

SAMA INSIDER

SEPTEMBER 2015

Medico-legal litigation: Do we have the solution?

Boxing under the
spotlight



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

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To qualify for Certificate of completion for this short course, participants should successfully complete the assessment process.

COURSE FEE

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This conference has become bigger and better over the years. The quality of the speakers, combined with the depth and breadth of topics discussed, continues to exceed the expectations of participants and experts alike.

The conference attracts, not only doctors but representatives from important healthcare stakeholders such as the National Department of Health, regulators, funders, administrators and managed healthcare entities.



FOR MORE INFORMATION:

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EDITOR'S NOTE SEPTEMBER 2015



Diane de Kock
Editor: *SAMA INSIDER*

Let's communicate

Any problem, big or small, within a family, always seems to start with bad communication. Someone isn't listening.

Emma Thompson

I'm a great believer that any tool that enhances communication has profound effects in terms of how people can learn from each other, and how they can achieve the kind of freedoms that they're interested in.

Bill Gates

The two quotes above remind us how important good communication is – connecting with each other and really listening is often a huge challenge in today's fast-paced, time-starved medical environment. The *SAMA Insider* is a monthly publication which aims to feature news, views and interviews and key articles on specific topics, matters and issues of interest and importance to both public and private doctors in their daily practices.

As Emma Thompson highlights in the quote above, in order to communicate effectively we need to listen. As the editor of this publication, I would like to listen. Let me know what is important to you, what you require from the *Insider* – a publication dedicated to the needs of ALL SAMA members.

To communicate well we need a tool to enhance that communication as Bill Gates so eloquently states above. *Insider* aims to be that tool – helping members to learn from each other to achieve a desired result.

The *SAMA Insider* team look forward to hearing from our readers.

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Medico-legal litigation: Do we have the solution?



Prof. Lizo Mazwai, President, SAMA

Since the beginning of the year much has been said, in discussion and writing, about the burgeoning numbers of medico-legal claims in South African medical practice. This has been a culmination of a progressive trend in South Africa and is often compared to the trends in the USA.

At this stage probably the most significant cause is the breakdown in human relations particularly the elements of individual respect, compassion, empathy and even sympathy

Is there a crisis? I raise this because my observation is that there is a tendency to respond reactively to crisis in our society rather than deal with issues in a proactive preventative approach. Be it a crisis or peak, the National Department of Health responded through a workshop and summit in May 2015. Without going into statistics it can be safely said that the burden of the litigation, both in numbers of cases and quantum of claims, is born by both the public and private sectors. Therefore a concerted joint effort by both

sectors is essential as this is a national crisis. The economies of scale around litigations are such that they threaten the fiscus to the extent of undermining funding for regular healthcare.

In these publications, workshops and meetings often the underlying causes are put forward, but I wonder if we have tackled the solution at a broader national level. It is quite clear that each sector institution would set up measures to prevent or mitigate such medico-legal claims.

In search for a solution, one would first look at the generic factors that would be common in most institutions or practice. A simplified classification would be along the lines of:

- Institutional system failure which can be broken up into :
 - Infrastructural; in this case major structural defects which would endanger the safety and security of patients in high-risk areas. The design of some hospitals may not meet the stringent modern standards
 - Equipment; either lack of proper equipment or equipment that is faulty and producing poor results or in high-risk areas are a hazard to patients.
- Professional considerations:
 - Professionals are required to perform above level of skill, experience and qualification often associated with shortage of staff. This may lead to errors of judgement in decision making for the appropriate management of patients.
 - Irrespective of appropriateness of qualification, the oldest and most common professional consideration is professional negligence and incompetence.
 - These are usually clearly defined in guidelines for professional conduct by relevant regulatory councils and associations. There is no room for these occurrences. Patients, courts and the legal system are honing in on these defects.
- Failure of the professional-patient relationship often involving Professional Ethics in the area of communication.

Ethics

With respect to Ethics it is worth noting at this stage probably the most significant cause is the breakdown in human relations

particularly the elements of individual respect, compassion, empathy and even sympathy.

Put together these represent attitude. The issue of attitude is also named by the Health Professions Council of South Africa (HPCSA) as one of the attributes that should be taught and inculcated even at the level of undergraduate training.

If this is a crisis then urgent intervention is required

Attitude has also been identified as one of the key causes of poor care by health professionals at health institutions. This is from the survey (mock inspection) of Health Establishments by the National Department of Health in identifying national core standards for compliance.

This question of attitude manifests itself in many ways from reception of the patients, to communication and physical care. Other matters directly related to Ethics are:

- Respect of individual rights and integrity
- Confidentiality
- Veracity and honesty
- Informed consent
- Right to refuse treatment and intervention.

Recently much has been debated on the right to dignified death and other end-of-life issues.

All these have medico-legal implications.

If this is a crisis then urgent intervention is required. Once institutions or professional bodies identify the predominant risk factors or areas, then corrective, preventative and mitigating measures should be put into place without delay.

As the long-term strategy the philosophy of high quality of care, safety and best practice for patients should be adopted by institutions and professionals.

In order to ensure and enforce this, compulsory CLINICAL AUDITS should be the order of the day in all institutions at all levels of care including the management and administrative section.

It goes without saying that the skills and qualifications of all professionals must always be upgraded through the compulsory

continuing professional development in a specific and productive fashion through monitoring and feedback.

Professional conduct and ethical behaviour should be re-emphasised at all times and role modelling and mentorship, and not just getting CPD points on ethics, are essential to achieve this.

This article seeks to capture and summarise some of the salient issues around this problem and is not the full answer or solution. Obviously more in-depth discussion on other related matters such as the issues of workload, poor facilities, education and training is needed.

Furthermore some ground has been covered and we should not lose the

momentum lest the crisis gets out of hand. We must develop a sustainable strategy nationally to deal with this 'scourge'.

Following the summit by the National Department of Health in May 2015 a follow-up on interventions and solutions should be organised at a national level involving all relevant stakeholders.

