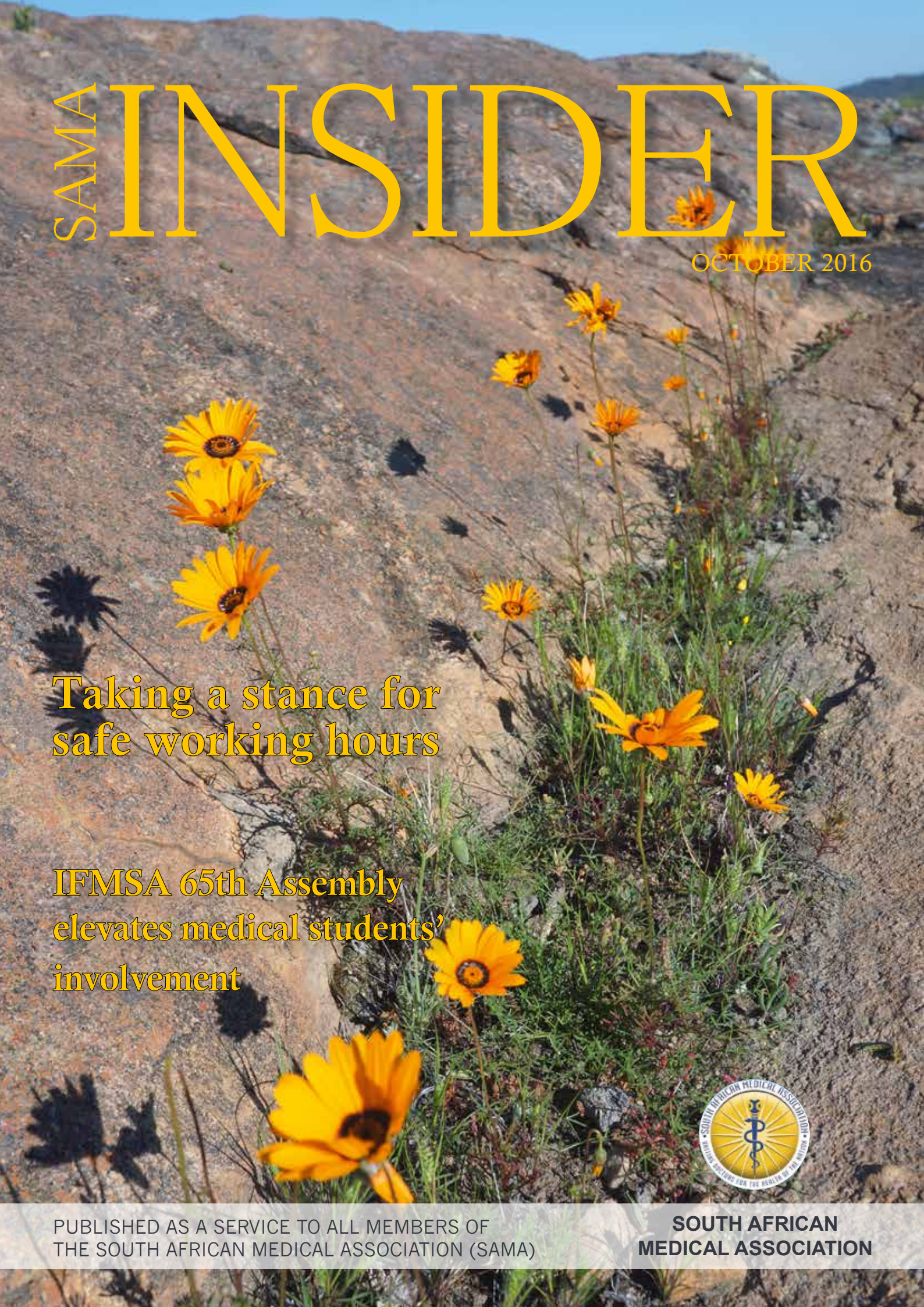


SAMA INSIDER

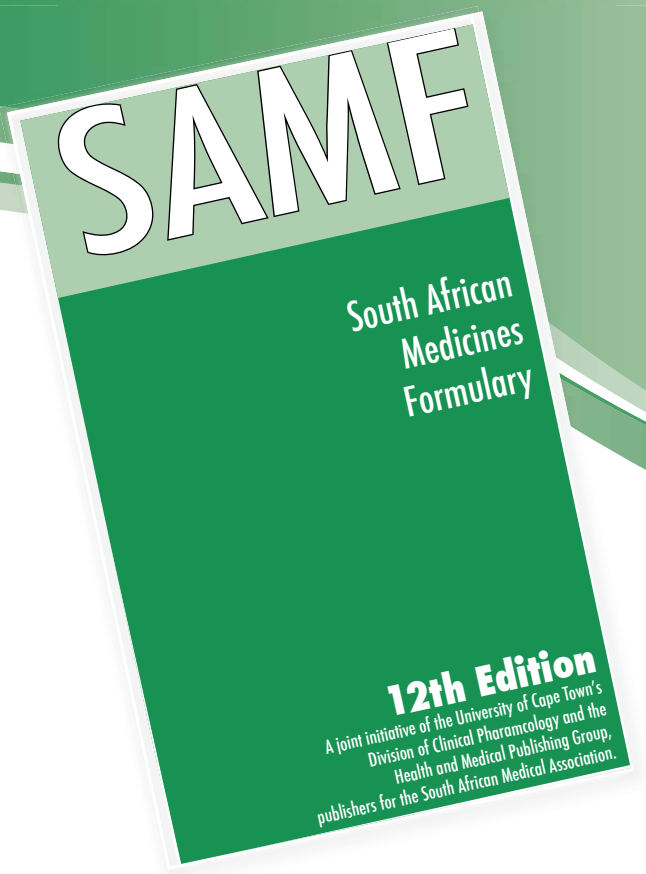
OCTOBER 2016

Taking a stance for safe working hours

IFMSA 65th Assembly elevates medical students' involvement

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

SOUTH AFRICAN
MEDICAL ASSOCIATION



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EDITOR'S NOTE

OCTOBER 2016

Diane de Kock
Editor: *SAMA INSIDER*

Strength in numbers

On our own we have limited power but in numbers we draw emotional and moral strength as a group. "There is always strength in numbers. The more individuals and organisations that you rally to your cause, the better." Mark Shields (American political columnist and commentator)

This approach is clearly illustrated by the article on page 5, detailing SAMA's official response to the NHI White Paper, which has been submitted to government. JUDASA's national secretary general, Dr Michael van Niekerk, gives us some background on page 7 about how doctors around the country are taking hands and standing up with a united voice. SAMA and JUDASA are leading the campaign calling for safe working hours and intend to launch an armband campaign (green, orange and red reflecting time periods worked) in the near future, which will "highlight the call and aims to educate the public on the effects," says Dr van Niekerk.

On page 8, an article about the International Federation of Medical Students' Associations (IFMSA) meeting in Mexico, attended by three University of Pretoria students, reinforces the power of strength in numbers: "IFMSA's greatest strength is that it consolidates the world's health issues, allowing delegates from various countries to scrutinise and learn from each other in health matters," writes Wilmé Steyn, one of the students who attended the Assembly.

Being able to award medical students bursaries and supplementary scholarships this year (page 11) is, to a large extent, thanks to SAMA members: "Without them we would have struggled immensely," says Karlien Pienaar.

The KZN Specialist Network is another organisation that has recognised the wisdom of strength in numbers. Representing the interests of approximately 300 private medical specialists, including surgeons, pulmonologists, paediatricians, anaesthesiologists and radiologists in KwaZulu-Natal, they are committed to helping patients and dedicated to finding innovative solutions to better healthcare in SA. Read more about them on page 16.

We look forward to hearing more from our readers about the value of strength in numbers in future issues.

Letters to the editor (dianed@hmpg.co.za), on any subject, are always welcome.

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Physician, heal thyself?

Prof. Denise White, *SAMA President*

Attending numerous meetings and gatherings over the past year as SAMA's president has provided a unique opportunity to witness the enthusiasm, competence and commitment of both the organisation's leadership and its operational staff in managing the serious issues confronting our profession. SAMA is a resilient and experienced professional organisation that I am confident will endure, despite being under constant siege by numerous uncertainties and challenges.

That said, how resilient are we as individuals in withstanding and coping at a personal level with the unavoidable conflicts and difficulties of daily living?

