

SAMA INSIDER

APRIL 2016

**There is no health
without mental
health**

**Obesity: Why South
Africans need to can
soft drinks**



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

**SOUTH AFRICAN
MEDICAL ASSOCIATION**

5th Annual **OUTBREAK CONTROL AND PREVENTION AFRICA CONFERENCE**

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Diane de Kock
Editor: *SAMA INSIDER*

Change is a given

One thing in life that is certain is that change happens. The necessity for change is reflected in this issue of *SAMA Insider*. On page 4 Prof. Denise White writes about the importance of mental healthcare delivery in South Africa and how our attitude to this reality needs to change: "the astonishing reality is there is little mention in the White Paper of mental healthcare design or delivery at 'district level'. This is a glaring omission..."

Change within SAMA is reflected in the article on page 5 which details how and why the SAMA Board has readjusted the collective bargaining functions of SAMA, including those of the Trade Union. Please visit the SAMA website (www.samedical.org) for ongoing information about this change.

Pravin Gordham's budget speech included the announcement of plans to introduce a tax on sugar-sweetened beverages on 1 April 2017 in a bid to "help reduce excessive sugar intake". South Africa is among the top ten countries in the world of consumers of sugar-sweetened drinks and our incidence of diabetes has doubled in the last 10 years. Change has to happen to prevent a "future with unprecedented rising healthcare costs, and deaths and disabilities from obesity-related diseases", say Prof. Karen Hofman and Aviva Tugendhaft in their article on pages 9 and 10.

The focus of the SAMA conference 2016 will be universal access to healthcare. On page 13 medical students, medical practitioners and members of SAMA are invited to submit abstracts of their scientific research to be considered for presentation at the conference.

Change is also reflected in the election of a new SARA National Executive Committee. The outgoing Chairperson, Dr Elliot Motloung, said there are new challenges facing the specialist in training in South Africa as the traditional training platforms and registration process have shifted over time.

A new pulmonary hypertension clinic at Groote Schuur hospital reflects the influence Jenna Lowe had in fighting for awareness and support for pulmonary hypertension treatment, and increasing the number of organ donors by tens of thousands with her internationally acclaimed Getmeto21 campaign. Read about this brave young woman on page 17.

Let us be the change we would like to see in South Africa.

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There is no health without mental health



Prof. Denise White, SAMA President

With the deadline for submissions on the NHI White Paper imminent it is important to reflect on aspects of mental healthcare delivery in the country.

The astonishing reality is there is little mention in the White Paper (Version 40) of mental healthcare design or delivery "at district level". This is a glaring omission in view of the fact that the progressive and ambitious *National Mental Health Policy Framework and Strategic Plan 2013-2020*, the new government blueprint for comprehensive mental health services in South Africa (SA), specifically makes provision for district-based mental healthcare services.

It is important that stakeholders in mental health ensure that the critical omission of mental health from the district health services in the White Paper is addressed with urgency

Historically the delivery of mental healthcare has been hospital based and skewed towards

urban populations, whereas community and rural mental healthcare services have been under-resourced or in many parts of the country are non-existent.

The World Health Organization (WHO) estimates that mental disorders account for approximately 13% of the global burden of disease. Of people with severe mental illness, up to 75% in low- to middle-income countries and between 35% and 50% in high-income countries do not receive appropriate treatment.

In SA data on prevalence are somewhat limited, but the situation appears to be extreme. According to the findings from the South African Stress and Health Study (SASH), an estimated one in six South Africans will have a mental disorder in a 12-month period and one in three at some point in their lifetime. The study estimated that only 28% of people with severe disorders and 24% with mild disorders receive treatment.

Acknowledging the social injustice and dehumanising lack of rural mental health services in the country, the abovementioned *National Mental Health Policy Framework and Strategic Plan 2013-2020* was formulated following the rallying cry to government for action at the Mental Health Summit held in 2012.

Through this document the government not only acknowledged the growing crisis in mental healthcare in SA, but also reaffirmed that access to mental healthcare is not a privilege but a constitutional right.

In 2014, frustrated by government's apparent lack of commitment to move on the implementation of the national policy, a group of concerned activists, the Rural Health Campaign, demanded action.

It is encouraging that the Minister endorsed the ministerial Advisory Committee (established at the 2012 Mental Health Care summit) in October 2015 to support and assist the National Department of Health in implementation of district mental health services. The national strategic plan ensures that mental healthcare is integrated into the basket of clinical services at primary healthcare level. District mental healthcare teams (comprising a psychiatrist, psychologist, occupational therapist, social worker and psychiatric nurse) will undertake training and supervision of general health workers delivering clinical services at the coalface. Stakeholders in mental health have been encouraged by the recent political will

to "walk the talk", and the roll-out of the district mental health model is already underway at certain of the NHI pilot sites. An example is the model being developed in collaboration between the national and provincial Department of Health and the PRogramme for Improving Mental health care (PRIME: www.prime.uct.ac.za) in the Dr Kenneth Kaunda District, North West Province.

Bouquets to the SAMA teams for their continuing efforts and commitment to the Association

It is important that stakeholders in mental health ensure that the critical omission of mental health from the district health services in the White Paper is addressed with urgency. And it is important that the Department of Health follows through on its policy commitment to develop district-based mental health services by ensuring that these services receive adequate funding through the NHI.

The SAMA Board held its first meeting for 2016 during February. The agenda was exhaustive with items requiring comprehensive discussion, critical analysis and bold decision-making. The striking feature was the unanimity the Board achieved in reaching resolutions on weighty and politically-charged matters.

Impressive too were the substantive reports submitted to the Board from SAMA's committees and management: evidence of the important work being done on issues relevant to a diverse membership.

Bouquets to the SAMA teams for their continuing efforts and commitment to the Association.

"Alone we can do so little, together we can do so much" Helen Keller

Herman AA, Stein DJ, Seedat S, Heeringa SG, Moomal H, Williams DR. The South African Stress and Health (SASH) study: 12 month and lifetime prevalence of common mental disorders. *South Afr Med J* 2009;99(SPt2):339-344.

SAMA resolution on the disestablishment of the Trade Union component: Clearing misconceptions

On 27 February 2016 the SAMA Board readjusted the collective bargaining functions of SAMA, including those of the Trade Union (TU). Following this decision, various misconceptions arose, leading to the perpetuation of misinformation around the issue. To address these misconceptions, and to clarify the Board's position, the Chairperson has, on behalf of the Board, issued the following statement:

The Board of Directors of SAMA has noted a variety of responses to its resolution to disestablish the TU component of SAMA, directed to SAMA National Councillors, appearing on social media, and in the press. As promised, we would like to provide additional information that we trust will place the matter in perspective and further explain the background to the resolution and its implications. This is done to avoid misinterpretation of the facts.

SAMA has been registered as a TU since 1996, an action necessitated by legislative changes in labour law following the enactment of the Constitution of South Africa. Prior to 1996, and up until February 2013, the TU function within SAMA has been performed by a SAMA membership committee, the Committee for Public Service Doctors (CPSD). In 2013 the CPSD was rebranded as a TU National Executive Committee (NEC) in an effort to enhance visibility and increase functionality for SAMA's employed members under the label of being a "trade union". The NEC remained a membership committee of the SAMA structure, subject to the rules and regulations of the company and governed under the oversight of the SAMA Board of Directors.

The expectation was that, following the formal launch of the SAMA TU in March 2013 and supported by a full-time General Secretary, structures were to be populated comprising institutional, branch, provincial and national levels. The intention was better representation of employed doctors' issues, and that the many challenges facing this category of doctor would be more effectively addressed.

