SAMA INSIDER

APRIL 2014

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COURSE CONTENT

This course covers the following modules:
- *Allergic disease;*
- *Respiratory allergy;*
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- *Food allergy and intolerance.*

ACCREDITATION

Accredited according to the HPCSA CPD Guidelines for Health Professionals - November 2006, for 30 CEUs on level 2. (Workshop: 12 CEUs, Assessment: 18 CEUs)

COURSE FEE, DATES AND VENUE

R 3 400 (Inclusive of all VAT and taxes where applicable)
This amount includes everything except travel and accommodation.

DATE	VENUE
5 – 6 April 2014	Pretoria
26 – 27 July 2014	Port Elizabeth

REGISTRATION

Ilana van Der Merwe / Lizanne van Niekerk
Tel: 012 816 9099/9080
Fax: 086 558 9535
Email: ilanavdm@foundation.co.za
lizannev@foundation.co.za

Address: P.O. Box 75324, Lynnwood Ridge, 0040
Website: www.foundation.co.za

DIAGNOSTIC ULTRASOUND

SHORT COURSE IN DIAGNOSTIC ULTRASOUND

In a report of a WHO scientific group on the future of new imaging technologies in developing countries it was stated that "the difficulties in making accurate diagnosis from ultrasound images are such that the purchase of ultrasound equipment, without making provision for the training of an operator, is contrary to good healthcare practice and is unlikely to be cost effective. Proper training and experience is required, preferably with facilitators who are highly skilled and who have practised ultrasound for many years.

COURSE CONTENT

After completing this course participants will be able to:
- *Choose ultrasound equipment;*
- *Identify the organs in the abdominal cavities, normal abdominal and gynaecological ultrasound anatomy;*
- *Recognise abdominal structures in multiple planes;*
- *Recognise the sectional ultrasound anatomy in the transverse and longitudinal planes;*
- *Describe the patient preparation and position;*
- *Interpret ultrasound findings in common abdominal gynaecological pathologies;*
- *Document ultrasound;*
- *Demonstrate ultrasound imaging;*
- *Understand the criteria for quality and*
- *Understand the capabilities and limitations of ultra-sound.*

ACCREDITATION

Accredited according to the HPCSA CPD Guidelines for Health Professionals -November 2006, for 30 CEUs on level 2. (Workshop: 12 CEUs, Assessment: 18 CEUs)

COURSE FEE, DATES AND VENUE

R 5100 (Inclusive of all VAT and taxes where applicable)
This amount includes everything except travel and accommodation.

DATE	VENUE
10 – 11 May 2014	Pretoria
21 – 22 June 2014	Durban
19 – 20 July 2014	Cape Town
23 – 24 Aug 2014	East London

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COURSE OBJECTIVES

At the end of the course the participants will be able to:
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- *Evaluate prescription and assess patient profile;*
- *Dispense the prescription;*
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- *Advise patients to ensure quality use of medicines and improve health status.*

COURSE FEE

R 2 622 (Inclusive of all VAT and taxes where applicable) the course fee includes all study material, assessment and certification through HSA. Study material will be dipatched once payment has been received.

REGISTRATION

Melany Manoharum/Nicole Theron
Tel: 012 816 9100 / 012 816 9101
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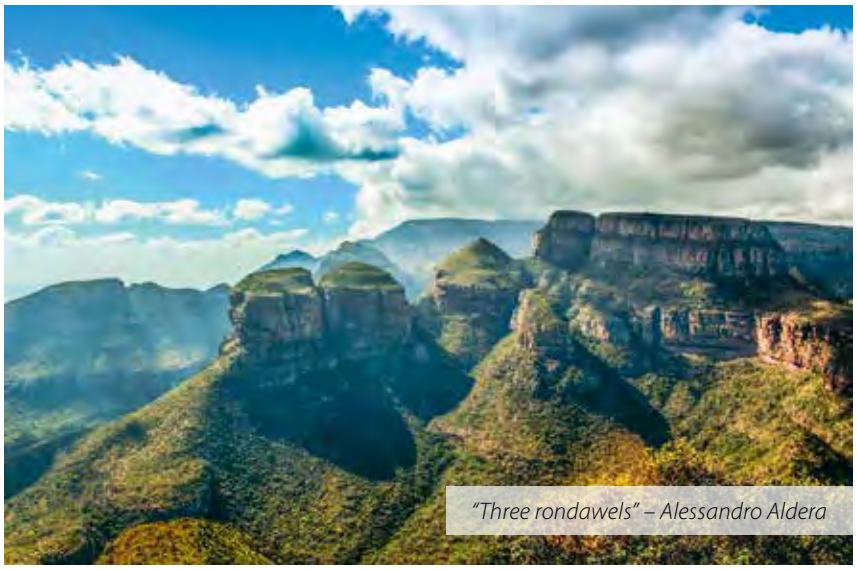

"Three rondawels" – Alessandro Aldera

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mcgfleet@daimler.com

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EDITOR'S NOTE APRIL 2014

Conrad Strydom
Editor: *SAMA INSIDER*

New blood

The medical profession in South Africa is always approaching a tipping point. This should surprise no one – at best, stability is an illusion we create to comfort ourselves; in nature, all is flux. But with the NHI programme nearing the White Paper stage it seems that everyone – from doctors and insurers to health institutions both private and public – is in a state of very acute uncertainty. Will the current government attempt to use NHI to drum up support just before the elections? And what will the effects be? We can only wait and see.

Both the South African Registrars Association (SARA) and the Junior Doctors Association of South Africa (JUDASA) recently held their annual general meetings. We take a look at the proceedings of these meetings on pages 13 and 14. JUDASA, the more outspoken of the two SAMA Trade Union-affiliated structures, can be counted on to provide a more radical perspective on the needs of South African healthcare. SARA raised an issue that has flown under the radar of our country's press corps for some time: Registrars are often unfairly passed or failed – particularly during oral exams – at the whim of their lecturers. We hope to investigate this matter in future issues.

We also received a very enlightening look at a possible future for the medical profession – one which is considerably more open-minded than the present configuration – courtesy of UCT Business School's Dr Shadrick Mazaza. The article is a distillation of a talk Dr Mazaza presented at last year's SAMA conference.

A final note: The date and time of this year's SAMA conference have been announced. This highly anticipated event will be held at the Durban International Convention Centre from 29 to 31 August. Early-bird registration discounts apply so make sure you book early!

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For further information please contact the SAMAREC/CPD Secretariat on 012 481 2000 OR email us on samarec@samedical.org or cpd@samedical.org

Dr W Basson – a case of ethics trumping the law

Prof. Ames Dhai, *President, SAMA*

Last year, after an inquiry spanning about seven years, Dr Wouter Basson was found guilty by the Health Professions Council of South Africa (HPCSA) professional conduct committee of breaches of medical ethics which resulted in unprofessional conduct as defined in section 1 of the Health Professions Act, 56 of 1974. In terms of this Act, unprofessional conduct *"means improper or disgraceful or dishonourable or unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of this Act, is improper or disgraceful or dishonourable or unworthy".*

Dr Basson was born on 6 July 1950. He completed his medical studies in 1973 at the age of 23. After enlisting in the SADF, where he worked as a military doctor, he continued his medical studies in the field of internal medicine and in 1980 registered with the South African Medical and Dental Council as a specialist physician. In addition, he obtained a master's degree in physiological chemistry in 1978. He continued working in the military until 1992 and registered as a cardiologist in 1997. He is currently in private cardiology practice. During this period he was registered with the HPCSA and its predecessor as a medical practitioner.

The HPCSA charges were extracted from evidence given by Dr Basson under oath in the course of a criminal charge in the then Transvaal High Court. He was acquitted and appeals against his acquittal were dismissed. While registered as a medical practitioner Basson led the process whereby chemical substances for warfare were manufactured, weaponised and provided for use in combat, kidnapping and suicide. During this time, as project officer of Project Coast and thereafter Delta G, he co-ordinated the production and stockpiling on a major scale of methaqualone (mandrax), MDMA (ecstasy), BZ (an incapacitating agent), CS (tear gas) and CR (tear gas). He also weaponised thousands of mortars with CS and CR. These were sent to Angola for use. Substances causing disorientation for over-the-border kidnapping ('grab') exercises were provided by Basson in order to tranquillise those who had been kidnapped. Cyanide capsules were provided to operational officers for distribution to members of specialised units for suicide use.