SAMA news in brief

Draft amendments to regulation 5 and 8 of the Medical Schemes Act

The Minister of Health, on 14 July 2015, published draft amendments to the General Regulations to the Medical Schemes Act and provided interested parties a period of three months to comment on the amendments.

SAMA expressed its concern at the intended revision of these regulations which pertain to the provision of and payment for Prescribed Minimum Benefits. In particular, the revision of Regulation 8 which will limit the liability of medical schemes to pay for the diagnosis, treatment and care of prescribed minimum benefits according to the 2006 Reference Price List adjusted for inflation in terms of CPI.

This revision is regarded as ill-advised by SAMA. Simply put, the 2006 Reference Price List is almost 10 years out of date and its deficiencies cannot be remedied by applying an adjustment for inflation. There have been numerous advancements in medical technology and procedures over the last decade, which are not included in the 2006 RPL list. The effect on medical scheme members would be significant as they would no longer be funded for optimal and up-to-date treatment if this treatment does not appear in the 2006 RPL. In respect of the amendments to Regulation 5, SAMA is concerned that the trend of medical schemes to require medical doctors to increasingly perform administrative functions on their behalf will be continuing and gaining statutory authority.

SAMA is in the process of compiling a considered and comprehensive submission in response to the Minister's draft amendments. It is our intention to examine the legal validity of the intended amendments, as well as the practical implications for both its members and the patients who receive medical services for prescribed minimum benefits. This submission will be made available, once completed.

Forced feeding

SAMA responded on 1 August to the decision of the Israeli Parliament (Knesset) to pass a law on 30 July 2015 allowing forced feeding of

prisoners and detainees on hunger strike (see page 20).

SAMA are in full support of the principled position of the Israel Medical Association to oppose the law and applaud all those doctors who have refused to carry out the dictates of this law and also support the view of the WMA that forced feeding of prisoners and detainees is not only degrading and inhumane but tantamount to torture.

Fake drugs alert

The *Pretoria News* reported on 12 August that according to health specialists the South African public is under threat from the heavy influx and availability of fake drugs, which if left to continue could lead to a health crisis across all sectors of society.

Doctors and pharmacists have stated that untested medicines have side effects and the healthcare industry is not prepared to deal with them.

"The commonest danger is that they may not do what is expected, and not treat what they are meant to," the SAMA's Dr Mzukisi Grootboom said.

Patients were also in danger of exacerbating their conditions, and developing conditions that might be difficult to treat, he added.

Pharmacy assistant Loyiso Mangxamba pointed out that besides developing allergic reactions and disturbances in the gut, consumers could also find themselves afflicted with heart conditions and changes in blood glucose levels. "They could suffer from serious nausea, vomiting and diarrhoea and they could find themselves struggling to breath," she said.

They also risked organ failure: "Patients with chronic conditions could exacerbate the signs and symptoms of their conditions."

The abundance of fake drugs was becoming a worrying trend, said Sunnyside family doctor Dr Aubrey Silinda. "They are available on every street corner and are being offered for so much less than the real drugs." That way, they were

within the reach of the most vulnerable and sick of society, he added.

In the past year, SARS reportedly confiscated 208 000 pills estimated to be valued at R21 million. A consignment of 40 000 Viagra tablets was found by customs officials at the Johannesburg International Mail Centre last month.

SARS said the pills were in boxes sent from Hong Kong, with packages labelled as plastic toys: "That is just the tip of the iceberg," said Mangxamba. Many more went undetected and ended up in the wrong hands.

Fake drugs are the product of individuals other than the genuine manufacturer, and are an imitation of the original product. On their website, the World Health Organization (WHO) explains that these drugs were cheaper because they contained substandard ingredients, or cheap substitutes.

The important ingredients responsible for the efficacy of the drug were sometimes omitted, WHO said. Production did not require building huge infrastructure or facilities and could take place in small cottage industries, in backyards or under the shade of a tree, which led to cheaper prices.

High up on the lists of the fake drugs which have flooded the South African market were sex enhancement products, chronic medication and pills for terminating pregnancies. "They offer faster results for next to nothing. Peddlers offer discretion and anonymity, so one does not have to sit in a room full of people they know to get services," Silinda said.

Some patients were attracted by the cheaper prices and ditched their prescribed medication, exposing themselves to unexpected and undocumented side effects, Grootboom added.

He explained that drugs available in the mainstream market were taken through rigorous tests and their efficacy tracked and recorded, so that side effects were known and planned for. It was the social dislocate in society that allowed dealers to get as far into the community as they had, Grootboom said.

Source: Ntando Makhubu, *Pretoria News*



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- South African Medical Association
Continued Professional
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- Our Mission:
 - Empowering Doctors to bring
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WHAT WE ARE ABOUT

SAMAREC:

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

CPD:

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.

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

SAJBL: Flagship special stem cell edition

Editor: Prof. Ames Dhai. Guest editor: Prof. Michael S. Pepper

This commentary is based on the editorials of Prof. Dhai and Prof. Pepper to the special edition: <http://hmpg.co.za/index.php/sajbl/issue/view/497>

Use of the words 'stem cell research and therapy' evokes a number of responses. In our emotionally vulnerable patients, this denotes a sense of hope and in scientists, a great deal of excitement about future prospects. In the case of legal experts and ethicists, it is a need to ensure that patient safety is ensured while at the same time a spirit of distributive justice and progress is maintained. In the minds of entrepreneurs, it implies an opportunity to develop a profitable business.

The ethical, legal, and social issues (ELSI) related to stem cells are numerous and complex. Critical to the success of research and therapy in the stem cell field is a well-balanced legislative environment. Stem cell legislation in South Africa is governed principally by the National Health Act (No. 61 of 2003) and the Medicines Control Act (No. 101 of 1965). While this legislation and the associated regulations (promulgated in April 2012) provide for some of the requirements including inter alia, ministerial authorisation, authorised institutions, patient informed consent, clinical trials, registration of new medicines (or biological medicines), anonymity, traceability, there are a significant number of important areas in the field that are not adequately covered, and South Africa, like many other parts of the world, is being subjected to the challenges of stem cell tourism.