It is well known that under sufficient stress the risk of burnout in physicians (or more serious physical or mental consequences) is a reality.

Studies indicate that the rate of burnout in physicians in the developed world is 25% to 60%

Judging by the increasing number of referrals to the health committee of the HPCSA in recent years, it would appear that the most vulnerable constituency for impairment is our junior doctors – the interns and community service doctors.

Burnout is usually identified by three major symptoms: emotional exhaustion with loss of enthusiasm for work, feelings of cynicism and detachment – sometimes dubbed "compassion fatigue", and a low sense of personal accomplishment and effectiveness. The syndrome is insidious in onset and can eventually result in an inability to function at a social and professional level. Physicians who are affected by work stress and burnout might go on to experience substance abuse, depression, relationship problems or physical illness.

With the responsibility of caring for the lives and welfare of others, it is not uncommon for doctors to become compulsively self-reliant, neglectful of their own wellness and averse to seeking help from others.

Many scholarly articles have been written about physician burnout over the past 2 decades. These studies indicate that the rate of burnout in physicians in the developed world is 25% to 60%. Wellness is complex and multifaceted – individual, professional and organisational factors might affect a physician's health.

To understand the meaning of burnout it is necessary to acknowledge the context. In the developing world doctors live and work in a technocentric, dehumanised and financially driven environment. Academic health-centre workers face institutional stress caused by financial constraints and the restructuring of healthcare with increasing numbers of patients and the growing burden of disease.

In the developing world the context is under-resourcing, shortage of healthcare workers and weak healthcare systems.

Many factors contribute to doctor distress in our society: long working hours, often under trying circumstances, uncaring bureaucracies and limited resources. Those working in the private sector are dealing with severe financial constraints: spiralling practice costs, inequalities in medical scheme funding and exorbitant medicolegal fees.

Furthermore, exposure to the bewildering scenario of serious politico-socioeconomic insecurities in the country does not engender feelings of optimism and wellbeing.

There are no quick fixes for the suffering of physicians, just as there are no quick fixes for the suffering of patients. It has been suggested that to help recover meaning and prevent burnout in vulnerable physicians, there needs to be respect, and opportunities should be created for them to express their feelings. Psychotherapeutic intervention may be necessary. But it is also important for institutions to provide scope and space for dialogue that allow for renewal, self-care, support and improved working conditions.

Doctors live and work in a technocentric, dehumanised and financially driven environment

A 2014 Cochrane review reported that cognitive-behavioural training and mental and physical relaxation reduced stress in healthcare workers more than no intervention, although not more than alternative interventions, including massage, meditation, and organisational interventions (notably, changing work schedules). According to a number of studies, the practice of mindfulness appears to be a helpful approach towards reducing burnout.

The ability to control hours of work and schedule has been shown to be effective in alleviating stress, enhancing career satisfaction and therefore minimising burnout. In one study, physicians reported that learning to set limits improved their sense of wellbeing and productivity and enabled them to balance and prioritise personal and professional life.

Self-care should be seen not as an option for physicians, but as an obligation. The obligation to care for patients necessitates care for the self, for when the health of the physician is compromised, so also is the quality of patient care.

An official response on the NHI White Paper

SAMA Communications Department

This is the third of a series of articles on SAMA's submission to the minister of health in respect of the White Paper for NHI.

SAMA, in compiling an official response on the NHI White Paper, consulted members in their various categories. In addition to a member survey that was undertaken in December 2015, the various structures of SAMA were consulted on a continual basis. The following is a brief summary of the fourth and fifth chapters of the submission:

Chapter 4: NHI piloting and PHC re-engineering

This chapter recapitulates the NHI pilot programme and its achievement to date, informed by the White Paper and Government's series of 12-month progress reports. Progressive achievements of the pilot exercise are acknowledged, such as the successful human papillomavirus school programme and the good pace of establishing District Clinical Specialist Teams.

Can we truly say NHI will assist in achieving a life expectancy of 70 years, improve access to healthcare, and turn back the potential diabetes tsunami?

The reports, covering pilot districts and some non-pilot districts, as well as wider developmental projects aligned to NHI, show that primary facilities scored more poorly than hospitals when assessed for infrastructural development/status. In this section SAMA provides a case for inclusion of the private sector in the delivery of healthcare.

SAMA raises three critical issues in relation to the NHI piloting exercise:

1. On what grounds are certain claims of "improvement" (as stated in the White Paper and reports) due to NHI-related initiatives in pilot districts based? For such claims to be valid there should have been an identified baseline health status of the population against which to measure any achievements. To SAMA's knowledge, no such baseline was established, nor was any such made publicly available. Can we truly say NHI will assist in achieving a life expectancy of 70 years, improve access to healthcare, and turn back the potential diabetes tsunami?
2. Engagement of doctors for NHI has been anomalous. **Contracting in** of GPs was refuted by doctors when the model was presented a few years back, but it went ahead irrespective of doctor response, hence the sluggish pace of contracting under that model. Only a few doctors signed the contract. **Contracting out**, which is another option of choice, has not been piloted. We recommend that this model be piloted. Also, there is paucity of information on GP involvement. GPs are not part of the district health services despite ability to contribute significantly. Government must tap into this resource to broaden access to a doctor for many South Africans.
3. Section 335 of the NHI White Paper proposes that the NHI Fund, in consultation with the minister, will determine its own pricing and reimbursement mechanisms. This presents as unfair, unconstitutional and dictatorial. Lack of consultation will place the Government or its entity at risk of legal challenge. Determination of capitation fees and timeliness of payments must be scientific and reasonable enough not to affect provider morale and the care delivery process.

Chapter 5: NHI financing

Chapter 5 analyses cost projections for NHI, in response to chapter 5 of the NHI White Paper, and identifies potential problems and possible solutions. Specific attention is also devoted to current inefficiencies in the health system. SAMA appreciates the rationale for universal health coverage, which is a vital need for South Africans. However, for such an enormous undertaking to be successful, it would require an additional investment into the national health budget. SAMA laments the preponderance of groundless financial/economic assumptions and claims in the White Paper. Also, the recent assertion by the health minister in line with the NHI White Paper – that "NHI costing is impossible" and should not be an object of attention – is troubling, as effective NHI policy planning cannot be devoid of proper costing.

SAMA laments the preponderance of groundless financial/economic assumptions and claims in the White Paper

The WHO has a variety of costing tools applicable in different country settings, which SAMA urges the government to consider. If government positions itself as the **single buyer** for NHI services as per the White Paper, at what cost levels does it intend to procure the goods and services? SAMA raises the following key concerns:

Need for definition of package of care: SAMA emphasises that the package of care needs to be defined first before embarking on a costing exercise. The discussion on cost can only take place once a determination on what will be capitated is made, and where we are going to be contracting on global fees, as well as remuneration models to be used. What would be most workable is to paint and model various scenarios and then have them costed. Projections should then be based on the preferred model.

Proper cost estimates for NHI: Our assessment is that the costing information provided in the White Paper is based on unrealistic assumptions. In the face of SA's current economic growth rate of less than 1%, the White Paper's assumption of a 3.5% annual growth rate is overly ambitious, and higher than real-term projections by several reputable international institutions, including

National Treasury, the International Monetary Fund (IMF), the World Bank, Investec and *The Economist*, among others. Since economic growth is a determinant of the tax base, proper estimations are urged.

We also underscore that the reluctance on proper costing by Government is the root of problems in the health sector, such as interrupted supply of medical supplies, salaries and budget allocations that lag behind population growth rates, including migrant populations.

A number of provincial health departments have been placed under administration due to poor financial management practices, among other reasons. Additionally, to obtain some form of financing through National Treasury, the minister will have to table financial estimates, which we believe should be informed by appropriate and scientific costing methodologies.

Proper, objective and scientific costing, based on a defined package, must be done, with the use of experts in addition to economists, such as epidemiologists, to properly estimate the burden of diseases. Adequate costing for anticipated services and essential medication for chronic patients in particular is emphasised, since chronic patients are among those that bear the brunt in the event of erratic service availability due to inadequate funding. Comprehensive costing of the agreed package based on an "ideal clinic" environment must be done.