While the unprofessional conduct attributed to Dr Basson began thirty years ago, his activities only emerged in the public domain in the late nineties. His criminal trial was lengthy and followed by two appeals. During the subsequent HPCSA inquiry, a postponement was requested in order to find a new expert witness. Further delays resulted from Basson applying for a stay of proceedings and bouts of ill health. The HPCSA's Professional Conduct Committee considered the charges from two aspects: firstly, whether the facts of the alleged conduct were correct, and secondly, whether that conduct was unprofessional. The committee in its deliberations considered evidence from all the expert witnesses and were guided by the rules in conventions and declarations for the medical profession. Specifically, the World Medical Association's (WMA) Declaration of Geneva (1948), Regulations in Time of Armed Conflict 91956 (1983), and the Declaration of Tokyo (1975) were used. The convention utilised was the United Nations Convention on the prohibition of the development, production and stockpiling of bacterial (biological) and toxic weapons and their destruction.

The WMA's Declaration of Geneva affirms that when being admitted as a member of the medical profession: *"... I will maintain the utmost respect for human life from the time of conception, even under threat; I will not use my medical knowledge contrary to the laws of humanity."*

The WMA's Regulations in Time of Armed Conflict stipulate as follows:

"1. Medical ethics in the time of armed conflict is identical to medical ethics in the time of peace .... The primary obligation of the physician is his professional duty; the physician's supreme guide is his conscience.

2. The primary task of the medical profession is to preserve health and save life. Hence it is deemed unethical for physicians to:

- *give advice or perform prophylactic, diagnostic or therapeutic procedures that are not justifiable in the patient's interest;*
- *weaken the physical or mental strength of a human being without therapeutic justification; and*
- *employ scientific knowledge to imperil health or destroy life."*

In addition, according to section six of the regulations, physicians are afforded certain privileges and facilities and these are never to be used for other than professional purposes.

The WMA's Declaration of Tokyo is a set of guidelines pertaining to torture and other cruel, inhumane or degrading treatment or punishment in relation to detention and imprisonment. Its preamble is quite profound and stipulates:

"It is a privilege of the medical doctor to practice medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any knowledge contrary to the laws of humanity."

The Declaration goes on to underscore that whatever the individual's offence, doctors cannot countenance, condone, or participate in torture or other forms of cruel, inhumane or degrading procedures, nor are they allowed to provide premises, instruments, substances or knowledge to facilitate or to diminish the ability of the individual to resist such treatment.

With regard to the UN Convention, state parties are not allowed to develop, produce, stockpile, acquire or retain microbial or other biological agents or toxins in quantities that have no justification for prophylactic, protective or other peaceful purposes. Neither are they allowed to produce weapons, equipment, or means of delivery for these agents for hostile purposes.

The HPCSA's Professional Conduct Committee, in arriving at a verdict of guilty has clearly demonstrated that ethics in the context of the conduct of medical doctors trumps the law and that where there is tension between the law and ethics, ethics unquestionably rises above the law.

4th SA TB Conference

10 - 13 June 2014
ICC DURBAN

Prof Bavesh Kana
Conference Chair 2014

Tuberculosis (TB) continues to claim more lives annually than any other bacterial infectious agent. Globally, this disease has been fuelled by various factors among which are slow diagnostic modalities, the lack of active case finding and the emergence of multi- or extensive drug resistance. In southern Africa, the rampant HIV pandemic has been the major underlying contributor to the inability to contain TB in the region.

Today, South Africa represents the highest TB burden country, per capita, in the world; it is also home to the largest number of TB-HIV co-infections. These shocking statistics have mobilised both local and international research and development programs to search for new interventions and novel treatments for this dreaded disease.

Whilst a chemotherapeutic regimen for TB exists, the positive effects of widespread use of directly observed antibiotic treatment are hindered by the amazing ability of tubercle bacteria to evolve drug resistance. Moreover, the current BCG vaccine is able to confer effective protection against the onset of TB meningitis in children but has limited benefit in protecting adults against pulmonary TB. In this context, novel drugs and vaccines are urgently sought after to combat the disease. Moreover, a comprehensive understanding of the biology of the tubercle bacillus, during infection in people, is lacking.

The management of TB disease at district, province and national levels all require immediate attention. Many programs are poorly resourced and not integrated. Another obstacle to the eradication of TB is the fact that this disease occupies little space, if any, in the public consciousness. The advocacy and associated public engagement efforts fall significantly short of what is required to contain the spread of disease.

In considering all these matters, the TB epidemic now represents one of the biggest public health challenges in the world. It is in this backdrop that South Africa will host the 4th SA-TB Conference to be held between the 10th-13th June at the International Conference Centre in Durban. In recognition of the urgency associated with the disease and the massive loss of human life, leading experts in various disciplines will gather to discuss important findings. Key stakeholders in the basic and applied sciences, drug development, clinical disciplines, diagnostic development, operational and health systems research will debate the topical issues associated with TB eradication through an abstract driven program involving oral and poster presenters, plenary talks, round table discussions, mini-symposia and skills building sessions.

The 2014 SA-TB Conference represents an unprecedented gathering of the brightest minds in the field with the ultimate hope of plotting a new course for containment and ultimate elimination of TB from our society.

CONFIRMED SPEAKERS

Chris Dye was the head of the Vector Biology and Epidemiology Unit at the London School of Hygiene and Tropical Medicine until 1996, carrying out research on leishmaniasis, malaria, rabies and other infectious and zoonotic diseases in Africa, Asia and South America. In 1996, he joined the World Health Organization where he has developed methods for using national surveillance and survey data to study the large-scale dynamics and control of tuberculosis (TB) and other communicable diseases.

Gary Maartens is a clinical pharmacologist and practicing specialist physician with an infectious disease interest. He has a joint appointment as chief specialist physician and professor at Groote Schuur hospital and University of Cape Town, South Africa, where he is head of the Division of Clinical Pharmacology. His main research interests are HIV-associated tuberculosis, and the safety, effectiveness and cost-effectiveness of antiretroviral therapy in resource-limited settings. He has been involved in guideline development for both the WHO and the CDC.

David G. Russell, Ph.D., is the William Kaplan Professor of Infection Biology in the Department of Microbiology and Immunology in the College of Veterinary Medicine, Cornell University. He received his Bachelor of Science from St. Andrews University in Scotland and was awarded a Ph.D. from Imperial College, London University, in 1982.

Dr. Friedland, Professor of Medicine and Epidemiology and Public Health at the Yale University School of Medicine, in New Haven Connecticut, USA and an Adjunct Professor at the Mailman School of Public Health at Columbia University in New York City. Dr. Friedland has focused his career on the prevention, care and treatment of infectious diseases in vulnerable and underserved populations in the US and globally.

Keertan Dheda is Professor of Medicine, and Head of the Division of Pulmonology, Department of Medicine, at the University of Cape Town. He has been the recipient of several prestigious awards including the 2013 MRC Gold Scientific Achievement Award and the 2010 International Union Against Tuberculosis and Lung Disease Scientific Award.

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Trade Union welcomes establishment of commuted overtime task team

SAMA Trade Union

SAMA Trade Union president Dr Phophi Ramathuba

The South African Medical Association (SAMA) Trade Union would like to express its satisfaction at the recent announcement by the Minster of Defence, Nosiviwe Mapisa-Nqakula, that the Department of Defence will establish a task team to deal with challenges related to the payment of commuted overtime to doctors in the South African Military Health Services (SAMHS). This task team is being established as a direct response to the irregular payment of commuted overtime of doctors employed by the SAMHS, a process which the SAMA Trade Union has been instrumental in exposing.

"We are also excited that the Minister has adopted a strict time frame of six weeks for the task team to finalise its work," Trade Union president Dr Phophi Ramathuba was quoted as saying. "This means we can look forward to this matter being finalised by early April." Commuted overtime payments are determined differently to standard overtime payments. According to official Department of Health policy (which the SAMHS adheres to), medical practitioners who work more than the prescribed 40 hours a week qualify for commuted overtime benefits.

There are four distinct categories of commuted overtime. Category 1 comprises doctors who perform up to four hours of overtime a week; they are paid according to the exact amount of hours they worked. Category 2 comprises doctors who work between five and 12 hours overtime a week; they are paid an amount equal to eight hours of overtime. Doctors in Category 3 are those who perform between 13 and 20 hours overtime a week; they are paid an amount equal to 16 hours of overtime. Finally, Category 4 is reserved for those who perform more than 20 hours of overtime a week; they are paid an amount determined by the head of the provincial Department of Health.

For some time the SAMA Trade Union has been inundated with complaints from members about the forceful manner in which they were expected to enter into new commuted overtime contracts without proper consultation. Trade Union members were also upset that they were expected, after filling in attendance registers and recording their overtime hours, to get their colleagues to co-sign for the recorded hours. Many have experienced this type of micro-management as humiliating.

SAMA concerned about corruption claims at CMS

SAMA Board of Directors

It is widely known that the Council for Medical Schemes (CMS) oversees a significant and critical sector. There are 97 medical schemes in South Africa with approximately 8.7 million beneficiaries between them. Collectively, the total annual scheme contribution by members amounts to almost R120 billion. This is a significant portion of our healthcare industry and needs to be managed responsibly.