Over the following 3 years, however, this vision was not effectively realised. The TU's lack of proper functioning in the interests of SAMA's employed members has become a major risk to the Association and an impediment to achieving the very objectives that it was intended to achieve.

An unintended consequence of the rebranding as a "trade union" was the creation of numerous leadership positions at provincial and national level which were considered politically strategic and which have provided politically ambitious members with platforms to engage with political and labour leadership at provincial and national levels. While it was anticipated that these platforms would be used to serve the interests of membership and advance the interests of employed doctors in general, they have in reality unfortunately become vehicles for individual members to further their own political aspirations and careers, with significant neglect and compromise of their responsibilities to SAMA members. Over a period of time, the structures have been infiltrated and ultimately dominated by individuals who have spent most of the past year:

- demanding more and more independence from SAMA, culminating in demands for a complete split from SAMA
- refusing to be subjected to the corporate governance policies, financial controls and auditing processes of SAMA
- refusing to be subjected to the management and administrative processes of SAMA
- demanding extensive resources from SAMA while demonstrating minimal, if any, benefit derived from the utilisation of such resources;
- demanding division of the assets of SAMA, these assets had to be transferred to the TU to be dealt with under the exclusive control of TU officials, notwithstanding the fact that the assets of a non-profit company do not belong to its members
- utilising the resources of SAMA intended for representation of its members' interests to engage with political and labour leadership at provincial and national levels, with little or no demonstrable positive contribution to actual membership representation
- adopting political positions on behalf of SAMA without being mandated to do so
- repeatedly misleading the Board of Directors in respect of the true position and activities of the TU, and in turn misrepresenting the position of the Board of Directors to the structures of the TU.

The TU has, within SAMA, become resistant to any form of proper governance or control

implemented and regulated by the corporate governance structures of SAMA to ensure responsibility and accountability to its members in terms of legislative prescripts.

Examples of misinformation that has been, or is currently being disseminated by some of the former TU structures, include:

- *The TU is an independent structure and is not answerable or accountable to the Board of Directors of SAMA.*

Fact: The TU is defined in the founding documents of SAMA as a membership committee which has the same standing within SAMA as the other two membership committees, namely the General Practitioners Private Practice and Specialists Private Practice Committees.

- *The TU is not represented on the Board of Directors of SAMA.*

Fact: There are positions for three TU members on the Board of Directors, as well as a standing invitation to the General Secretary to attend and participate in every meeting of the Board of Directors, the same courtesy as extended to the Head of the Private Practice Department in SAMA. Currently there are two members of the former TU NEC sitting on the Board of Directors, in addition to the General Secretary. The affiliation of Board positions is also balanced between private practice and employed doctors.

- *The TU is constantly victimised/suppressed/oppressed/undermined by the Board of Directors of SAMA.*

Fact: The Board of Directors has repeatedly expressed its commitment to support the representative activities of the TU and issued directives to various structures of SAMA to effect this. The obstruction to the implementation of intended projects and intended strategies of the TU has originated from within the TU itself, despite maximal support from the Board.

- *The TU is constantly inadequately supported by SAMA via its Head Office and branches.*

Fact: Audited reports revealed that resource allocation to the former TU structures has been disproportionately higher than that allocated to the private practice components of SAMA, relative to membership. There has been an element of cross-subsidy of TU activities by the private sector membership which was anticipated to equilibrate once the TU functionality and membership improved, whereas these have actually declined.

- *The Labour Relations Act (LRA) requires for TU structures to be "independent," hence the ongoing demands for the SAMA TU to be independent of SAMA, with further apportionment of SAMA resources to the SAMA TU.*

Fact: Section 95 (2) of the LRA defines the specified independence as "(a) it is not under the direct or indirect control of any employer or employers' organisation; and (b) it is free of any interference or influence of any kind from any employer or employers' organisation." SAMA is neither an employer of doctors nor a doctor employers' organisation and therefore the alleged "independence" requirement is unsubstantiated.

- *The TU was never given its own budget to manage, despite subscriptions being collected from employed doctors under the guise of SAMA being a union.*

Fact: The budget allocation to TU activities by SAMA has vastly exceeded the TU subscriptions collected from employed doctors. The number of employed SAMA members would not allow for a functional division if only these contributions were to be relied upon.

From a structural point of view, the burden placed on the TU by its own constitution requires properly constituted representation at every institution (workplace), branch and province, as well as in the NEC, in order for it to be regarded as properly established. This is a practical impossibility and there has never been any structure of the TU at any level, (branch structures, provincial executive committees (PECs) or the NEC) which is properly constituted in terms of its own constitution. In addition, the national and PECs have been constituted haphazardly, with little or no grassroots or institutional involvement, and with extensive appointments under unconstitutional and/or irregular circumstances. It is widely held that the processes of appointment of many TU officials has been conducted in such a manner as to provide specific individuals with the opportunity to further their personal aims with little regard for membership interests.

The achievements that SAMA has realised since the rebranding of its TU component have been largely from the activities of its industrial relations and collective bargaining units (which are permanent components of SAMA head office and function independently of the TU structures), and those SAMA branches which perform labour work directly, and which had been doing so before the launch of the envisaged TU structures. The TU NEC and PECs have minimally added to these achievements, and any such achievements have been overshadowed by the legal and reputational

risk that these structures have come to pose to a unified association.

The Board of Directors has been actively attempting to resolve these critical issues with the TU since 2014, including extensive correspondence, engagement and discussion with the former TU NEC, multiple strategic planning sessions including one specifically dedicated to resolving the dysfunction within the TU structures and a specific task team set up within the TU to resolve its own issues. Resolution was never reached. The Board resolved to maintain the functions of the TU under a committee of the Board of Directors as early as September 2015. However, some of the former TU NEC, renounced this resolution and continued to demand a split from SAMA.

Eventually, after exhaustive discussions at Board and Executive Committee levels, a detailed report was tabled outlining the legal options that the Board had to consider and the legal implications of the continued existence of a dysfunctional TU structure. After extensive discussions, members of the Board concluded that the ongoing risk to the stability of the Association was untenable, and that the Association required decisive protection from attempts to destabilise it. The resolution to disestablish the TU was then tabled, robustly discussed, and adopted at a board meeting in February 2016.

SAMA has ten registered directors and two acting directors (following the resignation of two previous directors). These acting directors are allowed full director status and entitled to vote at board meetings in terms of the Company Rules, until the next elective National Council meeting in 2017. The board meeting was quorate (all twelve directors were present) and properly constituted to proceed with business. Eleven of the directors voted in favour of the resolution, and one of the acting directors against the resolution. The resolution was therefore carried by an overwhelming majority. It is common cause that any director at a board meeting may move or second a proposed resolution and all proceedings at the board meeting, including the voting process, were conducted properly. SAMA board members were all elected in terms of the new MOI and Rules in May 2014. Their terms of service therefore started in May 2014, and all of them have served less than 3 years in their current positions.

Implications for future representation of employed doctors' issues by SAMA

The disestablishment of the TU component of SAMA is by no means intended to diminish SAMA's representation of the

interests of employed doctors in any way, manner or form, but rather to enhance this crucial function. The abolishment of positions at provincial and national level, that have provided platforms for politically-ambitious members to utilise SAMA resources for personal advancement, will allow these individuals to pursue these ambitions outside of SAMA, while allowing the work of employed doctor representation to be performed by those members who are genuinely dedicated to this cause. The responsibility of the committee established to take over these representative functions is envisaged to include all the functions of the former TU component, with the additional aims of developing grassroots representation at institutional and branch levels, develop labour/industrial relations training programmes for employed doctors, and represent employed doctor's interests on important issues such as commuted overtime, RWOPS, OSD implementation, EPMDs/performance appraisal issues, working conditions, resource and infrastructure issues.

