Bush, *Bhekisisa*)



Mthokozisi Gumede, a social worker at the Bethesda Hospital in Ubombo, a small village about 4 hours' drive from Durban, says he feels great fulfilment to serve people who knew him growing up (Dylan Bush, *Bhekisisa*)



To find out, anecdotally, *Bhekisisa* travelled to three hospitals in rural KwaZulu-Natal where Umthombo graduates now work. We spoke with 10 of them, each of whom grew up in these districts.

We also spoke to six Umthombo-supported medical students at the University of KwaZulu-Natal who come from deep rural communities about their intentions to return.

Family and finances: The pros of life in a rural area

Many of the students and health workers who *Bhekisisa* talked to echoed Mkwana's reason for coming back to work in rural areas.

Knowing how deprived their communities are of decent health services is a big part of what drives them home.

Mthokozisi Gumede, a social worker at the Bethesda Hospital in Ubombo, a small village about 4 hours' drive from Durban, says he feels great fulfilment to serve people who knew him growing up.

"Some people recognise me as that boy from that house in that village, and now they see that I've grown up and I'm giving back to my community."

But economic considerations can play a role as well.

It's a lot easier to save money while living in a rural place, where rent is cheaper than in the city, says Lungile Thwala, a social worker at Bethesda Hospital, where she's been working since 2015. She grew up in the small town of Mbazwana, roughly 60 kilometres away.

To make working in state hospitals in rural areas attractive, the health department also offers medical professionals an extra allowance – to the value of 8 - 18% of their basic monthly in some cases.

Many of the people *Bhekisisa* spoke to said that working in (or near) the rural settlements where they grew up makes it easier to see their families regularly. "It's important for me that I don't have to travel long distances just to see my family," Thwala mentions.

The town next door: Why some rural health workers prefer to work near their hometown, but not in it

But most of the former Umthombo students approached their giving back differently from Mkwana: very few wanted to work in the

exact same town they were raised in, preferring instead to work in neighbouring villages.

Lungile Njokweni, a physiotherapist at Hlabisa Hospital, says that "when patients come from the same town as the healthcare worker, they try to take advantage of them and demand special [medical] attention".

Back at Bethesda Hospital, Gumede agrees: "In the healthcare profession, you're trying to work according to ethical principles of fairness, but when people know you, they demand extra favours."

In Durban, some of the medical students at the University of KwaZulu-Natal were also anxious about returning home.

One young doctor-in-training, Sbhonginkonzo Mncwango, said he'd prefer not to treat patients who he knows personally, as it might be awkward to learn intimate details about them.

Thulani Ngwenya had a similar concern when he started working in rural KwaZulu-Natal in 2013 after qualifying as a doctor. For him, it was always important to serve people in uMkhanyakude, the district municipality where he grew up and now works.

But he wanted a bit of distance from his hometown of Ingwavuma, a rural village close to KwaZulu-Natal's northwestern tip, where the province borders Eswatini. Today, Ngwenya is the medical manager at Bethesda Hospital, about 80 kilometres away from Ingwavuma.

"In my culture, a mother or grandmother would not feel comfortable being examined by someone they saw growing up," he explains.

Smiling, Ngwenya says he will go back to his childhood village in time: "I just need the community to forget about me running naked in front of them as a child. Hopefully then they can comfortably be naked in front of me."

Source: *Bhekisisa*, 30 November 2022. <https://bhekisisa.org/features/2022-11-30-why-these-health-workers-are-spending-their-lives-in-south-africa-poorest-villages/>.

CPD certificates now available on HPCSA online portal

SAMA Communications

Effective from February 2022 the HPCSA CPD certificates will no longer be issued to HPCSA professionals. A template will be completed after each activity by the service provider of the event/activity and sent through to the HPCSA for capturing on points.

The new process will automatically upload the accredited CPD event/activity points to the HPCSA medical professionals' profile.

The new process alleviates the burden on professionals to keep track of certificates and allows automatic update of your CPD points directly to the HPCSA. It also places

no administrative burden on the medical professional but rather on the service provider providing the CPD activity.

Any discrepancies of point allocation can be discussed with the service provider of the event/activity. For more information contact: cpd@samedical.org.

What are medical humanities?

Dr Chris Ellis, family physician and Ingcweti Yesinkondlo, Pietermaritzburg, KwaZulu-Natal

In recent years, a discipline called medical humanities has been edging its way into the medical school curriculum. It has been a tough battle waged against the more mechanistic and formulaic disciplines in order to obtain curriculum time.

In a nutshell, medical humanities deal with aspects of illness that are experienced through various mediums, such as literature, art, theatre, poetry and narrative. There is now a wide body of recognised literature, film and poetry that those of us teaching medical humanities can draw on. There has also been the development of various online mediums and techniques that have made this teaching easier and more accessible.

Medical humanities help our ability to engage in imaginative and critical discussion about the meanings and purposes of our own lives and the lives of our patients

The interactive discussions that arise during the modules give rise to subjective experiences that are important for us to come to terms with in medical care and practice. The integrative care module in family medicine is an ideal place to fit in medical humanities if there is no time or space in the formal medical school curriculum. Teachers can also fit medical humanities into almost all clinical areas of the practice of medicine. Liaisons are made between the family medicine/general practice departments and other university departments such as English and drama. This helps with cross-educational projects as well as the choreography and construction of OSCEs [objective structured clinical examinations].

While teaching overseas I was fortunate enough to be involved in such a programme

with two innovative Canadian physicians. We presented and taught through film, art, theatre (as film) and poetry. One of the modules we introduced was a *WIT* workshop, which is based on the Pulitzer prize-winning play, *WIT* (actually written as *W;t*). It covers subjects such as end-of-life care, the ethics of consent, compassion and the use of communication skill sets.

The other commonly used teaching aid is art, which is relatively easy to access from the internet. Visual arts can be combined with visits to local art museums and with observational skills courses. These improve interpretative and observational skills as well as cultivating multicultural sensitivity.

It is well known that poetry has powerful descriptions of the human condition and enquiries into human nature. Critics still ask, how exactly does teaching with poetry help with the practice of medicine? The answer is that it helps you think outside of the box, expands flexible qualitative thinking, increases empathetic feelings and often resonates with patients' and doctors' lives. Much of the literature and texts come under the rather erudite heading of autopathography. These are patients' descriptions and points of view about their illnesses, such as heart attacks and cancer, as well as their experiences with the delivery of healthcare.

This all promotes our processes of reflection and self-reflection, and explores emotional and practical issues related to clinical care. Quatrains, rubaiyats, limericks, haikus and koans can all be used by experienced teachers to stimulate higher-order thinking, right-sided brain activity and the creation of insights and meanings into the problems of living.

Most of our knowledge in medicine is, correctly and importantly, based on quantitative and evidence-based analytical research. There is, however, another source of knowledge that is very difficult to negotiate in the medical arena. This is the Sufi and Jungian concept of Ma'rifa, which is the mystical or spiritual knowledge of "higher realities". Most of us lost this connection to nature and the numinous at the moment we stepped into a classroom in our infancy. Ma'rifa can be found in the poetry of the Sufi poets, Rumi and Attar.

As an example, and if you have the time, you might like to try Attar's epic poem



The Conference of the Birds, written in the twelfth century. It is in the genre of a quest narrative, similar to Homer's *Iliad* and John Bunyan's *The Pilgrim's Progress*. It involves a life journey replete with the dangers and perils that are faced by *homo sapiens* on a daily basis.

Attar's poem describes a journey by a group of birds in search of their king, the Simorgh. In the quest narrative of the *Iliad*, the objective of the journey is to return to as well as a longing for "home", and in *The Pilgrim's Progress* it is a search for the Celestial City. In Attar's poem, the birds of the world all congregate in order to go on a quest in search of the mythical Simorgh bird. It is a metaphor for the search for spiritual truth, enlightenment and the creator. The Simorgh dwells far away on the legendary Mount Qaf. The Hoopee, who is the wisest and most enlightened of the group, is their leader and he takes them on a journey through seven valleys.

There are the parrot, the finch, the partridge, the falcon, the dove and the peacock, among many other birds. Each bird represents a human flaw or weakness such as greed, envy or pride. The peacock is too concerned with his external beauty,

the partridge is too attached to her earthly treasures and jewellery, and the hawk is too conscious of his social status.

The birds set off on the journey through the seven valleys. Among them are the valleys of Knowledge, of Bewilderment, of Poverty and of Nothingness. Some of the birds give up, others fall prey to temptations while others die on the way. Only thirty birds arrive safely at the final destination.