Inefficiencies in the system: Using current costs as the basis for projections, as proposed in the White Paper, is a problem when inefficiency is considered. The WHO warns against "locking today's inefficiencies into future estimates". This warning is applicable in the SA health system which is riddled with substantial inefficiencies, in the public sector specifically. For example, unauthorised, irregular and fruitless expenditure for 2014/15 was about 4% of the entire national health budget. At the time of producing this report, the Auditor General reports for the PFMA 2014/2015 for the Free State and KwaZulu-Natal provinces, have not yet been made available publicly.

Tapping into medical scheme reserves: Currently medical scheme reserves are estimated to be R46 billion. The question is: suppose there is going be natural attrition from medical scheme cover towards NHI services, which is most likely, contingent upon competitive quality in the NHI system, what happens to those scheme members' contributions already made towards reserves of a medical scheme? In planning the future role of medical schemes the Ministry is encouraged to look at the disbursement of these funds in a way that would have maximal impact on citizens.

Comprehensive piloting: In order to attain estimates with a higher reliability factor, SAMA proposes that the number of NHI pilot sites be increased to 20 (approximately 40% of the number of districts in SA). The NHI sites should be selected in such a manner that results in clustering, i.e. that NHI sites are adjacent to each other. This should be done in order to include referral facilities up to and including tertiary facilities, so that referral patterns are piloted, and also so that the complete suite of NHI factors is piloted. Further, we propose that the newly established pilot districts be operational for at least 5 years in order to ensure that trends in costs and utilisation can be measured.

The full submission is available on the SAMA website: https://www.samedical.org/links/nhi-exec-summary
https://www.samedical.org/links/nhi-white-paper

Physician and nursing leaders condemn Syrian attacks on health personnel

World Medical Association

The leaders of the world's physicians and nursing associations have condemned the continuing violence against health personnel in Syria and other nations.

In a joint statement issued on 17 August 2016, the WMA and the International Council of Nurses (ICN) said that the persistent and targeted attacks on doctors, nurses, emergency medical personnel and other health workers in Syria have reached unprecedented levels that should alarm the world. The two organisations confirmed their support of the UN resolution (2268), which calls for a cessation of hostilities in Syria, and a respect for ceasefires of sufficient periods for the provision of humanitarian aid. They stated that: "We in the international health community have an obligation to speak out to urge world leaders to enforce an immediate truce to protect the hundreds of thousands of innocent victims caught up in this carnage."

"Respect for health services is one of the core values of international humanitarian law and the human right to health"

Dr Ardis Hoven, chair of the WMA, said: "The daily reports of violent incidents against healthcare personnel, medical infrastructure and the wounded are sickening the world community. The killing of nurses and doctors has become appalling. The shocking truth is that doctors and nurses are being specifically targeted in this armed conflict in a way that is almost beyond belief."

Dr Frances Hughes, ICN's chief executive officer, said: "Respect for health services is one of the core values of international humanitarian law and the human right to health. The attacks on nurses, doctors and healthcare facilities in Syria and other nations in conflict must urgently stop, so they can continue to provide the care needed by their populations."

ICN and WMA have long-standing positions condemning attacks on healthcare workers. Both organisations support the ICRC Health Care in Danger project, and ICN is also a member of the Safeguarding Health in Conflict Coalition.

Taking a stance for safe working hours

Dr Michael van Niekerk, *National Secretary General of the Junior Doctors Association of South Africa*

A doctor pricking herself with an HIV-positive needle after 28 hours on call, with the same happening to seven other doctors in one week. One fatigued junior doctor writing the wrong patient's details on a blood transfusion form, almost resulting in a possibly lethal blood transfusion reaction. Another doctor falling asleep at the wheel of his car a mere 2 km from home, barely alive to tell the story, and then a few months later Dr Ilne Markwat falling asleep while driving, leading to the loss of her life and that of another woman.

These are accounts of doctors from around the country that have come to light over the past few months during the campaign for safe working hours for doctors. "Why only now?" is a question that was asked on a radio interview addressing the recent increase in awareness of the inhumane hours junior doctors are expected to work. The fact of the matter is that doctors working for more than 30 continuous hours in hospitals around the country and the world is not a new phenomenon. It is a vicious circle which has been in existence for a very long time. Discussions with senior colleagues in the profession would easily yield recollections of nearly fatal car accidents, exhausted doctors, medical errors and occupational injuries.

Concerns regarding this unsafe practice have been raised on various platforms through the years. A petition calling for the re-evaluation of the number of continuous shift hours started before the death of Dr Markwat. Unfortunately, and tragically so, it had to come to the death of a junior doctor to spark an inevitable dynamic campaign and call for **change**.

Doctors around the country are taking hands and standing up with a united voice, saying "Enough is enough".

SAMA, together with its junior doctors (JUDASA), is leading the campaign for the call for safe working hours. Patients are suffering at the hands of a system forcing junior doctors to make critical decisions and take important actions when they are exhausted, with too little support to do so. Every junior doctor graduating from medical school aspires to be the best he or she can be, to promote life, to prevent harm. In a system where doctors are pushed beyond the limit of sheer exhaustion these ideals start to fade.

The problem is not one that only faces junior doctors (interns and community service doctors), as fatigue and exhaustion do not somehow diminish once you become a registrar or consultant. Therefore the call for shorter hours is for all doctors. The problem has multiple roots and components, but two key areas that need to be addressed are the structuring of calls, including the maximum number of continuous hours, and the number of employed doctors.

Doctors around the country are taking hands and standing up with a united voice, saying "Enough is enough"

Evidence clearly shows that impaired cognitive functioning, medical errors and occupational injuries increase after 16 hours of work, yet the cap for continuous shifts is currently at almost double that. The quadruple burden of disease and exponential increase in the patient population has led to a severe shortage of doctors. Clearly, the number of employed doctors needs to increase to buffer these effects. Medical schools are increasing the intake of medical students and there is an influx of Cuban-trained doctors, but as yet the number of posts is not matching the increase.

An issue of extreme concern is that there are currently not enough posts for the number of graduates leaving medical school at the end of this year. Decisive action is necessary to ensure that posts are available to accommodate more doctors to address the increase in patient load and output of medical doctors.

Intermediately, decisions to cap the maximum number of hours to 24 hours by the Western Cape Department of Health, and the HPCSA and National Department of Health alluding to doing the same in other provinces, certainly is a leap in the right direction as change has long been overdue. Something to understand from the point of view of junior doctors is that the call is not to work less – it is to work smarter. It is not necessary to do a 32-hour call when you can do two 16-hour calls and still function optimally.

The SAMA armband campaign being launched shortly highlights the call for safe working hours and aims to educate the public on the effects of doctors on call for such inhumane hours. The visibility of green, orange and red armbands will increase the public's awareness, but also that of senior colleagues, of the state of fatigue of a doctor who is expected to make critical decisions and provide adequate healthcare to a large patient population.

Change is needed, and SAMA, together with JUDASA, will not stop until that change is here.

Elevating medical students' involvement, IFMSA 65th Assembly

Wilmé Steyn, *medical student, University of Pretoria*

The introduction to the International Federation of Medical Students' Associations (IFMSA)'s general assembly August meeting reads as follows on its website: "In Mexico, hair gets lighter, skin gets darker, water gets warmer, music gets louder, nights get longer, work gets funnier and life gets better". On our return from this incredible opportunity, it was clear that nothing is truer.

The 65th Assembly was held from 1 - 7 August in Puebla, Mexico, and was attended by approximately 1 000 medical students from all over the world, including three students from the University of Pretoria: Len Duvenhage, Willem Landman and me.

The assembly incorporated the theme "Global vaccine action" and what an important topic it is. The footprints of this initiative are visible in achievements that have led to the eradication of diseases such as smallpox, a 99% decrease in the incidence of poliomyelitis and an overall prevention of 2.5 million deaths per year. At this stage, 25 diseases are vaccine preventable because of global advancement in this field.