With regard to labour legislation, SAMA remains registered with the Registrar of Labour as a TU. In this regard the necessary engagement with the Registrar of Labour forms part of the tasks of the Interim Committee appointed to evaluate and steer a process to ensure that the best interests of all SAMA members are at all times paramount.

It must also be kept in mind that SAMA has 20 branches countrywide, and that the service of either private or public members' interests are fully facilitated in rural and city areas by these branches. All branch councils are elected democratically and branch membership includes both public and private sector members, ensuring adequate representation of employed doctors on branch councils. In other words, it is envisaged that the new committee will implement the actions and interventions they had been expected to implement over the past few years.

The Board of Directors of SAMA reassures its membership, both in private practice and employed, that it is fully committed to serving the interests of all of its membership, and that the restructuring of its model of employed doctor representation will result in improved service to this important membership component.

A list of frequently asked questions (FAQs) will be published on the SAMA website for further information: www.samedical.org

Prof. Denise White inaugurated

On Friday 26 February, the newly elected President of SAMA, Prof. Denise White was inaugurated at the Centurion Lake Hotel in Pretoria.

The occasion was also a tribute to Prof. Janet Seggie who has retired as Editor-in-Chief of the *South African Medical Journal* and to Prof. Mazwai who handed over the baton to Prof. White as outgoing President.

Prof. White's career is summarised by her dedication. She graduated from the University

of Cape Town (UCT) in 1969, whereupon she worked as an intern at Groote Schuur Hospital and as a senior house officer at Red Cross War Memorial Children's Hospital. Later she worked as a medical officer in the Department of Medicine at UCT and at Victoria Hospital, after which, in 1984, she embarked on her registrarship in psychiatry and so began her service to the profession.

Prof. White worked for the Western Cape branch of SAMA. She was promoted to the

national level and then to the SAMA executive. She was Chairperson of the committee for public sector doctors and the Vice Chairperson of the organisation for 9 years and Acting Chair for a year.

Over and above all her leadership roles, Prof. White accepted her election to the prestigious position of President of the South African Medical Association for 2016.

Prof. White said that it is an honour and privilege to serve the organisation in this capacity.



Prof. Lizo Mazwai



Dr Mzukisi Grootboom



Prof. Lizo Mazwai and Prof. Denise White



Michael and Robin Pratt with Prof. Denise White



Hannah Kikaya (HMPG) and Adv. Yolande Lemmer (SAMA)



From left to right: Colette Martin (Financial Manager), Salaelo Mametja (KMRD Manager), Simonia Magardie (Marketing and Communication Manager), Tiysela Mahatlane (PA: General Manager)



Prof. Denise White and Prof. Janet Seggie

Second opinions, impeding a patient and referral of patients: Understanding the difference

Human Rights, Law and Ethics Committee, SAMA

We are often requested to assist our SAMA members with information and explanations surrounding the difference between a second opinion, impeding a patient and the referral of a patient to another practitioner.

The circumstances under which each of the above is allowed in terms of the Guidelines of the Health Professions Council of South Africa (HPCSA) and the Health Professions Act (the Act), will be discussed in more detail below.

What is the difference?

Second opinions

It has become a routine part of the medical process for many patients to get a medical diagnosis or treatment plan and then seek a second opinion.

In the USA, there are several online services which offer second opinions, many of which are supported by established medical centres such as the Johns Hopkins Institute, Massachusetts General Hospital and Cleveland Clinic to name but a few.

The Oxford Dictionary defines a medical opinion as the “advice or judgement of a doctor or group of doctors”

In the South African context this will not be a viable manner in which to provide a second opinion due to the fact that the HPCSA has brought forth guidelines based on the Act which determine that a medical practitioner must physically examine a patient before making a diagnosis and providing a proposed treatment plan.

In order to understand the meaning and reasoning behind second opinions, one must

look at the definition of an opinion in the medical context.

The *Oxford Dictionary* defines a medical opinion as the “advice or judgement of a doctor or group of doctors”.

Obtaining a specific definition for a second opinion proved quite difficult. Most dictionaries, general or medical, indicate that a second opinion is what is obtained after a medical opinion was provided, which will be reviewed by another medical practitioner or specialist.

Second opinions are defined on the base definition of what a medical opinion is.

Johns Hopkins confirmed in an online article that persons who were diagnosed with cancer would be wise to ask for a second opinion on their pathology specimen for example, this being indicative that this practice is supported and deemed in a positive light.

Impeding a patient

In terms of the Act, a practitioner shall not impede a patient, or in the case of a minor, the parent or guardian of such minor, from obtaining the opinion of another practitioner or from being treated by another practitioner.

This specifically refers to situations where a practitioner attempts to prevent a patient or relevant person holding authority in the patient's life, to seek another medical practitioner's opinion on a diagnosis or proposed treatment.

The confinement of medical opinion by a medical practitioner to the detriment of a patient goes against the principles of beneficence and non-maleficence as set out in the HPCSA Guidelines on the Core Ethical Values and Standards for Good Practice.

Referral of patients

“Refer” is defined as sending or directing someone to a medical specialist.

In this regard referral of a patient to a medical specialist by a general practitioner is standard practice in instances where specialty diagnosis, treatment and care in a specific field is required.

But we must also take into account that referral of a patient can also be done for the purpose of obtaining a second opinion on a diagnosis made or proposed treatment plan.

It is imperative that medical practitioners understand what the differences are between a second opinion, impeding a patient and referral of a patient

This is to be encouraged in light of the duties placed on medical practitioners where it relates to patient care in terms of the core ethical values as discussed supra.

Conclusion

In reminding ourselves of the duties each medical practitioner has to his/her patient, it is imperative that medical practitioners understand what the differences are between a second opinion, impeding a patient and referral of a patient.

These concepts exist alongside each other and all have the same projected outcome, namely to ensure the highest level of integrity and accountability from medical practitioners, as well as provide a platform from which medical practitioners can provide the best possible quality of care to their patients.

HPCSA. Guidelines for Good Practice in the Health Care Professions: Booklet 1 and 2 – Ethical and Professional Rules of the Health Professions Council. In: Government Gazette R717/2006.

Health Professions Act 56 of 1974. Pretoria, Government Gazette 1974. Reddy S. New Ways for Patients to Get Second Opinions. <http://www.wsj.com/articles/new-ways-to-get-a-second-opinion-1440437584> (accessed 11 January 2016).

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Oxford Dictionary. <http://www.oxforddictionaries.com/definition/english/refer> (accessed 11 January 2016).

Obesity: Why South Africans need to cut soft drinks

Aviva Tugendhaft, Deputy Director PRICELESS SA; Karen Hofman, Programme Director PRICELESS SA

In his 2016 budget speech Finance Minister Pravin Gordhan announced plans to introduce a tax on sugar-sweetened beverages. The state intends to introduce the tax on 1 April 2017 in a bid to "help reduce excessive sugar intake". The move is in line with growing action by other governments around the world, to reduce sugar consumption, which is linked to high instances of conditions such as obesity and diabetes. These non-communicable diseases (NCDs) strain the financial and human resources of healthcare systems. A research institute at the University of the Witwatersrand School of Public Health, PRICELESS SA (Priority Cost Effective Lessons for Systems Strengthening South Africa) recently reported that a 20% tax on sugary drinks could bring in an estimated R7 billion in additional revenue each year.