So what, we ask the students, do they think the birds find at the end of their journey? The answer is a lake, and on looking into the waters they see a reflection of themselves.

So, to put it rather grandly, medical humanities help our ability to engage in imaginative and critical discussion about the meanings and purposes of our own lives and the lives of our patients. In practice, apart from their physical ailments, patients bring wider

issues (grand narratives) to the consultation. These are about unemployment, divorce, crime and insecurity, as well as fear, anxiety and death. Much of this cannot be didactically taught, as it is an intuitive and experiential knowledge gained in the practice of medicine and of living on this planet. It is all included, however, in the discipline of medical humanities.

Source: S Afr Gen Pract, 2022;3(6):141-143.

Childhood emotional abuse – a lifetime of invisible scars

SAMA Communications

More than a third of SA children under the age of 17 suffer emotional abuse and neglect, resulting in invisible scars that put them at greater risk of mental illness and limit their chances of a fulfilling and functional adult life.

Psychological abuse and neglect of children's emotional needs for affection and support are committed most often by those closest to them and responsible for their nurturing and development – parents, caregivers and relatives – and this cuts across all levels of society and income.

Although physical abuse in childhood is the most prevalent, affecting 56.3% of children, the risk of developing serious mental health problems is four times greater for the 35.5% who suffer emotional and psychological abuse, says Dr Eugene Allers, spokesperson for the South African Society of Psychiatrists (SASOP).

While physical and sexual abuse are regularly seen in the courts and the headlines, psychological abuse, including emotional neglect, receives much less attention and awareness, but is one of the most traumatic forms of abuse that a child can experience, he said.

"Children should be given the best opportunities in life, living in loving homes, free from all forms of abuse. This will ensure their optimal development, with less chance of psychological or psychiatric problems later in life. Children who are abused often become abusers, continuing the vicious cycle.

"The childhood trauma of emotional abuse and neglect affects the child's sense of self and their capacity to trust and build healthy relationships. It can also affect a child's physical health and educational outcomes, all

with great impact on their future prospects," Dr Allers said.

The types of abuse overlap, in that children who suffer physical and sexual abuse are likely also to experience emotional abuse and neglect. Almost 70% of SA children will experience any type of abuse before the age of 17, and 27% will be victims of multiple types of abuse.

Exposure to family conflict and domestic violence also constitutes emotional abuse and leaves lifelong scars, Dr Allers said. This was particularly concerning for SA children, with domestic violence at "epidemic proportions" and intimate partner violence affecting between a third and half of households.

"All abuse leaves emotional or psychological scars. While physical injuries can heal, emotional scars are disabling and crippling to most individuals, and psychological abuse and neglect are much more prominently associated with mental illness in later life than physical or sexual abuse," Dr Allers said.

He said the impact on children's future mental health is substantial, with a third of all psychiatric disorders originating before the age of 14, and half before 18.

The Children's Act 38 of 2005 defines abuse as any form of harm or ill-treatment deliberately inflicted on a child, including assault, deliberate injury, sexual abuse, bullying, exploitation or exposing or subjecting a child to behaviour that may harm the child (such as exposure to domestic violence).

Dr Allers said there was a lack of knowledge of what emotional abuse entails and the signs and symptoms, and it was often not addressed as it is more difficult to define and recognise than physical abuse.

Emotional abuse is more subtle, ongoing and generally not connected to a single incident such as a beating or sexual assault.

Emotional or psychological abuse forms include withholding love and support, rejection, berating and threatening the child, insults and name-calling, belittling or humiliation, cold-shouldering, guilt-tripping and emotional blackmail.

Acts of emotional neglect include spending little time interacting or talking with the child, being unresponsive to or dismissing their feelings, giving little positive feedback or praise, persistently finding fault, and offering little help or encouragement when they are struggling with schoolwork or other tasks.

"At the other end of the scale, overprotection is just as detrimental to children as neglect," Dr Allers said.

He said signs of emotional abuse and neglect in children included anxiety and depression symptoms, isolating themselves, disruptive behaviour, mood changes including aggression and agitation, depression, sleep problems, school refusal or lower school performance, and developmental and language delays.

There is also a heightened risk of self-harm and suicidal behaviour, he said.

He emphasised that medical professionals and social workers are bound by law to report any form of child abuse, including emotional abuse.

"Where emotional abuse or neglect is suspected, children should be referred for psychological interventions that can help them to cope and rebuild their self-esteem, and abusers must be dealt with by the legal system, he said.

References available on request.

SA team devise cost-effective genetic breast and ovarian cancer screening

SAMA Communications

In November last year, *Medical Brief* reported that in a breakthrough that is hoped will reduce time, save money and save lives, a Free State medical scientist in genetics and a PhD candidate have, in a collaborative project with a research group from Stellenbosch University, devised new cost-effective genetic testing for breast and ovarian cancer.

Once operational, women with these types of cancers in their families can be quickly, easily and cheaply screened to identify risks early.

“Any effort to save lives will have a meaningful impact”

TimesLIVE also reported that the development is thanks to researcher Dr Nerina van der Merwe, principal scientist within the University of the Free State’s division of human genetics and the National Health Laboratory Service, and colleague Jaco Oosthuizen, who have been working with Prof. Maritha Kotze’s research group in Stellenbosch.

Through a new technology based on rapid point-of-care (POC) testing, they have implemented a new diagnostic test for familial breast and ovarian cancer that “will reach more communities and hopefully contribute to saving more lives”.

Van der Merwe said they were first approached by Kotze. “Prof. Kotze and her team, in collaboration with a UK company, have been working on designing a POC assay for this technology, based on our research results,” she said.

Her unit is the state referral centre for familial breast and ovarian cancer in the country, where they have screened more than 3 000 patients diagnostically.

“With our research results and access to positive controls, we are able to assist with the validation and potential implementation of this technology in the future,” she said, pleased with the development that comes after nearly 30 years of SA-specific genetic research on familial breast and ovarian cancer.

Van der Merwe said the new technology, after validation as a diagnostic genetic test, is the future of familial breast and ovarian cancer testing in SA, when performed with genetic counselling.

It is a user-friendly, practical method, she added, very suitable for use in rural clinics, eliminating the need for expensive laboratory equipment.

Van der Merwe was appointed to determine the range and contribution of genetic changes in the two *BRCA* genes. Her work, in collaboration with Prof. Lizette van Rensburg from the University of Pretoria, identified the first SA-specific variants, which proved to represent SA-unique recurrent, or founder, variants found in African and Afrikaner populations.

As her research grew, the number of founder variants grew to six – the number she says is “ideal for the implementation of rapid POC testing, as these variants are common in affected patients and justify being screened first, before moving to more expensive diagnostic testing”.

She is particularly excited about the progress in her field because it will not only benefit patients but also their at-risk relatives.

The test, through saliva taken via an inner cheek or buccal swab, is less invasive than a blood test. Results are available in 90 minutes.

“Through genetic counselling, while the test is running, patients and their family can ask questions about genetic testing and cancer, simultaneously increasing community awareness. By face-to-face consultation, the counsellor can ensure the patient and their relatives understand the test’s value,” van der Merwe said. The aim was to eventually increase the low uptake of genetic testing in related at-risk relatives, as this cancer type is inherited.

Most patients/ who test for cancer are already affected.

“However, we need to screen relatives to identify who is at an increased risk, but this is not happening. So, this will change if we take the test to the patients, because members of their family often accompany them to the clinics. This gives us a chance to inform them, as we have noticed that patients seldom

discuss their diagnosis and test results with relatives, who are also at risk of inheriting the disease.”

Van der Merwe and her team have since broadened their founder testing regime from screening for *BRCA1* and *BRCA2* only, to multi-gene panel testing using next-generation-sequencing to include other genes causing these two and other specific cancer types.

Their work has been welcomed by the Cancer Alliance, a collective group of 29 cancer-control NGOs and advocates.

Their work has been welcomed by the Cancer Alliance, a collective group of 29 cancer-control NGOs and advocates

“This is good news – the ultimate question is the cost, mainly for the public sector, as this is where most women access health services. For this type of test to be included as standard care for the early diagnosis of women with breast and ovarian cancer, affordability will play a major role,” said the alliance’s CEO, Salomé Meyer.

“This is also where appropriate health technology assessment could help determine the long-term savings of genetic testing where applicable against the actual treatment costs and the overall economic benefits.

