

SAMA INSIDER

December/January 2018

Is critical-care medicine in ICU?

Introducing
SAMA president,
Dr Xaba-Mokoena



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
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Diane de Kock
Editor: *SAMA INSIDER*

Meeting the challenges

2017 has once again been a year of challenges for SAMA in their quest to provide support and services to members. Looking back at editions of *SAMA Insider*, the association's relevance has been reflected in, among other articles: SAMA's response to the NHI White Paper, the legal challenges of medical aid schemes and treating patients, climate change, huge inequalities in healthcare, the SAMA code of conduct, mental healthcare, a SAMA-led revision of the WMA statement on telemedicine, an increase in attacks on healthcare workers, new coding challenges and, of course, the many CPD workshops, training sessions and CSI outreach programmes led by SAMA branches countrywide.

In this issue we welcome new SAMA president, Dr Marina Xaba-Mokoena (page 5), challenge members on the existence of professional courtesy (page 6), examine the state of critical care in the country (page 8) and introduce a new clinical support platform in the form of an app (page 15) that aims to improve patient outcomes.

We hope you enjoy the read and look forward to meeting again in February 2018. The *SAMA Insider* team would like to wish readers a peaceful, productive and hopefully restful end to 2017.

Cover photographs for *SAMJ*

The Health and Medical Publishing Group (HMPG) is calling on doctors who have high-quality images of themselves and/or colleagues in medical contexts to make them available for next year's *South African Medical Journal* covers. If you have images that you consider coverworthy, please send them to publishing@hmpg.co.za. All contributions will be acknowledged.

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Pioneering the establishment of a medical faculty at the University of Transkei



Dr Marina Xaba-Mokoena, SAMA president

Many will wonder why, in the 21st century, I am writing about a faculty established at the University of Transkei (now Walter Sisulu University) in 1985. The story behind it is that it was established in a homeland, the Transkei, by a black woman who was given about ZAR12 million for the project. People never thought this dream could be realised, so if there is something you wish to pioneer in your field of medicine, be encouraged to follow your dream – you will make it.

As the founding dean of this Faculty of Medicine and Health Sciences, I was vilified even by people I expected to encourage and support me. They labelled me “an ambitious woman who had lofty ideas and an exaggerated view of her capabilities”. The “pioneer” students were told that they were wasting their time with something that would collapse and be abandoned. This to me was a challenge to Transkeians, and to us all. To open the eyes of the public to the importance of this venture, I decided to entitle my inaugural address “Health for all by the year 2000”.

Considering the population and patient/doctor ratio, the Transkei was far below the WHO's acceptable standards. In 1984, the ratio was 1:44 000, and with expatriate doctors it was 1:15 000. In 1983, a joint pilot committee was established, in conjunction with the Health Department, to urgently establish a medical faculty. We needed to train pharmacists, health educators, radiographers and all kinds of paramedical workers. One

wondered how some of our 28 hospitals were run and manned without these personnel. We had coped with dispensary assistants, darkroom attendants and, in the main, untrained and unqualified staff.

The faculty of medicine at the University of Natal had been established to train non-white medical practitioners in the mid-1950s. Up to 1963, there were few problems, as only half of the applicants met the requirements for admission. However, from about 1968, the number of applicants increased out of all proportion to the available facilities, so that many more probable candidates could not be admitted. This caused some reaction in African communities.

The black students emerging from Bantu Education had to compete with better-educated Indians and coloureds, and those from the rest of Southern Africa. To alleviate this impossible situation, the University of Natal was able to increase its places in 1974 with the assistance of the national Department of Education. The Medical University of South Africa (Medunsa) was also opened to cater for black students. The department, being fully aware of the situation, had for many years sought a solution. Even if the facilities were increased in Natal from 80 to 160 per year, very few more black doctors would qualify. Thousands were needed throughout the republic and “independent states”. It had become an embarrassing situation, and admission was on a competitive basis. Of the existing six SA medical schools, only two accepted blacks then, a token figure.

Of the 70% of the SA population who are black, most were in the developing rural areas, while 80% of doctors were in the cities or big towns. Only about 5.5% of SA doctors practised in villages and rural areas; I am proud to say that my father, who was the 23rd non-white SA doctor and had trained in Edinburgh and Glasgow, was one of those few.

It was and is my belief that rural and urban communities suffer from diseases that are, in the long term, related to people's socioeconomic predicament, and are preventable and curable at relatively low cost. As a result, I came up with the idea of emphasising primary healthcare and

community-oriented and problem-based education. Also, it was realistic to train doctors for the Transkei in the Transkei. Initially, of the enrolment of 12 students, we accepted students from everywhere. Medical education had to be relevant to the needs of the students on qualification, as well as of the community to be served. It pleased and honoured me when other faculties in SA eventually came to learn and take notes from our ideas.

In his inaugural speech at the University of the Witwatersrand (Wits) in 1984, Prof. Gear slated SA's medical curriculum, and accused graduates of abrogating their responsibilities. He stated that the then-curriculum was irrelevant, because it did not encourage graduates to work where the need was greatest. Calling for radical reform to their curriculum, he said: “Our present system of a Western model of excellence is discriminatory and essentially leads to the production of doctors whose training is irrelevant for most of SA's needs.” I agreed with him, and felt that we should strive for excellence rather than perfection, as it is better to get more things done well, than one thing perfectly.

However, in an article in the *South African Medical Journal* of 8 June 1985, “Some challenges to SA universities”, the then-vice chancellor and principal of the University of Cape Town, Prof. Saunders, wrote about the unnecessary proliferation of universities, which would make tertiary education a laughing stock. On medical education, he wrote:

“I do not disagree at all with those who say that community and preventive medicine is more important than curative, nor am I saying that none of our graduates should be practising in community medicine. It is important for medical students to be exposed to role models, both inside and outside the teaching hospitals, in both urban and rural environments, but this does not imply a less rigorous education. We have to increase the number of doctors in rural SA, but they must be first-rate doctors.”

Some of these criticisms remind me of the day in 1955 that the University of Natal was to be inaugurated by a Natal administrator, Mr J G Shepstone, and the SA press printed cartoons of black “witch doctors” graduating!

Did the doctors who graduated in Natal regard themselves as witch doctors? No! Incidentally, one of them, Dr Oscar Jolobe, went on to become a lecturer in the UK.

The potential for the Transkei medical faculty was great. The country had people. The Transkei had wonderful land and access to the sea. In addition, the country was endowed with a conducive climate for prepared people and personnel, so I could not understand why pessimists felt that a medical faculty was needed in East London or Port Elizabeth rather than Mthatha. The late Dr C L Bikitsa, Minister of Health, pointed out that "today's Transkeian hospitals, with 288 posts, have 155 of these filled, and out of these, only 10 by Transkeians."