As the regulator of these medical schemes, the role of the CMS is to protect members of the medical schemes from exploitation. It serves a valuable and vital function in a sector that can be prone to irregularities if left unchecked. The maintenance of an open, honest and uncorrupted environment at the CMS is therefore crucial for the wellbeing of the healthcare industry as a whole.

SAMA would like to appeal to the Board of the CMS to speedily address the current allegations levelled against the Registrar, who is a critical cog in the governance of the CMS. This will be important in order not only to restore the credibility of the CMS in the view of the public, but also to restore the confidence of all medical aid members in the ability of the Council to execute its functions.

SAMA also appeals to the Department of Health to exert its influence to ensure a resolution of the potential problems at the CMS in order to protect the interests of the members of the medical aid schemes. A resolution on this matter is needed, since the CMS plays too important a role in our healthcare industry to allow doubts to be raised regarding the state of its regulatory capacity.

The maintenance of an open, honest and uncorrupted environment at the CMS is crucial for the wellbeing of the healthcare industry as a whole

WMA holds Central and Southern African forum

Conrad Strydom

The World Medical Association (WMA), under its newly elected president Dr Margaret Mungherera, hosted a Central and Southern African forum on 22 February 2014. The forum was a rare chance for the national medical associations (NMAs) of southern and central Africa to engage each other concerning vital healthcare issues, as well as allowing the WMA a chance to gauge the effect of issues affecting the lower half of the African continent.

In attendance at this meeting, which focused on the English-speaking NMAs, were Dr Mungherera, WMA chairman; Dr Haikerwal, WMA secretary-general; Dr Kloiber and members of SAMA's board of directors, as well as representatives from Namibia, Lesotho, Swaziland and Zambia. Dr Mungherera experessed concern that out of 54 African countries, only 20 were being represented internationally by the WMA. "It is prudent that we focus on Africa because it has such low development and health indices," Dr Mungherera said. "Our African health outcomes are weak because our health systems are weak."

Dr Mungherera and the other WMA delegates took time to explain the WMA's policies and procedures to the assembled guests. She outlined the possible actions NMAs can take if they have a grievance or if they would like to bring a matter to the attention of medical practitioners internationally. Next were presentations by SAMA's Dr Mzukisi Grootboom and Dr Mark Sonderup, who brought to the WMA's attention many of the most pressing issues in the current South African healthcare environment.

Among the issues raised by SAMA were the Cuban exchange training programme, HIV/AIDS, the extreme regulation of the healthcare industry in South Africa (by the HPCSA and others) and legal constraints placed on doctors. The forum is seen as a good preparatory meeting before the WMA General Assembly which will take place in Durban in October this year.

WMA chairperson Dr Mukesh Haikerwal

The WMA Central and Southern African forum was attended by delegates from South Africa, Lesotho, Swaziland, Zambia and Namibia

SAMA speaks out against Ugandan anti-gay law

SAMA Board of Directors

The South African Medical Association (SAMA) expresses its concern at the signing into law on 24 February 2014 of the Anti-Homosexuality Act by the President of Uganda.

This legislation imposes a penalty of life imprisonment on any person who commits the offence of homosexuality and contains various other criminal sanctions relating to homosexuality.

The effect of this law is that human beings are discriminated against on the basis of their sexual orientation. It amounts to a violation of their fundamental human rights and is no different to the apartheid legislation which we have overcome in South Africa and the persecution of homosexual persons in Nazi Germany.

Sadly such legislation is commonplace on the African continent – 38 countries in Africa have legislation which criminalises homosexuality, a shameful indictment of our continent.

As South Africans, we enjoy the protection afforded to us by the Bill of Rights. South Africans have certain entrenched rights. One of these rights is that the state may not discriminate against anyone on the basis of sexual orientation. Another entrenched right afforded by the Bill of Rights is the right to dignity. In addition, any interference in the consensual sexual activity of persons would constitute a violation of the right to privacy and the right to dignity of the person.

A person's sexual orientation is not a disease or mental illness that must be treated or punished.

Moreover, the human rights violations that such legislation commits result in further danger to public health, particularly in respect of HIV transmission, in that it serves as a deterrent to persons coming forward and being tested for HIV for fear of criminal prosecution.

The criminalisation of homosexuality also increases the stigmatisation and victimisation of persons based on their sexual orientation.

SAMA condemns all forms of discrimination and violations of human rights, and we call on all bodies, organisations and associations in South Africa and in those countries which have anti-homosexual legislation to make their voices heard and take a stand against these violations.

Bad prognosis for the medical profession in South Africa

Dr Mahlane Pahlane, *General Secretary, SAMA Trade Union*

While South African medical doctors are sought after internationally, they get no respect in their native country. It is a fact that our country's medical doctors are, with very few exceptions, well trained, highly skilled and competent. We are known to have a high level of endurance, the ability to work very hard under difficult conditions and the ability to improvise and be innovative.

A South African doctor taught the world how to transplant a human heart. South African doctors can perform even the latest, most complicated medical procedures. This is why local politicians and wealthy people rarely leave the borders of this country for medical attention. On the contrary, high-ranking politicians, government leaders and wealthy people from around the globe come to our shores for affordable and excellent medical care. While President Robert Mugabe frequently visits Singapore for his medical needs, former president Nelson Mandela did not have to, since he was in the care of a competent, dedicated and caring medical team.

Unfortunately, the local medical profession is being engulfed by apathy about the management of healthcare systems and health economics. If this state of affairs continues, the prognosis for our medical profession looks very bad. South African medical doctors are highly knowledgeable about medical science but highly ignorant about health economics. In simple terms medical doctors, in the main, know very little about the subject of money. They also know very little, or show no interest in, the management of the healthcare system. This explains why everyone is making money from the labour of medical doctors, including medical aid schemes, pharmaceutical companies, private healthcare institutions and malpractice lawyers.

The government and the private healthcare industry have capitalised on these weaknesses over the years. Doctors are blackmailed into saving lives while having to sacrifice their own; to abhor money while others cash in on their labour; and to only concentrate on the business of taking care of the sick while leaving the management and business side of healthcare to others. This has to come to an end.

It is high time doctors realise and accept that they have been relegated to the labouring class. We are highly skilled but poorly respected, hard working and underpaid.

It is disheartening that doctors do not know their worth. Medical training is long and draining, but does not even touch on the subject of financial management. This is the reason why most doctors struggle financially. In private practice, doctors often have to pay people to recover money from their patients.

The war between the current Minister of Health, Dr Aaron Motsoaledi, and the pharmaceutical industry is well documented. Imagine if many of our medical and surgical innovations had been made by these companies. Even today they would still be making money from the patents! Doctors are likely to be involved in the development of most multi-billion medical inventions and discoveries in the healthcare industry. No drug trial can occur without the involvement of medical doctors and no private or public hospital can run without them. But doctors are never partners in such processes. Instead, they are reduced to mere employees.

No one should ever pull wool over our eyes again by misquoting the sacred Hippocratic Oath at us. The oath declares that: "If I abide by this oath, may I enjoy my life". Show me any doctor who is enjoying life! In order to make a decent life doctors have to work long hours, miss out on personal and family time and be given crumbs in terms of remuneration.

It is high time doctors realise and accept that they have been relegated to the labouring class. We are highly skilled but poorly respected, hard working and underpaid. We save lives while sacrificing our own, are told to hate money but make others wealthy. This may surprise many people, but most doctors cannot afford to retire, while judges, presidents and deputy presidents all go through life with great perks. Medical doctors are only respected by their patients during a time of need. As soon as the crisis is over, doctors again become a target for relentless attacks from the owners and management of the private institutions they work so hard to make rich.

The treatment of doctors poses a serious health risk to the medical profession. People forget that doctors are also human, with the same needs as politicians, pastors, mine workers and managers. We also love the finer things in life, and it is not a shame or a crime to do so. The abuse of doctors' goodwill nurtures hardened and venomous doctors, who will start adopting an attitude of "me first" and "what is in it for me?" If a paradigm shift is not made, the 2009 OSD strike will look like a Sunday picnic in comparison to what will happen.

The future doctor – a teacher and a coach

Dr Shadrick Mazaza, *Senior lecturer: UCT Graduate School of Business*

Medicine in future will need to move away from the narrowly Newtonian emphasis on disease towards a more inclusive approach that allows for other traditional healing systems and approaches.

South Africa is in the process of planning for the introduction of healthcare reform to deal with the challenges the country faces in delivering healthcare. The proposed National Health Insurance is largely about healthcare funding and improving infrastructure and human resources to improve access and quality of healthcare to the public. However, lessons from around the world show that this may not adequately deal with the problems of health.