In April 2013 the South African Medical Research Council (SAMRC) published a

request for applications for a new funding opportunity called the University Flagship Awards. After initial internal selection processes in the country's universities and science councils, a rigorous external review process of the selected applications was undertaken. One of the successful applicants was the stem cell group based at the University of Pretoria (UP). In addition to a young dynamic team at UP, this ambitious and forward-looking project involves accomplished scientists from diverse disciplines both in South Africa and abroad. The University Flagship awards are the largest medical research grants awarded by the SAMRC.

The Flagship project aims to contribute to the alleviation of the heavy burden of disease in South Africa through the translation of high quality, high impact research findings into practice and policy. Some of the objectives from an ELSI perspective are:

- To critically evaluate existing legislation in South Africa dealing with human tissues and in particular stem cells;
- To compare stem cell legislation in South Africa to legislation in the European Union and the United States, and also in other developing nations;
- To propose legislation in areas where important gaps currently exist such as the use of autologous stem cells and the requirements relating to cells that have been manipulated *ex vivo* (including the notion of 'minimally-manipulated');

To determine the presence and magnitude of the stem cell tourism in South Africa and to assist the National Department of Health in establishing measures to halt this practice.

In order to meet these objectives, and in collaboration with the *South African Journal for Bioethics and Law*, a call was issued in late 2014 for proposals for articles for a special issue on stem cells. The ten manuscripts published in the special edition were chosen after a rigorous selection process, and represent, we believe, a relevant and balanced overview of many of the important stem cell issues facing patients, medical and legal practitioners, researchers and business.



Prof. Michael Pepper

The special edition, which has been funded by the South African Medical Research Council in terms of the SAMRC's Flagship Award Project SAMRC-RFA-UFSP-01-2013/STEM CELLS, has been divided into five subsections each with two articles. The first deals with human tissue and stem cell legislation both in South Africa and abroad. The second deals with pluripotent stem cells, which include embryonic and induced pluripotent stem cells. The third section deals with stem cell tourism and the fourth with informed consent. The fifth and final section deals with biobanks and also takes an in-depth look at the notion of benefit sharing.

In order to reduce South Africa's heavy disease burden, particularly in the context of new and innovative therapies, it is critical that the legislative environment is robust to ensure patient safety and to prevent exploitation of emotionally vulnerable individuals. However, it is also necessary to ensure that the legislation is not restrictive with regard to investment into new technologies and the emergence of start-up biotechnology and other companies.

We believe that the *SAJBL* special edition will assist legislators and other relevant entities to ensure the realisation of these objectives in a well-balanced legislative environment.



Prof. Ames Dhai

The death of a doctor's dreams

Dr Mahlane Phalane, General Secretary: SAMA Trade Union

We are noticing with a grave concern various developments that are killing our dreams as doctors. We went through medical school with great hopes, full of energy, buoyed by the love for our profession, caring beyond measure and dedicated to the course. Unfortunately a lot of negative forces are killing our dreams to build our profession, and to provide quality medical services for all.

We have noticed with great concern the recent politicisation of the medical profession; politicians insulting doctors, harsh punishment summarily being meted out against doctors, sometimes without any sound basis, deteriorating services in public healthcare, hostile environments for our private sector colleagues, and a general sense of a healthcare system in a looming crisis.

The struggle to liberate doctors belongs to us as doctors

The medical profession by its omission and/or commission has to take some responsibility; we create space for 'tenderpreneurs', the profit thirsty private sector, and some indifferent politicians or health managers to strain the healthcare system. We are eagles that behave like chickens. We always complain and criticise without any action. We are divided to the core for our selfish and egoistic characteristics. We have become so numb that we have even lost the ability to complain. We can never afford to experiment with a collapsed healthcare system, because all of us will perish. We should learn harsh lessons from West Africa with the Ebola pandemic. Is South Africa ready for the next pandemic?

There are pertinent issues the medical profession in South Africa must address earnestly and immediately:

- We should unite unconditionally and speak with one voice, despite all the imaginary factors that divide us.



Dr Mahlane Phalane

- We should swiftly reclaim our role in society and healthcare system; bring back the days when a hospital superintendent was running a healthcare system not the 'tendercare' we are subjected to today.
- We should create viable structures and systems to deal with issues and advocate for our profession and the public. Our current reactionary and fragmented approach is ineffective and inefficient. There should be nothing about healthcare that is said or done without our input.
- We should improve our training, research and the quality of services we offer to be among the best in the world. We can run out of money, resources or equipment, but we must never run out of caring for the sick, compassion for colleagues and advocacy for the medical profession. We have no excuses to perish with passion in silence.
- We should honestly and quickly realise that we are only important in our own imaginations; the world does not give

medical doctors much respect anymore. The human resource personnel can make sure you don't get paid for months, the administrators of the medical aid schemes make more money than you, and the bank does not see your potential to earn enough money to finance your dream car or home.

We have noticed with great concern the recent politicisation of the medical profession

- We should accept that we are very intelligent, hard working and essential, but we are in the main financially illiterate. We

should quickly discuss the best ways for us as individuals and as a profession to make money, spend money wisely, invest and save money. Truth be told the majority of us are one pay check away from total bankruptcy. If government or medical aid scheme delays your payment, all hell breaks loose. We can't even afford retirement. We work so hard, do many jobs, and in essence die from living just to survive.

- Everyone sucks money out of our hard work except us; private hospitals, pharmaceutical companies, administrators, healthcare funders, lawyers and everyone else under the sun.

It is unfortunate that the dreams that doctors had for so long, and worked so hard to achieve are dying an excruciatingly painful death. Medical doctors seek refuge in other areas outside medicine, their first love. The exodus of doctors from the public sector into the private sector is well known, the emigration of doctors to First World countries was understood, the exodus of doctors from the medical profession is puzzling, and it hurts even more to notice the death of many doctors' dreams of becoming the best and caring doctor.