For the new medical faculty, I drew up the 2nd- to 6th-year curriculum single-handedly, and gave it to other medical schools to critically evaluate it before presenting it to Senate. I saw to the erection of dissection rooms and laboratories, and had to approach our parliament about the use of unclaimed or donated bodies as cadavers, which was not an easy task at all. I could go on and on narrating about this supposed "mission impossible".

The idea of a Transkei medical faculty was acceptable to some academics, such as the late Prof. Sonny du Plessis, then vice chancellor at Wits Medical School and a council member at the University of Transkei. He was the one who introduced me to Prof. Maurice McGregor, the faculty dean of medicine at Wits, who together with some of his colleagues was of great assistance in the establishment of the medical faculty in the Transkei. The University of Natal's Prof. Kallichurum Simpson, and Prof. Taljaard of Medunsa, where I was a council member for 4 years, offered to assist where they could. Some even attended the inauguration of the faculty. These are just a few of those who supported the dream to fruition.

The first graduates qualified in 1990, and today, following the 2005 merger, the new Walter Sisulu University boasts of having produced close on 2 000 medical doctors, recognised all over the world, with approximately 300 of them specialists who have graduated to date.

It is my belief that many of those students might never have seen the door of

a medical school, nor be professors today, had that school not been initiated. Today, demand is so great that the student intake is 120 per annum, with many deserving candidates turned away. SA is still in need of more and more doctors, and so new medical faculties are being proposed, to which I am willing to give advice. This is a challenge to young people! Where there's a will there's a way! Nothing is impossible when there is a vision. With determination, hard work and dedication, all things are possible. It is important in life to have dreams and pursue these no matter what. Setbacks and criticisms are common, but there is no mountain that can't be moved or hurdle that cannot be overcome.

I am very proud of the brave pioneer students with whom we initiated this project, and of the lecturers who were not daunted in the initial stages. Some stayed on for approximately 30 years, doing sterling work, and they must be proud to see the results of their persistent labours. The medical faculty has been a resounding success.

Introducing SAMA president, Dr Xaba-Mokoena

SAMA Communications Department

SAMA communications manager, Dr Simonia Magardie, interviews new SAMA president Dr Marina Xaba-Mokoena.

Where and when did your career start?

My career started as a professional nurse and midwife at King Edward VIII Hospital in Durban, after training in SA. I received awards and prizes from the hospital and the Durban City Council. Later I moved to Edendale Hospital in Pietermaritzburg, before moving to London to study postgraduate orthopaedic nursing, which I completed in 1965 with the highest marks in the whole of England and Wales. The British Medical Association awarded me a SIDA (Swedish International Development Association) scholarship to study medicine in Stockholm, at the Karolinska Institute.

When and why did you join SAMA?

I think I must have joined the Transkei Medical Association and Council in 1980 and joined SAMA in about 1993/4, when I came to work in SA. I joined because I knew it was wise to

be associated with the trade union of one's profession, and because the association fights for and makes recommendations on professionals' rights, and protects and advises on relevant issues.

What is your field of specialisation?

I am a pulmonologist, which I practised in Mthatha and in Frere and Cecilia Makiwane Hospitals until 2013, when I retired.

Please tell me a bit about your family?

My father, who had a degree from the USA, studied medicine in Scotland, graduating in 1936. He was the 23rd non-white doctor in SA, married to a teacher daughter of a minister of the Methodist church. There were seven of us siblings who were born and bred in Willowvale in the Transkei, and most of us completed our secondary education at Healdtown Missionary Institution, near Fort Beaufort. Many of my siblings became professional nurses, for obvious reasons, and two of them married doctors. I have three

nieces who are doctors, one of whom is a neonatologist in paediatrics at Tygerberg Hospital. My husband was, before retirement, a senior auditor, then deputy director general in the SA Department of Commerce and Industry, and lastly director general in the Department of Welfare and Pensions in Mthatha. We have two children – a daughter who is a dancer and singer in Sweden, and married to a Swede, and a son who is in the marketing business, based in Johannesburg. We also have three grandchildren.

How do you spend your free time and what do you do to relax?

My hobbies used to be sport and ballroom dancing, but nowadays are reading, going to gymnastics at Virgin Active, hydrotherapy and watching sport on TV, especially soccer, rugby and tennis. I am a lay-preacher of the Methodist church, and participate in many communal and professional activities, for example, as a member of the Frere Hospital Board, the University of Fort Hare Research Ethics Committee and the governing council of Seth Mokitimi Methodist Seminary.

SAMA National Council meeting postponed

Dr Mzukisi Grootboom, *chairman, SAMA*

After careful consideration by the board of directors, it has been decided to postpone the National Council meeting planned for 24 - 25 November 2017 to approximately late March or the first part of April 2018.

The reasons for our decision mainly relate to a National Council instruction of 2016 – namely, to ensure the proper functioning of SAMA's employed-doctors component and the services related thereto. A lot of persistent hard work has gone into this project since the previous National Council, and excellent progress has been made.

However, the finalisation of the various practical plans and changes envisaged and implemented to ensure complete fulfilment of the National Council directive necessitates changes to the SAMA Memorandum of Incorporation (MOI) and company rules. In this regard, we have recently finalised draft versions of these changes, which we would like to present to the SAMA membership with ample opportunity for comment. The MOI

and company rules must be adopted at an extraordinary general meeting with at least 15 business days' notice. Since we have to allow more time for comment than only 15 business days, it will be practically impossible to have an extraordinary general meeting to adopt the MOI and company rules prior to the planned date of the National Council meeting. Adoption of the MOI and company rules will also entail changes to the national-councillor component emanating from the employed-doctors sector, to ensure these doctors' fair representation at a National Council meeting. In that regard, once adopted, the company rules will also dictate election processes that could thus far not be effected in terms of the current rules.

Therefore, to ensure that all the aforementioned processes are run fairly, we are left with little choice but to postpone the National Council meeting.

The annual general meeting that was planned to take place during and as part of the National Council meeting will continue in

November 2017 in the form of an extraordinary general meeting to deal with statutorily required business only (thereby allowing membership business to be discussed at the full National Council meeting in March/April 2018). SAMA is required to have an annual general meeting where a certain minimum of matters (financial statements and the appointment of auditors) must be dealt with, since its Public Interest Score dictates that its financial statements must be audited.

Prof. Dan Ncayiyana, our current president, will also still hand over to our new president, Prof. Marina Xaba-Mokoena, in November 2017, as previously planned.