In spite of the fact that the World Health Organisation has pointed out that health is not the absence of disease, our answer to health issues remains disease management. A colleague constantly reminds every fellow doctor within earshot that national health departments are not 'health' departments but 'disease' departments. Modern medicine is predominantly about studying diseases and how to manage them.

Biomedicine, also known as Western medicine, evolved from its traditional roots of Hippocratic medicine which emerged from an ancient Greek tradition of healing. At the core of Hippocratic medicine was the conviction that illnesses are caused by natural phenomena that can be studied scientifically and managed therapeutically.

The discipline of medicine has evolved in line with the Newtonian view of the universe that there is an objective physical world out there separate from the subjective world of mind and consciousness. Modern medicine is a science that treats the human body as a machine and doctors as mechanics whose job it is to stick things into it to find out which bits are dysfunctional – using technologies to fix them or take out what is beyond repair. The inner world is left to the theologians, philosophers, psychologists and psychiatrists.

Our hospitals look more like airports

Our high-tech hospitals look more like airports than places for healing, as Fritjof Capra points out. Medical students go to medical school to learn to heal the sick and graduate as doctors whose main agenda is to look for pathology. The human being is lost in the process. The discipline of family medicine makes an attempt to correct this by "bringing back the patient" that got lost during the training period of doctors. Modern medicine needs to review its biomedical model in light of a paradigm shift in science brought about by quantum physics and new insights from systems, complexity, and evolutionary theories and our increasing awareness that the body is not separate from the mind.

Candace Pert in her work on molecules of emotions shows clearly the role of emotions on physiology and molecular function. There is a strong relationship between psychology, physiology and pathology. Emotion and stress that biomedicine leaves to individual patients, psychologists and psychiatrists to deal with, ought to take centre stage in biomedical research. The number of diseases impacted by emotions has increased from a handful at the turn of the century to almost all known clinicopathological conditions today. The biomedical model is failing to accommodate this. Body-mind integration will take the medical profession back to 'healing' and beyond disease management.

Biomedicine's reductionist and Cartesian pursuits have denied it the insights gained in other disciplines about the nature of life and living organisms. A human being is a living organism, as is the basic unit of life – the cell. To understand health and ill health, we need to understand the behaviour of living organisms. A human being is an open system and like all systems, it has self-organising properties as well as emergent properties which are not present in its constituent parts. Self-healing is an inherent property of living organisms including human beings.

Stress is an imbalance of the organism in response to environmental influences. The stress syndrome is consistent with the systems view of life and demonstrates the interplay between body and mind. According to Capra, the phenomenon of stress occurs when one or several variables of an organism are pushed to their extreme values, which induces increased rigidity throughout the system. In a healthy organism, the other variables will conspire to bring the whole system back into balance and restore its flexibility. The physiological response to stress is the fight or flight response which in most cases is only temporary. Prolonged stress results from our failure to integrate the response of our bodies with our cultural habits and social rules of behaviour.

Unrealistic expectations cause stress

This may lead to suppression of the immune system. The relatively new field of psychoneuroimmunology (PNI) demonstrates how psychology affects physiology and in turn leads to pathology. The trigger of the syndrome is an activity in the mind, a perception of impending danger or more appropriately an experience of imbalance in our perceptions. The source of the imbalance is our expectation of how events should be in a given situation and our attachment to that situation. The more attached we are to our expectation, the more stress we experience.

John Demartini explains this in terms of values. Every human being has a set of priorities or a hierarchy of values. Whatever is highest in our values informs our perceptions and dictates what we see, how we interpret what we see and how we feel and behave. Stress, according to this theory, occurs when we have unrealistic expectation of ourselves and others to live outside of our and their own values and universal laws. In other words, stress occurs when we have lopsided perceptions.

William Glasser's choice theory explains this values hierarchy in relation to man's five basic needs (survival, freedom, power, love and fun) and his 'quality world'. Every human being has a quality world – a perceived world in which balance is maintained. We use our hierarchy of values to scan the world for people, events or situations that support whatever is high in our values and brings balance in this quality world. Anything that supports our values is labelled 'good' and we are attracted to it, and anything that challenges our values is labelled 'bad' and we are repelled by it.

This understanding of human behaviour and particularly the role played by our perceptions in creating our reality is central to understanding and thereby reducing stress. It is an understanding all physicians should have, and should be communicated to their patients in consultations.

The future of medicine

The medical practice of the future will be 'biomedicine plus' not 'biomedicine minus'. It will be scientific plus not minus. There will be a bigger role for generalist physicians who will be specialists in the human condition. They will be 'aware' physicians who understand the body's self-healing ability and the contribution to ill health from psychological (emotional), cultural, social and ecological factors. This physician will resume the role of supporter of the patient's responsibility for their health – the doctor as teacher and coach. This doctor will be competently trained in bio-psycho-social medicine but in addition will have sufficient knowledge of other traditional healing systems such as the Chinese and Ayurvedic systems. In South Africa, this would include some knowledge of African traditional healing. Capra describes this future generalist as a 'sage' physician.

This generalist sage physician should be the future primary care physician. Our current disease management public healthcare system in South Africa does not have physicians as first point of contact – it is nurse practitioner-based with medical officers where these are available. It has been argued that resources do not permit a system based on primary care physicians. It can also be argued that if we cannot afford a good primary care delivery for health, maybe we should not be in the business of modern healthcare delivery. Shifting of resources to strengthen primary healthcare coupled with massive public and medical students' education should enable governments to implement this type of care.

Ian McWhinney and other founding fathers of family medicine had a generalist primary care physician as the backbone of modern healthcare. Its patient-centred approach coupled with the three-stage assessment (clinical, personal and contextual) makes this ideal. In South Africa a decision was made to introduce postgraduate training before independent general practice – it was felt that this was a step towards such a future primary care generalist physician.

Sadly, the current public primary care service in the country is not general practitioner based and general practitioners only practise in private service. For the sage physician (suggested above) to be introduced will require a major shift in the consciousness of healthcare planners in South Africa. It makes sense that the family physician (with appropriate additional training) be the future primary care generalist sage physician in public and private service.

The biomedical model is also in need of a shift to a model that is consistent with mind-body integration. The resulting expanded bio-psycho-social medical framework will call for a system built on an appropriately trained primary care generalist physician. The family physician training seems the obvious starting point for the development of the future doctor (teacher) and sage physician.

Dr Shadrick Mazaza is a medical doctor and senior lecturer at the University of Cape Town Graduate School of Business on courses relating to health management and quality healthcare management. This article is based on the presentation he made at the 2013 South African Medical Association (SAMA) conference.

Complexities of vaccination acceptance: The Nigerian case study

Bernard Mutsago, *SAMA Health Policy Researcher*

Alongside other miracles of modern medicine, such as radiotherapy and organ transplants, vaccines have brought immense strides in quality of life and longevity globally over the past century. Since the discovery of vaccination in its modern form by Edward Jenner in 1796, vaccination has been one of the most important public health measures for preventing disease. According to the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in 2007, more than 2.5 million deaths annually are prevented in all age groups through vaccination against four diseases – diphtheria, tetanus, pertussis (DTP) and measles. The number of polio-endemic countries in the world dropped drastically from 125 in 1988 to three in 2014, making global travel more enjoyable without health fears – all this due to the use of vaccination.

The success of immunisation programmes depends on high public acceptance and uptake of the vaccines. For example, it is prescribed by WHO guidelines that, in order to eliminate measles, immunisation coverage must be maintained at over 95% throughout a particular country. The problem of vaccine scepticism is as old as the discovery of vaccines itself; as far back as 1796 Edward Jenner was ridiculed for inoculating an eight-year-old boy with cowpox. Yet today, more than 200 years after Jenner's mockery, routine vaccination programmes have eliminated or reduced many infectious diseases that once killed or harmed children and adults.

Just how such an initiative with enormous life-saving benefits can succumb to societal rejection and mistrust, is truly an enigma. It is the rise of anti-vaccine campaigns and vaccine refusals by communities around the world that led to the recent birth of unique initiatives such as the UK-based Vaccine Confidence Project (VCP) and the Vaccine Hesitancy Working Group of the Strategic Advisory Group of Experts (SAGE) on Immunisation. Some countries have even introduced policies of mandatory vaccination as a prerequisite for enrolment into primary school.

One of the most remarkable examples of resistance towards vaccine initiatives is the

infamous 11-month polio vaccination boycott in northern Nigeria in 2003, which is the focus of this article.

For South Africa, the question of vaccine acceptance becomes luminous presently, as the human papillomavirus (HPV) vaccination programme in schools was launched in March this year and as South Africa participates in what could be the last steps before a vaccine is found for AIDS. Vaccines for both HPV and AIDS in particular easily lend themselves to societal criticism because of the link to sexual transmission. Whether vaccine objection is a reality or possibility in South Africa needs to be checked. The Nigerian example, shrouded though it is in intricate local political and religious factors, can help shed light on effective current and future vaccine dissemination strategies and policy in South Africa.