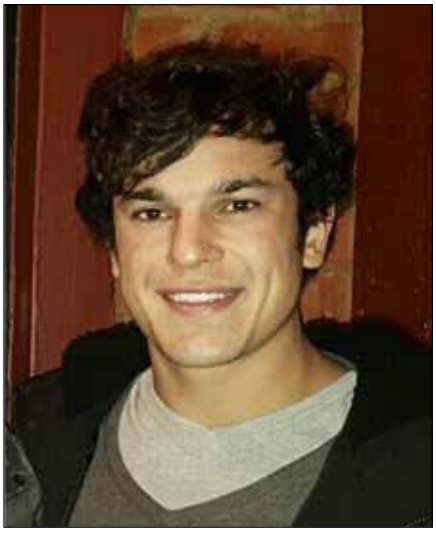
During this phenomenal event, three sessions were covered under the umbrella theme and were compulsory to all delegates. The sessions were in the form of round-table discussions with renowned doctors, covering three different aspects involved with vaccination. The first session was presented by Dr Rafael Lozano Ascencio (Instituto Nacional de Salud Pública (INSP), Mexico) and Dr Eduardo Missoni (Bocconi University, Italy) and addressed the issue of inequality and coverage associated with vaccines.

One of the core discussions was the movement of global surgery which is described as an effort to improve the quality and access of surgical care around the world

The second session was presented by Dr Jesus Ramon Valdez Castro (Rotary) and Dr Jose Ignacio Santos Preciado (National Autonomous University of Mexico (UNAM)) and addressed the eradication of poliomyelitis and other diseases. The third and final session was presented by Dr Lawrence Loh (Canadian Health Ministry) and Eng Lilia Cenobia Ramirez, a writer, and focused on the cultural and social acceptance of vaccinations. Each session was extremely informative and definitely left each of the delegates more aware and knowledgeable on the topic of vaccinations.

Breaking from the umbrella session, Len attended the Standing Committee on Medical Education (SCOME) sessions, Willem attended the Standing Committee on Public Health (SCOPH) sessions and I attended the Standing Committee on Professional Exchange (SCOPE) sessions. These sessions commenced with fun games to enable delegates to get to know each other and establish mutual relationships. Nonetheless, they went beyond expectations as they ended up creating an environment of collaboration among students from various countries. These sessions comprised very diverse topics and included interactive sessions where current issues and affairs faced by medical students in various countries were debated.

The SCOME sessions commenced by clearly outlining the goals and objectives



Len Duvenhage, attended the Standing Committee on Medical Education sessions

Willem Landman, attended the Standing Committee on Public Health sessions

Wilmé Steyn, attended the Standing Committee on Professional Exchange sesssions

Len, Willem and Wilmé at Puebla's main attraction, the second largest Ferris wheel in the world

Teotihuacan pyramids on the outskirts of Mexico City

one should strive for in this committee. They defined the role that medical students play in developing medical education. Achievements made by medical students in the curriculum over the years were highlighted to encourage current medical students on the committee to make an impact. After these informative sessions, the delegates were tasked to make in-depth enquiries from each other to establish the medical curriculum in their respective countries.

SCOME sessions progressed to discuss difficulties faced by prospective students in registering for medical courses. Included in the session was a poster fair where each country displayed and explained all the medical projects they have done, are currently busy with, and are planning. This was followed by a lecture on how to introduce change or new material to the current curriculum.

SCOPH sessions tackled a variety of topics concerning public health, and some of the policies of the IFMSA regarding public health issues were amended. One of the core discussions was the movement of global surgery, which is described as an effort to improve the quality and access of surgical care around the world. This is a vision that goes hand in hand with universal access to healthcare.

Urban development, the rise in non-communicable diseases, organ and tissue donation efforts, advocating public health issues, and other significant topics were presented and discussed.

SCOPE is focused mainly on the promotion of exchanges for medical students around the world. South Africa is proud to be part of this incredible programme despite the current inadequacy of such programmes in the country.

IFMSA's greatest strength is that it consolidates the world's health issues, allowing delegates from various countries to scrutinise and learn from each other in health matters

The assembly's SCOPE sessions covered a wide range of topics, including how best to manage outgoings and incomings, as well as how to manage and approach insurance-related aspects of exchanges. The most significant purpose of the SCOPE sessions during the assembly was the contracts fair, where each country had a stand to promote their country to entice other countries to sign exchange contracts with them.

SA was very successful in creating mutual relationships with other countries as far as professional exchanges are concerned, and we are looking forward to accepting many international students in the near future.

IFMSA's greatest strength is that it consolidates the world's health issues, allowing delegates from various countries to scrutinise and learn from each other in health matters. One of the insights we gained during the assembly was not just improving on what we are already doing, but gaining new perspectives and approaches that are totally overlooked within our national members' organisations (NMOs).

Mexico was an adventure! During intervals, the SA delegation became avid explorers. We explored every corner of the lovely city of Puebla, mostly on bicycles. This city has a very rich history as it is built around ancient Aztec ruins and pyramids, as well as a preserved Native American culture. It is also home to the world's largest transportable Ferris wheel. We also couldn't resist Le Calle de los Dulces (The Candy Street), a street filled with shops selling Mexican sweets, including tequila-flavoured jelly sweets.

We truly saw and experienced the Mexican culture, an adventure I am certain that all of us shall treasure for life. All this was made possible by the SAMA Gauteng North Branch, and for that we are grateful. We look forward to being part of this association that helps young people develop and grow in such an amazing way.

Medical certificates – whether to disclose the diagnosis?

Julian Botha, *Strategic Accounts Manager: SAMA Private Practice Department*

The question whether or not to disclose the diagnosis of a patient on a medical certificate is, on the face of it, a fairly simple one to answer, but there are certain considerations that make the question a little more complicated.

Ethical Rule 16 as outlined by the Health Professions Act No. 56 of 1974 (HPA) provides a detailed list of requirements for a valid medical certificate:

16. Certificates and reports

(1) A practitioner shall grant a certificate of illness only if such certificate contains the following information -

(a) the name, address and qualification of such practitioner;

(b) the name of the patient;

(c) the employment number of the patient (if applicable);

(d) the date and time of the examination;

(e) whether the certificate is being issued as a result of personal observations by such practitioner during an examination, or as a result of information which has been received from the patient and which is based on acceptable medical grounds;

(f) a description of the illness, disorder or malady in layman's terminology with the informed consent of the patient: Provided that if such patient is not prepared to give such consent, the practitioner shall merely specify that, in his or her opinion based on an examination of such patient, such patient is unfit to work;

(g) whether the patient is totally indisposed for duty or whether such patient is able to perform less strenuous duties in the work situation;

(h) the exact period of recommended sick leave;

(i) the date of issue of the certificate of illness; and

(j)the initial and surname in block letters and the registration number of the practitioner who issued the certificate.

(2) A certificate of illness referred to in subrule (1) shall be signed by a practitioner next to his or her initials and surname printed in block letters.

(3) If preprinted stationery is used, a practitioner shall delete words which are not applicable.

(4) A practitioner shall issue a brief factual report to a patient where such patient requires information concerning himself or herself.

All the above requirements must be met for the certificate to be valid. It must be remembered that the ethical rules are, in fact, legislation – they are published as regulations in the HPA. Non-compliance with the Ethical Rules is not only unethical conduct, it is unlawful conduct as well.

Of importance for the purposes of this article is Ethical Rule 16(f). Effectively this rule means that if the patient does not provide informed consent, the practitioner may not record the diagnosis or nature of illness, disorder or malady on the medical certificate.

Rule 16 does not require the patient to sign or give written confirmation of informed consent to the practitioner to disclose the diagnosis. It does, however, require the practitioner to obtain such consent. It is risky to infer that consent has been given when the patient takes the certificate and submits it to the employer – it may be argued, for example, that the patient was unaware that they had the right to insist that their diagnosis should not be reflected on the certificate. In addition, consent must be expressed, and implied consent is insufficient for legal and ethical compliance.

To make matters more complicated, according to section 14 of the National Health Act No. 61 of 2003 (NHA), all information relating to a "user"/patient's health status, treatment or stay in a health establishment (which by the broad definition contained in the Act would include a private medical practice) is confidential and records/information can only be released or made known to third parties with the **written** informed consent of the "user"/patient.

Both Ethical Rule 16 and section 14 of the NHA should be read and applied simultaneously – they do not contradict each other (even if they did, section 14 would prevail as the Ethical Rules, as regulations in the HPA are subordinate legislation).

It must be remembered that the ethical rules are, in fact, legislation – they are published as regulations in the HPA

Applying the above legislation to medical certificates in particular, my recommendation would be that the informed consent of the patient to disclose their diagnosis on the medical certificate must be obtained and recorded in writing. It is not advisable for the patient to sign the medical certificate itself, as the document leaves the possession of the doctor and there would be no proof on hand in the event of a subsequent dispute on whether written informed consent was given or not.