We would like to spend the last part of 2017 productively engaging with the SAMA membership in respect of the suggested alterations to the MOI and company rules, to ensure that all remaining processes are successfully finalised prior to our elective National Council meeting in March/April 2018. We apologise for any inconvenience caused by the postponement.

Has professional courtesy been lost?

Malikah van der Schyff, *SAMA Cape Western branch*

I have been involved in SAMA for over two decades, and consider its ultimate purpose to be to unite doctors. I have also been involved with ethics and peer review committees, and in these committees, I have noted a trend towards a lack of collegiality among my colleagues.

It has consistently been brought to my attention that the ethos of collegiality and professional courtesy has been lost in recent times.

In the past, there was always an unwritten code of conduct that when a colleague presented as a patient, the practitioner elected either not to charge them a professional fee (especially if they were private paying patients), or to bill their medical scheme directly at the scheme rate. This was a professional courtesy sometimes extended to either the medical practitioner or their closest kin. This was always at the discretion of the practitioner. This is not a rule, but a token of collegiality.

In recent times, SAMA has received complaints and comments from doctors

(many of them elderly retired practitioners) who are not only billed, but billed excessively, by their colleagues. The increasing number of applications to the SAMA Benevolent Fund in recent times, as well as the current scary SA economy, reflect the fact that doctors entering retirement are struggling financially. It is, then, in fact, shocking that a colleague would then bill them tariffs in excess of 200 - 300% above the National Health Reference Price List (NRPL) rate.

I would encourage everyone to revive this unwritten rule of making a special consideration for a colleague (especially retired doctors). We, as a profession, encounter many obstacles within our practices (funders, litigation, practice costs, etc.), but we should attempt to preserve this standard of practice where our colleagues are concerned. It is an act of kindness that we should "pay forward" so that we may enjoy its rewards when we are the patient one day.

I am sure there are many differing opinions on this view that some deem very old-fashioned in

these times. I am well aware that many practices or practitioners suffer from financial constraints. Our professional value and services are often undervalued despite the attention and good care that we provide to our patients. We are not appropriately remunerated for the services given at all, and it is sometimes not easy to not bill a colleague or give someone a discount.

In fact, acrylic nails cost more than actually having a consultation, with all of the intellectual capabilities and intelligence that we have, in order to try to save people's lives, empower them and improve their healthcare. However, we are all in the same boat and suffer the same issues and problems within this flawed healthcare system.

And before you launch a scathing criticism of this suggestion of collegiality, kindly bear in mind that the suggestion is written by an obstetrician and gynaecologist whose medical indemnity is creeping close to ZAR1 million.

In closing, colleagues, value your fellow practitioners, especially retired doctors, and treat them as you would like to be treated.

Ncayiyana: A Dan for all seasons

Prof. J P van Niekerk

As Prof. Dan Ncayiyana steps down as president of SAMA we publish the following tribute by friend and colleague Prof. J P van Niekerk.



Prof. Dan Ncayiyana, past president of SAMA, is among the most respected and influential medical men in SA, given the variety, scope and importance of his contributions. His career has taken him from student activist through practising obstetrics and gynaecology, to becoming an editor and a vice chancellor, with many other activities in addition.

A true Zulu, Dan was born and raised in Port Shepstone, KwaZulu-Natal. He was admitted to the University of Natal medical school in 1960, where he was a student activist, having joined the Pan African Congress (PAC) political party (The PAC anti-pass campaigns were to be non-violent, but these turned violent in Sharpeville and Langa when police fired on and killed many protestors. Philip Kgosana then led the Langa march to the police headquarters at Caledon Square on 30 March 1960).

Dan's studies were interrupted in his third year when he was jailed for underground political activism, and on release he was required to report to the police daily. As his situation had become intolerable, Dan skipped the country, which is a fascinating saga on its own!

From Lesotho he went overland to Botswana, and from there to the Congo, where he was again jailed in Kinshasa (the Congolese government were against South Africans). Jonas Savimbi played a role in his release. Through the Dutch embassy he obtained a scholarship (for refugees from Hungary!) to continue his studies at the University of Groningen in the Netherlands. In addition to obtaining his primary medical degree, he also met and married Klem, who shared his remarkable career until her untimely death from cancer.

Dan continued his postgraduate studies at New York University, specialising in obstetrics and gynaecology, which he practised and taught in the USA for 15 years, gaining citizenship in the process. He was admitted as a Fellow of the American College of Obstetricians and Gynaecologists (FACOG).

Despite a comfortable and happy stay in the USA, Dan longed for SA, where he felt that he belonged and could contribute more. At that time the only place that he could go to was the "independent" homeland of the Transkei, where he practised for 7 years. It was not long before he was involved in the establishment of the University of Transkei (now Walter Sisulu University – WSU) medical school, where he pioneered the community-orientated curriculum that also promoted problem-based learning. He was variously professor of obstetrics and gynaecology, chief medical superintendent of the Umtata General Hospital, dean of the Faculty of Health Sciences (1989-1991) and acting vice chancellor of WSU (1991-1993). However, by this stage, Klem had zero enthusiasm for remaining in Umtata.

At this point, chance stepped in, as the *South African Medical Journal (SAMJ)* was looking for a new editor. Dan was asked to apply by Lorraine Griessel, who had been secretary to previous editors and knew of Dan's contributions to the publication *You and Your Baby* and others. The selection committee found that Dan was the most suitable candidate, and enthusiastically recommended his appointment. However, this was opposed by members of the Medical Association on the grounds that he did not speak Afrikaans – yet Dan is competent in English, Dutch, Zulu and some French, while the previous editor had no Afrikaans experience. Clearly this was a racial issue, which was resolved only after some embarrassing incidents.

Dan served as a distinguished editor-in-chief of the *SAMJ* for 20 years (1993 - 2012), and as an editor emeritus he still reviews manuscripts and provides advice to the journal. He continued his editor's role in a part-time capacity when he was appointed deputy vice chancellor at the University of Cape Town (1996 - 2001) and founding vice chancellor of the Durban University of Technology (2001 - 2005). The latter

university was the result of the first successful academic merger in SA.

Influence

Dan's CV is that of a busy and influential leader. His academic publications and many editorials, lectures and appointments attest to the fact that he is universally liked and trusted. This does not mean that he shies away from controversy. Thoughtful contributions have raised the ire of many, such as his prescient editorial 20 years ago advocating the legalisation of marijuana; his impish lament ("Islam needs a Pope") about religious fanatics in Nigeria preventing vaccination against smallpox, which resulted in a fresh outbreak of the disease; and his strong words on the Israel/Palestinian war (imagine in short succession angering both conservative Muslims and Jews!)