“Any effort to save lives will have a meaningful impact. We can only hope this work will be presented to the appropriate decision-makers who influence policy at the national health department, as well as the medical schemes,” she said.

Source: *Medical Brief*, 16 November 2022. <https://www.medicalbrief.co.za/sa-team-devises-cost-effective-genetic-breast-and-ovarian-cancer-screening/>.

Breast cancer patients in SA may find it hard to stick to treatment: Here's what they told us

Jenny Edge, *specialist consultant/Head: Breast and Endocrine Surgery Unit, Stellenbosch University*, Brigitta Kepkey, *senior research assistant, Stellenbosch University*

Worldwide, breast cancer is the most commonly diagnosed cancer. It's also the leading cause of cancer-related death among women. The incidence of breast cancer is expected to rise, with the majority of breast cancer cases occurring among women in low- and middle-income countries such as SA, where adherence to treatment remains a challenge. For example, outcomes are dependent upon patients following the recommended chemotherapy protocols, and getting the recommended drugs at the right time.

There were 10 174 new known breast cancer diagnoses in SA in 2019. These accounted for 23% of all the new cancer cases in women in SA. It is likely that the burden of disease is even higher, though, as not everyone has access to diagnostic facilities. Some people don't know they have breast cancer because it hasn't been diagnosed.

As a breast surgeon and scholar I have worked in the field for decades. Together with Dr Bronwyne Coetzee and Prof. Ashraf Kagee from the Department of Psychology at Stellenbosch University, I supervised Brigitta Kepkey (a Masters student), who conducted a study of the factors that challenge adherence to breast cancer treatment among SA women.

After conversations with patients attending the Breast and Endocrine Unit at Tygerberg Hospital in Cape Town, she documented some of the barriers that affect their ability to adhere to breast cancer management. The perspectives of patients, family members and oncology healthcare workers involved with chemotherapy treatment and administration were sought.

Adherence to treatment plans, particularly chemotherapy, is complex. Our research found that there were personal, environmental and structural factors that influenced a patient's ability to be adherent. These included access to transport, socioeconomic level and social support.

Treatment

In low- and middle-income countries such as SA, more patients present with advanced cancer. For example, in the USA, approximately 64% of women have early-stage cancer at the

time of diagnosis. In comparison, more than 60% of patients seen in the public healthcare system in SA have locally advanced (inoperable) breast cancer at the time of diagnosis. They therefore receive a relatively aggressive form of treatment: usually chemotherapy. The aim is to downsize their cancer, so it becomes operable.

Timely diagnosis in SA is dependent on many factors, including where a person lives.

Data from another study in Soweto in Johannesburg showed that the stage of cancer at the time of diagnosis depended on the distance from the healthcare facility. Patients who lived more than 20 km away from the breast clinic were more likely to have locally advanced disease than those who lived nearby: 62% v. 50%.

Distance, socioeconomic status and transport affect not only diagnosis but adherence to treatment.

Barriers to sticking with therapy

To define some of the barriers faced by women, Kepkey interviewed two small groups of women: those who had remained adherent and those who were non-adherent to chemotherapy treatment.

Some patients struggled with side-effects such as hair loss, fatigue, weight loss and change in body image. These concerns were more prevalent among younger patients, who were also concerned about the impact of chemotherapy on their fertility and ability to have a family later on in life.

But these concerns were not raised more commonly by those who weren't sticking to their treatment regimens. This may be because women who were non-adherent were generally older.

Patients may miss out on treatment due to family responsibility, if they are the breadwinners and cannot afford to miss a day of work or cannot find a child-minder.

According to StatsSA, 42% of SA households are headed by females. Children are more likely to live with their mothers in both rural (38%) and urban (49%) areas.

The extra pressure put on an individual with breast cancer was illustrated by a healthcare worker:

"They (patients) would rather go to work than come for treatment cause they still need to feed their family."

A patient also said:

"When I'm not feeling well [as a result of treatment], I must get up [and] struggle to go to walk around and look for money."

The importance of health education was highlighted by healthcare workers, as many patients have preconceived ideas as a result of social knowledge and second-hand accounts. Some patients assumed that chemotherapy affected everyone in the same way, and therefore the negative side-effects of chemotherapy such as hair loss, treatment side-effects and infertility were deterrents to adherence as patients thought they would experience these side-effects to the same or a worse extent.

Patients who lack social support are also more likely to be non-adherent to treatment as the cancer journey is difficult to go through alone.

Why this matters

In order to help patients adhere to their treatment protocols, more time needs to be spent unpacking the challenges that patients experience. One of the practical outcomes from the study was that the oncology healthcare workers realised the importance of using simplified explanations of treatment, and answered patients' questions. We recommend that healthcare workers be sensitive to the influences on a patient's decision-making and treatment outcomes. If possible, patients should receive psychological support throughout their cancer journey. Addressing the barriers to care is essential, as failure to do so may compromise patient health.

The barriers identified are not unique to our clinic. It takes time to address the practicalities needed to provide adequate care, but doing it will increase patient compliance, make the cancer journey less daunting and therefore improve cancer outcomes.

Source: *The Conversation*, 12 December 2022. <https://theconversation.com/breast-cancer-patients-in-south-africa-may-find-it-hard-to-stick-to-treatment-heres-what-they-told-us-193112>.

HIV treatment in SA is changing. Here are 7 things you need to know

Joan van Dyk, Linda Pretorius, for *Bhekisisa*

From April 2023, everyone with HIV who is older than 4 weeks (and who weighs more than 3 kg) will be able to go on a treatment plan that includes the antiretroviral (ARV) drug dolutegravir, according to Thato Chidarikire, the health department's acting head of HIV programmes.

Chidarikire was speaking on a *Bhekisisa* webinar on 7 December, during which the Southern African HIV Clinicians Society (SAHCS) previewed its 2023 (private sector) treatment guidelines for adults and children, which should also be available to the public early next year.

Dolutegravir, which was first recommended as first-line treatment in SA in 2019, is one of the ARV drugs in a three-in-one pill for first-line treatment. The other two drugs in the pill are *tenofovir* and *lamivudine*.

First-line treatment is the combination of ARVs that works the best, and has the fewest side-effects, as initial treatment for HIV infection. If first-line treatment starts to work less well for some patients (so if the virus in their bodies becomes resistant to the treatment), they are switched to second-line treatment.

Dolutegravir, which belongs to a group of ARVs called *integrase inhibitors*, replaces *efavirenz* in first-line treatment. Research shows it's better than efavirenz at dropping the amount of HIV in someone's blood to levels low enough so that it can no longer be passed on to other people via sex (called *viral suppression*). Dolutegravir is also more forgiving of skipped doses, reducing patients' risk of developing drug resistance.

Lastly, dolutegravir is cheaper than efavirenz and has fewer side effects.

The health department started to gradually phase in dolutegravir in December of 2019.

From next year, SAHCS will recommend dolutegravir not only for patients who start taking ARVs for the first time, but also for second- and third-line treatment, says Jeremy Nel, an infectious diseases specialist who's based at the Helen Joseph Hospital in Johannesburg.

This is good news, says Nel, because doctors often had to opt for pricier, more complicated drug prescriptions when patients had to go onto second- and third-line treatment.

But getting people to buy into the new guidelines could prove tricky for health workers, Nel argues, as they'll have to undo the bad press



dolutegravir received since the WHO first backed the use of the drug in 2018.

Researchers initially cautioned that the medicine could cause birth defects if taken by pregnant women and that it leads to considerable weight gain.

Later data has, however, cleared up both concerns, but communities remain uninformed and, therefore, fearful, says Luckyboy Mkhondwane, who leads the Treatment Action Campaign (TAC)'s education projects for HIV treatment and prevention.

The reputational damage could be behind the slow uptake of dolutegravir in the private sector, Nel says, which has lagged behind government facilities.

But poor communication and a lack of training might be to blame as well. Health workers in the private sector had less information about dosing guidelines for dolutegravir and possible side-effects than their peers in government facilities, found a 2022 study published in the *South African Medical Journal*.

Mkhondwane explains: "If a doctor prescribes or talks about medication a patient has never heard of, it can intimidate patients and prevent them from asking questions."

From strawberry-flavoured HIV medicine for children to undoing dolutegravir's bad rap, the updated guidelines promise positive changes to treatment for the 7.8 million people in SA living with HIV.

Here's what you need to know.

Why do both the health department and SAHCS have guidelines?

Guidelines consolidate the newest, science-

backed evidence for treating a disease into a standardised package, explains Juliet Houghton, the chief executive officer of SAHCS. This means that health workers can give all patients the care that's best for them, she says.