If South Africans don't drastically reduce the number of cold drinks, juices and sugar-sweetened beverages they drink every day, there will be more than nine million obese adults in the country by 2017.

Just three years ago, the country hit the mark of eight million obese people, making it the most obese nation on the continent and joining the likes of global heavyweights such as Mexico and the USA.

The 2017 projection, captured in our study, means there will be 1.2 million more obese adults in South Africa (SA). And more than one-quarter of these people will be obese because of the sugar-sweetened beverages they drank.

These drinks are not the only reason for the increase in obesity. But because they are high in sugar and contain no essential nutrients, they are a significant contributor. For adults, drinking just one of these beverages a day increases the likelihood of being overweight by almost 30%.

For children, this risk increases to more than 50%. Other factors that contribute to obesity and overweight are eating fast food or processed food on a regular basis and not exercising.

Across the country, sugar-sweetened beverages result in one death every hour. Lifestyle diseases related to obesity, which can result in stroke, blindness, amputations and kidney failure, not only shorten one's lifespan but also affect one's quality of life. These deaths and disabilities place a major financial strain on families and on the already overburdened healthcare system.

If preventive measures are not introduced it is highly likely that people will drink more and more sugar-sweetened drinks over the next few years.

Tackling the fat problem

The SA National Department of Health has set a target of reducing the number of people who are obese or overweight by 10% by 2020. Its strategic plan for NCDs identifies several cost-effective preventive interventions to achieve this. One of these is a tax on unhealthy products like a sugar tax. This would mean the cost of cold drinks would increase, making them less affordable.



Prof. Karen Hofman



Aviva Tugendhaft

About the authors

Prof. Karen Hofman is the Programme Director of PRICELESS SA (Priority Cost Effective Lessons for Systems Strengthening. www.priceless.ac.za) based in the Wits/MRC Agincourt Unit at the Wits School of Public Health. A medical graduate of Wits and trained as a paediatrician, Karen previously served as Director of Policy and Planning at the US NIH, Fogarty International Center and spent a decade on the faculty at the Johns Hopkins School of Medicine. She has consulted for the World Health Organization/Pan American Health Organization and is published widely in international journals.

Aviva Tugendhaft is the Deputy Director of PRICELESS SA. She is involved in all research activities by the unit and is also very active in the dissemination of the research results to the public, largely through engagement with the media and publication of short articles. Aviva has an undergraduate Bachelor of Arts with Law and Political Science and a Masters in Health Sociology from Wits University. Prior to joining PRICELESS she worked in the NGO and public sectors where she was involved in programme and policy analysis and development, specifically with regard to HIV/AIDS and community initiatives. She also worked in the private sector where she developed workplace wellness programmes. Aviva is pursuing a PhD focused on applying tools to engage the public in priority setting for health in SA.

But in addition to a sugar-sweetened beverage tax, a complete package of interventions is needed for the greatest impact on obesity reduction. Other measures include:

- food advertising regulations
- easy to understand food labelling
- worksite and school-based interventions.

The government could also subsidise healthy products. Ideally this should be accompanied by strong education campaigns about the dangers of excessive sugar consumption.

Although the national strategic plan acknowledges the need for a set of interventions including a sugar tax, specific regulations have not yet been passed. But

lessons can be learned from Mexico – one of the most obese countries on the planet.

For almost a decade, the Mexican soft drink industry spent millions blocking efforts to reduce soda consumption. But impressive public health campaigns and demands for interventions led to a National Prevention and Control Strategy in 2013 and the implementation of a soda tax in January 2014.

By 2015, soda sales had decreased by 10% and people were drinking more water.

Consumers have little choice

There is an overwhelming perception that if consumers are educated, they will make good choices. But currently food and beverage

choices are shaped by availability, affordability and most importantly relentless marketing. The food and advertising environment in SA makes it increasingly difficult to make healthy choices.

Currently, higher-income groups drink more sugar-sweetened beverages. But this is likely to change as the industry has started to target lower-income groups, who are more vulnerable.

The largest soft drink bottler in the country is clear about its intentions to aggressively grow its reach within the poorest sector of the population. The growth strategy will be driven by marketing and advertising to connect particular brands with aspirations and passions. This will place an already vulnerable population at even greater risk for obesity-related diseases, and will be exacerbated by existing poor access to quality disease screening and healthcare.

The impact on children is even worse. One study shows that although many of the leading brands in the country have committed to marketing that promotes healthy choices for children, half of the sugar-sweetened beverage billboard advertising in Soweto is deliberately close to schools with nearby vendors providing convenient access.

In both the formal and informal convenience stores, locally known as spaza shops, these products are also strategically placed to ensure the most profitable and high-sugar ones are at eye level and easily accessible.

Levelling the playing field

Consumers are persuaded to make unhealthy choices through the use of tactical marketing techniques and strategic placement and availability of unhealthy products.

The playing field needs to be levelled with interventions that nudge people to make healthier choices. In the absence of such measures, SA is headed towards a future with unprecedented rising healthcare costs, and deaths and disabilities from obesity-related diseases.

An interview with the authors

SAMA Insider chatted to Prof. Hofman and Aviva Tugendhaft about the work they do.

Please tell us more about the role you both played in motivating for the implementation of the sugar tax in 2017?

The sugar tax has been on the cards for quite a while, since the 2013 obesity and NCDs strategy. The tax has been considered for a while. Our evidence possibly motivated them as well. There has been lots of engagement on our side with the policymakers and with treasury, more specifically. We have also ensured that our research is communicated using the media. This has played a role in putting it on the agenda and getting the conversation going around the subject. What we do, as the PRICELESS team is provide evidence on where we can get value for money in health, promote health and prevent disease.

At least a dozen manuscripts were produced by the team showing evidence on how a tax could address the target put out by the government around obesity and related NCDs. For example, one of the goals of the government's strategy plan, from 2013 to 2017, is to reduce the number of overweight and obese people by 10% by 2020. We showed how a tax would contribute to that.

Why sugar-sweetened drinks?

Two reasons: This kind of intervention, a tax, is going on around the world in multiple

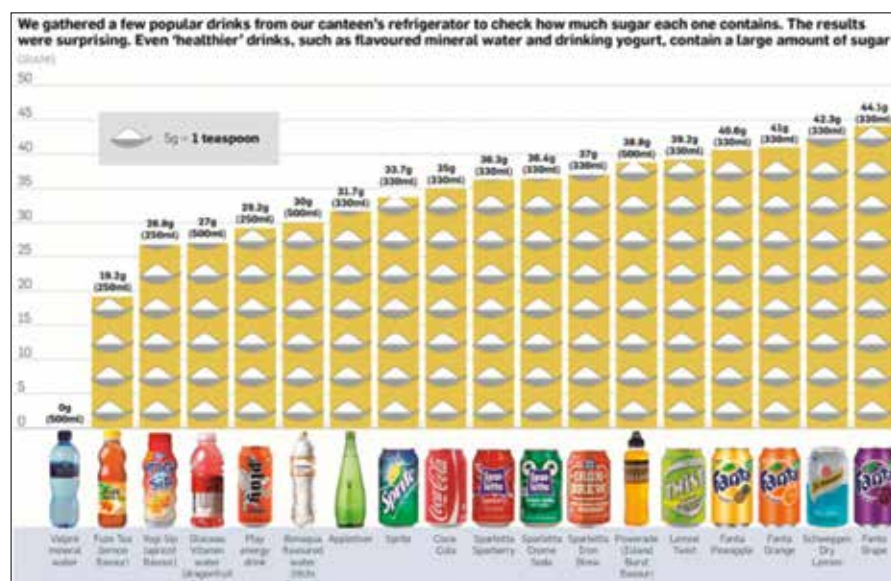
countries. And at least a dozen have instituted it. And research that was published in the *New England Journal of Medicine* in 2013 stated that 80% of people in 75 countries around the world favour regulation on sugar-sweetened beverages. Also, these drinks are high in sugar; some have up to 12 teaspoons of sugar content. SA is in the top ten countries in the world of consumers of sugar-sweetened drinks. They have no nutritional value. We do believe it needs to be part of a broader approach, for example: advertising, food labelling, etc.