A preferable alternative would be to sign a consent form or add in a clause on the informed consent documents that deal with ICD-10 and National Credit Act matters. Provided there is a written record of the consent in the possession of the doctor that can be produced in the event of a dispute, the doctor should be covered.

SAMA medical student bursaries and PhD supplementary scholarships awarded

Karlien Pienaar, *SAMA Administrative and Legal Assistant; SAMA Bursary Committee*

SAMA is focused on encouraging post-graduate research, specifically with a view to promoting research and development in the medical field in SA.

With financial assistance in the form of voluntary donations from many SAMA members, we have been fortunate to yet again award two SAMA PhD Supplementary Scholarships to the amount of R100 000 each to two PhD candidates in 2016. They were awarded to Dr Cathy Cluver and Dr Nqoba Tsabedze at the beginning of 2016.

We were also able to fund two additional medical students with bursaries to the amount of R20 000 each, which is paid towards their tuition fees at the relevant universities. We wish to extend a word of sincere thanks to our members, as without them we would have struggled immensely to keep up the bursaries and scholarships.

Currently, the following students receive the bursary from SAMA (among others): Ms C de Klerk (4th year), Ms A Ahmed (3rd year), Mr I Chauke (2nd year), Mr L Mnqandi (1st year) and Mr T Mphaka (1st year).

More information on the two PhD candidates for 2016:

Dr Cathy Cluver is an obstetrician and gynaecologist at Tygerberg Hospital, Stellenbosch University Medical School, where she is currently registered for her PhD. Dr Cluver completed her specialist training in 2011 and received her MMed degree cum laude. She was awarded the Daubenton Medal from the South African Colleges of Medicine for outstanding results in the Obstetrics and Gynaecology Fellowship examination, and was also awarded the medal for Best Postgraduate Student for a Structured Master's Degree at Stellenbosch University. She has recently completed her subspecialist training in Maternal-Fetal Medicine and is currently writing her examination for her certification.

She was awarded the SAMA PhD supplementary scholarship for her research topic: The Pre-eclampsia Intervention trial with Esomeprazole (PIE trial): A double-blind randomised control trial for the treatment of early-onset pre-eclampsia.

Pre-eclampsia for an unknown reason is much more common in the developing world

Pre-eclampsia and the hypertensive disorders of pregnancy are one of the most common causes of maternal morbidity and mortality in SA and they cause countless cases of neonatal mortality and morbidity, particularly in the developing world. Early pre-eclampsia is characterised by hypertension in the mother with target organ damage, which can include the kidneys, liver, brain, lungs and haematological system. Usually the fetus is also affected and suffers from growth restriction, and may develop complications like abruptio placenta. Currently there is no known treatment for pre-eclampsia apart from delivery, which can result in the delivery of a very small premature baby with all the risks of prematurity, including death.

The PIE trial aims at trialling esomeprazole, a commonly used proton pump inhibitor, for the treatment of early-onset pre-eclampsia. If esomeprazole works, it would be the first therapeutic treatment and would allow these high-risk pregnancies to continue to a more advanced gestation, and hopefully decrease the chances of a premature delivery and the risk of complications for the mother. Thanks to funding from the SAMA PhD Supplementary Scholarship and the Discovery Foundation Academic Fellowship, Dr Cluver has been able to concentrate on this important research. She has already recruited more than half of the required 120 participants and is aiming to have an answer on whether esomeprazole could be the first treatment for early- onset pre-eclampsia by 2017.

Her work is due to a unique collaboration with Mercy Hospital and the Translational Obstetrics Unit, Melbourne University, Australia. In 2013 she was privileged to be awarded a fellowship to Australia for subspecialist training in Maternal-Fetal Medicine. While working there, she set up this opportunistic collaboration with a leading translational obstetrics group who identified esomeprazole as a possible therapeutic in laboratory and animal studies. Pre-eclampsia for an unknown reason is much more common in the developing world. For this reason it was decided to run the trial at Tygerberg Hospital, Stellenbosch University, which is a world-renowned institute for the expectant management of pre-eclampsia.

In the future, Dr Cluver is aiming to set up a research unit where novel therapies for pre-eclampsia can quickly be translated from the laboratory workbench into clinical trials to find a cure for this deadly disease.

Dr Nqoba Israel Tsabedze is an aspiring clinician scientist at the University of the

Witwatersrand. He is a certified cardiologist currently completing his PhD project on the genetics of idiopathic dilated cardiomyopathy (IDCM) in Johannesburg.

IDCM is a primary myocardial disease of unknown cause. The incidence and prevalence of the illness are unknown in SA.

IDCM is a primary myocardial disease of unknown cause. The incidence and prevalence of the illness are unknown in SA. In the USA it is estimated to have a prevalence as high as 1 in 250 individuals, with higher predicted rates in people of African origin. IDCM manifests with left ventricular dilatation and impaired myocardial contractility. It commonly presents in the third and fourth decades of life with most patients dying within 5 years of their first symptom if not treated optimally.

This study is the first in S A to investigate the genetics of IDCM systematically. Affected patients and their families will have an advantage of early diagnosis and management. In collaboration with researchers from Vanderbilt University (Nashville, TN), the research team plans to perform whole exome sequencing and gene analysis to identify local (sub-Saharan African) genetic variants responsible for this disease. This project is expected to lay a foundation to pioneer novel diagnostics and therapeutics.

This study is expected to improve his research skills and grow his confidence and competence in initiating other projects locally. His success in this endeavour would motivate other upcoming professionals of a similar socioeconomic background to pursue academia seriously.

The SAMA PhD supplementary scholarship has enabled both Dr Cluver and Dr Tsabedze to focus on their PhD work on a full-time basis, with less financial stress.

Unpacking the Public Service grievance procedure

Modisane Lelaka, *Industrial Relations Advisor*

Grievances are managed in terms of the Public Service Coordinating Bargaining Council (PSCBC) Resolution 14 of 2002, known as "grievance rules" in the public service. Definition of a grievance as contained in the Resolution is dissatisfaction regarding an official act or omission by the employer which adversely affects employees in the employment relationship, excluding an alleged unfair dismissal.

Some examples of grievances: supervisor continually picking on an employee; employee's workstation may be situated in a draughty area which gives him/her a health problem; occupational detriment in contravention of Protected Disclosure Act No. 26 of 2000; conflict between the employee and co-worker; non-granting of merit awards or promotion; training issues; benefits granted in terms of a policy or practice subject to the employer's discretion; probation; unfair suspension; or any other unfair disciplinary action short of dismissal in respect of an employee. It must be noted that the grievance procedure may not be used to address salary or wage issues, demands for other benefits, or as an appeal mechanism following a disciplinary hearing.

The grievance rules require the employer to resolve the grievance promptly and without bias. The rules also require that the employee lodging a grievance must not be victimised or prejudiced directly or indirectly for lodging a grievance.

Procedure to follow

Within 90 working days of becoming aware of the omission, the employee should start the grievance process by first informing his or her supervisor, who should attempt to resolve the grievance. If the supervisor fails to resolve the grievance, she or he should refer it to the next level of supervision for resolution. If both the supervisor and the senior staff member fail to resolve the grievance, the employee should fill in a grievance form and forward it to the institutional labour relations office. In cases where there is no labour relations office, the form should be handed to the human resources department. From the date when the grievance is handed over, the employer is given 30 working days to resolve the grievance. If the employer is unable to resolve the grievance within 30 working days, a written request for extension should be made to the employee. The progress and outcome of the grievance should be communicated in writing to the employee. Upon expiry of the 30 working days and in the absence of a request for extension, or if the employer has provided the outcome within 30 days and the outcome is not satisfactory to the employee, he/she must inform the employer within 10 working days to refer the grievance to the Public Service Commission (PSC). The employer must forward the grievance within 5 working days in terms of section 35 (1) of the Public Services Act No. 103 of 1994. Alternatively, the member with the assistance of SAMA can declare a dispute to the relevant Bargaining Council depending on the nature of the grievance and the jurisdiction of the council.

Grievances can be lodged by individuals or a group of employees with similar dissatisfaction (collective grievance).

Grievances can be managed in two ways: The employer can appoint another employee to investigate the grievance and provide a report with recommendations. Alternatively, the employer can hold a grievance meeting with the aggrieved employee and any staff member with authority to resolve grievances or any affected party. The employee has the right to be represented during the grievance process, including the grievance meeting.