Because the public and private health sectors cater for different markets, they each have their own guidelines – the health department's for state patients and SAHCS's document for private sector clients.

The health department may, for instance, have a tighter budget that could impact on its guidelines, explains Houghton.

But Nel stresses that the two sets are very similar, so that people can get standardised care whichever facility they use and know that their treatment won't change dramatically, should they switch between the sectors. In cases where the two documents differ, SAHCS will explain its thinking.

For the new sets of guidelines, says Houghton, SAHCS and the health department are trying to align public and private sector guidelines more closely than previously.

Why do treatment guidelines change?

Treatment guidelines evolve as better medicines and treatment plans emerge, Chidarikire says.

Under the country's first set of treatment rules from 2004, for instance, people could only get HIV treatment if their CD4 count had dropped to 200 or lower. A patient's CD4 count is a measure of how strong their immune system is.

But today, anyone who tests HIV-positive can get treatment.

Says Houghton: “The bottom line is that recommendations are updated to make sure that everyone in SA living with HIV gets the best care available to them.”

What's new for children?

Caregivers of newborns and children can look forward to simpler HIV treatment plans.

The current guidelines say children from age 10 and up (and who weigh at least 30 kg) should take the adult form of the medicine.

But with the new plan, infants and kids can take a child-friendly form of dolutegravir from when they're 4 weeks old (until the age of 10 years), instead of having to stick with the earlier, older medicines *nevirapine* and *azidothymidine*.

The child-friendly version of dolutegravir holds huge promise.

Why?

It's a four-in-one, strawberry-flavoured pill that will replace the series of syrups that caregivers and health workers currently have to give children – but struggle to get them to take.

The medicines taste bad and so “children don't always get the full dose they need because they spit it out”, explains James Nuttall of the University of Cape Town. They can also have side-effects and have to be given twice a day, which can be difficult for caregivers, he says.

The new dolutegravir pill recommended for children from next year can be dissolved in water or sprinkled over soft food, and needs to be taken only once a day. SA's medicines regulator, the SA Health Products Regulatory Authority, approved this form of the drug in June.

Better treatment for children is a crucial step to get the HIV epidemic under control, Nuttall says.

Children fare far worse than adults when it comes to HIV treatment. One way to see the difference is by looking at the two groups' progress in reaching the UN-backed 95-95-95 targets.

The goal is for countries to have diagnosed 95% of all HIV-positive people, provide ARV therapy to 95% of those diagnosed and to get the viral load of 95% of people being treated down to undetectable levels by 2030.

On the whole, South Africa stands at 94-78-89. But the picture changes dramatically when children's numbers are separated out: for children of 0 - 15 years, we stand only at 80-69-64.

Is it safe to use dolutegravir during pregnancy?

“One word on that,” says Nel: “Yes.”

He continues: “They [ARVs] are not only safe; they're essential.”

“I'm a warrior”: How the anti-HIV injection empowers young women

Yolanda Mdzeke, Mohale Moloi, Jessica Pitchford, for *Bhekisisa*

SA's medicines regulator, the SA Health Products Regulatory Authority, has approved a 2-monthly anti-HIV injection. At the Emavundleni Prevention Research Centre in Nyanga outside Cape Town, more than 200 women have been taking the jab as part of a clinical trial. The shot almost entirely cancels people's chances of contracting HIV through sex. It's also easier to stick to than the daily HIV prevention pill because it only has to be taken once every 2 months.

Our reporters travelled to Cape Town and spoke to three women who've become HIV prevention advocates in their communities. Watch the video to find out why they're worried about getting the virus (<https://bhekisisa.org/multimedia/2022-12-08-anti-hiv-injection/>). They also tell us how the injection, called CAB-LA, has changed their lives.

When a pregnant person has a lot of HIV in their blood, they pass on the virus to their baby, Nel says.

But dolutegravir's ability to cut someone's viral load quickly means it can stop the HIV from spreading from a mom to an infant. That's why the health department currently recommends that all HIV-positive moms should be considered to be at high risk to transmit the virus to their babies until proven otherwise, explains Chidarikire, and be on HIV treatment.

Nuttall concludes: “It would be great if paediatric HIV could be something we read about in books, rather than a condition we treat every day.”

Does dolutegravir cause weight gain?

No.

A study suggested people on dolutegravir gain more weight than those on efavirenz.

But new research from SA shows that it's not dolutegravir itself that makes people gain weight while on the treatment, Nel explains, it's just their body's normal reaction to returning to health (because the virus has been virtually thwarted).

The researchers also found that people not gaining weight while on efavirenz is likely because their bodies struggled to break down the drug quickly enough, which interferes with normal metabolism.

Will any nurse be able to start people on HIV treatment and prevention?

No.

At the moment, only nurses who have completed the so-called NIMART training programme (which stands for nurse-initiated management of antiretroviral treatment) can

prescribe and administer ARVs and prevention medicines such as the HIV prevention pill (currently available in SA) or the new 2-monthly anti-HIV injection cabotegravir (not yet available in the country).

That won't change under the health department's new guidelines, says Chidarikire.

Will testing guidelines for newborns change?

No.

In 2015, the health department began using polymerase chain reaction (PCR) tests to determine a newborn's HIV status, so that they could start treatment as soon as possible if they got infected during pregnancy, explains Nuttall.

Newborns have to be tested with PCR tests, rather than with antibody tests (which are cheaper), because with a positive antibody test it's not clear whether it's the mother or the baby who has HIV. Any infant born to an HIV-positive mother will test positive for the virus at first because the mom's antibodies will be transferred to the fetus through the placenta.

A positive PCR test, on the other hand, means that the virus itself is present.

Nuttall says that HIV-negative infants should be tested again in their first year of life, in case they got infected during breastfeeding, and can then be started on treatment immediately.

Source: Bhekisisa, 13 December 2022. <https://bhekisisa.org/health-news-south-africa/2022-12-13-hiv-treatment-in-sa-is-changing-here-are-7-things-you-need-to-know/>.

Source: Bhekisisa, 8 December 2022. <https://bhekisisa.org/multimedia/2022-12-08-anti-hiv-injection/>.

Clinical report writing – tips and common pitfalls

Dr Shivani Chirkut, *medicolegal consultant, Medical Protection Society*

This article is an abbreviation of a presentation at the 15th Ethics For All conference held last year. The full session can be viewed online.

When would you be required to write a clinical report?

There are various circumstances in which the writing of a report may be necessary.

A request to prepare a report for legal or other purposes may be received from the following:

- the patient
- an attorney
- the patient's insurance company
- a statutory or regulatory authority like the HPCSA
- an employer
- the police (e.g. in criminal proceedings or an inquest investigation)
- court.

Any report, like your clinical records, should be considered a medicolegal document, so you need to be mindful of what you write and how you express yourself.

Before preparing the report

Given that the report will contain the patient's personal information, ensure you have permission from the patient to provide the report. Ideally, any medicolegal report – generally one written to be used in legal proceedings – should be prepared in response to a written request, accompanied by an appropriate signed authority and/or the patient's permission.

What if the request comes from an authority other than the patient?

In that case, it may be appropriate to confirm with the patient that the authorisation is valid by ensuring that (s)he is aware of what has been requested, and agrees to release this information. A breach of confidentiality and privacy is one of the most common causes of complaints after a practitioner has provided a report.

Before agreeing to compile a medical report, it is crucial to understand its purpose and intended use. Seek clarification from the requesting party if the purpose is unclear. When writing it, it is important to remember three key questions:

- Who and what is the information for?
- Who will read it?
- How might it be used and possibly misused?

This will help guide your writing in terms of content, tone and clarity.

Am I obliged to provide a report when requested?

Most practitioners do not delight in writing reports. Nevertheless, it comes with the territory of clinical practice, and is a vital and empowering skill.

A question often asked is: just because a report has been requested, am I obliged to provide it? Can I simply decline the request?

In general terms, there is no legal obligation for you to prepare a report, although some statutory bodies may compel the preparation of one in certain circumstances.

However, a treating practitioner has a professional and ethical obligation to assist by providing factual information concerning a patient's condition or injury, at the patient's request, to the patient's legal advisers or, with the patient's consent, to any nominated third parties.

Importantly, while there is an ethical obligation to assist the patient by providing a factual report, you are under no obligation to give an opinion in your report. Of course the context is different if you have agreed to be an expert witness, in which case your professional opinion is a requirement.