2003 Nigerian boycott of the polio vaccination campaign

Nigeria is a multi-party Federal Republic of 36 states. The country is about 50% Muslim. The states have administrative control over health issues at the primary and secondary levels (such as vaccination programmes) while the federal government has control at the tertiary level. A mass immunisation campaign against polio was launched in Nigeria in 2003 at a time when polio prevalence was very high in Nigeria, accounting for 45% of global polio cases and 80% of cases in Africa at that time. In 2003 the Nigerian federal government launched a campaign as part of the WHO's Global Polio Eradication Initiative (GPEI). Unfortunately the campaign came to a standstill as political and religious leaders in three states in northern Nigeria (Kano, Zamfara and Kaduna) resisted it by influencing parents to deny consent for their children, citing a number of reasons. The Kano state government, which had authority to do so, issued a directive to halt the immunisation programme. A harrowing tussle ensued – between the federal government and the boycotting states – that only resolved in 2004 after intensive dialogue involving national and local leaders, albeit at the expense of a 30% rise in polio prevalence.

The Nigerian anti-vaccine lobby was based on a number of reasons:

- **Mistrust of government services:** There were contextual factors to this. Recent international political events affecting the Muslim community at that time, especially the September 11 attacks and the war in Iraq, were some of the underlying drivers (nevertheless, there had still been poor vaccine coverage in previous campaigns in Nigeria). The northern states believed that the southern-led federal government's vaccine rollout was serving hidden interests of Western powers. Political and religious leaders suspected that the vaccine could be contaminated with anti-fertility chemicals (estradiol hormone) as the locals believed that the campaign was a masked continuation of the fertility control policies introduced in Nigeria in the 1980s. The communities also suspected that the vaccines contained cancerous and HIV agents aimed to decimate or harm them.
- **Perceptions on the vaccination modalities:** The locals suspected the aggressive door-to-door campaign. In a country where utilisation of health services was generally low (8% utilisation in northern Nigeria in 2003), being offered free externally sourced medication so strenuously aroused suspicion.
- **Religious beliefs on health:** As in many other countries, there was traditional or religious disdain of biomedical interventions.
- **Previous controversial trial (Trovan trial):** There were still lingering fears following a bungled 1996 Pfizer trial in northern Nigeria (Kano state) of the new antibiotic trovafloxacin (Trovan) during a meningitis epidemic. Eleven children died in the trial and Pfizer was accused of undertaking an "illegal trial of an unauthorised drug". Five hundred and forty-seven Nigerian families sued Pfizer. (Subsequently, after a protracted battle, the first payments to families were made only in 2011, with four families receiving $175,000 each from a $35 million fund created for the settlement).

To end the boycott, the Nigerian government had to take a number of steps under pressure from dominant religious groups, namely:

- Forming a technical team that, by demand, had to include local clerics.
- Sending samples of the vaccine overseas for laboratory tests.
- Independent tests of the vaccine in a Muslim country (Indonesia).
- A series of WHO-organised meetings with political and religious leaders.

The boycott ended in 2004 and polio immunisation resumed, with Indonesia as the preferred supplier. However, the regional and international damage wrought by the boycott remained huge and vaccine resistance is far from over in certain parts of Nigeria. In the aftermath of the boycott new polio outbreaks were experienced in Nigeria. Further, polio cases traceable to Nigeria also caused harm in other African countries that were previously polio free, e.g. Sudan and Botswana, and far away countries such as Yemen, Indonesia and Saudi Arabia.

Catastrophically, today Nigeria is one of only three countries in the world (the other two being Afghanistan and Pakistan) that are still polio endemic, although the cases are few. Vaccination still goes on in Nigeria but not without incidents and fatalities. In early 2013, nine polio vaccinators were killed in the northern state of Kano (several vaccine workers were also killed in Pakistan around the same period, causing suspension of the operations). But there is hope, as not everyone in Nigeria is against vaccination.

Vaccination scepticism is not confined to Nigeria: there have been similar cases in India; USA and Europe (e.g. thiomersal-containing vaccines; the 'Cutter incident'); Japan (whooping cough vaccine); and France (hepatitis B).

Is vaccine acceptance a challenge in South Africa?

One of the most significant markers of South Africa's shift in focus from curative to preventive has been a stronger vaccination drive, with the school human papillomavirus vaccination programme being launched in March 2014; the prospects for a vaccine for HIV are heightened, and the search for a new TB vaccine continues.

Although there could be more studies, a South African study in Gauteng, Sayles et al. (2010)[1] identified the following barriers to a potential HIV vaccine: associations of vaccine stereotypes of promiscuity; preference for traditional African medicine; scepticism about Western drugs; mistrust of government and scientists; distorted perceptions of personal vulnerability to HIV infection; fear of side-effects; stigma because of the required pre-testing for HIV.

In conclusion, proper communication and education is not the only consideration in introducing any new intervention. Other critical ingredients need consideration, namely: safety and efficacy of vaccine; disease burden; cost; feasibility; and acceptability. Unfortunately the issue of vaccine acceptance or rejection is complicated by the universally recognised theme of patient freedom of choice in healthcare.

[1] *Sayles, JN. Macphail, CL. Newman, PA. Cunningham, WE. (2010) Future HIV Vaccine Acceptability Among Young Adults in South Africa, Health Education & Behaviour 2010. 37(2):193–210*

JUDASA holds revolutionary AGM

Conrad Strydom

The Junior Doctors Association of South Africa (JUDASA) was proud to host its annual general meeting at the SAMA headquarters in Pretoria on 15 and 16 March. JUDASA is known as the most 'revolutionary' and activism-oriented of the SAMA Trade Union-affiliated structures, and its AGM was a firebrand affair that provided valuable insight into the minds of the new generation of medical practitioners. Under the theme 'New age doctors suited in trade union armour', the event saw 42 doctors from across the country gather to discuss the future of the association and to elect new national office bearers.

After a word from the event sponsor Old Mutual, the assembled doctors were treated to an opening address by SAMA Trade Union president Dr Phophi Ramathuba. Dr Ramathuba spoke at length about the challenges being faced by junior doctors in the public health sector. She noted that a tight organisational structure was paramount to the achievement of the Trade Union's goals. "We can actually prevent strikes by being more organised," she said. She called on the JUDASA members to make use of the power they have as doctors to apply pressure where it is needed.

Dr Ramathuba was scathing in her criticism of the Department of Health's (DoH) inability to pay its doctors on time – something she has experienced first-hand as a hospital administrator. "A situation will arise in which all hospital staff – admin people, cooks, cleaning staff and so on – get paid their due, but doctors, the most important staff members, do not get a cent!" She was critical of the DoH's eagerness to implement its NHI policy in a sector which does not yet have the infrastructure to manage it. She also urged the junior doctors to keep in mind that while NHI is a good programme on paper, it must only be implemented when it is practical to do so.

The next speaker was well-known COSATU stalwart Theodora Steele, who currently serves as COSATU's national organising secretary. She provided clarity to JUDASA regarding the importance of effective shop stewards and guidance on the various stakeholder roles in a trade union. She also emphasised the necessity of returning to basics when dealing with union matters: "The basics are always the principles of equality and justice."

The next speaker was Chris Fourie of the South African Medical Students Association (SAMSA). Fourie has recently revived SAMSA and urged further co-operation between SAMSA and JUDASA. His request was welcomed by those attending. Outgoing JUDASA president Dr Kgopotso Pege had some advice for the organisation's new leaders. She stressed the need for leaders to be willing to make sacrifices and highlighted the need for JUDASA to move away from a top-down structure towards one that relies more on input from members.

A recurring theme at the AGM was the need to improve the image of Cuban doctors. JUDASA deals directly with the Cuban exchange programme and annually appoints an international relations officer to deal with the needs of South African trainee doctors in Cuba. "We need to improve the image of Cuban-trained doctors among our peers," Dr Pege said. "The common misconception that they are not able to function in a South African work environment is incorrect."

Many speakers stressed the importance of unity. "If we unite, there is no limit to what we can do," Dr Phophi Ramathuba said. A collaborative rather than top-down structure was often touted as the proper union structure for JUDASA. Other matters of interest were the responsibility of members to mobilise support for trade union initiatives and the need to plan around financial constraints.