No one can change the fortunes of medical doctors but themselves. Our apathy and failure to actively participate

in health politics and health economics is like a critically ill patient refusing hospital treatment. Our individualistic approach to work, business and money has drastically failed over the years. The poor quality of the life we lead is not sustainable. Our reliance on others to improve our lot will never yield any results, except worsening it. It starts with you and all of us. Stop trusting others to say or do something for you or your profession, and do it yourself. Let us do it as a collective.

It is time doctors treat themselves and their profession

The struggle to liberate doctors belongs to us as doctors. SAMA Trade Union is trying its best, more needs to be done. We have established structures in eight provinces except the Northern Cape. These structures will deal with problems doctors face in their provinces and workplaces. The next step is to make sure that doctors have representatives at all levels where they work. This enables us to deal with problems in a unified, orderly and protected way. If your hospital does not have a SAMA leader,

it is your responsibility to fix that. These structures will make inputs on matters affecting your profession. The matters that require your input currently are:

- Presidential Remuneration Review Commission: how should doctors be remunerated? Is the pay structure for doctors correct? Submissions should reach SAMA Trade Union head office by 10 September 2015
- What is our input on amendments to Regulations 5 and 8 of the Medical Schemes Act?
- What is our input on the RWOPS policy?
- How do we make sure doctors receive the benefits due to them; subspecialty posts, OSD translation and pay progression, danger allowance?
- How do we reclaim our professional and strategic role in running a quality healthcare system?

If we do not wake up and smell the coffee, things will get worse and it will be more difficult or impossible to change our fortunes. The increasing hostility of management and politicians will get worse. The most devastating and dangerous thing is the emergence of violence by the public on health professionals. It is time to adapt or die. It is time doctors treat themselves and their profession.

An invitation to all SAMA members

Letters to the editor

From the October issue of *SAMA Insider* we would like to feature a 'Letters to the editor' page. This new feature will 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 300 words
- Can be published anonymously, but writer details must be submitted to the editor in confidence
- Subject matter must be pertinent to healthcare delivery
- Should be submitted before the tenth of the month in order to be published in the next issue of *SAMA Insider*.

Please email contributions to Diane de Kock: dianed@hmpg.co.za



SAMA news in brief

“Rookie doctors doing surgery”

The survey which concludes that one in three South African medical interns canvassed are performing relatively minor interventional or surgical procedures without supervision is based on a small sampling and has a debatable methodology – but professional introspection is required.

This was the SAMA's response to recent reports that Health Professions Council of South Africa (HPCSA) guidelines stating that interns should be supervised by a medical practitioner with at least three years of post-internship experience were being 'frequently flouted'. Over half of the interns surveyed reported that they were regularly supervised by a medical practitioner with less than three years experience.

More than a quarter had required help from a senior but the senior had not been on the hospital premises. The study, published in the latest edition of the *South African Medical Journal* (SAMJ) argued that this lack of supervision not only potentially endangers patients but results in interns learning and repeating procedures incorrectly.

Vice-chairman of SAMA, Dr Mark Sonderup, said most of the survey's 90 responses (from doctors who had completed their internships at HPCSA-accredited hospitals between 2010 and 2013) covered fairly uncomplicated procedures taught to senior medical students. He said of the survey responses, more than two-thirds were from three Universities, possibly skewing the data while the study itself was methodologically open to critique. He explained that it would perhaps have been more helpful had the survey been broken down into responses from who had done an internship in a central versus regional hospital or an urban versus a more rural facility. While the sample was small, it nevertheless raised the important issue of a perceived lack of senior support which was “an inward-looking professional issue that SAMA must deal with”. SAMA and the Profession had an ethical duty to train the next generation of doctors correctly. Sonderup said that on the plus side, the study, (based on the UK's National General Medical Council training survey), also highlighted many positives about South Africa's internships, including their preparedness for Internship, support from medical officers, registrars and

access to academic teaching. Elaborating on why he thought the weekend newspaper article sensationalised the issue, Sonderup said: “for example as an intern I had to learn to do more highly skilled procedures such as placing a central venous line (needs a greater technical skill), dealing with new-borns, being taught to do a circumcision, caesarean sections, reducing a dislocated joint and so on. These are important skills that must be taught and learnt. If this is where it's failing then it must be addressed”. The newspaper report failed to properly distinguish between these types of procedures and lesser routine techniques.

He reassured the public that, taken as a whole, the training of doctors in South Africa remained very good. Sonderup cautioned interns that they should never feel duty-bound to tackle something they felt they could not do. “If they do – unless the clinical situation demands it – then they are being unnecessarily enthusiastic.”

While there was a serious shortage of doctors and specialists in South Africa, the issues raised by the survey were multi-factorial in nature and it would “simplistic” to solely attribute the problem to shortages of staff.

Seamless banking solutions for SAMA members

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MEMBER BENEFITS



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MEMBER BENEFITS

Sports injuries: Boxing under the spotlight

Bernard Mutsago, SAMA Health Policy Researcher



Boxing is classified as a dangerous sporting activity. Over decades, its continuation has become a subject of great debate and controversy globally. For several decades now, there has been increased attention to the harmful and sometimes deadly effects of boxing on the participants. Acute, sub-acute and chronic injuries and complications, mainly affecting the head, are experienced by participants, occasionally leading to fatalities. In particular, boxing injuries in children and adolescents have attracted great attention. Professional boxers are more prone as they participate without the protective measures (e.g. head guards) applicable in amateur boxing.

The concern is about both formal and informal boxing. There is an unchecked continuation of unsupervised boxing competitions (bareknuckle battles or 'street fights') in many parts of the world including South Africa (e.g. in Limpopo). Underground boxing puts at risk the lives and health of many athletes, especially uninformed youngsters who are lured by money.

Although there is a seeming slight decrease in the number of reported fatalities in the boxing ring globally due to the introduction of safety restrictions, a number of medical bodies, including the World

Medical Association (WMA) have called for a ban on boxing. The WMA first called for a ban on boxing in its 1983 Statement, with renewed calls made in 2000 after the Briton, Paul Ingle, suffered severe head injuries in a world title fight with South African boxer Mbulelo Botile. Calling for the abolishment of boxing, the then secretary general of the WMA in 2000, Dr Delon Human, described boxing in strong terms: "It [boxing] cannot fairly be described as a sport; it is simply a barbaric practice".