His wisdom and competence to undertake many important projects has been recognised by both local and international organisations such as the WHO and the World Bank. These projects have included the establishment of new medical schools in Limpopo and Ghana. Recognition has also come in the form of honours and awards, such as honorary memberships and fellowships of prestigious organisations, and an honorary MD from WSU. He is currently chair of the SA Advisory Committee of the Medical Protection Society.

In Robert Sobukwe's inaugural speech as the first president of the PAC, he spoke in favour of "non-racialism", as the term "multiracialism" implied basic and insuperable differences between the various national groups. In word and actions, Dan epitomises this ideal. His happy, mixed family comprises three biological children and a similar number adopted. They also raised several grandchildren.

It has been said that the closest we can get to immortality is to have influenced others (preferably for the good). Through his works, values, modesty, kindness, understanding of human strengths and failures, and belief in and encouragement of others, Dan has influenced many. Those of us who are privileged to count him as a friend and colleague especially appreciate his warmth and sense of humour.

Source: The Cape Doctor, August 2017

Is critical-care medicine in ICU?

SAMA Communications Department

Critical-care medicine, or intensive-care medicine, remains a vital component of health provision locally and worldwide. But the provision of this “critical” service is not without its challenges. These range from a shortage of available ICU beds, a scarcity of human resources and, almost unseen, a massive emotional and physical burden on those who provide it.

The recent Critical Care Society of Southern Africa (CCSSA) congress, held at the Sun City conference centre in the North West province, not only explored the different aspects of critical care, but, importantly, sought to address these challenges.

“You can read journals, and do research on critical care, which is exceptionally important. But to actually meet other people who are involved in ICU care, experts from SA, and from all over the world, adds another dimension. When you can share experiences with the experts we invited here, it takes it to an altogether higher level,” says Prof. Fathima Paruk, chair of the CCSSA congress and head of the Department of Critical Care at the University of Pretoria.

Prof. Paruk says an important element of the congress was the key insights that were shared by important opinion-makers regarding how different conditions are managed by different people.

“It’s this engagement between peers which leads to introspection and thought-

provoking self-analysis. People walk away here asking, ‘Am I doing the right thing?’ and that’s important. Another major benefit is [that] people in the industry get involved, and the delegates are exposed to new technologies and therapies in their field of work,” adds Prof. Paruk.

She says people left the congress invigorated, and the seeds of new ideas on how to better manage ICU care were sown.

But underneath this obvious benefit is a major problem facing critical-care provision in SA.

“Clearly, understanding the business of providing intensive care is only one element of what’s happening at the moment. The other side is that there is a huge shortage of nurses, particularly for critical care, and then we also have this problem of a shortage of ICU beds,” she says.

It’s a view shared by Prof. Ivan Joubert, president of the CCSSA, and head of critical care at the University of Cape Town.

“Nursing shortages and beds are big issues. But so is the lack of career pathing for intensivists. This is an interesting paradox, because the need for intensive-care specialists is actually growing as the modernity of intensive-care technology increases. There’s a buzz to being involved in critical care, and an intellectual challenge every day, but not enough doctors are following this route,” he says.

He adds that funding for intensive-care posts is also not as it should be, meaning academic hospitals are struggling to produce the required number of intensive-care doctors and nurses.

Triage for critical care

It’s these and other issues that led the congress organising committee to come up with ideas on how to address challenges facing intensive-care medicine. It did so through arranging a round-table meeting, involving national experts to discuss and provide direction on triage for critical care in SA.

“This triage approach to critical care, we believe, will provide some answers on how we should address the issues we face going forward. For the CCSSA, it’s about also having a meaningful output from congress, and addressing challenges that our clinicians face,” says Prof Paruk.

The round-table discussions were chaired by Prof. Gavin Joynt, an SA doctor now resident in Hong Kong. He is the chairman of and a professor in the Department of Anaesthesia and Intensive Care at the Faculty of Medicine of the Chinese University of Hong Kong.

“A major problem with assessing intensive care in SA is the lack of published data. And SA has unique problems in terms of the incidence of HIV and TB. So the purpose of our round table was to create a set of guidelines that take all of these factors into consideration, and can then be used as a template for intensive-care provision,” he says.

Prof. Joynt agrees that the current system is, as he says “resource-insufficient”, and that the provision of intensive care is extremely expensive.

“But there are resources available, which maybe aren’t being used effectively. Through our discussions, and the eventual guidelines we create, we want to provide a framework that is fair, just and equitable, and that utilises the available resources to the maximum. They must inform critical care going forward,” he says.

He explains that this means doctors will have to ask themselves questions before making decisions on who receives critical care, and for what reasons. It’s not about making an emotional decision, he says, it’s about making



Audience participation at the Critical Care conference

a rational, thought-through analysis of what's best for the patient, and for the ICU.

And, says Prof. Joynt, by adopting a clearer set of guidelines which govern the triage of patients in ICU, a better understanding of why patients aren't getting into ICU will develop.

"Are patients not getting into ICU because of resources, or are they not getting in because of their prognosis? And when they do get in, what happens to them, and how? These are important questions which can be answered through a more methodical approach," he contends.

Plans are to formulate the guidelines and publish them so that they can be scrutinised and, effectively, peer-reviewed by the broader critical-care community.

"We hope these will be adopted by both public- and private-sector hospitals and units, because the benefits will be greater than if they are not. It will also, hopefully, make data collection better, and give us a more complete picture of the current situation regarding critical care in the country," he says.

Burnout

Apart from the ongoing issues of a lack of human resources and beds, critical-care

healthcare workers also face the real problem of burnout.

"Burnout is real. It's not a character flaw or a weakness, and the biggest challenge is to recognise it in ourselves, and to put measures in place to prevent it," says Prof. Ruth Kleinpell, president of the Society of Critical Care Medicine and director of the Centre for Clinical Research and Scholarship at Rush University Medical Center in Chicago, USA.

"Burnout is not something we should laugh about," she says, adding, "It affects a lot of clinicians and health workers. Many leave ICU, and many others leave the profession entirely. In fact, it's the medical speciality with the highest burnout rate."

As a result, much research is being done to deal with burnout among intensivists. This research has come up with some unique solutions. Among these is pet therapy, where service dogs are brought to "visit" health workers once a week.

"The effects have been great, with many workers reporting lower stress, and an ability to function better after the visits," notes Prof. Kleinpell.

Other measures being used by Rush University Medical Centre include limiting the number of days worked consecutively by

workers, creating support groups and having team debriefing sessions.

"We also have stress-reduction training available, encourage workers to sleep more and offer so-called respite rooms for workers to have a nap and destress," she says.

All in all, Prof. Kleinpell explains, the issues faced by intensive-care staff are enormous, and need resilience to overcome.

In the SA context, these issues may be heightened, as other issues apart from clinical and ethical questions must also be considered.