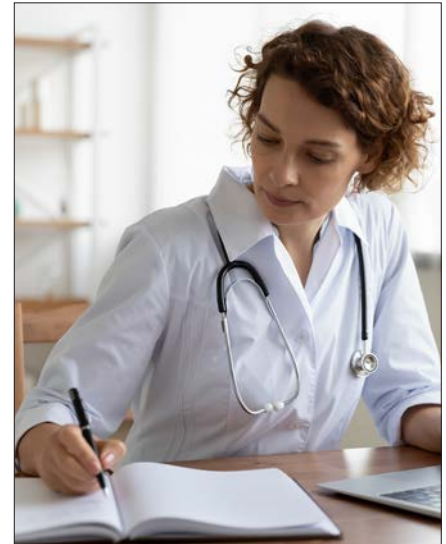
Some tips for a good report

Ideally, you would use your clinical records to prepare your report. Therefore, ensure your day-to-day clinical notes are clear and comprehensive.

Be clear and accurate in your writing, and always be objective. Avoid ambiguity. Be clear about who did what, when, why and to whom.

Write in the first person for clarity. So instead of saying, "Mr X's left knee was examined," rather say, "I examined Mr X's left knee."

The report must be factual, relevant to the request and understandable to a non-clinical audience. Always consider who will read the information, and write for their understanding. Sufficient and relevant detail is required. While information that is obviously unnecessary should be excluded, if in doubt, err on the side of caution and include information that



may be relevant. The extent of the clinical information contained will depend on the report's nature and purpose, and is a matter of clinical judgement. You should decide that on a case-by-case basis.

Only report on facts you know, and comment within your expertise.

The report should be structured and well organised. Lay out your points in chronological order. If the report is long, use headings and subheadings, and numbered short paragraphs for ease of reference for the reader

Common pitfalls to avoid

- Rushing due to a deadline: ensure you have a reasonable time frame within which to prepare. If necessary, discuss this with the party who has requested the report.
- Failure to adequately proofread your draft: dictation issues, typographical errors and spelling and punctuation faults are unpleasant. It is careless, chaotic and irritating for the reader. It comes across as unprofessional and disrespectful.
- Using jargon and abbreviations: if you have to use pure clinical terminology, explain the terms and concepts in layman's language, either in the text or in a footnote. Make sure your terminology is technically correct. If you are challenged or cross-examined, be prepared to explain the meaning accurately.
- Using legal terms: some concepts, such as "grievous bodily harm", "rape" and "sexual assault" have clear legal definitions and

are not technically clinical terms. In your report, simply write what the patient said or describe the injury you saw.

- Providing an opinion on negligence: there is a tendency, even for experts, to opine on negligence when it is not really their gift. Experts can opine on duty of care, foreseeability, standard of care and medical causation, but should be cautious of opining on the composite of all these factors – negligence.
- Altering reports: do not alter your report at the request of the patient or a third party – if you need to amend your report or you have made an error, you may always provide a supplementary report or addendum. This is acceptable in legal proceedings and indicates transparency and good intent.
- Providing opinions beyond your knowledge: stick to what is within your expertise and don't provide an opinion in an area in which you lack expertise. You may have a reasonable and sensible opinion on an issue, but it may not be within your professional capacity to indicate so at that point. However, if you feel you need to provide an opinion for

any reason, be sure to clearly distinguish between fact and opinion. An opinion may come under particular scrutiny and be publicly tested in court. Accordingly, be confident in those instances, and be prepared to explain your reasoning if required. If you are asked for your opinion and are not comfortable opining because the matter is beyond your expertise, you may state this and decline to provide an opinion. Do not be pressured into stating anything with which you are uncomfortable or which you are not confident about. If you wouldn't say something under oath in court, you should not write it in your report.

- Using emotive and personal remarks – towards the patient, family or colleagues: remember that the patient or their family may have sight of the report, so avoid humorous and unnecessarily subjective remarks.
- Unreasonably criticising or slating colleagues: this comes across as unprofessional and unethical. Ensure that your language is impartial and that your words don't have hidden assumptions. Be careful and read through your draft report with a critical eye.

Final task

Finally, sign the report, date it, and make a copy for your records. When you submit the report, indicate in your records to whom you gave it, in what format, and the date and time you did so.

Conclusion

The preparation of a clinical report for medicolegal or other purposes is an essential part of the service provided by healthcare practitioners. Sadly, it is seldom, if ever, mentioned or discussed during undergraduate or even postgraduate training. However, it forms a significant part of our professional duties to our patients.

Consequently, we must accept and embrace the responsibility by developing the skills required to write well-structured, clear reports that will assist patients effectively. Whatever the reason for the report, a good one will lead to an early resolution of the case, resulting in better outcomes for all concerned, including you. From a medicolegal perspective, a good quality report is incredibly valuable in addressing and resolving a host of issues.

Source: Medical Brief, MPS column, 15 December 2022.

WHO to identify pathogens that could cause future outbreaks and pandemics

World Health Organization

The WHO is launching a global scientific process to update the list of priority pathogens – agents that can cause outbreaks or pandemics – to guide global investment, research and development (R&D), especially in vaccines, tests and treatments.

Starting with a meeting held on 18 November 2022, the WHO is convening over 300 scientists who will consider the evidence on over 25 virus families and bacteria, as well as “Disease X.” Disease X is included to indicate an unknown pathogen that could cause a serious international epidemic. The experts will recommend a list of priority pathogens that need further research and investment. The process will include both scientific and public health criteria, as well as criteria related to socioeconomic impact, access and equity.

The list was first published in 2017 and the last prioritisation exercise was done in 2018. The current list includes COVID-19, Crimean-

Cong haemorrhagic fever, Ebola virus disease and Marburg virus disease, Lassa fever, Middle East respiratory syndrome (MERS) and severe acute respiratory syndrome (SARS), Nipah and henipaviral diseases, Rift Valley fever, Zika and Disease X.

“Targeting priority pathogens and virus families for research and development of countermeasures is essential for a fast and effective epidemic and pandemic response. Without significant R&D investments prior to the COVID-19 pandemic, it would not have been possible to have safe and effective vaccines developed in record time,” said Dr Michael Ryan, executive director of the WHO’s Health Emergencies Programme.

For those pathogens identified as priority, the WHO R&D Blueprint for epidemics develops R&D roadmaps, which lay out knowledge gaps and research priorities. Where relevant, target product profiles,

which inform developers about the desired specifications for vaccines, treatments and diagnostic tests, are developed. Efforts are also made to map, compile and facilitate clinical trials to develop these tools. Complimentary efforts – such as to strengthen regulatory and ethics oversight – are also considered.

“This list of priority pathogens has become a reference point for the research community on where to focus energies to manage the next threat,” said Dr Soumya Swaminathan, WHO Chief Scientist. “It is developed together with experts in the field, and is the agreed direction for where we – as a global research community – need to invest energy and funds to develop tests, treatments and vaccines. We thank our donors like the US government, our partners, and the scientists who work with WHO to make this possible.”

The revised list is expected to be published in the first quarter of 2023.

Notch/grade progression and timeframes

Ruan Vlok, *Head of Unit: Employment Law, SAMA Legal Affairs Department*

On a continuous basis, SAMA receives queries from members regarding a failure by provincial Departments of Health to properly implement notch and/or grade progression. Instances exist where medical practitioners employed within the public sector realise that they have not been properly progressed in line with Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) resolutions 03 of 2009 and 01 of 2010 (collective agreements) for several years. The question then arises, what timeframes are applicable on declaring disputes of such a kind? A misconception exists that no timeframes are applicable in disputes of this nature, and the purpose of this article is to provide insight on the applicable timeframes with reference to legislation and applicable case law.

Legislation and case law

Disputes of this nature are found in section 24 of the Labour Relations Act No. 66 of 1995.

The Labour Relations Act determines:

"24. Disputes about collective agreements

1. Every collective agreement excluding an agency shop agreement concluded in terms of Section 25 or a closed shop agreement concluded in terms of Section 26 or a settlement agreement contemplated in either Section 142A or 158(1)(c), must provide for a procedure to resolve any dispute about the interpretation or application of the collective agreement. The procedure must first require the parties to attempt to resolve the dispute through conciliation and, if the dispute remains unresolved, to resolve it through arbitration.

2. If there is a dispute about the interpretation or application of a collective

agreement, any party to the dispute may refer the dispute in writing to the Commission if:

a. the collective agreement does not provide for a procedure as required by subsection (1);

b. the procedure provided for in the collective agreement is not operative; or

c. any party to the collective agreement has frustrated the resolution of the dispute in terms of the collective agreement.