Impact of obesity on healthcare costs?

This impact has been huge and also in the workplace in terms of absenteeism and lower productivity. The incidence of diabetes has doubled in the last 10 years.

What else would you like to see happen, outside of the tax?

We would like to see front of pack labelling, from coalition to guide an advocacy and education campaign, school and worksite interventions, and potentially advertising regulations. As far as doctors and hospitals are concerned it would be helpful if sugar-sweetened drinks were not sold in hospitals, and in or near healthcare clinics. Some progress has been made: for example, Woolworths have removed unhealthy snacks from their check-out counters. There should be more momentum around these independent measures.



Source: www.cartelblanche.co.za

Population v. individual strategies for prevention of non-communicable diseases

Selaelo Mametja, *Head of Knowledge Management and Research Development, SAMA*



The World Health Organization (WHO) reports that 38 million (68%) of 56 million deaths in 2012 were due to non-communicable diseases (NCDs). The four main NCDs are cardiovascular disease, cancer, diabetes and chronic lung disease. The burden of these diseases is increasing proportionately among lower-income countries. In 2008, NCDs accounted for 29% of all deaths.

Recommendations of behaviourally inappropriate change may put the individual outside the norms of society

The most common and modifiable risk factors for these NCDs are:

- tobacco
- physical inactivity
- unhealthy diets
- alcohol.

In this article I will discuss prevention strategies for NCDs.

Geoffrey Rose proposed that disease prevention, by trying to shift the entire population distribution of a risk factor, can be more efficient than focusing interventions solely on people at high risk. The distribution of health determinants and risks in a population has implications for successful prevention strategies. While a population-wide strategy for prevention targets are controlling the determinants of health in the population as a whole, an individual-based (also known as high risk) strategy for prevention identifies high-risk susceptible individuals and offers them some individual protection. The interventions are cost-effective and the benefits are population wide. The small benefit to most individuals can be outweighed by the risk of the intervention, even if this is also small. There is little motivation for low-risk individuals to change behaviour. Because population-based strategies are applied at population levels, the society starts to see this as the norm, which encourages change in behaviour within high-risk populations.

The strategy aims to reduce access through various mechanisms which could include the banning of certain substances, taxation, and restricting access.

Examples of population-based strategies in South Africa (SA) include alcohol and tobacco legislation which regulate the marketing and sales of alcohol/tobacco, age restrictions, and banned use of these products in certain areas. Recently the Minister of Finance announced a sugar tax to be implemented in 2017. Salt has also been reduced in common food stuffs.

Individual strategy is offered to those at high risk of non-communicable diseases. This individual strategy is often carried out one-on-one by medical professions. The strategy is likely to reach those most at risk, but has little impact on the disease burden in society as most cases of disease occur in people with low or

moderate risk. Most individuals at risk are likely to accept these interventions, although personal motivation is required to change behaviour. Recommendations of behaviourally inappropriate change may put the individual outside the norms of society. Individual prevention strategy is resource intensive. The costs associated with screening, care and education of high-risk individuals are usually high and only benefit individuals who had intervention.

Because population-based strategies are applied at population levels, the society starts to see this as the norm, which encourages change in behaviour within high-risk populations

The SA NCD strategic plan for prevention and control of NCDs (2013 - 2017) includes population (upstream), societal (midstream) and individualised (downstream) interventions. The year 2020 target is to reduce NCD-related mortality by 25% in under-60-year-olds, tobacco and alcohol consumption by 20%, obesity by 10% and mean salt intake to < 5mg/day/capita.

We are only 3 years away from 2020 and can only wonder what the outcome might be.

Rose G. Sick individuals and sick populations. *Int J Epidemiol.* 1985;14:32-38.

SAMA CONFERENCE, EXHIBITION & ANNUAL DOCTOR'S AWARDS

21-23 OCTOBER 2016
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Universal Access to Healthcare



For further information:
www.samedical.org/events | Registration opens 1 March 2016

SAMA Conference 2016 will focus on the universal access to healthcare

SAMA Communications Department

The 2016 SAMA Conference will be held at the Sandton Convention Centre from 21 to 23 October and will focus on the following themes:

- Integrated private care: A means of providing healthcare access
- Quadruple burden of disease: A threat to university health alliance (UHA)
- National Health Insurance (NHI): Moving from policy to practice
- Using technology to bring health to the nation.

A call for papers

All medical students, medical practitioners and members of SAMA are invited to submit abstracts of their scientific research to be considered for a poster/oral presentation at the 2016 national SAMA Conference.

Abstracts submitted will be reviewed by the Educational, Science and Technology (EST) sub-committee of SAMA for selection to present a poster or do an oral presentation at the conference. In addition, the best poster and the best oral presentation will be awarded a prize.

Abstracts using no more than 250 words should be submitted in line with the themes and sub-themes identified, and should be structured as follows:

- **Background:** Indicate the purpose and objective of the research, the hypothesis that was tested, or a description of the problem being analysed or evaluated.
- **Methods:** Describe the study period/setting/location, study design, study population, data collection, and methods of analysis used.

- **Results:** Present as clearly, and in as much detail as possible, the findings/outcome of the study. Please summarise any specific results.
- **Conclusions:** Explain the significance of your findings/outcomes of the study for prevention, treatment, care and/or support, and future implications of the results.

The following review criteria will be used:

- Is there a clear background and justified objective?
- Is the methodology/study design appropriate for the objectives?
- Are the results important and clearly presented?
- Are the conclusions supported by the results?
- Is the study original, and does it contribute to the overall theme?



Free e-learning for medical students launch

Foundation for Professional Development

Registered medical students across the country will, as of March, be eligible to receive free management training thanks to a partnership between the Foundation for Professional Development (FPD), Medical Practice Consulting (MPC), and Mr Gabriel Nel, a medical student, from the University of Pretoria. FPD is a subsidiary of the South African Medical Association (SAMA).

"This partnership is in response to an approach by a group of medical students who identified the need for leadership and management training, given that this is not covered by the medical curriculum. Since our first course in 1998, FPD has been dedicated to professionalise the healthcare sector and we are committed to developing leadership in healthcare because we believe that doctors have a unique obligation to provide leadership within the health sector" said Dr Gustaaf Wolvaardt, Managing Director of FPD.

The launch was held at the FPD Head Office on 26 February in the presence of the Chairman of SAMA, Dr Mzukisi Grootboom, Dr Gustaaf Wolvaardt, Mr Werner Swanepoel and Mr Gabriel Nel. Local medical students were invited to witness the event.

According to Dr Grootboom, this day holds great significance in the calendar of the healthcare sector because of the commitment made by SAMA and FPD to walk with medical students in their journey



Dr Gustaaf Wolvaardt and Dr Mzukisi Grootboom

to become ambassadors of their profession. He advised the students to embrace the leadership roles that come with their line of work: roles of being teachers, ministers of religion and even taking part in the struggles of the community.