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Coding 101 – guidelines and interpretations for items 0146, 0147, 0148 and 0149

SAMA Private Practice Department: Coding Unit

In the November 2013 *SAMA Insider*, we published a similar article on items 0146, 0147, 0148 and 0149. As there were updates made to these codes, it was decided to repeat the article. Please again familiarise yourselves with the content.

Item 0146

Description: *For an emergency* OR *an unscheduled consultation/visit AT the medical doctor's home or rooms: ADD only to the consultation/visit items 0190-0193, items 0161-0164 or items 0151-0153, as appropriate (refer to general rule B). Note: Only one of items 0145, 0146 or 0147 may be used and not combinations thereof.*

Interpretation

- Only one of items 0145, 0146 or 0147 may be added to a consultation/visit item (as appropriate) and not combinations thereof
- To be added to items 0190-0193 (as appropriate) for emergency or unscheduled consultations in rooms
- To be added to items 0190-0193 (as appropriate) for consultations by doctors normally using 24-hour emergency facilities
- The patient is responsible for the payment if his/her medical scheme does not grant benefits for this service (not applicable to Compensation Fund cases)
- Applicable to Compensation Fund cases for after-hours emergency only (refer to Rule B applicable to Compensation Fund cases only)
- General Rule P is only applicable to emergency travel to a place where the doctor does not normally perform voluntary services, such as hospital visits.

Unscheduled and emergency visit in the rooms

When a patient visits a medical doctor without an appointment and is prepared to wait until the doctor can see him/her, item 0146 may not be applied to the consultation (items 0190-0193).

When a patient visits the medical doctor's office without an appointment and insists on seeing the doctor immediately (taking preference over booked patients), the patient considers his/her condition as an emergency and it is the doctor's ethical duty to deal with it as such. In this case, item 0146 may be added to items 0190-0193 (as appropriate).

Item 0147

Description: *For an emergency* OR *unscheduled consultation/visit AWAY from the medical doctor's home or rooms, all hours: ADD only to the consultation/visit items 0190-0193, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be used and not combinations thereof.*

Interpretation

- Only one of items 0145, 0146 or 0147 may be added to a consultation/visit item, as appropriate, and not combinations thereof
- To be added to items 0190-0193, 0173-0175, 0161-0164, 0166-0169 or 0151-0153 (as appropriate) for an emergency visit away from the consulting rooms or doctor's home
- Not to be added to items 0190-0193 for consultations by medical doctors normally using 24-hour emergency facilities
- Not to be added to items 1205-1210 (Intensive care: Category 2 or 3 codes)
- Not appropriate to add to items in the case of normal vaginal deliveries (non-elective) in after-hour periods, where a global obstetric fee is applicable
- The patient is responsible for the payment if his/her medical scheme does not grant benefits for this service (not applicable to Compensation Fund cases)
- Applicable to Compensation Fund cases for after-hours emergency only (refer to Rule B applicable to Compensation Fund cases only)
- Item 0147 may be added to items 0151-0153 (as appropriate) when an elective operation list was not submitted to the anaesthesiologist/anaesthetist by 16:00 on the day prior to the procedure(s)
- General Rule P (travelling fees) is only applicable to emergency travel to a place where the medical doctor does not normally perform voluntary services, such as hospital visits.

Item 0148

Description: *For elective after-hours services on request of the patient or family (non-emergency) (refer to General Rule B(a)): ADD 50% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0193, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153 as appropriate) and reflect this as a separate item 0148. Usage: This item is used when, for example, a patient or the family request the medical doctor for a non-emergency consultation/visit outside of the doctor's normal hours.*

Interpretation

- Item 0148 may only be added to the appropriate consultation/visit item (item 0190-0193, 0173-0175, 0161-0169 as appropriate) when a non-emergency visit is made at request of the patient or the patient's family (not applicable to medical schemes' benefits and Compensation Fund cases)
- The value of this item is 50% of the appropriate consultation/visit item
- The patient is responsible for the payment if his/her medical scheme does not grant benefits for this service.

Item 0149

Description: *After-hours bona fide emergency consultation/visit (21:00 - 06:00 daily): ADD 25% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0193, items 0173-0175, items 0161-0164, items 0166-0169, items 0151-0153 or item 0113 as appropriate) and reflect this as a separate item 0149.*

Interpretation

- Item 0149 may only be added to the appropriate consultation/visit item (item 0190-0193, 0173-0175, 0161-0169, 0166-0169, 0151-0153 or 0113 as appropriate) for emergency consultations/visits between 21:00 and 06:00 (not applicable to Compensation Fund cases)
- Not appropriate for 24-hour emergency facilities
- The value of this item is 25% of the appropriate consultation/visit item
- The patient is responsible for the payment if his/her medical scheme does not grant benefits for this service.

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- South Africa Medical Association Research and Ethics Committee - SAMAREC
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- Our Mission:
  - Empowering Doctors to bring health to the nation
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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.

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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

General Rule B

Normal hours and after hours:
(a) When non-emergency elective visit/ consultation falls outside of the normal practice hours and is requested by patients for their own convenience, refer to item 0148.
(b) Bona fide emergency consultation/visit (21:00 - 06:00 daily), refer to item 0149.
Please note: Patients will be personally responsible for payment of the applicable items if these services fall outside of the medical scheme benefits.

General rule B applicable to Compensation Fund

Applicable to Compensation Fund cases only:
Rule B: Normal hours and after hours:

Normal working hours comprise the periods 08:00 to 17:00 on Mondays to Fridays, 08:00 to 13:00 on Saturdays, and all other periods voluntarily scheduled (even when for the convenience of the patient) by a medical practitioner for the rendering of services. All other periods are regarded as after hours.

Public holidays are not regarded as normal working days and work performed on these days is regarded as after-hours work.

Services are scheduled involuntarily for a specific time, if for medical reasons the doctor should not render the service at an earlier or later opportunity.

Please note: Items 0146 and 0147 (emergency consultations) as well as modifier 0011 (emergency theatre procedures) are only applicable in the after-hours period).

KZN Specialist Network – multidisciplinary approach to bettering healthcare in SA

SAMA Communications Department

The KZN Specialist Network is a non-profit multidisciplinary medical specialist organisation representing the interests of approximately 300 private medical specialists, including surgeons, pulmonologists, paediatricians, anaesthesiologists and radiologists, in KwaZulu-Natal (KZN). They are committed to helping patients and dedicated to finding innovative solutions to better healthcare in SA. The organisation has established strong partnerships with other healthcare organisations, and is therefore in a position to offer services focused on keeping its members up to date with the latest medical developments and on providing patients with the best medical care.

The Network will be holding their annual conference and exhibition on 22 October 2016 at the Southern Sun Elangeni Hotel. The programme includes presentations on HIV, antibiotics, stem cell and gene therapy, a radiology and pathology update, as well as robotic surgery, the legal implications of retrieving informed consent and an update on the doctors Bill of Rights.

Multidisciplinary network

The KZN Specialist Network is the only fully established regional, multidisciplinary, private medical specialist network in SA. Its executive committee (exco) consists of 11 members who are all qualified and practising specialists – with each playing a vital role in the operations of the network. While remaining dedicated to their patients and managing their individual private practices, exco members meet regularly to discuss healthcare issues, review projects, facilitate monthly academic meetings for members, and meet with funders and pharmaceutical companies to collaborate on resolving key healthcare barriers.

A multidisciplinary approach to managing health conditions is a key focus of the KZN Specialist Network. It aims to empower each specialist in their specialised medical field while offering an environment conducive to consulting and engaging with their peers.

Background to network formation

Established in 2004, the KZN Specialist Network was born out of the desire to unite all specialists in KZN.

This desire for unity came about because medical specialists in KZN were being faced with a number of unique issues impacting on their work, their practices and on the level of patient care they could provide. It was felt that a collective voice was needed to represent the needs of specialists and patients.

"The demographic profile of KZN is quite different to many other parts of the country," explains vice-chairman of the KZN Specialist Network, Dr André Reddy. "Many specialists working in the private sector in KZN serve lower-income communities whose members are covered by only the most basic medical or hospital insurance plans available.