JUDASA's national executive committee. Front row, left to right: Dr Khoza, Dr Shinta, Dr Sadiki. Middle row: Dr Mkhabela, Dr Mashele, Dr Muila. Back row: Dr Ngema, Dr King. Absent: Dr Madikana

The new JUDASA website has gone live. The website has a wealth of content, including a list of important policy documents that junior doctors might find useful. Visit the website at *www.judasa.co.za*

JUDASA's newly-elected National Office Bearers are:

Chairman: Dr Courage Khoza
Vice-Chairman: Dr Sinazo Shinta
Secretary-General: Dr Tshilidzi Sadika
Provincial Co-ordinator: Dr Abongile Makuluma
Internship Co-ordinator: Dr Gabaza Mashele
Medical Co-ordinator: Dr Yenziwe Ngema
Treasurer: Dr Sheshoka Muila
Projects and Marketing Officer: Dr Jonathan King
Student Liaison: Dr Sivuyile Madikana
International Relations Officer: Dr Johane Mkhabela

SARA AGM highlights registrars' needs

Conrad Strydom

The annual general meeting of the South African Registrars Association (SARA) was held at the Birchwood Hotel and Conference Centre in Boksburg on 22 and 23 February. Registrars from across the country gathered to map out a path towards improving and strengthening a supportive academic environment for registrars. The meeting was also attended by members of the SAMA Trade Union executive, of which SARA is an affiliate structure.

SAMA Trade Union deputy president Dr Shailendra Sham opened proceedings. He assured the registrars present that the needs of registrar doctors were a very serious concern for the Trade Union. "The demands placed on specialists in this country are overwhelming," Dr Sham said. "Not only are you expected to perform well academically, you also have to function as a doctor and experience all the pressure that accompanies that." Dr Sham, a former registrar, lamented the fact that registrar training often demoralises doctors and sends them in search of a more comfortable life in the private sector.

"If the doctor who is supposed to be training you does not like the look of you, you can kiss your training goodbye, regardless of whether you are knowledgeable or not"

Outgoing president Dr Langanani Mbodi, fresh from a shift in the wards, gave an honest and thoughtful appraisal of the previous year's issues and activities. He highlighted the growing co-operation between SARA and the Trade Union, as well as the role SARA was offered in a number of HPCSA committees.

The SARA AGM attracted registrars from across the country

Of greatest concern was the fact that many registrars were continuing to report unfair and biased examination practices, particularly during oral exams. "This is an issue of the utmost importance that makes a mockery of registrar training in this country," Dr Mbodi said. A demand was issued for taped examination sessions.

Next was Dr Samkelo Jiyana, who provided an overview of SARA's social responsibility activities in 2013. He also touted the next SARA projects, namely the building of a library for the Nothenga Primary School in King William's Town. The project will comprise constructing a library building and buying books for it. The next speaker was Advocate Daniel Madiba, the public sector negotiator for the SAMA Trade Union. He presented the various ways in which the SAMA Trade Union can elect to represent its members in legal terms, including the lodging of applications before the Bargaining Council and the Labour Court.

A recurring theme at the AGM was the lack of oversight and regulation in the registrar training process. Most of the registrars present had some anecdote to relate about unfair or downright discriminatory practices during training. "If the doctor who is supposed to be training you does not like the look of you, you can kiss your training goodbye, regardless of whether you are knowledgeable or not," Dr Mbodi said. The SAMA Trade Union representatives who were present promised to take the matter further.

Professor Sakkie du Plessis of the University of the Free State medical school gave the assembled registrars some practical advice about running an effective medical practice. He stressed the fact that there is a lack of medical practitioners in South Africa, which does not mean doctors do not have to do their utmost to be competitive. He counselled the registrars to build a brand image for themselves through word of mouth and detailed ways in which doctors can build a good image among their patients. According to Prof du Plessis, studies have indicated that a professional appearance is one of the most important factors influencing a patient's attitude to a physician.

SARA National Office Bearers 2014:

Chairperson: Dr Ntsaki Masinga
First Vice-Chairperson: Dr Elliot Motloung
Second Vice-Chairperson: Dr Mammekwa Mokgoro
Treasurer and Marketing: Dr Mary Adam
Secretary: Dr Bulelani Matha
UP representative: Dr Tebatso Boshomane
Medunsa representative: Dr Ofentse Mosiane
Wits representative: Dr Daren Calleemalay
UCT representative: Dr Lindisa Mbuli
OFS representative: Dr Pedian Vuthela
UKZN representative: Dr Emmanuel Ati
WSU representative: Dr Samkelo Jiyana

Member profile: Dr Zanele Bikitsha

Dr Bikitsha is a medical officer in anaesthetics at Ngwelezana Hospital in KwaZulu-Natal, a 554-bed hospital close to Empangeni that provides district, regional and tertiary services to communities from the Uthungulu, Umkhanyakude and Zululand districts. She is a member of JUDASA's provincial structure in KZN.

What are your impressions of the job so far?

It definitely has its fair share of challenges. At Ngwelezana, our main issues are a lack of equipment and medicines and an overwhelming patient load. Despite all that, I honestly can't say it hasn't been fulfilling.

Fulfilling in what way?

Firstly, if it has been your dream since you were little to be a doctor one day, then you derive a tremendous amount of pride from becoming one. Every day I am proud of having achieved my dream. Also, when you are able to intervene positively in another human being's life, it gives you a sense of enormous well-being.

Is there hope for our public health system?

If we can change our attitudes, yes. Doctors have to realise that the only way forward is to organise collectively instead of emigrating. This business of doctors emigrating is very sad – it is a betrayal. A true physician stays here and fights for their patients. I believe NHI is a step in the right direction, but they will have to phase it in slowly given the current state of public health.

What are the biggest challenges for public health?

A huge skills shortage and a lack of infrastructure. But I think if we remain positive we will see how far we have come already. Look at the strides we have made against HIV/AIDS. Another challenge is the gradual change to a system of preventive medicine that we will have to undertake someday. But our track record leaves me hopeful.

A warning to SAMA members about PPS rates increases

Conrad Strydom

Recently, the Professional Provident Society (PPS) announced an unprecedented – and not widely publicised – rates increase. At the beginning of 2014, PPS phased in an "automatic annual increase" of their premiums to their members, amounting to 8% (an amount noticeably higher than the inflation rate). This was followed by a second increase at the beginning of March (amounting to another 7% on top of the first increase). The reason provided was that the society's underwriters, Hollard, had to adjust their premiums due to an increased risk profile.

According to feedback PPS sent to a member, this was due to: "Fires in St. Francis Bay in November 2012, which caused damage in excess of R250 000 000, and was one of the biggest single losses experienced by the local insurance industry ... severe hailstorms in the latter part of both 2012 and 2013" and "the ever-increasing cost of repairs for damaged motor vehicles". A PPS release stated: "The short term insurance industry has seen progressively lower rates over the past decade. These decreasing premium rates have resulted in levels that are unsustainable and it was simply a matter of time before some catastrophic losses would trigger the reversal of this cycle."

Regardless of the reasons for such an increase, it is nevertheless unprecedented that rates increase by 15% and this is likely to affect the bottom line in practices nationwide. According to Dr Gustaaf Wolvaardt of the FPD: "In a 5% CPI environment it is not acceptable for rates to increase this much and one would expect PPS to at least shop around for another underwriter, since they are basically saying that Hollard made them increase rates. It is especially disappointing since PPS marketed their services to the profession with a guarantee to reduce insurance costs."

PPS was approached for comment but failed to do so by the time the *SAMA Insider* went to press.

[This rates increase is] "especially disappointing since PPS marketed their services to the profession with a guarantee to reduce insurance costs"

Dear CPD client,

We wish to take this opportunity to thank you for your continued support through the completion of our online CPD questionnaires as well as to share some exciting news with you. HMPG's journal CPD questionnaires will be moving to the Medical Practice Consulting (MPC) CPD platform (www.mpconsulting.co.za) as part of a strategy to consolidate all South African Medical Association (SAMA) members' CPD certificates and history.

All SAMA CPD certificates (whether for annual conferences, branch meetings or workshops) are already available online on the MPC CPD platform and moving all active HMPG online CPD questionnaires to the same platform will mean that all SAMA member CPD certificates will be issued in one central, convenient location – resulting in less admin for our CPD clients.

An additional benefit is that the MPC CPD manager can complete your IAR form on your behalf (no more countless hours of reconciling CPD records before a compliance audit) and submit your CPD history to the HPCSA once you have approved it and are happy with the results. All that is required of you, when you are ready, is to click a single button to submit your CPD Activity Record to the HPCSA. Nothing will, of course, ever be submitted without your prior approval and consent.

The MPC system also adds additional functionality to the CPD questionnaires and the system has been set up to make the process as easy to follow as possible.

The South African Medical Association (SAMA) board has concluded that the CPD services associated with the S*outh African Medical Journal* (incorporating Continuing Medical Education) and the *South African Journal of Bioethics and Law* will only be offered to registered and fully paid-up SAMA members, as per the SAMA member benefit schedule; therefore, you will be required to register a profile on the MPC CPD system (if you do not already have one – if you already have one, login as usual) and to supply your SAMA membership number. You will be required to do this only once. Your membership will be validated in real-time and you will be able to access the journal CPD questionnaires. This once-off registration should not take more than 2 minutes and you will be on your way to completing the CPD questionnaires.