3. The party who refers the dispute to the Commission must satisfy it that a copy of the referral has been served on all other parties to the dispute.

4. The Commission must attempt to resolve the dispute through conciliation.

5. If the dispute remains unresolved, any party to the dispute may request that the dispute be resolved through arbitration."

Readers will note that in this section, no reference is made to any timeframe relating to the referral of disputes, and reference should be made to the applicable case law.

In the matter of HOSPERSA obo Tshambi v Department of Health KZN Province (2016) 7 BLLR (LAC), the Labour Appeal Court addressed this matter and held that in true labour disputes, the provisions of section 191 of the Labour Relations Act are a more obvious general yardstick to test what a reasonable time is for a referral. The absence of a prescribed period does not automatically license a longer period than is the norm for other labour disputes to be referred. In labour disputes, expedition is the watchword, not because that is simply a good idea, but because the prejudice of delay in matters concerning employment often is

not capable of remedial action. This applies to both employees and employers.

Section 191 of the Labour Relations Act determines:

"191. Disputes about unfair dismissals and unfair labour practices:

1a. If there is a dispute about the fairness of a dismissal, or a dispute about an unfair labour practice, the dismissed employee of the employee alleging the unfair labour practice may refer the dispute in writing to –

i. a council, if the parties to the dispute fall within the registered scope of that council; or
ii. the Commission, if no council has jurisdiction.

b. A referral in terms of paragraph (a) must be made within –

i. 30 days of the date of dismissal or, if it is a later date, within 30 days of the employer making a final decision to dismiss or uphold the dismissal;

ii. 90 days of the date of the act or omission which allegedly constitutes the unfair labour practice or, if it is a later date, within 90 days of the date on which the employee became aware of the act or occurrences."

Conclusion

As per the HOSPERSA case, it's quite clear that a strict timeframe in line with section 191 of the Labour Relations Act will be applicable in disputes of this nature. Medical practitioners are advised to closely track their yearly notch progression and periodical grade progression, and should not confuse these with the yearly cost of living adjustment. The necessary grievance and dispute procedures should be initiated as soon as possible, should it be discovered that the proper progression was not implemented.

Removing names from, and restoration to, the HPCSA register

Sibahle Mhlongo

The Health Professions Act No. 56 of 1974 (the Act) governs all healthcare practitioners, not only medical practitioners. While the Act defines

healthcare professions as "any profession for which a professional board has been established in terms of section 15 and includes any category or group of persons

provided for by such a board", section 15 does not specify which health and allied professions are included. The Act has created a Health Professions Council (the council),

which supervises the various professional boards in the training, examination and continued supervision of the healthcare practitioners who fall under its control.

Section 17 provides that no-one may practise their healthcare profession unless registered with the registrar, and deals with the procedure to obtain registration. This prerequisite is reiterated in sections 34 and 39 of the Act, which prohibits healthcare practitioners from performing certain actions unless they are registered in terms of the Act. Contravention of this provision can result in a fine, imprisonment, or both.

The implication of removal or suspension due to the non-payment of annual fees is enormous

Section 18 of the Act requires the registrar of the council to maintain a register of all practising healthcare practitioners. An important practical requirement is contained in section 18(3), namely that all registered persons who change their contact details must notify the registrar in writing within 30 days of any such change. This requirement is mentioned again in section 19A(1)(a).

The registrar may from time to time make necessary alterations to the entries in the register, including the removal of deceased practitioners and persons who have been removed from the register in terms of the Act. Section 19 sets out the grounds for removal, which may occur if a practitioner is found guilty of unprofessional conduct, was registered fraudulently or in error, had their degree revoked, and for various other serious misdemeanours. However, another ground for removal from the register is for what the general public would consider a much lesser breach – a failure to pay their annual registration fee 3 months after it is due!

In order to maintain their registration with the council, all healthcare practitioners must pay annual fees. Should a healthcare practitioner fail, or refuse, to pay their annual fees to the council within the specified time, the council may recover the fees by instituting legal action in terms of section 62(2). Section 19 of the Act allows

the registrar both to remove a practitioner's name from the register, and to restore it to the register. Specifically, section 19(1)(d) allows the professional body or committee to remove the name of any person who has failed to pay their annual fees, which are due by 1 April each year. A practitioner may be suspended or removed from the register even if partial, rather than full, payment of the annual fees has been made. Unfortunately, neither the Act nor the regulations make a distinction between removal from the register and suspension.

It appears to be the registrar's prerogative whether to remove or suspend a practitioner for non-payment or partial payment of annual fees.

The Registrar must provide the healthcare practitioner with a notice of their removal from the register. This is given by way of certified mail address (i.e. registered mail), fax, or electronic transmission to the practitioner, at the address appearing in respect of that particular practitioner on the register.

Where a practitioner has been removed from the register due to non-payment, he or she must pay all outstanding fees before their name may be restored on the register.

The Council penalises practitioners for non-payment of annual fees and, if a practitioner wishes that their name to be restored on the register, the penalties are calculated as follows:

- If a practitioner has been suspended or removed from the register for less than 6 months, they will have to pay the equivalent of twice the applicable fee for the current year plus the outstanding fee;
- If a practitioner has been suspended or removed from the register for more than 6 months, but less than 12 months, they will have to pay the equivalent of four times the applicable fee for the current year plus the outstanding fee;
- If a practitioner has been suspended or removed from the register for more than 12 months, they will have to pay the equivalent of five times the applicable fee for the current year plus the outstanding fee.

Practitioners who are specialists, subspecialists or have an additional qualification are required to pay an additional fixed fee for their name to be restored. Where a practitioner is in arrears, any monies paid will be allocated first to the oldest debt.

The implication of removal or suspension due to the non-payment of annual fees is enormous. The practitioner's registration certificate is deemed to be cancelled and the practitioner must cease to practise until such time that his or her name is restored on the

register. Another implication of removal or suspension is that the practitioner concerned will be blocked by medical aid schemes, and as a result claims by patients might not be paid out. This also means that claims submitted by the practitioner will not be paid. Additionally, (s) he will be at risk should (s)he be subject to a civil claim or a complaint, either to the council or to the healthcare facility where (s)he practises as (s) he will, in principle, be practising and rendering services while not permitted to do so.

It may happen that a practitioner is removed or suspended from the register without being provided with appropriate and proper notice. This usually happens in situations where the registrar issues the notice of suspension or removal and it is delivered by way of registered post. The registrar then proceeds to remove or suspend the practitioner without satisfying himself or herself that the practitioner has actually received the notice.

A practitioner who finds him- or herself suspended as a result of non-payment of annual fees should fact-check that the correct procedure has been followed, i.e.:

- Have 3 months passed since the day on which payment became due (i.e. 1 April of that year)?
- Has a notice of suspension or removal been received either by registered post, email, or fax?
- If not, was the notice forwarded to the correct address or email address as it appears on the register?

As mentioned above, the Act requires healthcare practitioners to update their personal and professional details with the registrar. The practical implications of any failure to do so, apart from the sanctions that the registrar may impose (section 19), are apparent. But, provided that these details have been updated and are correctly recorded, should the council fail to satisfy any of the abovementioned three steps, a practitioner who finds him- or herself suspended or removed may challenge their suspension or removal.

Various practical amendments to the Act are required. The provisions allowing for notices to be forwarded by registered post and fax are no longer feasible. These modes of communication have become superannuated and are no longer effective. Should a practitioner find him/herself removed from the register or suspended by the registrar due to partial or non-payment of annual fees, we recommend that (s)he seek advice from his/her legal representative.

The cost of poor records and a missed diagnosis

Dr Comfort King, case manager, Medical Protection Society

Dr P was a medical officer who was covering locum shifts within a busy emergency medicine department. He was asked to see a 17-year-old patient, BB, who had presented with a 1-hour history of acute left-sided abdominal pain. The pain was described as sudden and excruciating. Her mother was also concerned that she had been vomiting and was extremely restless. She had a history of ovarian cysts and a previous presentation to hospital with pain in the same location, but of a lower severity.

Dr P reviewed the patient and undertook further investigations, including a urine dip, which was negative for pregnancy. He also initiated symptomatic management to address the patient's pain and vomiting – antiemetics and analgesia.

With a diagnosis of another ovarian cyst in mind, he called the specialist gynaecologist on call to discuss the patient further and consider whether she was suitable for discharge home.