Mr Nel believes that medical students can greatly influence the way the health system works in both public and private sectors. In his opinion the students need to commit and take responsibility for making a positive impact on the future of healthcare and this programme is going to assist them to have a better understanding of the leadership role that they have to play in society. His vision is to see future healthcare professionals being more involved in leadership at a macro level.

The training offered covers 15 modules, each with specific exit-level outcomes. The 15 modules are spread over four practice areas presented through business short courses. The areas covered are:

- managing an organisation
- managing others
- managing self
- managing clients.

These areas cover topics such as:

- introduction to operations management
- thriving in and surviving change
- introduction to project management
- your role as supervisor
- diversity management
- presenting yourself

- leadership that gets results
- introduction to markets and marketing.

"This partnership is in response to an approach by a group of medical students who identified the need for leadership and management training, given that this is not covered by the medical curriculum"

Others areas covered include financial planning, human resources management, and relationship management. The short courses will be offered free of charge to all MB ChB students and the intention is to expand this initiative to students in the other health professions.

Lastly Dr Gustaaf said to the students: "Go into the working environment not only to change the status but to effect change – not to break things but to make them better."



Gabriel Nel

New SARA leadership elected

South African Registrar's Association

The South African Registrar's Association (SARA) recently held its annual general meeting (AGM) in Pretoria, where a new National Executive Committee (NEC) was elected, and several awards were presented at the events gala dinner.

In his Chairperson's Report to the AGM, outgoing Chairperson Dr Elliot Motloun noted that SARA remains an active, robust arm of SAMA. He said there are new challenges facing the specialist in training in South Africa, as the traditional training

platforms and registration process has shifted over time.

"SARA has finally shaped itself to become the legitimate channel for registrars to direct their academic challenges, participate in examination credentials processes, as well as acting in an intermediary role on employer-employee-related labour relations," Dr Motloun noted.

During the AGM, delegates were treated to presentations from Dr M Lukhele from the Health Professions Council (HPCSA),

and Dr F Senkubunge, of the Colleges of Medicine.

A new NEC was elected, with Dr Emmanuel Ati and Dr Tebatso Boshomane being elected as Chairperson and Vice Chairperson respectively. A number of awards were also presented, among them the SARA Medical and Academic Excellence Awards to Dr Fusi Mosai and Dr Amisha Maraj.

The SARA Service Excellence Award was presented to Prof. Thifheli Luvhengo from the University of the Witwatersrand.



Dr Fusi Mosai receives the SARA Medical and Academic Excellence Award from Dr Thandi Mahuluhulu and Dr Elliot Motloun.



Dr Amisha Maraj receives the SARA Medical and Academic Excellence Award from Dr Tebatso Boshomane and Dr Elliot Motloun.



Dr Elliot Motloun and Dr Shailendra Sham presenting Prof. Thifheli Luvhengo from Wits University with the SARA Service Excellence Award.



Dr Sechaba Palweni (middle), receiving the SARA Most Promising Candidate Award from Outgoing SARA Chairperson Dr Elliot Motloun (left), and Dr Emmanuel Ati, New SARA Chairperson.



The new SARA National Executive Committee (NEC)

Back row: Dr T Mahuluhulu, Dr P Songo, Dr S Shinta, Dr C Viljoen, T Lengana, Dr T Lithaphang, Dr T Mahooa, Dr G Rikhotso, Dr S Selepe

Middle row: Dr L Maki (General Secretary), Dr L Ngobese (Second Vice-Chairperson, EDOPS), Dr E Ati (Chairperson), Dr T Boshomane (Vice Chairperson, Public Sector), Dr M Msingapantsi (National Co-ordinator), Dr S Phinzi (Treasurer and Marketing Officer)

Front row: Dr L Mfingwana, Ms G Moseki (National Co-ordinator), Dr MH Motloun

The 2016 MDCM book is now available

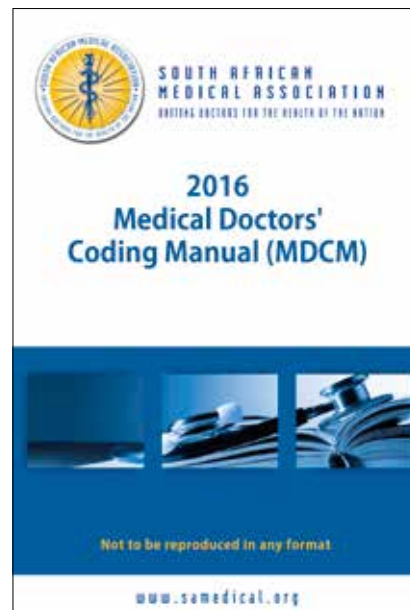
SAMA Medical Coding Department

The 2016 SAMA Medical Doctors' Coding Manual (MDCM) book, previously known as the Doctors' Billing Manual (DBM) is now available.

The 2016 version is vastly improved compared with the previous versions:

- All code-related interpretations come with the code for easier and quicker reference.
- All changes and updates dating back to 2009.
- Separate sections for the Road Accident Fund and the Compensation Fund.
- Reflecting the current scope of practice of medical doctors.

Please go to the SAMA website for more information and to place your orders: <https://www.samedical.org/products>



Prices:

SAMA members – First copy only	R570 (discounted rate)
SAMA members other than first copy/non-SAMA members	R1 506

Postal options available:

Postage cost:	R75.99 (incl. VAT)	We mail the book as a parcel with a TRACKING NUMBER; client must collect @ the Post Office. An additional R5.50 will be charged for each additional book ordered.
Courier cost:	R81.16 (incl. VAT)	Main centres (Johannesburg Central, etc.)
Courier cost:	R142.60 (incl. VAT)	Regional areas (Krugersdorp, PMB, etc.)
Outside RSA:		Cost on request

By hand collection:

Pretoria: SAMA Head Office: Block F, Castlewalk Corporate Park, Nossob Street, Erasmuskloof Ext3, Pretoria (entrance in Kuiseb Street)	R0.00
Cape Town: HMPG Offices: Suite 9 & 10, Lonsdale Building, Gardener Way, Pinelands	R0.00

2016 eMDCM (electronic version)

Please also note that one copy of the 2016 eMDCM (electronic version) is now FREELY available to every SAMA member in private practice (including limited private practice). As a SAMA member you must log on using your name and password to qualify for this FREE Licence

Please click on the following link to download the file: <https://www.samedical.org/products/buy/1>

2016 eMDCM browser price – For additional licences for SAMA members and for non-SAMA members

Number of copies/licences	Price per unit
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First licence for non-SAMA members	R899.00/licence (incl. VAT)
Second - tenth licence	R749.00/licence (incl. VAT)
Eleventh - unlimited number licences	R451.00/licence (incl. VAT)

Please direct any coding queries to our Coding Department on 012 481 2073 or email coding@samedical.org and we will gladly assist you.

Groote Schuur Pulmonary Hypertension Clinic and the Jenna Lowe Trust

Jenna Lowe Trust



One of Jenna Lowe's most fervent objectives was to do something for all the pulmonary hypertension (PH) patients in South Africa (SA) who had no access to treatment or expertise. The PH clinic at Groote Schuur was established in 2014 by Dr Greg Symons, a pulmonologist who identified the desperate need for pulmonary hypertension patients within the Western Cape to receive the right medical care and follow-up. The clinic currently has 34 patients and is under the guidance of a team of pulmonologists. The clinic is the first of its kind in SA, and is working towards becoming a much-needed centre of excellence for both state and private PH patients in SA.

In essence, pulmonary arterial hypertension (PH) is a progressive, degenerative disease caused by the narrowing or tightening of the veins and arteries in the lungs.