Below are some questions and answers that will assist you in getting started.

When will the CPD questionnaires move to MPC?

All HMPG-issued journal CPD questionnaires will move to the MPC CPD platform from February 2014 onwards. This will include all prior CPD questionnaires that are still active.

What website do I access to complete the HMPG questionnaires?

www.mpconsulting.co.za

Who is MPC?

Medical Practice Consulting (MPC) is a group company of SAMA. MPC has historically hosted CPD at SAMA's annual conferences, issued all SAMA member CPD certificates and has hosted SAMA's online branch elections. By moving active HMPG journal CPD questionnaires to the MPC system, SAMA members will have all their CPD certificates in one central, convenient location. MPC has also been supplying the Foundation for Professional Development distance learning courses online for the last 2 years and has hosted some of the largest online training initiatives in the South African healthcare industry.

What do I need to register a profile on the MPC CPD system?

MPC does not retain any confidential information on their database, so you will not be requested to share your telephone number, practice or home address. All that is required for registration is your name, surname, specialty, SAMA membership number and HPCSA number (which is included on your CPD certificate to comply with HPCSA CPD requirements).

How long will registration take?

Completing registration should take no longer than 2 minutes – please remember to have your HPCSA (MP Number) and SAMA membership number at hand.

What about my historic CPD certificates on the www.cpdjournals.co.za website?

If you register on the MPC CPD platform with the same email address as you were using on the www.cpdjournals.co.za website, MPC will import all your CPD certificates for the last 36 months into your MPC CPD manager for you. Alternatively you can still login to www.cpdjournals.co.za and save any CPD certificates that are still valid (remember that CEUs have a 24-month shelf life and expire after 24 months).

What happens if I run into technical difficulties?

Simply complete an online contact form and MPC will assist you with your technical problem. If your SAMA number for some reason does not match that in the SAMA membership database, MPC will assist with rectifying the problem. MPC's contact details are available online: www.mpconsulting.co.za/contact-us

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Sincerely,
Gert Steyn
CEO, Health and Medical Publishing Group (HMPG)

Risk Management in medical practice and hospitals

This article on systems and resources is the third part of the article first published in the February edition of *SAMA Insider*.

Following appropriate systems

Every hospital should have policies and procedures in place for checking medications, identifying the site of an operation, counting swabs and instruments, and so on. However, there are numerous incidents, complaints and negligence claims to show that these checks are far from foolproof; if you place too much trust in them, you may easily become complacent and assume that they have been carried out competently.

Before carrying out a procedure, always check the patient's identity and look at the case notes and relevant images to establish the nature and site of the procedure, even if someone else has already prepared or marked the site.

- Familiarise yourself with your hospital's policy on ordering and administering blood products.
- Make sure that any specimens and accompanying forms or reports are accurately and fully labelled.
- See that all hazardous substances and waste are labelled with appropriate warnings.
- Be conscious of health and safety issues, e.g. disposal of sharps, etc.

No-one is perfect, so you will occasionally overlook, forget, or not be aware of crucial information that has an important bearing on a patient's wellbeing. Patients therefore have an important role to play in the information system. If they are kept well informed and are encouraged to voice their concerns, they can act as a vital failsafe in the information system. Patients usually know what they are in hospital for; they know their medical history, they are usually familiar with their medication, they have their own welfare high on their agendas, and they rarely mistake themselves for another patient, so it therefore makes good sense to stop and listen to them if they express concern about an intended procedure or treatment.

Adverse incident reporting system

What do you do if something goes wrong, or you have a close call? Do you think about reporting the incident? Many hospitals have an adverse incident reporting system to help them identify safety hotspots and to learn from experience. If your hospital has such a system, you should report any adverse incidents or 'near misses' as soon as possible after the event.

Resources

If you have concerns about the effects of under-resourcing on patient safety, you should formally notify the hospital management, explaining why you are concerned and outlining the possible consequences of continued under-resourcing. In some respects this is a 'back-covering' exercise. If you are involved in litigation following an adverse incident due to resourcing problems, the fact that you had alerted managers to the problem may assist your defence.

On a less cynical note, it is important that managers who are trying to balance limited budgets know where the risks to patient safety lie so that they may direct the hospital's finite resources where they are most needed.

Staffing levels

If you work in an under-staffed hospital, you probably work excessively long hours. You will know from direct experience the effects this can have on your ability to function effectively, but you may still be interested to know that after only one night of missed sleep your cognitive performance may decrease by 25% and, after a second night of missed sleep, you will probably be functioning at only 40% of baseline. If you accumulate a sleep debt (getting two to three hours' less sleep than optimal in 24 hours) over five to ten days, you will not only find it difficult to function cognitively, but your response times will be lowered and your mood altered. You will also probably find your morale and sense of initiative adversely affected.

Obviously, all of the above have implications for the safety and wellbeing of your patients. So is there anything you can do to minimise the risks? Yes, there is. Although you cannot eliminate all the risks associated with fatigue, there are things you can do to improve your performance or to guard against some of the worst effects of fatigue:

- You should guard against a natural tendency to be short-tempered, irritable or rude when you are over-tired.
- Try not to rely on caffeine and sugar to see you through. Both of these substances will give you a short-term boost but then bring you crashing down a couple of hours later. They have the additional disadvantage of making it difficult to sleep when you do finally get off duty. Although your over-tired body will probably start nagging at you to feed it something sweet, you will do better to give it a piece of fruit or a homemade sandwich rather than something from a vending machine.
- When it comes to meals, frequent snacks will serve you better during a long shift than large dinners, which require a lot of digestion and can make you sleepy. Try not to go too long without eating, and try to stick to complex carbohydrates and proteins. Drink plenty of water.
- There are some indications from research that taking a prophylactic nap before you go on duty can effectively reduce feelings of fatigue. Maintenance naps during your shift may also be useful, but there is a risk of 'sleep inertia' after being woken. Sleep inertia is the term used for that awful feeling of complete disorientation when you wake from a deep sleep. It may last for up to 30 minutes, so this is not ideal if you are working on call and likely to have to deal with emergency situations.
- Off duty, it is important that you catch up with your sleep so that you do not end up chronically sleep-deprived. This may be difficult if you are trying to sleep during the daytime, when the quality of your sleep may be reduced by light, noise and temperature. You should do your best to replicate night-time conditions by using blackout curtains or an eye mask, earplugs and a fan or air conditioner to keep the room reasonably cool. Here are some techniques for promoting sleep:
  - Go for a short walk, relax with a book, listen to music and/or take a hot bath before going to bed.
  - Avoid vigorous exercise before sleep as it is stimulating and raises the body temperature.
  - Avoid caffeine, 'energy' drinks and other stimulants a few hours before bedtime as they can stop you going to sleep.
  - Do not go to bed feeling hungry: have a light meal or snack but avoid fatty, spicy and/or heavy meals as these are more difficult to digest and can disturb sleep.
  - Avoid alcohol as it lowers the quality of sleep.

Failures of communication

- Underpinning good patient care is good communication, and this goes beyond establishing good relations with patients. In today's team approach to delivering healthcare, communication has to extend to more people and there are therefore more opportunities for it to fail.
- Communication between primary care, secondary care and social and voluntary services should be seen not as a chain but as a communication net, within which any one member may need to communicate with any other. Good management requires all members of the communication net to be conscious of who is doing what – an adequate standard of continuing medical care can be achieved only if all participants, both medical and non-medical, understand their roles.
- Keeping people informed in the interests of continuity of care must be balanced against the need to maintain confidentiality, and both these issues should be borne in mind when sharing relevant information about patients. Unless the patient asks you not to, it is entirely appropriate to share information about patients with people involved in their care.

Case report: Dual system causes communication breakdown

Mr A, a 67-year-old hotelier, was referred to A&E with a suspected transient ischaemic attack. He was seen by Dr K, the junior doctor on duty, who arranged a CT scan for the following morning. Mr A was transferred to a medical ward for observation overnight and the scan was performed later the next day by Dr E, the radiologist on call. Dr E was not able to report the scan straight away, but Mr A was told that he could go home and that his GP would be contacted in due course with the result of his tests.

Two weeks later, Mr A was found collapsed in the hotel dining room. He was readmitted to A&E where an emergency CT scan showed a large cerebellar tumour with evidence of recent haemorrhage.

There were signs of ventricular dilatation and raised intracranial pressure. Unfortunately, Mr A died before he could be transferred to a neurosurgical centre for specialist treatment. It later came to light that no-one on the ward had followed up Mr A's first CT scan, which showed a mass in the cerebellum that the radiologist reported as "consistent with a primary or secondary neoplasm".