After speaking to Dr U, Dr P discharged the patient with analgesia and gave safety-netting advice to the patient's mother to bring BB back if the pain persisted for longer than 48 hours.

Patient BB re-presented to another gynaecologist, Dr S, 12 hours later with ongoing pain. An ultrasound of the abdomen was performed and further investigations were undertaken. BB was diagnosed with missed ovarian torsion with gangrenous changes.

An HPCSA investigation and claim then ensued against both Dr P and Dr U.

Developments

This matter became very problematic as Dr U reported that he was not aware of the severity of pain or the presence of vomiting. He asserted that if the severity of the symptoms experienced was communicated to him, he would have had a higher degree of suspicion of the diagnosis of ovarian torsion. He reported that the medical officer stressed the fact that he had ruled out a serious gynaecological emergency. He also reported that the conversation that he had with the junior was more of a "checking in" conversation, quite informal in nature, and he did not perceive this as a referral. If he had known that this was a referral, he would have asked further detailed questions.



Dr P said that he informed Dr U of all the findings on examination and the full patient history, and had referred for official guidance from a specialist. If he was confident of a diagnosis of ovarian cyst pain, then he would not have phoned in the first instance. He did admit that he had said that he did not feel there was a serious gynaecological emergency, but only because ovarian torsion was not a differential diagnosis that he considered, and he was in fact referring to the likelihood of an ectopic pregnancy when he made that statement.

This presented difficulties for both clinicians involved for two distinct reasons.

Record keeping

Firstly, the issue of documentation. Instances such as this illustrate the importance of documentation in clinical practice. Although Dr P had recorded that he had consulted Dr U for advice, he did not actually include the specifics of the discussion, leaving the door open for ambiguity about what was actually communicated. He had not documented that he had communicated with Dr U about the history of vomiting, nor had he recorded that he had raised the question of whether an ultrasound would be appropriate. Instead, his notes read:

"Discussed with on call gynaecologist. Agrees with discharge."

Dr U, on the other hand, did not have any documentation of the conversation, as he did not perceive it would be required, given the informality of the conversation he thought he was having.

Secondly, there was the issue of the missed diagnosis.

Missed diagnosis: A problem for Dr P?

While a medical professional is not infallible, in formulating a diagnosis the HPCSA *makes it clear* (in guideline 5.1.8) that a medical practitioner has a duty to apply their minds when making diagnoses and considering appropriate treatment.

Never forget that although "common things are common", certain diagnoses are extremely important to actively exclude. Ovarian torsion in an adolescent patient presenting with acute iliac fossa pain is one of these; similarly, an ectopic pregnancy in a sexually active woman of childbearing age presenting with lower abdominal pain is another. Missing a diagnosis such as this through failing to perform the appropriate bedside investigations, such as an ultrasound or pregnancy test, is a more difficult position to defend.

Does HPCSA guidance assist with resolving liability for Dr U?

One of the core ethical values of a medical practitioner according to the *General Ethical Guidelines for the Health Care Profession* contained in [booklet 1](#) is that medical practitioners should always act in the best interest of patients and, conversely, should not act contrary to those interests. Guideline 6 of the *General Ethical Guidelines* sets out the duties that practitioners owe to their

colleagues. Guideline 6.1.2 envisages that practitioners should treat patients referred to them in the same manner in which they would treat their own, and in terms of guideline 6.2.1, they should work with and respect other healthcare professionals in pursuit of the best healthcare possible for all patients. Guideline 7 states that practitioners owe a duty to the patients of other practitioners to act quickly to protect patients from risk due to any reason.

From this one can safely conclude that the guidelines intend you to treat your colleague's patients, about whom they approach you for advice, as if they were your own. Therefore, as a clinician you should ensure that you put yourself in a position to exercise sound clinical judgement. This involves considering whether you have the patient's necessary medical history in order to form an opinion on diagnosis, treatment or further management of the patient, and if not, it should be obtained from the referring practitioner before pronouncing a diagnosis or providing advice on management. Consideration should be given to whether it may be in the patient's best interests to be examined personally by you as the advising practitioner in order

to form a thorough opinion, and whether a desktop assessment of the patient's medical case could ultimately result in subpar clinical advice.

Liability can still be attracted even if you did not see the patient; consequently, it is prudent to ask yourself:

- Do I have all the information necessary to provide advice on the diagnosis and management of a patient over the phone?
- Is there any further information I require to make a safe diagnosis remotely?
- If I was able to review the patient myself physically, would I approach the patient's management any differently?

Although a referral may appear informal, it is always good practice to ensure that you are informed about the extent to which the advice will be relied on in the patient's management, and consider whether the advice given will be recorded or implemented accurately by the referring practitioner.

Be aware that where it is found that you as an advising practitioner have acted negligently in providing advice, for example by not applying your mind to the patient's

Learning points

- Always document any discussion you have with another colleague regarding a patient, and include the salient points communicated to the clinician in the notes.
- Always consider and document important positive findings as well as negative findings when formulating a diagnosis.
- Liability can be attracted for physicians by offering subpar clinical advice on a patient's management plan, even if you do not see the patient directly.

medical history, or not assessing the patient in person where this would have been more appropriate, then you as the advising practitioner can be found liable for any damages that the patient may suffer as a result of the negligent conduct. This is the case irrespective of whether or not the principal practitioner had discharged his or her duties owed to the patient by managing the patient appropriately or not.

New HPSCA regulations – ethics CPD meeting with Elsabé Klinck

On the summer's evening of 24 November 2022, the SAMA Eastern Province branch council hosted a talk at the Beach Hotel in Summerstrand, Gqeberha. Both public and private sector medical doctors were well represented.

The knowledgeable, insightful Elsabé Klinck, a highly qualified and experienced lawyer and health law expert, was the guest speaker. Elsabé informed the attending doctors of changes in the HPCSA and medical aid regulations that will affect them, and gave an in-depth explanation of the expected time frame for the NHI Bill. Sparking honest debate from the attendees of the evening, Elsabé clarified to all present what the medicolegal landscape's future may very well come to be.

Doctors enjoyed the tasty treats and beverages, received complimentary SAMA coffee mugs, and one doctor present was quite happy to have his number drawn in a lucky



Dr M Eyanganya (lucky draw winner), Dr G Hanslo and Mariana Johnstone (branch administrator)

draw, winning a special gift from the SAMA EP branch council. As 2022 drew to a close, an informative evening such as this one helped to prepare doctors for the changes ahead.



Dr L Gqoli, Elsabé Klinck and Dr G Hanslo (SAMA EP branch councillor)

A refreshing change of pace

For most, the end of the year is a flurry of excitement and exhaustion, frustration and festive frenzy. And while for many the pressure to wrap things up is motivated by a much-anticipated summer break, for those of us in healthcare, there seems little to no end in sight. Only deepening sighs in the build up to what is usually the busiest time of the year as emergency departments overflow with the normal cocktail of alcohol-related trauma and poorly controlled chronic comorbid conditions, as families drop off senile grandparents that they don't have space for over the busy festive season.

Among all of this, medical interns are preparing to move cross-country to start their community service year in yet another unfamiliar place, likely nowhere near where their families carry on with traditional festivities.

This is what we signed up for. It might not have been a completely well-informed decision, but it was a decision nonetheless.

So in a refreshing change of pace, the PMBLife community of interns arranged an evening where, for once, the scrubs could stay at home, the dresses could be steamed, shirts pressed, hair and make-up done. A night to celebrate making it through another year of crazy calls and strenuous shifts.



SAMA's Dr Sazi Nzama delivers a motivational speech to the interns

Yet again, SAMA KZN Midlands branch came to the party (literally), and in support and celebration of the hard work and many hours grafted by our Pietermaritzburg interns, sponsored both the photographer and sound for the evening. The kind contribution went a long way in helping to create a special evening, which was hosted at the beautiful Garlington's Bistro in Hilton where our doctors were given the opportunity to unwind and enjoy a night off before hunkering down for the final stretch of 2022.



Dr Abby van der Westhuizen (PMBLife committee leader), Mandy Hattingh (KZN Midlands branch administrator), Dr Sazi Nzama (SAMA director), Dr Luthando (PMBLife committee leader)



Enjoying the function

Griqualand West thank councillors

The Griqualand West branch (GWB) recently held their year-end dinner function at the Nare Boutique Hotel in Kimberley.

The branch expressed their appreciation to their councillors for all the time they spent attending meetings, and all the work done by this group of dedicated SAMA members. The branch also said a big thank you to their spouses, as it is a sacrifice that affects the whole family.