Forms of boxing

Boxing is categorised into two main forms: amateur and professional boxing. While there are similarities between the two, there are glaring differences. Critically in amateur boxing, unlike in professional boxing, rounds are fewer, protective head gear is always worn and athletes do not get paid to compete. These differences explain the different injury profiles observed for these two forms and also determine the related safety interventions possible for each form.

Boxing injury epidemiology

Data on boxing, especially the epidemiology of injuries and fatalities, is complicated by the retrospective nature of most studies and the fact that many of the data are collected on retired rather than currently participating boxers. The sample sizes are also generally small and none of the studies have followed up boxers from start of boxing career through to retirement to analyse progression of deterioration. Further, much of the available literature focuses only on head injuries and associated neurological deterioration. Currently injury or mortality data available from various boxing authorities are not sufficiently detailed and/or in an appropriate form for injury surveillance.

Like any contact sport, boxing can inflict injury on any part of the body. However, the head is the primary target in boxing and several studies document minor to serious head injuries and associated neurological complications leading to

long-term neurodegenerative diseases such as Parkinson's and Alzheimer's disease. According to a study published in the *British Journal of Sports Medicine*, the most commonly injured body region was the head/neck/face (89.8%), followed by the upper extremities (7.4%). Specifically, injuries to the eye region (45.8%) and concussion (15.9%) were the most common. However, other studies have not found neurological consequences among amateur boxers.

Short- to long-term consequences

Sustained blows to the head lead to acute and subacute neurological consequences, such as cerebral concussions ('knock outs'), headaches, tinnitus, forgetfulness, impaired hearing, dizziness, nausea, impaired gait, cognitive deficits and acute neuronal and astroglial cell lesions associated with Alzheimer's disorder. Long-term consequences include tremor, dysarthria, Parkinson's disease, ataxia spasticity, dementia, memory disorders, depression, irritability, aggression, criminality and addiction.

Boxing fatalities

Boxing fatalities are documented in various sources, including the media. The famous Manuel Velazquez fatality collection of boxing compiles broad mortality data on boxing. The majority of injuries related to boxing are due to head trauma. According to a recent article in the *South African Journal of Sports Medicine*, the cause of sudden death in the ring is either cardiac or neurological.¹ For both amateur and professional boxing, acute subdural haematoma is the most common cause of death, according to studies. In 1994 the British Medical Association made calls for the ban of boxing following the death of Bradley Stone, 23 years old, hours after a boxing fight. A blood clot was removed from his brain. In March 2015, the Australian Medical Association also called for a ban following the death of Braydon Smith, 23 years old. Ironically, sources say Smith was trying to prove that boxing is not as dangerous as thought.

Role of the ringside physician

Critical in the boxing debate is the role of the ring physician. Although the relationship between the referee and the ringside physician differs across the world, in South Africa the South African Boxing Regulations stipulate that only the referee has power to terminate a bout. Calls have been made (for example by the WMA and the Australian Medical Association, among others) for ringside physicians to be given the power to terminate a bout.

Interventions to increase safety in boxing

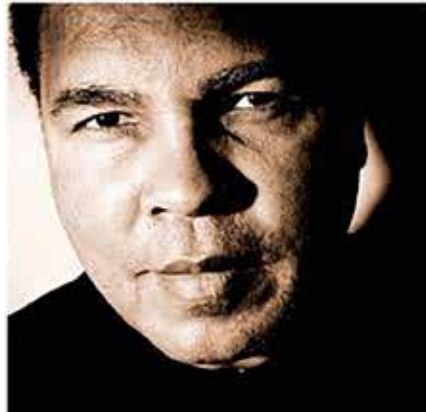
Interventions to enhance boxing safety differ from country to country. Some of the proposed safety measures include: One or more physicians available at a contest; physician must have authority to stop a bout at any time; medical advisory boards that advise boxing jurisdictions; computer-based national registry of boxers; and mandatory neuro exam, CT scan, EEG for boxers suspended after a knockout. The WMA Statement on boxing has nine recommendations that could enhance boxing safety.

For some countries, increasing boxing safety is an interim step towards completely banning the sport. The following medical associations support banning of boxing: American, British, Canadian, Irish, Danish, Finnish, Portuguese, German and Belgian. Among countries that currently ban or have banned boxing at some point in time are: Iceland, Iran, North Korea, Sweden, Albania, Cuba and Norway.

The recent wave of banning in some countries (Sweden, Norway, Albania and Cuba) appears to be based on technical adjustments to the sport and seems to be fuelled by interests not quite related to boxers' safety.

Case 1: Muhammad Ali

Born on 17 January 1942 and aged 73 in 2015, Muhammad Ali was diagnosed with Parkinson's disease (PD) in 1984 (at the age of



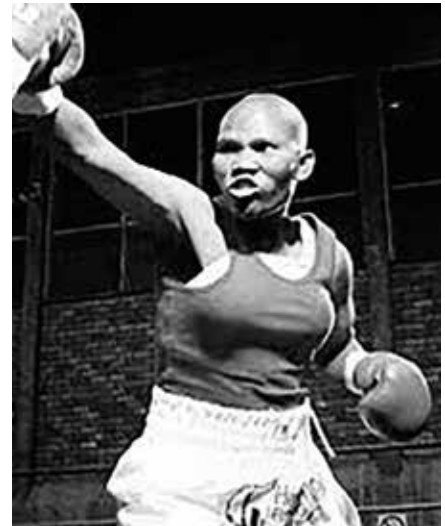
Muhammad Ali



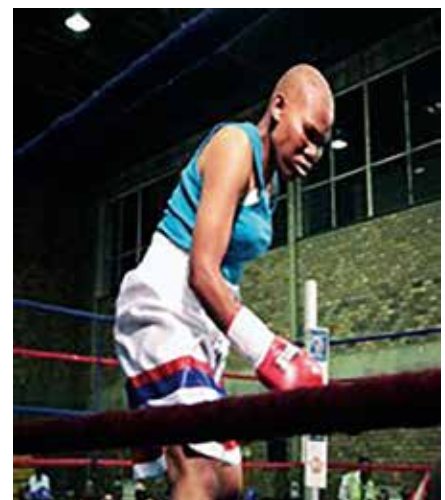
42), after a 30-year boxing career which began at the age of 12. The PD diagnosis came three years after his retirement from boxing in 1981. Today, Ali's PD is so advanced and his quality of life has significantly deteriorated. It is argued that boxing could have contributed to the PD, although his medical doctor denies this, citing, among other arguments, that George Foreman had a longer fighting career than Ali but is still in better health.