"Prior to 2004, specialists' tariffs in KZN were related to and determined by the national index, which did not match the demographic profile of KZN patients. In addition, the disease burden in KZN differs substantially to the national picture. In KZN, we deal with a high number of HIV-positive patients and the condition dramatically affects both outcomes and profiles.

"By establishing the KZN Specialist Network, we were able to provide a united front against the prescriptive attitude of medical funders and hospital groups in the KZN area. Our unity has enabled us to force these groups to reconsider ill-conceived plans to manipulate specialists' tariffs."

Growth

Since its formation in 2004, the KZN Specialist Network has grown substantially and now represents just over half of the specialists in KZN. This growth is ongoing, with membership expanding by about 20% per year.

Objectives

After a brief period of discovery, the network was formed with an established constitution with definite objectives in mind. These are:

- to protect and promote the professional interests of the specialists in private practice in the area
- to facilitate the provision of ethical, quality and cost-effective treatment of patients in the area

- to negotiate collectively rather than individually in the interests of the members and patients of the area.

Continuing professional development

The network involves itself in various aspects of specialist care in KZN – both in the private and public sectors. Vibrant academic meetings are held monthly to stimulate interest in clinical aspects in the management of patients in KZN.

Regular meetings updating members on the latest funder issues are held, and further information is dispensed at regular intervals to members.

Dealing with the culture of litigation

One of the issues being actively worked on by the KZN Specialist Network is the increasing trend of aggressive medical litigation. The concept of medical malpractice, as driven by the legal profession, is rapidly gaining traction among the general public, and the perceived role of doctors in the community is changing.

Antibiotic stewardship initiative

The Antibiotic Stewardship Programme promotes responsible and effective antibiotic use, and has been widely embraced both internationally and nationally by all stakeholders involved in patient care.

While isolated and independent stewardship programmes had been launched in KZN, in 2012 the KZN Specialist Network began advocating for a single body to which regional hospital programmes could be affiliated.

For more information contact Tania Govender:
Email: info@kznspecialist.co.za
031 309 6748
website: http://kznspecialist.co.za

WMA – physicians at the frontline of climate-related health challenges

World Medical Association

Attending the Second Global Conference on Health and Climate: "Building Healthier Societies Through Implementation of the Paris Agreement", held on 7 - 8 July 2016 in Paris, the WMA, the French medical council, Conseil National de l'Ordre des Médecins (CNOM) and the International Federation of Medical Students' Associations (IFMSA) continue to reiterate the essential role of physicians at the frontline of climate-related health challenges.

At the Paris Conference (COP21) in December 2015, health emerged at the centre of the climate-change debate. We expect that the next Conference of the Parties in Marrakech (COP22) will emphasise the key role of physicians in addressing climate change. We appreciate the continued commitment of the WHO and the French Government to ensure health is high on the climate-change agenda.

"Physicians have the ethical responsibility to alert and advise decision-makers at local and national level, on the social determinants of health including climate change and identify the best solutions to prevent and address these challenges." said Sir Michael Marmot, president of the WMA.

Physicians play an important role in all aspects of climate action and urge action by governments including:

- climate mitigation, recognising the crucial health co-benefits
- adaptation to health impacts of climate change, including investment in health systems strengthening
- development of a loss and damage framework to address disparate health inequities attributable to climate change
- health sector engagement in implementation and review of national level commitments.

"Climate change is above all a question of public health. Doctors are in the front-line in responding to the harm from climate turmoil."

The WMA, the CNOM and the IFMSA welcome the recommendation of the Health Action Agenda delivered at the closing of the conference to the Moroccan Government, as the incoming Presidency of COP22, to develop the capacity of the health workforce to address climate risks, to co-ordinate a multisectoral approach and provide technical assistance to national governmentsand to ensure adequate financing for health systems strengthening.

"We believe health professionals, medical students and the youth must come together to address the challenges posed by climate change on our health and must be given opportunities and resource to learn about and act upon climate change," says Skander Essafi, IFMSA liaison officer for public health.

Our organisations remain committed to training the health workforce on climate-change issues, for example by the development of tools such as the Training Manual on Climate and Health, the development of resources such as the French medical council Webzine video on "Health & Climate", research on climate-change policy, such as through the INDC (intended nationally determined contribution) analysis conducted by the WMA, and regular workshops on climate change and health during statutory meetings.

"Climate change is above all a question of public health. Doctors are in the front-line in responding to the harm from climate turmoil. We have a privileged position and a moral duty to protect and promote the population's health," says Dr Patrick Bouet, CNOM president.

A problem with polyps – be prepared to reassess

Medical Protection Society

Mr S was a 35-year-old taxi driver who was visiting his extended family abroad. While he was there, he decided to have a routine health check in a private clinic. He told the doctor in the health clinic that he had noticed some rectal bleeding over the previous 4 months. The doctor did a digital rectal examination and proctoscopy and saw two rectal polyps. He gave Mr S a letter to take to his GP at home, explaining the findings and recommending a colonoscopy to further investigate his bowel. Mr S returned from overseas a week later and made an appointment with his GP, Dr A.

He gave Dr A the letter from the overseas health clinic and explained that he had noticed occasional rectal bleeding. Dr A noted that he had seen one of his colleagues a month before who had seen external haemorrhoids that were bleeding slightly. Dr A advised Mr S to avoid constipation to help with his haemorrhoids. He filed the letter from the health clinic but did not act on it.

Common, normally benign symptoms can on occasion be more serious

The following year Mr S was still bleeding occasionally. He remembered the concerns of the overseas doctor and rang his GP surgery. He was given an appointment with Dr B. He explained that he had seen maroon blood on the toilet paper and in his stool for months and was concerned about the cause. Dr B examined him externally and noticed some simple haemorrhoids. He noted that Mr S was not keen on medication so advised him to drink more fluids and increase his fibre intake.

Mr S tried following this advice for 6 months, but the bleeding persisted so he visited Dr B again. Dr B did a purely external examination again and documented "simple external piles". He prescribed anusol suppositories.

Over the next 3 months Mr S began to lose weight and feel very tired. His wife was concerned that he looked pale. The bleeding was still occurring, and he was having episodes of diarrhoea and constipation. He made an appointment with Dr C, another GP from his practice, who arranged for some blood tests, which showed significant iron deficiency anaemia. She referred Mr S to the colorectal team, who diagnosed rectal carcinoma.

He had a panproctocolectomy and the histological diagnosis was of two synchronous rectal carcinomas, Dukes' stage C1. Multiple adenomas were found, some with high-grade dysplasia, and it was considered that Mr S had attenuated polyposis syndrome.

Mr S and his family were devastated. He struggled through chemotherapy and radiotherapy. He was told that it was not possible to reverse his iliostomy and that his 5-year survival rate was 45 - 55%. He was very angry and made a claim against Dr A for not referring him earlier or taking notice of the overseas health clinic's recommendations.

Expert opinion

MPS sought the advice of an expert GP. He was critical of Dr A for failing to perform any examination of his own, relying instead on a prior examination by one of his colleagues. He felt that Dr A should have taken a fuller history including possible alteration in bowel habit, weight loss and abdominal pain. He felt that choosing to ignore the recommendations of the overseas clinic without making any attempt to reach his own diagnosis to explain the rectal bleeding failed to provide a reasonable standard of care.

He commented that haemorrhoids are a common cause of rectal bleeding in a 35-year-old but the decision to dismiss the clinic's advice without adequately assessing the patient could not be defended.

The expert GP was also critical of Dr B. The notes from his two consultations gave no indication that any further history was taken. He felt that he should have conducted a digital rectal examination rather than just an external inspection and that this represented an unreasonable standard of care. He felt that a digital rectal examination would have revealed the polyps and therefore a more timely referral.

The opinion of a professor in colorectal surgery was sought. He considered that if Dr A had performed a digital rectal examination at Mr S's first presentation, he would have been able to palpate the polypoid lesion in the lower rectum. This should have raised suspicions such that he would have made the referral for colonoscopy. He felt that Mr S would not have avoided a panproctocolectomy because he had multiple other polyps in his colon and was thought to have attenuated polyposis syndrome.

He did state that if the resection had been done closer to presentation, the tumour would have been more likely to be a Dukes' stage A or B and he would have had a 5-year survival rate of 70 - 95%.

The case went to court and was finally settled for a high amount.