At the time, the hospital had been operating a mix of electronic and paper records. The radiologist had lodged his report in the electronic system, but this had not been transferred to the patient's case notes, which had been filed away after the patient's discharge.

Acknowledgement: The above article forms part of the MPS risk management booklets and has been published with consent from the MPS.

An unavoidable amputation

The Medical Protection Society shares a case report from their case files

Mrs N was a 26-year-old researcher with a four-year-old daughter. She enjoyed dancing and went to a salsa class with her husband each week. Her right knee was slightly painful so she missed a class to see if it would improve, but it got gradually worse over the next few weeks.

She made an appointment with her GP, Dr B, to discuss her knee pain and seek his opinion on a skiing holiday she had booked. His notes commented on her right knee pain which was "possibly due to dancing". He documented some tenderness over the tibial insertion of the medial collateral ligament. He noted that the joint was stable and that there was no effusion. Dr B prescribed diclofenac and explained that he felt her skiing holiday did not need to be cancelled, but that it might not help matters.

Mrs N enjoyed her holiday but was becoming aggrieved by the knee pain, which was now troublesome most of the time. She saw Dr B and explained that the pain had been ongoing for four months with no improvement and that she couldn't remember any specific injury. Dr B documented the history and referred her to physiotherapy. His completed musculoskeletal referral form did not highlight any red flags including intractable night pain, weight loss, systemic illness or previous history of cancer.

While she was waiting for her physiotherapy appointment Mrs N rang the surgery again asking for a GP appointment. This was the first appointment she was given with Dr G. Mrs N explained that she had not taken the diclofenac because she was nervous about possible side-effects and she felt the pain was getting worse.

Dr G's records stated "history as above" and also noted that there was no locking or giving way. His examination notes were thorough. He documented that she was able to weight bear, that there was no swelling and that the knee was stable with a normal range of movement. He noted mild tenderness medially. He encouraged her to take the diclofenac and to rest, ice and elevate the knee. He advised buying a tubigrip to offer some compression to the knee. He gave safety-netting advice: asking her to return if things got worse while waiting for physiotherapy.

Mrs N saw the physiotherapist, Mr Y, who noted her four-month history of gradual onset knee pain. He recalled the patient saying that the pain flared up intermittently. His examination noted a limping gait and an inability to extend her right knee fully due to pain. He noted slight swelling and that the knee was very warm to touch. McMurray's test was positive. Mr Y's initial thoughts were an injury, mono-arthritis or cartilage damage. He advised a review after two weeks of anti-inflammatories and ice.

At the review it was noted that there was swelling most days and the pain was worse. Mr Y was concerned that there was an inflammatory cause and suggested inflammatory marker blood tests through Mrs N's surgery. These were found to be normal, but Mr Y referred her to a consultant rheumatologist because her knee was still hot and swollen with no obvious cause.

Good note keeping is important for good medical practice and essential in defending a case

Mrs N was seen urgently in the rheumatology clinic. Blood-stained fluid was aspirated and an X-ray arranged. The X-ray reported 'possible tumour' and a subsequent MRI scan and biopsy confirmed the diagnosis of osteosarcoma of her right tibia.

Mrs N sustained a tibial fracture and was given chemotherapy. She struggled with nausea and fatigue and was devastated when she was told that she needed an above-knee amputation because the tumour was aggressive and had not responded to chemotherapy. She later had a prosthesis fitted.

Mrs N was extremely upset and made a claim against Dr G. She felt that there had been a delay in the diagnosis of her tumour and that earlier diagnosis could have saved her leg from amputation. Mrs N claimed that the first time she had seen Dr G, she had complained of severe pain during the day and night, and that the knee was hot and swollen at that time.

Expert GP opinion was sought. It was felt that the history obtained by Dr G was reasonable and appropriate, although he could have asked directly about nocturnal pain. Dr G stated that he had asked about aggravating and alleviating factors and that he would have recorded any history of nocturnal pain if it had been given.

It was felt that Dr G's examination was of a good standard and that his actions were reasonable. The decision to wait for the physiotherapy appointment with the safety net of re-attending if symptoms worsened was found to be reasonable. No indication could be found to arrange an X-ray, blood tests or referral at Dr G's initial consultation.

It was noted that Mrs N was still dancing at this point and had just returned from a skiing holiday, which would not raise alarm bells. It was also noted that Mrs N was not taking the diclofenac, so it was reasonable to think that her pain was manageable.

Expert opinions were sought from a consultant orthopaedic surgeon, a professor of medical oncology and a consultant radiologist. It was their agreed view that an amputation would have been needed even with an earlier diagnosis, because of the tumour's poor response to chemotherapy and its aggressive nature.

The case was successfully defended and Dr G was not found to be in breach of duty. MPS took steps to recover their costs.

Learning points:

- Although the patient's circumstances were very tragic, this did not equate to negligence.
- This case reflects the importance of strong expert opinion. The successful defence hinged around the experts' opinion.
- Good note keeping is important for good medical practice and essential in defending a case.
- If a patient attends multiple times with the same problem, alarm bells should start ringing. It is useful to stop and think "what could I be missing?"
- Always try to exclude the worst-case scenario. It is useful to document the absence of red flags.

Soy sauce overdose

From www.livescience.com

Risky drinking games usually involve alcohol, but one teen learned not to swig soy sauce, either. A 19-year-old man in Virginia drank a quart of soy sauce on a dare.

He first started twitching, and then had seizures and eventually landed up in hospital in a three-day coma. Doctors diagnosed hypernatraemia, or dangerous levels of salt in the bloodstream.

One quart of soy sauce can contain as much as a third of a pound (150 grams) of sodium. Excess sodium in the bloodstream pulls water out of nearby tissues by a process called osmosis, which equalises the concentrations of salt across cells. Hypernatraemia can extract so much water from the brain that it starts to shrink and bleed.

It took doctors about five hours and 5.7 litres of sugar water pumped into the teen's body to get his sodium levels back to normal.

Water urticaria

From dermatology.about.com

Water urticaria, or aquagenic urticaria, is a rare condition in which hives develop within one to 15 minutes after contact with water. The hives last for 10 to 120 minutes and do not seem to be caused by histamine release like the other physical hives. Most investigators believe that this condition is actually exquisite skin sensitivity to additives in the water such as chlorine.

Diagnosis

Water urticaria is diagnosed by applying tap water and distilled water to the skin and observing the reaction.

Treatment

Water urticaria is treated with a cream called capsaicin (Zostrix) that is applied to the irritated skin. Antihistamines are of questionable benefit since histamine is not the causative factor in water urticaria.

Human spinal cord redundancy

From listverse.com

The spinal cord forms a tightly wired nerve bundle that is both complex and easily injured. While complete severing of the spinal cord will generally remove all function below the injury site, the spinal cord is different from a man-made electronic cable in that impairment levels do not correspond to the degree of spinal damage. The spinal nerves are in fact highly redundant and interconnected, so even a 90% gap in the spinal cord may not deprive a victim of the ability to walk. The implications of this include the fact that a cure for spinal cord injuries may be easier to achieve than once thought. Partial, 'random' regeneration, rather than nerve-by-nerve reconnection, may suffice to return mobility. In an even more bizarre finding, blue dye injections dramatically reduced the impact of spinal cord injuries in rats, a treatment that must be tracked for humans.

KZN Coastal invites you to their Facebook page

The KZN Coastal branch has taken the initiative to bring social media to SAMA. Their Facebook page is regularly updated and has become a hub of activity for branch members to discuss the travails of practising medicine in South Africa. Growing contingents of users who visit this page are SAMA members who are not affiliated with the KZN Coastal branch, making it a sort of *de facto* page for the whole of SAMA.

According to Dr Shailendra Sham, the specialist representative at KZN Coastal, the Facebook page has garnered a lot of interest and is serving to stimulate debate among doctors. "There is a growing need for this sort of interactive platform in SAMA and we invite all members of the association to join us online." It is also hoped that social media platforms such as this will serve as a way to unite South Africa's doctor corps and mobilise them to use their considerable influence to effect changes in the healthcare system.

To join the Facebook page, go to *https://www.facebook.com/SAMAKZNCoastal* or contact the branch on (031) 201 2087.

Readership survey results are in

The recent *SAMA Insider* readership survey proved highly successful at gauging the thoughts of our readership. Most responses were overwhelmingly positive, with positive comments on both the content and design of the *Insider* being the norm.

We also received a number of more strongly worded responses that nevertheless provide valuable direction for the future of the magazine. Remember, the *SAMA Insider* is published solely for the benefit of SAMA members. As a member, you have the right to influence the magazine's content. So send an email to *conrads@samedical.org* or phone (012) 481 2041 with suggestions, comments or potential articles.

The winner of the R500 executive gift hamper is:

Dr Abie Allie of Garlandale Estate, Lansdowne, Cape Town

Dr Allie will be receiving his gift hamper shortly.

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