Case 2: Phindile Mwelase (South African)

Phindile Mwelase died on 25 October 2014, at the age of 31, after two weeks in a coma, following a technical knockout (TKO) from a blow to the head delivered by opponent Liz Butler during a bout in Pretoria. Ringside



Phindile Mwelase



physician Dr Solly Skosana attended to her before transferring her to Steve Biko hospital where doctors confirmed brain haemorrhage. Surgery was performed on her. A doctor at Steve Biko said a blood vessel in Mwelase's brain had burst, causing severe swelling. It was stated at that time that "Her injuries are the most serious to a woman boxer in this country". (www.timeslive.co.za)

1. Sethi N K. Boxer safety, and the relationship between the referee and the ringside physician. S Afr J Sports Med 2015;27(1)

SAMA would like to appeal to any doctors with an interest in or involved in boxing to kindly indicate so that they can form part of a SAMA collective that will take an in-depth look into this topic. If interested, please contact: Bernard Mutsago at SAMA: bernardm@samedical.org

COLD: Here we go again

Julian Botha, Strategic Accounts Manager: SAMA Private Practice Department



"The DG concluded that the current short-term interventions would seek to address three broad areas of human resources, processes and systems operations. He said as the interventions unfolded, in the medium to long term attention would be paid to addressing the recent auditor general's concerns in regard to leadership and performance management issues."

"He said the Fund would also be pursuing alternative speedy processing methods and further stakeholder engagements to initiate appropriate solutions."

Sound familiar? These remarks are drawn from a Department of Labour statement which was issued on 17 March 2013 regarding the address made by the then Director General of Labour, Nkosinathi Nhleko to a Summit of the South African Society of Occupational Medicine (SASOM) in March of that year.

The individuals involved have changed, but the promises and undertakings are almost a carbon copy of what was stated two and half years ago. Admittedly there is a new culprit named in the ongoing saga of the backlog in claims payments at the Compensation Fund, namely the new claims management system – Umuhleko. Converting to this system is being blamed for said backlogs.

Recently, the South African Medical Association (SAMA) drew a line in the sand and, at a press conference convened on 15 July 2015 made it clear that the Association would no longer tolerate the significant delays in payment for the professional services of its members. To that end, SAMA members were called upon to refer all compensation fund matters away and only to treat such cases where there is an imminent threat to "life and limb". Such emergency cases should always be dealt with by practitioners in line with the provisions of Section 27 of the Constitution.

This decision was not taken lightly and was made as the culmination of several year's frustration in dealing with the Compensation Fund. SAMA has previously and repeatedly engaged with the Compensation

Commissioners and the Fund to address this problem, but to no avail. The promises and assurances received by the Fund and the interventions that the Fund has allegedly put in place have shown no improvement and the backlog of claims now spans decades.

**On 15 July 2015
SAMA made it
clear that the
Association would
no longer tolerate
the significant
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services of its
members**

Astonishingly, the current Acting Commissioner expressed disappointment that SAMA elected to make this statement to the media before meeting with his office to address the concerns. SAMA has learned from experience that any engagement with the Fund in respect of the claims backlogs is perceived as an endorsement by SAMA of the interventions, or lack thereof, that are put in place by various officials at the Compensation Fund from time to time.

Continued engagement with the Fund and the Compensation Commissioner would appear to be an exercise in futility and, as such, SAMA is, and will continue to pursue other avenues to compel the Commissioner and the Fund to comply with their statutory obligations. Our members cannot continue to personally bear the cost of treating COLD patients particularly where there is funding available at the Fund, but seemingly perpetual maladministration prevents payment for services rendered.

"The Director General of Labour said the 'battery' of direct interventions currently underway would also include employing best practices from other organisations that have undergone the same processes like the Road Accident Fund and the Unemployment Insurance Fund. One of these interventions include engaging services of turnaround and forensic audit specialists. The potential service providers were briefed this week on the specifications of the work and the expectation is that this process would be well underway in April."

"The DG said a stakeholder input was critical to address the claims backlog and other efficiency challenges, promising to consider their input into improving CF's processes. While the service providers experienced a manner of frustrations in terms of payments, "our major frustration is the lack of protection of vulnerable workers as a result of our problems in settling claims on time. We have received reports, for example, that some doctors have refused to treat COLD cases. We understand their frustration but equally, we have a duty for the care of injured workers," he said."

"The DG said there was now a clear recognition of the extent of the problems."

An insight into the Thuthuzela Care Centres

Dr Grace Makgoka

Thuthuzela Care Centres are one-stop facilities that have been introduced as a critical part of South Africa's anti-rape strategy, aiming to reduce secondary trauma for the victim, to improve conviction rates and to reduce the cycle time for finalising cases. Patients don't have to move from one place to another to get help; they are offered the necessary services at one place with all the required resources.

The Centres operate in public hospitals in communities where the incidence of rape is particularly high and they are also linked to the Sexual Offences Courts which is a new and unique South African anti-rape intervention. As part of the strategy, the specialised Sexual Offences Courts are staffed with a committed cadre of prosecutors, social workers, investigating officers, magistrates, health professionals and police officers. The courts are located in close proximity to the Care Centres.

The Thuthuzela's integrated approach to rape care is one of respect, comfort, restoring dignity and ensuring justice for children and women who are victims of sexual violence. To receive dignified treatment; after reporting the crime, the victims are removed from the crowds at the police station to a more victim-friendly environment, then transported by ambulance to a Thuthuzela one-stop care centre at a nearby hospital.