Given this, then, the CCSSA believes its congress, and the way it intends addressing the issues in intensive care, is critical to the wellbeing of the profession.



Conference attendees

The modern Physician's Pledge

SAMA Communications Department

In October this year, SAMA joined thousands of physicians in welcoming a modern successor to the Hippocratic Oath. As the contemporary successor to the 2 500-year-old oath, the Declaration of Geneva, which was adopted by the WMA at its second General Assembly in 1948, outlines in concise terms the professional duties of physicians, and affirms the ethical principles of the global medical profession.

The updated version, called the Physician's Pledge, addresses a number of key ethical parameters, and refocuses the text to reflect changes over the decades in the relationship between physicians and their patients, and among physicians themselves.

For the first time, the text states that physicians are to respect "the autonomy and dignity" of patients, calling for doctors to keep patient information confidential and to share medical knowledge. Respect within the profession is also emphasised.

The Physician's Pledge

As a member of the medical profession:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELLBEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity, and in accordance with good medical practice;

I WILL FOSTER and honour the noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, wellbeing, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour.

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MEMBER BENEFITS

WMA statement on medical cannabis

Dr Selaelo Mametja, *acting general manager, SAMA*, Dr Mzukizi Grootboom, *chairman, SAMA*

The proposed WMA statement on medical cannabis was prepared by SAMA. The WMA council in Buenos Aires (April 2016) decided to circulate it for comments. After consideration, the 203rd council sent back the document to SAMA for further revision before a new circulation for comments.

The 206th council in Livingstone forwarded the statement to the General Assembly for adoption. The statement was finally adopted by the 68th General Assembly in Chicago, in October 2017.

We wish to express our gratitude to the SAMA health policy committee and the knowledge, management and research department team for researching the topic and compiling and reconciling comments from a number of medical associations. This statement would not have been possible without their hard work and dedication.

To our doctors, who raised the issue and kept on knocking on our doors to obtain advice, thank you for raising this important topic.

The suggestion of legalising medical cannabis in SA was proposed in 2014 by the late Inkatha Freedom Party (IFP) Member of Parliament, Mario Oriani-Ambrosini, in the form of a private member's bill, the Medical Innovation Bill. Our interest in cannabis arose as a result of requests from the media to comment on the potential legalisation of cannabis for both recreational and medical purposes. Despite diverse opinions on the benefits of medical cannabis, there is an overwhelming agreement amongst health professionals that the recreational use of cannabis should be opposed, and strategies to prevent and reduce cannabis use supported.

Because of the local high burden of disease due to cannabis use, it is important that local research be conducted.

We are pleased to present this WMA home-grown statement to our members, and will continuously update you on the developments regarding cannabis.

WMA cannabis statement

- Cannabis is the generic term used to denote psychoactive preparations of the plant *Cannabis sativa*, which grows wild in many parts of the world and is known by numerous other names, such as: "marijuana", "dagga", "weed", "pot", "hashish" or "hemp".
- Cannabis for medical use refers to the use

of cannabis and its constituents, natural or synthetic, to treat disease or alleviate symptoms under professional supervision; however, there is no single agreed-upon definition.

- Recreational cannabis use refers to the use of cannabis to alter one's mental state in a way that modifies emotions, perceptions and feelings, regardless of medical need.
- This WMA statement is intended to provide a position on the legalisation of cannabis for medical use, and highlight the adverse effects associated with recreational use.
- Recreational cannabis use is an important health and social issue across the world. Cannabis is the most commonly used illicit drug in the world. The WHO estimates that about 147 million people, 2.5% of the world population, use cannabis, compared with 0.2% using cocaine and 0.2% using opiates.
- The WMA opposes recreational cannabis use, due to serious adverse health effects such as increased risk of psychosis, fatal motor vehicle accidents, dependency and deficits in verbal learning, memory and attention. The use of cannabis before the age of 18 doubles the risk of psychotic disorder. The ominously growing availability of cannabis or its forms in foodstuffs such as sweets and "concentrates", which have enormous appeal to children and adolescents, requires intensive vigilance and policing.
- National medical associations should support strategies to prevent and reduce recreational cannabis use.
- Evidence for use of cannabis for medical use:
 - Cannabinoids are chemical constituents of *Cannabis sativa* that contain similar structural features; some of the chemical constituents act on human cannabinoid receptor cells. Conceptually, the cannabinoids that activate these receptors: (i) occur naturally in the human body, like other endogenous neurotransmitters (endocannabinoids); (ii) occur naturally in the cannabis plant (phytocannabinoids); or (iii) are pharmaceutical preparations containing either synthetic cannabinoids, (e.g. delta-9-tetrahydrocannabinol (dronabinol, Marinol), or a related compound, nabilone (Cesamet), or extracts of phytocannabinoids (nabiximols (Sativex)).
 - Amongst the phytocannabinoids is

naturally occurring *Cannabis sativa*, delta-9-tetrahydrocannabinol (THC), the main bioactive cannabinoid and the principal psychoactive constituent, while cannabidiol (CBD) is the second most abundant. CBD lacks significant psychoactive properties but may possess analgesic and antiseizure properties.

- The human endocannabinoid system is believed to mediate the psychoactive effects of cannabis and is involved in a variety of physiological processes, including appetite, pain-sensation, mood and memory. The significant medical and pharmacological therapeutic potential of influencing the endocannabinoid system has been widely recognised.
- The medical benefits of cannabis reported in the scientific literature are widely debated globally. Cannabis has been used for the treatment of severe spasticity in multiple sclerosis, chronic pain, nausea and vomiting due to cytotoxics, and loss of appetite and cachexia associated with AIDS. Evidence suggests that certain cannabinoids are effective in the treatment of chronic pain, particularly as an alternative or adjunct to the use of opiates, so that the development of opiate tolerance and withdrawal can be avoided. Evidence supporting the use of cannabis for medicinal purposes is of low to moderate quality, and inconsistent. The inconsistency can be partially attributed to the prohibition of cannabis. Its classification as an illegal substance in some countries has constrained safe and high-quality clinical research.
- The short-term adverse effects of cannabis use are well documented. However, the long-term adverse effects are less well understood, particularly the risk of dependence and cardiovascular disease. There are also significant public-health concerns for vulnerable populations such as adolescents and pregnant or breastfeeding women.
- Despite weak evidence of its medical benefits, cannabis for medical use has been legalised in some countries. In other countries, medical cannabis is forbidden or under debate.
- Medical professionals may find themselves in a medicolegal dilemma as they try to balance

their ethical responsibility to patients for whom cannabis may be an effective therapy, and compliance with applicable legislation. This dilemma can manifest itself both with patients who may medically benefit from the use of cannabis, and those who are not likely to do so, but pressure medical professionals to prescribe it.