By definition, PH is characterised by an increase in the mean pulmonary arterial pressure and the gold standard test for this final diagnosis is an invasive, catheterised pulmonary angiogram. As PH develops, blood flow through the pulmonary arteries is restricted and the right side of the heart becomes enlarged due to the increased strain of pumping blood through the lungs. It is this strain on the heart, and decrease in blood to the left heart and systemic circulation through the lungs, that leads to the most common symptoms of PH, such as severe breathlessness, fatigue, weakness, angina and fainting.

Unfortunately, PH is often diagnosed when patients have reached an advanced stage of the disease. It is rare, and difficult to diagnose, and the most common misdiagnosis is asthma. Jenna was already World Health Organization Category III by the time she reached final diagnosis. She went through exhaustive tests

along the way from regular blood tests, lung function tests, oxygen saturation tests, CT scans, lung X-rays, ventilation perfusion (VQ) scans, MRIs, CT venogram, catheterised pulmonary angiograms, walk tests, ECGs and more.

There are still major barriers however to providing PH patients in SA with the right treatment to alleviate symptoms and slow down the progression on the disease. This is one of the main obstacles faced by doctors treating PH patients. With a lot of advocacy and education this is where we hope to change things.

The Jenna Lowe Trust is currently funding our expert "Nurse Lizzie" to work at the clinic to support their team. Nurse Lizzie is highly experienced; she worked with Jenna for nearly two years and was trained in the management of PH by the international experts Prof David Badesch and Nurse Practitioner Debra Zupancic whom we brought to SA in 2013.

We are also supporting the PH Clinic by funding much-needed mobility equipment and oxygen support equipment for state



patients who are otherwise totally immobile; we are putting in place some support groups, running training; writing, designing, printing and distributing information/care brochures for patients; working on a proper tri-phase PH registry.

For more info about the Jenna Lowe Trust and the work being done at the PH clinic please check out the Jenna Lowe website <http://jennalowe.org/>

A message from the family

In 2012 Jenna Lowe, our gorgeous, healthy daughter then aged 17, was diagnosed with an extremely rare lung disease called pulmonary arterial hypertension. This little-known, degenerative and life-threatening condition changed not just Jenna's life, but all of our lives, forever. Bright, beautiful and extraordinarily eloquent, Jenna demonstrated exceptional leadership and courage throughout her three-and-half-year battle with this debilitating illness. She helped raise much needed awareness for PH, opened up new treatment options and brought global expertise to SA. Tragically, Jenna passed away in hospital on 8 June 2015. In her short life she made a massive social impact, most notably with her internationally acclaimed and award-winning Getmeto21 campaign that significantly increased organ donor registration in SA. The Jenna Lowe Trust honours her legacy in all that it does and it supports Pulmonary Hypertension, Organ Transplantation and Rare Diseases in SA. Written by: Gabi and Stuart Lowe, Cape Town, SA.

About the Jenna Lowe Trust

Twenty-year-old Jenna Lowe influenced massive social change in SA. She fought for awareness and support of PH and increased the number of organ donors by tens of thousands with her internationally acclaimed Getmeto21 campaign.

Following Jenna's death in June 2015 the trustees decided to continue the work of the trust in order to honour Jenna's remarkable legacy.

The new objectives of the trust are as follows:

- To raise awareness for PH in SA, to encourage and facilitate earlier diagnosis, and to provide better care for patients, caregivers and patient families
- To increase public awareness around the shortage of organ donors in SA, address misconceptions and drive registration
- To create platforms that raise funds for, and donate money to, campaigns and projects that are directly related to PH and organ transplantation in SA
- To support projects and people who educate and train individuals, families and organisations in broad or specific areas of PH and organ transplantation.

The dispute resolution procedure in terms of the Labour Relations Act

Wandile Mphahlele, Legal Advisor: Labour Relations, SAMA

This is part two of a series of articles on this subject.

The Commission for Conciliation, Mediation and Arbitration (CCMA) has a duty to appoint a commissioner to arbitrate if any of the parties request the arbitration process. The request for arbitration must be made within 90 days after receiving a certificate of non-resolution, failure to do so means the party must apply for condonation. Arbitration is similar to litigation, although less formal. The Commissioner is given discretion to conduct the arbitration proceedings in a manner that s/he considers appropriate. Whatever procedure the commissioner intends to use, s/he must be able to determine the dispute fairly and quickly, deal with the substance of the matter and use legal principles. Parties may give evidence, call and question witnesses and make closing arguments. As already seen from the rule above, in arbitration proceedings, legal representation is permitted except where the dispute concerns fairness of dismissal for misconduct or incapacity. In such cases, legal representation can only be allowed where both parties consent to it or the commissioner is of the view that the matter is complex.

The provisions of Rule 25(3) (c) have already withstood a constitutional attack brought by the Law Society of the Northern Province acting on behalf of its members. The Society launched the attack on the basis that the rule infringed their constitutional right to choose their trade, occupation and profession freely, and further, that it infringed the right of a person to have any dispute, which could be resolved through application of law, resolved in a fair public hearing before a court or another independent and impartial tribunal.

The court *a quo* ruled in favour of the Law Society and found that the impugned rule was inconsistent with section 3(3) of the Promotion of Administration Justice Act. The court relied on the principle of legality. It found that the rule was not rational, taking into account that legal representation was allowed in other disputes but for misconduct and incapacity disputes.

On appeal at the Supreme Court of Appeal (SCA), the decision of the high court was overturned. In finding that the rule was constitutional, the SCA took cognisance of the historical context of the rule. In this regard, it

went further to extract the following from the explanatory memorandum:

"Legal representation is not permitted during arbitration except with the consent of the parties. Lawyers make the process legalistic and expensive. They are also often responsible for delaying the proceedings due to their unavailability and the approach they adopt. Allowing legal representation places individual employees and small businesses at a disadvantage because of the cost."

The SCA found in favour of the CCMA. Unsatisfied with the SCA judgment, the Law Society applied for leave to appeal to the Constitutional Court (CC). The CC dismissed the Application with costs.

As part of an attempt to fast track these disputes, the LRA states that on completion of the arbitration hearing, the Commissioner must issue an arbitration award with brief reasons, signed by that commissioner, within 14 days. According to the LRA, the time period for issuing of awards is not preemptory but directory.

WMA resolution on the global refugee crisis



The World Medical Association (WMA) recognises that the mass movement of people often follows disasters that flow from armed conflict or natural phenomena as populations seek to escape danger and deprivation. The current mass movement of the populations, to escape the effects of armed conflict including bombing, lack of access to utilities, clean water, and the destruction of homes, schools and hospitals, has been numerically larger than any mass movement of populations in over 70 years.

While the WMA recognises that countries may have concerns about their ability to absorb significant numbers of new migrants, we recognise that people fleeing warfare, or natural phenomena,

are doing so because they are desperate and often face life-threatening conditions. They are afraid for their health, safety and welfare, and that of the family members who accompany them.

The WMA:

- recognises that the process of becoming a refugee is damaging to physical and mental health
- commends those countries that have welcomed and cared for refugees, especially those currently fleeing Syria
- calls on other countries to improve their willingness to receive refugees and asylum seekers
- calls on national governments to ensure that refugees and asylum seekers are

enabled to live in dignity by providing access to essential services

- calls on all governments to work together to seek to end local, regional, and international conflicts, and to protect the health, safety and welfare of populations
- calls on all governments to cooperate in providing immediate help to countries facing the effects of natural phenomena, remembering that those already the most socio-economically disadvantaged will face the most challenges
- calls upon global media to report on the refugee crisis in a manner that respects the dignity of refugees and displaced persons, and to avoid bigotry and racial or other bias in reporting.