Once at the centre, the survivors receive comfort and crisis counselling from a trained counsellor. After counselling, they are taken to a quiet, private space where they are welcomed by the site coordinator and a doctor who conducts a medical



examination. The doctor then provides the patient with information on the procedures to be performed and a consent form to be signed for medical examination and blood specimens.

After completing the medical examination, the patient is provided with follow-up dates for counselling with the psychologist and the procedure of the judicial system is explained by the site coordinator. Survivors are assisted until their cases are closed.

As a medical doctor, my role is to make sure that patients who experience sexual assault, domestic violence and those under the influence of alcohol are seen and examined. It is very important to engage with my patients

and make sure that I gain their trust as I go through the examination.

Survivors, most of the time, are very reserved and don't want to disclose information. It is therefore crucial to approach them in a calm manner and to remember that we don't want them to undergo secondary trauma. As a medical doctor I am also expected to represent the patient in court as a witness and to make sure I give valuable evidence in court.

There are a lot of success stories. Survivors often see justice being served and their perpetrators being convicted. They are able to become heroes because they have been able to overcome their fears.

I am honoured to be a part of the team that assists these ladies.

FPD celebrates reaching 300 000 students in training

FPD is proud to announce that they have trained over 300 000 students since their establishment in 1997. This milestone was reached during the Department of Planning, Monitoring and Evaluation short course, customised for the Office of the Premier based in Pretoria, Gauteng. Ms M E Mbambo attended this

course as our 300 000th student. FPD's approach with all its programmes is to combine excellent theory and personal experience. Students are able to contextualise key concepts and apply these in the workplace. FPD ensures quality of facilitating is always of the highest standard as excellence is the underlying value in all

learning and teaching programmes at FPD. The former President, Mr Nelson Mandela once said: "Education is the most powerful weapon which you can use to change the world". In 1998, the first year of training, FPD had a total of 72 students therefore reaching our 300 000th student total is a true celebration not only to us as FPD but to all our partners, donors



Ms Mbambo receiving her certificate as 300 000 student from Mrs Sunet Jordaan

and funders and most importantly our students. We are proud to be able to con-



Map representing FPD training centres

tinuously provide teaching and learning to those who need it, empowering those who want to go out and change the world.

FPD has experience in working in all provinces of South Africa as well as in 16

countries in Africa. We specialise in customised programmes to meet our clients' individual needs. We are a cause driven organisation and continuously strive to remove the barriers to education such as: geographical, cost, disruption of service delivery and access to continuous learning.

FPD's current portfolio boasts more than 150 unique training programmes through the School of Health Sciences, the Business School and the School of Education and through these schools we are able to offer formal registered qualifications, internationally certified short courses, business and clinical short courses, distance-based clinical and business short courses, distance-based education clinical courses, short courses for educators and various E-Learning courses.

We would like to thank each and every person involved in helping FPD reach this tremendous milestone.



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Looking for heroes and heroines

Do you know a doctor who has contributed significantly to healthcare in South Africa? Please help us celebrate contributions of excellence and selflessness by nominating a doctor or doctors in your area who have made remarkable contributions to their patients' lives and the profession at large.

This year SAMA's annual conference, to be held at the Sandton convention centre from 18 to 20 September, will include the Association's Annual Awards Ceremony.

One of these awards – the SAMA-Bonitas House-call Doctor's Awards – aims to single out heroes of the profession, the often neglected and unsung heroes in our midst and put them in the spotlight for some overdue recognition by their peers.

Nominations close on 4 September 2015.

Categories range from Human Rights and Health, Equity and Justice, Women and Children's Health, Community Service and distinguished service to their colleagues



through service to the SAMA (SAMA Award of the Year).

For more information contact Renzo Pretorius on renzop@samedical.org or (012) 481 2065, or Chrissie Naidoo on christianan@samedical.org or (012) 4812044.

Terms and conditions: 1. Non-SAMA members are eligible for nominations; 2. Submissions may only be made by fully paid-up SAMA members, SAMA branches or SAMA affiliated groups. 3. Submissions must be made on a formal nomination form. 4. Submissions not containing the accompanying documentation will not be considered.

THE SOUTH AFRICAN MEDICAL ASSOCIATION - KZN MIDLANDS BRANCH

44th CME ANNUAL SAMA CONFERENCE

DATE: Sunday 25th of October 2015

VENUE: Protea Imperial Hotel

TIME: 07H00-17H00

RSVP: Mandy

TEL: 033 347 0628

FAX: 086 630 5124

EMAIL: samanmb@samedical.org



Missed critical limb ischaemia

The Medical Protection Society shares a case report from their archives

Mr S was a 60-year-old lorry driver. He was overweight and smoked, and couldn't walk far because he suffered with pain in his calves. During a long drive, he became aware of pain in his right calf and foot. This became so severe that he attended a local GP in the town where he was staying overnight. The GP measured both calves and found them to be the same. A history of forefoot pain but no calf tenderness was noted and a DVT was excluded. He told Mr S he most likely had a problem with his circulation. Mr S was prescribed aspirin and advised to consult with his own GP for further follow-up.

Mr S struggled to sleep for the next two nights because he had a burning sensation in his right foot and lower leg, which felt cold and numb. He had to get up and walk around to relieve the pain. He made an appointment with his own GP, Dr A, the next day. Dr A noted the history of numbness and rest pain. He documented that his right foot was pale and felt cold. He requested a non-urgent Doppler assessment because he could not detect any pulses in his right foot and prescribed quinine sulphate.

Mr S's Doppler scan was arranged for the following week but he rang his GP surgery three days later because the pain in his foot and lower leg was becoming more severe. He had to hang his foot over the edge of the bed to get relief from it. Dr A advised him to go straight to the Emergency Department (ED).

The ED doctor sent him home despite documenting limb pain at rest and a cool, pale right foot with weak pulses. A diagnosis of arterial insufficiency rather than acute ischaemia was made. Mr S was advised to stop smoking and to attend his Doppler assessment in four days' time.