Recommendations

- Cannabis research:
 - In light of the low-quality scientific evidence regarding the health effects and therapeutic effectiveness of cannabis, more rigorous research involving larger samples is necessary before governments decide whether or not to legalise medical cannabis for medical purposes. Comparators must include the existing standards of treatment. The expansion of such research should be supported. Research should also examine the public-health, social and economic consequences of cannabis use.
 - Governments may consider reviewing laws governing access to and possession of research-grade cannabis for the purpose of allowing well-designed scientific research studies to broaden the evidence base on the health effects and therapeutic benefits of cannabis.
- In countries where cannabis is legalised for medicinal purposes, the following requirements should apply:
 - Requirements for producers and products:
 - The provision of cannabis plant products for treatment must be in accordance with the UN Single Convention on Narcotic Drugs of 30 March 1961, including the convention's rules on production, trade, and distribution. Therefore, it is essential that the cannabis included in the products delivered for medical treatment is provided and handled in accordance with the requirements of the convention.
 - Requirements include that the cannabis plants meet appropriate quality demands for growing and standardisation. The produced cannabis plant products must have a specific indication (interval) of ingredients, including the content of delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD), and a strength indication of these.
 - Requirements for the prescription and dispensing of cannabis for medical purposes:
 - Cannabis must be prescribed by an authorised physician/prescriber in accordance with the best level of evidence and the country's regulatory frameworks.
 - It is recommended that treatment with approved conventional drugs is

attempted before cannabis products are used for treatment.

- Each individual physician must make a decision regarding and take responsibility for treatment with cannabis products, in accordance with the best available evidence and country-specific registered indications.
- Cannabis for medical purposes must only be dispensed at pharmacies or by authorised dispensers in accordance with the country's regulatory frameworks.
- Effective control measures must be put in place to impede the illicit use of medical cannabis.
- Public-health surveillance systems to monitor prevalence of cannabis use and trends in utilisation patterns are necessary.
- In considering policy on and legislation of cannabis, governments, national medical associations, policymakers and other health stakeholders should emphasise and examine the health effects and therapeutic benefits based on the available evidence, while also recognising various contextual factors such as regulatory capacity, cost-effectiveness, societal values, social circumstances of the country and the public health and safety impact on the wider population.

References are available on request.

Know your rights!

Phumzile Gwala, *SAMA industrial relations advisor, Public Sector Department*

It has been brought to SAMA's attention that some sessional doctors have been inadvertently entering into unfavourable contracts, due to the fear of being without these sessions. Legally speaking, this conduct has negative implications, in that it can weaken one's case when a dispute is challenged under the auspices of the bargaining council as a claim for dismissal in terms of Section 186(1)(b) of the Labour Relations Act No. 66 of 1995. A sessional doctor might think that a contract is of benefit to him/her but, the complications start when that less favourable contract comes to an end and the employer decides not to renew it.

Case law has shown that, for an employee to succeed in claiming dismissal based on this section, the following factors have to be

taken into consideration. From the evidence, the employee must prove that:

- The employer did not give reasonable notice that the contract will not be renewed.
- The affected employee had a reasonable expectation of renewal of a fixed-term contract of employment on the same or similar terms as the previous contract, but the employer offered to renew it on less favourable terms.
- The contract has previously been renewed on a regular basis for a lengthy period without any break in service.
- There is a need for a sessional doctor's services (for example, some departments cannot provide a 24-hour service without engaging these doctors)
- There are no permanent posts advertised

to cover the work that should be done by sessional doctors.

- The employer was inconsistent, in that certain sessional doctors' contracts were extended, while others were terminated.
- There was no consultation about the change in the employer's operational requirements, as stipulated on the policy on employment of sessional doctors, as well as their contract of employment. (Doctors were not afforded an opportunity to come up with alternative solutions short of their termination or a change in the terms of their annual fixed-term contracts).

Based on this premise, I therefore appeal to members to at least consult SAMA industrial relations for advice and guidance prior to entering into sessional contracts.

International lessons on effective and successful organ-donation systems – considerations for SA

Bernard Mutsago, *SAMA health policy researcher*

Despite the momentous global achievement – thanks to advances in medical science – of many successful, lifesaving human organ and tissue transplants, the organ-transplantation space has been beleaguered by numerous challenges, unscrupulous happenings and higher global demand for than supply of organs. The impact of a global donor shortfall has manifested in a number of unethical activities, most commonly organ trafficking, transplant tourism and organ commercialisation, all targeting vulnerable populations such as poor people, prisoners, the illiterate and immigrants. The number of legal organ donors in SA remains critically low, and the nation has not been spared by organ-trafficking incidents.

There are two ways to donate organs or tissues: either as a living donor, or after death (cadaveric donation or deceased donor). Deceased donations are more common than living donations in SA. Many ethical debates surround organ donation and transplantation, including the issue of presumed consent, and the reimbursement of funeral costs for a deceased donor. The Declaration of Istanbul (DOI), established in 2008 and currently endorsed by over 100 nations, sets out the principles for the international promotion of ethical and effective organ donation and transplantation, with particular emphasis on the protection of vulnerable organ donors. SA organisations which endorse the DOI include the SA Transplant Society, the SA Renal Society and the ministry of health.

The success of organ-donor programmes differs from country to country. In the USA and Australia, for example, as many as 37% and 24% of the populations, respectively, have registered as donors, compared with only 0.2% in SA. Certain countries have initiated local measures to improve donation rates. Presumed consent or ‘mandated choice’, for example, is a policy being implemented in countries such as Belgium, Sweden, Spain, Austria, Finland, France, Norway, Denmark and Singapore. This policy makes every citizen in those countries an organ donor by default, with an option for opting out.

The ethics of organ donation and transplant are too deep and complex to be exhausted in this article. Three of the key ethical concepts in organ donation are the principles of:

- **financial neutrality** (living donors should neither gain nor lose financially as a result of their donation, but can be reimbursed for general reasonable and verifiable medical expenses, and any loss of earnings incurred)
- **self-sufficiency** (organs must be donated and used within the local population concerned, with international co-operation where needed)
- **allocation priority** (granting priority on organ-donor waiting lists to individuals who have consented to be donors).

The principle of financial neutrality therefore prohibits the explicit sale or purchase of human organs and tissues, which are already illegal in SA. The notion of donation as altruism ought to be consistent with the philosophy of *ubuntu* in SA.

Achieving self-sufficiency entails a government and its citizens co-operating to increase the number of willing donors, and at the same time working to decrease the burden of chronic diseases that lead to organ failure.