Dr Mbese Ngundu, chairperson of the branch, welcomed guests during his speech, and Dr Jimmy Amsini, vice-chairperson, enacted the toast to SAMA.

The dinner was a good social encounter for branch councillors to meet and indulge in sharing memories.



Dr Elrico Oliphant (JUDASA representative), Dr Mbese Ngundu (SAMA GWB chairperson), Dr Jimmy Amsini (SAMA GWB vice-chairperson) and Dr Lesego Diphatse (SAMA GWB treasurer)

Celebrating growth, showing appreciation

The Free State Branch (FSB) recently held their year-end function at Kleinplaas, Goosehill Wedding and Guest Farm in Bloemfontein.

The branch celebrated the growth of the past year, which surpassed previous years. Appreciation was given to councillors and their spouses for enabling the Free State branch to further their work in the province.

Prof. Steven Matshidza, chairperson of the branch, presented the welcome and motivational speech, and Dr Benjamin de Bruin, honorary secretary, enacted the toast to SAMA.

Dr Chantelle van der Bijl, vice-chairperson, presented the 2022 overview of the branch's activities, which comprised the hosting of several successful CPD events, intern support recruitment programmes, registrars' functions and others.

The dinner was thoroughly enjoyed and a good conclusion to a very successful year. It also laid the foundation for an even more successful 2023.



The SAMA Free State branch (FSB) council at the year-end function. Back row, left to right: Prof. Dirk Hagemester (SAMA FSB treasurer), Prof. Steven Matshidza (SAMA FSB chairperson), Dr Benjamin de Bruin (SAMA FSB honorary branch secretary), Dr Liam Selfridge (SAMA FSB councillor) and Dr Deon Menge (SAMA FSB councillor). Front row, left to right: Dr Chantelle van der Bijl (SAMA FSB vice-chairperson) and Sultana Hartzenberg (SAMA FSB secretary)

Successful registrars' function held in Bloemfontein

The Free State branch hosted a very successful and well-attended registrars' event at the Faculty of Health Sciences at the University of the Free State in Bloemfontein on 29 November 2022.

Prof. Steven Matshidza, Free State branch chairman, opened and welcomed everyone. Dr Benjamin de Bruin, Free State branch honorary secretary elaborated on the benefits and relevance of SAMA for medical professionals.

Mr Wiann van Zyl, director of Capitaux Financial Services, enacted the toast to the registrar doctors in celebration of their achievement. The keynote speaker for the event was Dr Nicholas Pearce, head of School of Clinical Medicine. Dr Pearce shared his pearls of wisdom with regard to many lessons learned over the last few years in his career.

The dinner was a good opportunity for social interaction and networking.



Lizaan Spangenberg (practice manager at Capitaux), Wiann van Zyl (director at Capitaux), Dr Nicholas Pearce (head of School of Clinical Medicine, UFS), Prof Steven Matshidza (SAMA FSB Chairperson), Dr Benjamin de Bruin (SAMA FSB honorary branch secretary) and Dr Abigail Elliott (SARA representative)

Recruiting members in Kroonstad

On 17 November 2022, the Free State branch held a membership recruitment drive at Boitumelo Hospital in Kroonstad.

SAMA and non-SAMA members were welcomed with open arms. Information was exchanged by handing out a branch information pack and SAMA-branded items to the doctors as a token of appreciation.

Dr Benjamin de Bruin, Free State branch executive honorary secretary, delivered a presentation on SAMA member benefits and spoke about the importance of joining SAMA.

Moreover, the members checked and confirmed their membership status and details, and 11 doctors signed up as SAMA members.



Dr Kabelo Mahasa (clinical manager at Boitumelo Hospital) and Dr Benjamin de Bruin (SAMA FSB honorary branch secretary)

Eastern Province branch visit hospitals

Last year SAMA Eastern Province (EP) branch visited Port Alfred Hospital and Cradock Hospital. Both visits were part of an outreach to support district doctors and to recruit more members.

We were well received and the doctors were eager to engage on a number of topics. Topics discussed included PMDS, notch progression and calculation of overtime hours. A total of three new members were signed up.

SAMA EP branch has committed to sponsor a member for an industrial relations course to better empower district doctors.



Visiting Cradock Hospital, left to right: Dr Ludidi (acting medical manager), Dr Khan (SAMA), Dr Bester, Dr Nomavuka, Dr Sigqozo, Dr Nkonza and Dr Tilana

Western Cape promote Aids awareness

Chenienne Gericke, Cape Western branch senior branch administrator, was invited to take part in an AIDS awareness day at Groote Schuur Hospital. Two fifth-year students, Emma Cohen and Raphael Symon, signed up as SAMA members and the branch handed out boxes to students of daily essentials while promoting SAMA.



Chenienne Gericke welcomed two new SAMA members, Emma Cohen and Raphael Symon, at Groote Schuur Hospital



The SAMA table



Welcome to SAMA

SAMA welcomes the following new members who joined our association in December 2022.

Cape Western branch

Elmien Vos
Mogamat Shafique Jakoet
Lucas du Toit
Brad Africa

Eastern Province branch

Naydene Dorothea Josephus
Synnox Bonginkosi Magadu

Eastern Highveld branch

Azile Mawisa
Lungelo Sidingo Seluleko Ntuli
Thayosni Ponnen

Free State branch

Elke Harms
Jowellen Vaaltyn
Sifiso Treasure Gama
Reitumetse Mmasetjhaba Mmabatho Mahlaba
Cameron Albert Joseph
Sharnu Hendri Snijman
Thandokazi Sondishe
Retshidisitswe Connie Mohapi
Francis Maruping

Gauteng branch

Ernest Jabulane Moloi
Malesela Legodi

Ngoie Saddat Kitengie
Gontse Portia Mawela
Mulanga Makhwanya

Gauteng North branch

Wilson Sphiwe Mntambo
Nomvula Nancy Mahlangu
Oreratile Rrammutla Ntsoko
Feziwe Dalingozi
Sahlako Saney Nchabeleng
Rosyn Lindiwe Mailula
Barend de Bruyn Botha
Oratile Rorisang Sookane
Nhlakanipho Zwakele Lubisi

KZN Coastal branch

Ndumiso Mpumelelo Bulunga
Balungile Dzingwe
Prenolan Aiden Pillay
Phumzile Florence Carries
Abdullah Seedat
Mayespero Kanniappen
Lona Mpepo
Lenthuri Naidoo
Aston Heeralal
Jolaine Anthony
Patrick Makaise
Sabathile Ntombikayise Dube
Lethokuhle Refuge Dangazela

Sesethu Mjoki
Nduduzo Wandile Mhlongo
Saraah Bee Bee Hassan
Bongani Dzanibe
Urekha Ballasur

KZN Midlands branch

Sanelisiwe Shabalala

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Tiiso Philemon Dikobo

Lowveld branch

Carol Naidoo
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Transkei branch

Bomkazi Sihlahla

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Karla Anna Talbot
Simone Nicole Booysen

West Rand branch

Gaynor Miranda Balie
Tsholorelo Maredi Mphahlele

Letters to the Editor

The *Letters to the Editor* page aims to give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare, which you feel should be shared with your colleagues and fellow readers.

Please note that letters:

- should be no longer than 500 words
- can be published anonymously, but writer details must be submitted to the editor in confidence
- must be on subjects pertinent to healthcare delivery
- should be submitted before the 6th of the month in order to be published in the next issue of *SAMA Insider*.

Please email contributions to: Diane de Kock, dianed@samedical.org.





CPD

For further information
please contact the
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012 481 2000 

cpd@samedical.org 

WHAT ARE WE ABOUT

Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association is one of the institutions that have been appointed by the Medical and Dental Professions Board of the Health Professions Council of SA to review and approve CPD applications.

SERVICES AVAILABLE

- South African Medical Association Continued Professional Development Accreditation
- **Our Mission**
 - Empowering Doctors to bring health to the nation
 - Excellent Service
 - Quick Turnaround
 - Efficiency



Did You Know?

SAMA Offers The Following Legal Assistance & Advice to SAMA Members:

- Expert legal advice and support to SAMA and its members
- Managing and resolving medical scheme disputes and forensic audits
- Assisting members with HPCSA matters and disciplinary proceedings
- Advising on business/practice management issues
- Assisting in medico-legal matters
- Mediation of disputes
- Establishment of new practices (Employment contracts, lease agreements, business law advice etc.)
- Assisting with ethical and professional compliance issues
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