Mr S was really worried about his leg despite being reassured in the ED. He rang his GP explaining that his leg was still very painful and was becoming swollen. Dr A reassured him because he had been discharged home from the ED and advised him to come for his Doppler scan the following day.

When he attended the operator was unable to get a result due to swelling and pain but noted that his foot pulses were difficult to detect. Mr S was given an appointment with Dr A the next day to discuss the results.

Dr A discussed the Doppler results and documented that his right foot was cold. He made the diagnosis of 'worsening peripheral vascular disease' and arranged for Mr S to attend a surgeon the following day.

Mr S was admitted urgently by the surgeon with a diagnosis of an acutely ischaemic right leg. On femoral angiography, he was found to have thrombus in the distal superficial femoral artery. He had a right femoral embolectomy, which was unsuccessful and converted to a right femoral popliteal bypass. Unfortunately his leg was still not viable following this procedure and he went on to have an above knee amputation. Mr S suffered with phantom limb pain and despite undergoing rehabilitation he remained severely limited in his daily activities.

He was devastated and made a claim of negligence against his GP. It was alleged that Dr A had not appropriately acted upon his symptoms of rest pain or made the correct diagnosis of critical limb ischaemia. It was claimed that Dr A had failed to refer him for urgent surgical review and that he had wrongly asked him to wait for a week for a Doppler scan.



Expert advice

MPS sought the advice of an expert GP. She felt that Dr A had performed below the acceptable standard of GP care. She considered that there was sufficient evidence of critical ischaemia in the description of rest pain at night coupled with an alteration in colour and temperature of the foot. She said that this required urgent same-day surgical assessment.

She felt that there was no clinical indication for quinine sulphate and the decision to request a Doppler scan, which was clearly not performed with any degree of urgency, was insufficient in the light of the history and clinical findings.

The opinion of a professor in vascular surgery was also gained. He considered that Mr S's foot was obviously ischaemic when he presented to his GP. He thought that an amputation may well have been avoided if Mr S had been admitted earlier. The case was settled for a high amount against both the hospital and the GP.

Learning points

- NICE has published useful guidelines on the diagnosis and management of lower limb ischaemia.
- Critical limb ischaemia is characterised by any of: rest pain, arterial ulceration or gangrene. It has a high risk of amputation. If a patient has rest pain they need same-day surgical assessment.
- You should not be completely reassured by another doctor's assessment. In this case the GP had been reassured by the diagnosis in the ED, which was incorrect.
- Doctors should use their own clinical acumen.

WMA appeals to Israeli Prime Minister to reconsider force-feeding bill



The World Medical Association (WMA) has appealed to Israel's prime minister, Benjamin Netanyahu to reconsider government legislation before the Knesset which would explicitly allow the force-feeding of detainees on hunger strike. In a letter to the Prime Minister, the WMA president Dr Xavier Deau and chair Dr Ardi Hoven say that doctors should not be involved in any way in torture or inhumane and degrading treatments.

They add: "Force-feeding is violent, very painful and absolutely in opposition to the principle of individual autonomy. It is a degrading, inhumane treatment, amounting to torture. But worse, it can

be dangerous and is the most unsuitable approach to save lives.

"The evidence from many cases around the world that our colleagues have been working on over the past four decades, shows that the best results are obtained when the patient/physician relationship is maintained, even under the difficult circumstances of a hunger strike. This includes patient confidentiality, proper medical care and advice by the physician, but also respecting the free will of the patient. Force-feeding is completely incompatible with this and destroys any patient/physician trust"

The WMA leaders say that there are far better results in handling hunger strikes than

by force-feeding and they supported the initiatives for medical care put forward by the Israeli Medical Association. Israeli physicians had treated dozens of hunger strikers very successfully over the past two decades and were able to deal with the situation, if only they were only allowed to establish a real patient/physician relationship without threats and interference from prison authorities.

"For the sake of the people involved and the safety and reputation of your country, please reconsider this step which is already broadly criticised internationally, but worse, which will not help the problem you wish to solve."

New report on climate change and health welcomed



The World Medical Association welcomed the Lancet Commission's latest report on climate change, which it says reiterates the serious concerns of physicians that climate change poses an unacceptably high threat to health.

In particular the WMA strongly supports the report's new estimates of exposure to climate change and human health. It also welcomes the indications that climate change mitigation has the potential to substantially improve public health by reducing the burden

of disease from a variety of illnesses, provide economic savings, support sustainable development and advance global equity.

WMA President Dr Xavier Deau said: "The Lancet Commission's findings that changes in population distribution and demographic structure over the coming century will put more people in harm's way highlights the need for urgent action to cut greenhouse gas emissions to protect health.

"We, physicians, have the opportunity to help the public and decision-makers better understand

the health implications of climate change. We can explain how the rapidly emerging risks associated with climate change are connected with individual and community health and we can help develop public understanding of the full scope of the problem, and contribute to relevant and comprehensive responses.

"I would hope that governments across the world will take seriously this report's suggestions for action now and its proposal for a 'countdown 2030' process to monitor progress over the next 15 years."

SAMA Gauteng AGM 2015

The SAMA Gauteng branch held its AGM on the 13 May at the Department of Surgery in the Wits Medical School. The event was well attended by branch members and was a great opportunity to reflect on the happenings of the past year. Prof. Johnny Mahlangu, branch president for

2014 welcomed Dr Tony Saner to the council as the branch president for 2015.

The AGM is an opportunity to honour the branch's life members. These are members who have belonged to the branch for 40 years or more. The Life Members recognised were: Dr Barlin, Prof. Esser, Dr Fine, Dr Jacobs,

Dr Kalk, Dr Middlewick, Prof. Obel, Dr Pierce, Dr Porteous, Dr Shein, Dr van Schourenburg and Dr Zeilstra.

The evening concluded with a panel discussion around 'Practising medicine in the 21st Century' and the discussion was professionally chaired by Dr Tshidi Gule.



Dr Tony Saner and Prof. Johnny Mahlangu



Dr Shein, Prof. Esser, Dr van der Wat, Dr Zeilstra, Dr Barlin, Dr Kalk



Dr Tshidi Gule

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