There have been mixed results in countries implementing the presumed-consent legislation. On one end of the spectrum, some countries have experienced a spike in donations, e.g. Spain, which saw a 20% increase, and which now has the highest donation rate in the world. Yet legislation was not the only factor in Spain’s success, and countries at the other end of the spectrum, e.g. Chile, failed dismally, despite having presumed-consent legislation. With regard to the effect of reimbursing for donations on rates of donation, it is difficult to draw conclusions, because of mixed experiences in various countries, but the countries with the highest organ-donation rates do not directly pay for organs but cover for “reasonable costs”, to avoid financial harm to donating persons or their families.

WMA Statement on Organ and Tissue Donation

The medical community and health policy makers, particularly transplant professionals, have a duty to create an ethical national system of organ transplantation, to combat organ trafficking, to promote the maximum availability of organ donations within their respective countries and to advance their countries toward self-sufficiency in organ donations and transplants. This is in line with the policy thrusts of key international health and medical authorities, such as the WHO and the WMA. In October 2017, the WMA issued a revised version of the statement first adopted in 2012, called the *WMA Statement on Organ and Tissue Donation*. This policy is based on a number of core ethical principles: altruism, autonomy, beneficence, equity and justice. The statement, which applies to organ and tissue donations but not to blood donations, emphasises the notion of donation as a gift that should be freely and voluntarily given.

The statement promotes the principle of informed donor choice, and supports public-awareness campaigns for both doctors and patients. It encourages the establishment of national protocols through the agency of medical associations. Importantly, the statement discourages transplant surgeons from accepting organs or tissue obtained unlawfully. The full statement can be accessed on the WMA website.

SA

In SA, the legal framework for organ and tissue donation mainly comprises of the Constitution (Bill of Rights), the National Health Act No. 61 of 2003 (Section 60(4)(a)) and the regulations regarding the general control of human bodies, tissue, blood, blood products and gametes. Despite SA having huge potential for organ donations (due to many trauma cases), the number of South Africans willing to donate organs remains critically low, at 0.2% of the country’s population. The country’s miniscule donation rates (less than one per million population for Gauteng Province alone)

compares poorly with countries like Spain, which has a donation rate of 36 per million. As many 6 000 SA adults and children are on the waiting list for transplantation, and sadly, many die while waiting, as fewer than 600 transplants are performed each year. The Organ Donor Foundation of SA (ODF) – a national not-for-profit and public-benefit organisation – runs and maintains a database where members of the public can register as organ donors. The ODF's goal is to register 1% of the SA population as donors by the end of 2020.

It seems utterly paradoxical that in a country where the world's first human heart transplant was performed by Dr Christiaan Barnard in a state facility (Groote Schuur Hospital), the same state sector only performs about 10% of all transplants in the country, the remainder being handled by private facilities.

One of the routine publications of the ODF raised fundamental questions for SA: is transplantation really supported in our society, and is the information readily

available? Is the public optimally educated? When next of kin refuse donation, are they really giving informed denial? Are medical professionals optimally educated? Are there enough transplant co-ordinators? Is there a co-ordinator team that is valued, cohesive and supported? Is the state invested in providing this lifesaving service? Is transplantation reasonably accessible to all? This set of questions is a precise diagnosis of the character of the donation and transplant problem in SA.

The most widely quoted contributing factors to SA having one of the lowest donor registration rates in the world are: religious and social beliefs; a lack of infrastructure and government support; legislative loopholes; a shortage of transplant facilities; public ignorance; poor funding; health professionals' ignorance about brain-death diagnosis; the high burden of organ-damaging chronic diseases; and many brain-dead patients not being medically suitable as donors, or not referred to transplant teams by treating doctors.

How can SA steer itself out of these problems? As mentioned earlier, implementing presumed-consent policy is not in itself a guarantee of better donation rates. A recent roundtable discussion on organ donation in SA, convened at the University of the Witwatersrand by Prof. Ames Dhali and other medical and ethics experts, agreed on a set of possible measures needed in SA, namely:

- legislative overhaul, to focus on organ donation
- an intense public-awareness drive
- the promotion of the establishment of organ-donor registries
- the involvement of health professionals in developing policies
- engagement with the health department's Directorate of Chronic Diseases.

In view of the dire shortage of organ donors, and the need to improve the organ-donor system in SA, SAMA will adapt the WMA statement and tailor it into a local (SAMA) statement to be used as an advocacy tool.

Setting up a CPD questionnaire

Lisa Reid, SAMA CPD accreditation officer

The following are SAMA guidelines on how to set up a multiple-choice questionnaire (MCQ) for CPD accreditation.

Aims of an MCQ

- Assessment of learning achieved through CPD activities.
- Assessment of education acquired from the relevant reading material.

No more than three questionnaires may be completed at a single activity or linked to a specific activity. CPD points for MCQs may only be issued to delegates as a standalone activity. Points may not be allocated to delegates for MCQs and live presentations. Either the Level-1 activity must be accredited, or the MCQ – not both within 24 hours.

Setting an MCQ

- Accompanying reading material should be of acceptable content/scientific published material, requiring approximately 1 hour of reading per 10 pages.
- A single individual should be responsible

for compiling, marking and archiving MCQ questionnaires.

- Reading material, questionnaires and the CV of journal editor(s) should accompany applications for accreditation.
- Applicants may not issue points to medical professionals for Level-1 and Level-2 activities for the same learning topic within 24 hours. Level-1 applications must be separately accredited, not in combination with the questionnaire.
- A score of 70% is required to successfully complete a questionnaire.
- On successful completion of the accredited questionnaire, points are issued according to HPCSA guidelines.

For accreditation of CPD applications by SAMA email cpd@samedical.org.

Content of the MCQ questionnaire

- MCQs must be based on the accompanying reading material, which should be published evidence-based material of no older than 5 years.



- The questionnaire must contain a minimum of five MCQ questions.
- Each MCQ question must contain a minimum of four answer options, when not using true-or-false questions.
- MCQs may be of the "single correct answer" or "multiple correct answer" formats.
- The questionnaire should contain no commercial product promotion, sarcasm or jokes.
- A maximum of 20% of the questions may contain true-or-false answers
- Each questionnaire must be approved, and no annual accreditation numbers may be issued.

For further information on CPD accreditation, please contact Lisa Reid on 012 481 2082, or cpd@samedical.org.

EMGuidance: Prescribe with confidence

SAMA Communications Department

Founded by local South African doctors, and used by over 8 000 medical professionals, Essential Medical Guidance (EMGuidance) is a clinical support platform which aims to improve patient outcomes by providing instant access to locally relevant, evidence-based medicines information and clinical guidelines, clinical-decision support tools and care co-ordination information.