Crying wolf

Medical Protection Society

Mrs Z was a 34-year-old mother of four who smoked 20 cigarettes a day. She had recently been under investigation for central chest pain related to minimal exertion. Her general practitioner, Dr B, had arranged an ECG, which had been normal, and done some blood tests, which showed raised cholesterol. He had also found her to be hypertensive. He had made no firm diagnosis regarding her central chest pain but was considering a referral to cardiology.

Mrs Z developed what she thought was indigestion, which was also causing aching in both her arms. When she started feeling unwell with it she rang the emergency unit complaining that in addition to the indigestion she also felt hot and sweaty. Mrs Z was very well-known to the emergency unit staff because she used the service very regularly for herself and her children. The triage nurses advised her to take some antacid or milk for the indigestion. The nurse had failed to get a past history for Mrs Z's cardiac symptoms.

Mrs Z waited for an hour after drinking some milk but felt worse. She was still feeling sweaty and hot with the chest pain and rang the emergency unit again to explain this. She asked to speak to the doctor but the triage nurses remarked that "the doctor would not be able to do much more for that kind of problem".

That evening she became really concerned after several hours of pain were showing no signs of remitting. She had managed to get all her children to bed but was feeling like something awful was going to happen. She rang the emergency unit again but was given the same advice by the triage nurses.

It is important to listen to patients who make recurrent calls regarding the same problem

Unfortunately during the late hours of the evening, Mrs Z collapsed at home. One of her



children called an ambulance but attempts by the paramedics to resuscitate her were unsuccessful. She was pronounced dead. The postmortem confirmed that the cause of death was an acute myocardial infarction.

Mrs Z's relatives made a claim against the triage nurses and the emergency unit doctors that night. The doctors denied having any knowledge about her. There were long discussions about the standards of training and support for the triage nurses and the levels of general practitioner cover. The case was settled for a high amount.

Learning points

- It is important to listen to patients who make recurrent calls regarding the same problem. Mrs Z had contacted the emergency unit and the general practitioner surgery on multiple occasions. Doctors must not let an element of "crying wolf" blind their judgment.
- There are risks associated with telephone triage and consultations whereby information is not being passed on to the medical team. It is harder to make a diagnosis without the visual information from a patient's appearance, behaviour and non-verbal cues so great care must be taken.

- Written protocols should exist for the management of chest pain with clear guidance about when to pass on information to doctors. Although protocols often lack the "intuition" of experience, it would have been helpful if one had been adhered to in Mrs Z's case.

Ischaemic heart disease is rare in younger women, but not impossible, particularly when associated with risk factors

- Ischaemic heart disease is rare in younger women, but not impossible, particularly when associated with risk factors. It is important to consider this diagnosis in the differential even if it is uncommon.

<http://www.medicalprotection.org/southafrica/casebook-and-resources/case-reports/case-reports/sa-crying-wolf>

Gauteng North hold dermatology workshop

SAMA Gauteng North Branch in collaboration with sponsors Adcock Ingram held a dermatology workshop at Kievietskroon Country Estate, north of Pretoria on 5 March.

The event was in the form of a round table discussion, with discussions in smaller groups after each session. Questionnaires were handed out for doctors to complete and send through at their leisure to gather extra CPD points.

Subject matter included the following:

- Speaker: Dr K De Beer – Diagnosing psoriasis, fungus and eczema
- Speaker: Dr N Ramlachan – Acne
- Speaker: Dr U Naidoo – Bacterial skin infections.

It was well attended by approximately 70 doctors who left each session informed and motivated enough to discuss the topics with each other and share experiences.

Great big thank you has to be extended to our sponsors Adcock Ingram who supplied the doctors with starter packs, information booklets, stationery packs and

the like. Their Marketing and Brand Manager joined the rest of their Dermatology representative team in ensuring that the event ran smoothly. SAMA thanks Alexander

Beukes and Herman Louw together with Judy Mills from the Gauteng North Branch for all their hard working in making this such a successful occasion.



Dermatology workshop. From left to right from Adcock Ingram: Alexander Beukes, Peter Henning, Salma Rajah, Lauren Meijit, Annelize Dobelle, Izanda Fleet, Abdoel Mohamed, Herman Louw



Speakers Dr N Ramalathan and Dr N Naidoo



Discussions after each session



Branch council members attended: Dr L Shange and Dr J Kunzmann





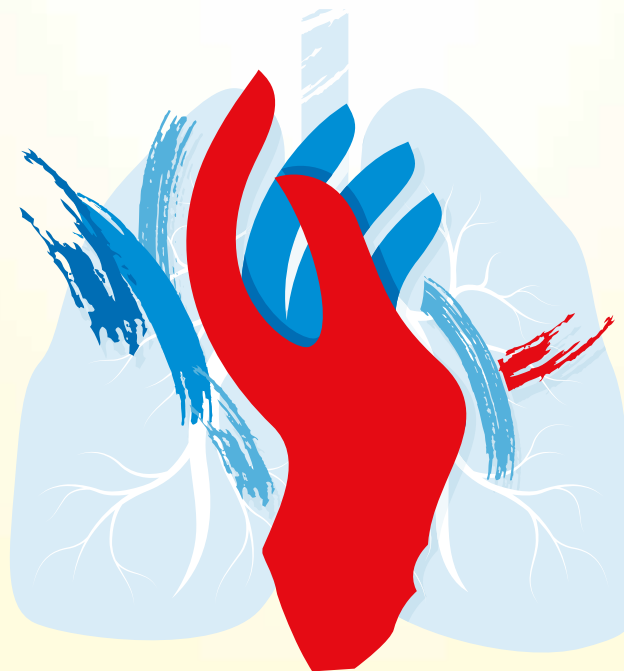
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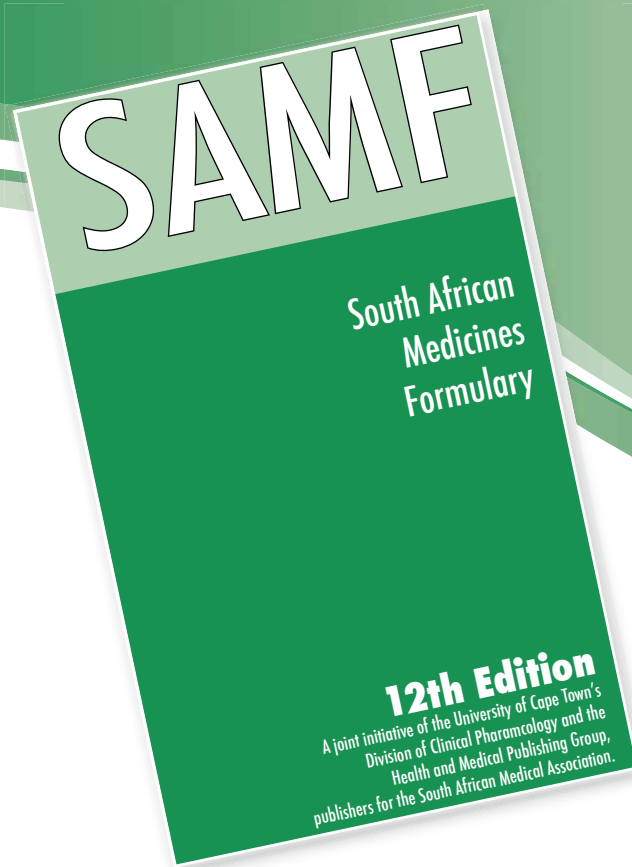
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