Learning points

- Common, normally benign symptoms can on occasion be more serious.
- Be prepared to reassess patients if their symptoms are not resolving by taking a detailed history and conducting a thorough examination.
- A diagnosis may need to be revisited during subsequent consultations rather than relying solely on former colleagues' decisions.
- Regardless of the fact that a patient has a consultation overseas out of context, it is never safe to ignore the findings of those consultations and investigations without properly ruling them out first.

Gauteng North host Nephrology CPD

Bokang Motlhaga, *Junior Marketing Officer, SAMA*

On 17 August 2016, the SAMA Gauteng North Branch hosted a successful Nephrology CPD meeting. Gauteng North Branch council members were of the opinion that medical practitioners need to continually be kept abreast of new clinical procedures and ethical conduct regarding nephrology and kidney diseases. The CPD programme highlighted new developments in clinical research pertaining to diagnostic procedures and innovation of effective medication, bearing in mind rigorous protection of participants. The presentations covered chronic kidney disease (CKD), as there is a need for efficient CKD diagnosis and treatment. Moreover, there is an absolute need to start recognising CKD as a silent killer. This educational event featured enthusiastic and knowledgeable speakers: Dr Michelle Middle, Prof. Ida van Biljon and Prof. Anthony Meyers.

Dr Michelle Middle holds the post of Medical Advisor at Synexus SA. She has an MB ChB degree and a Diploma in Pharmaceutical Medicine (including ethics module).

Dr Middle delivered an informative presentation on Ethics in Clinical Research, which looked at the critical events in the history of research ethics and discussed clinical research in developing countries. SA falls within the category of developing countries with logical regulations pertaining to ethical clinical research. She emphasised the four guiding principles for ethical research in humans, namely: respect for persons (autonomy and dignity), non-maleficence (do no harm), beneficence (provide benefit, balance benefit and risks) and distributive justice (fairness in distribution of benefits and risks) and reiterated that these guiding principles should be at the heart of any medical practitioner's treatment. In closing, she quoted George Santayana: "Those who cannot remember the past are condemned to repeat it", hence the necessity of highlighting the critical events in the history of research ethics.

Dr Michelle Middle delivering her presentation about Ethics in Clinical Research

Prof. Ida van Biljon obtained an MB ChB in 1978, MMed Paediatrics in 1984 and Fellowship of the College of Paediatricians of SA in 1984. She is currently the senior consultant paediatrician at the University of Pretoria and an external examiner for medical exams within various academic institutions.

Prof. Van Biljon's well-constructed presentation encompassed the diagnosis, risk factors for progression and management of CKD. The focal point of her presentation was CKD in paediatrics, quoting John Connolly's saying: "For in every adult there dwells the child that was, and in every child there lies the adult that will be." According to Prof. Van Biljon, medical practitioners should always remember that testing of proteinuria forms the basis of CKD diagnosis. Quoting Thomas Addis (1948): "When the patient dies the kidneys may go to the pathologists, but while he lives, the urine is ours … the examination of urine is the most essential part of the physical examination of any patient …" emphasised her point.

Prof. Meyers is currently a nephrologist at Klerksdorp Hospital and in private nephrology practice at Donald Gordon Medical Centre. He is also chairperson of the Board of Directors of the National Kidney Foundation of South Africa (NKFSA).

Prof. Ida van Biljon presenting her talk on CKD

Prof. Anthony Meyers presenting the practical approach to CKD

Prof. Meyers's presentation covered the practical approach to CKD and chronic renal failure (CRF). He lectured on kidney structure and functions, general tests and interpretations, and closed by discussing the extended role of the general practitioner in CKD management.

This meeting was an auspicious occasion and the Gauteng North Branch in unison with the attendees noted a need for a full-day discussion of such topics.

West Rand host CPD symposium

The SAMA West Rand Branch in conjunction with Netcare Krugersdorp Hospital, Netcare Pinehaven Hospital, Netcare Bell Street Hospital, Netcare Constantia Day Clinic and Netcare Protea Day Clinic hosted a 2-day CPD symposium on 27 and 28 August at Misty Hills Conference Centre, Muldersdrift. This informative event encompassed great presenters who gave lectures on topics of core value to every doctor.

The topics tackled at the symposium were presented in such a manner that the attendees could denote the gap and changes between how things were previously done and how they are currently done. This gave them a new perspective in terms of how they could change certain "old" procedures for the better. The presentations covered clinical, ethical and even general aspects that needed to be highlighted within the medical field.

The event was attended by approximately 280 doctors and the West Rand Branch has received positive feedback from the attendees regarding the event.

Tracey Gurnell (SAMA West Rand branch secretary) and Jeanette Snyman (senior marketing officer at SAMA Head Office)

Eastern Province branch – adult ADHD under control at our AGM

Dr James Burger

Attention deficit hyperactivity disorder (ADHD) is one of those relatable conditions that arouse the inner "second-year syndrome" inside all of us whenever we read through the DSM criteria. As many of us have experienced somewhat less-than-enthralling AGMs, the EP Branch decided to deal with the concentration concerns that frequently arise and include a talk on adult ADHD in the evening's schedule.

On Thursday 28 July 2016, the SAMA EP Branch held its AGM at Elizabeth Place to celebrate another successful year. The evening kicked off with phenomenal finger-foods and a glass of wine for those who wished, before all being welcomed. The previous minutes were read by Dr Berkowitz, Dr Benson gave us a rundown of our finances in his Treasurer's Report and Dr Tabata presented the Chairman's Report on the happenings of the branch over the last year. We are really looking forward to a great year ahead with our new Branch president, Dr F Khan, who was inducted on this evening. We thank our outgoing president, Prof. L Pepeta, for all his work so far with the branch and look forward to a continued relationship where we can together benefit our local SAMA members.

After the formalities, we were lucky to have Dr Wim Esterhuysen, senior consultant psychiatrist at Elizabeth Donkin Psychiatric Hospital, to give us a talk on adult ADHD. Dr Esterhuysen helped us with an approach to the complicated diagnosis.

Adult ADHD is a topical and somewhat trendy diagnosis for patients, who seem intrigued by the neuroscience behind the disorder. ADHD is a neurodevelopmental disorder and is predominantly thought of as a condition occurring in children and adolescents. It, however, may persist throughout the lifespan, and adult ADHD is conceptualised as an extension of childhood ADHD rather than a separate entity.

Dr J Burger, Dr S Toni, Dr C Mahleza, Dr F Khan

Prof. L Pepeta (outgoing president), Dr F Khan (president)

Dr KP Tabata (chairperson), Dr W Esterhuysen (guest speaker)

Dr I Berkowitz handing a life membership certificate to Dr J D T Zaaiman

The talk explored the diagnostic uncertainty, highlighting certain issues with the DSM criteria that arise with adult patients, as well as difficulties due to comorbidities, coping mechanisms, and the lack of an overt comparison group such as a classroom.

After explaining the theories about pathogenesis, he outlined the presentation and the complexity of this in adults, with a different set of manifestations of their impulsivity, hyperactivity, executive dysfunction and emotional dysregulation. In making the diagnosis, one needs to identify symptoms and behaviours consistent with the criteria for ADHD, rule out other disorders such as mood and anxiety, and most importantly, since it is a neurodevelopmental disorder, one needs to elicit whether the onset of symptoms was before age 12.

Before concluding a very interesting presentation, Dr Esterhuysen highlighted that although the data are less extensive than with children, stimulants such as methylphenidate are still shown to be most effective for ADHD, but comorbidities and many other factors need to be taken into account, with consideration of medication such as the selective norepinephrine reuptake inhibitor (SNRI), atomoxetine, and cognitive behavioural therapy.

Overall, the evening was a great combination of informative on the current state of affairs in the branch, as well as updating us with pertinent information on one of the topical areas in practice currently. Many thanks to Dr Esterhuysen for a very stimulating talk.

Cape Western branch hold successful presidential dinner

On 30 July the Cape Western Branch (CWB) held a function at the River Club in Mowbray to acknowledge the outgoing president of the branch, Dr Robert Rapiti.

Back row, Dr Rehaaz Adams. Front left to right: Dr Truda Smit, Chenienne Gericke and Emily Nel (branch secretaries)

Left to right: Prof. Zephne van der Spuy (CWB new president), Dr Robert Rapiti (outgoing president), Drs Solly Lison (outgoing chair CWB) and Malikah van der Schyff (new chairman of CWB)

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