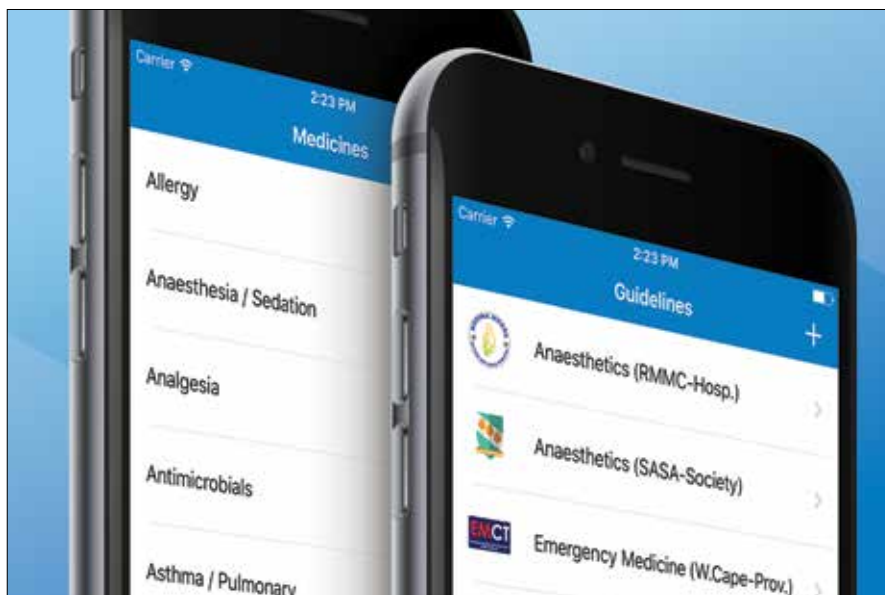
"As doctors, we've all found ourselves having to dig around and trawl for information when treating a patient, and certainly what Mohammed and I found was that much of the available information is either not necessarily accurate for our country, or is out of date ... we knew that technology could fix this, and set about building medical informational apps (the HIV Clinical Guide, EML [Emergency Medicines List] Clinical Guide and others), which we've now brought into a single platform. From a user's perspective, a platform approach delivers the most value ... people don't want lots of point-focused apps, they want the convenience and efficiencies which platforms can deliver," says one of the founding doctors, Dr Yaseen Khan.

The EMGuidance platform is free for medical professionals (it requires registration of your professional details), and is available via an iOS, Android, and website/desktop app.

EMGuidance currently has four core sections: Medicines, Guidelines, Tools and Care Co-ordination.

The **Medicines** section is SA's most comprehensive and consistently updated, fully referenced medicines resource, created in partnership with a national network of pharmacologists, specialists and academic institutions. Here you find information such as paediatric and adult dosing, contraindications and cost information for each active ingredient and medicine, and there are also interactive features which let you search intuitively for medicines, request more information, speak to medical reps, report an adverse reaction and perform National Department of Health reporting around certain medicines.

The **Guidelines** section publishes over 1 200 locally relevant clinical guidelines on behalf of 25 local institutional partners. This section of the app is constantly growing as



Meet the founders

Mohammed Dalwai (COO of EMGuidance) holds an MB ChB from Stellenbosch University, and is passionate about the impact of medicine within the rural context, having completed his community service at Manguzi, a rural community, in the Maputaland region of KwaZulu-Natal Province. This led him to join Médecins Sans Frontières/Doctors Without Borders as an ER doctor in various countries, including Pakistan, Libya and Syria. In 2012, the *Mail & Guardian* recognised Mohammed as one of SA's Top 200 young and most interesting people, specifically for his groundbreaking work around the SA triage score and its implementation across the world. He is currently pursuing a PhD in emergency medicine. Mohammed cofounded the mobile health initiative, the Open Medicine Project SA, which essentially seeks to empower SA healthcare workers through mobile technology, in partnership with the National Department of Health (NDoH) and other institutions. Mohammed believes in the accumulative value of individual contributions, with the overall imperative of changing the world, one step at a time.

Yaseen Khan (CEO of EMGuidance) is a medical doctor and technology entrepreneur. Five years ago, after his experiences as a practicing ER doctor and GP, he cofounded the non-profit organisation, the Open Medicine Project, to address clinical support and information needs among healthcare workers, which saw the development of numerous mobile medical apps, and acted as a mobile innovation partner to the NDoH and Médecins Sans Frontières/Doctors Without Borders, among other institutions. He has been involved in a number of mobile- and medical-device initiatives, and has received distinguished global accolades for his work in mobile health and social entrepreneurship. His academic background includes a Master's degree in clinical epidemiology, and a diploma in primary emergency care.

new guidelines and protocols are brought on. It is geolocated so that users only see the guidelines most relevant in their location.

The **Tools** section is a growing library of common clinical-decision support tools. This library will also include more bespoke/focused tools to support specific prescribing.

The **Care Co-ordination** section is a user-generated directory to assist in the management of patients through the system. It includes information such as clinic referral criteria and call rosters, and service providers.

EMGuidance is primarily focused on supporting point-of care-scenarios. Founders Yaseen Khan and Mohammed

Dalwai believe that pharmaceutical companies, provided with the right channels, have a lot of value to add to medical professionals. The Medicines section of the app enables pharmaceutical companies to provide supplementary content around their products, which will add value and augment the EMGuidance-produced and curated content. To maintain a high level of transparency within the platform, all sponsored content is very clearly marked, and only presented at the point where it is of contextual relevance –

i.e. when a medical professional is looking for it.

By focusing on supporting medical professionals with exactly what they need to deliver care in the local setting, and taking a collaborative approach in involving academia, key opinion leaders, industry and health authorities in any given region, EMGuidance aims to ultimately become an instrumental platform in supporting medical professionals and improving the quality of patient care at scale across SA and the developing world.

Some user feedback

Wilmarie De Villiers: “Thank you for the fantastic app! I’m working in a government facility and it’s making my life a lot easier!”

Vusani Ndou: “I have been using the app for some time and it’s been amazing thank you ... The app has made a massive impact on how I practise. Much appreciated.”

Ndumiso Sibisi: “Thank you Mohammed ... I live on this app ... very useful.”

Telemedicine in SA

Wendy Massaingaie, SAMA Governance and Legal Department

Are there are current guidelines or regulations with regard to telemedicine? The HPCSA defines telemedicine as “the practice of medicine using electronic communications, information technology or other electronic means between a healthcare practitioner in one location and a healthcare practitioner in another location. This is for facilitating and enhancing clinical, educational and scientific healthcare and research, particularly to the underserved areas in the Republic of SA.”

The HPCSA, in 2012, proposed that clinical, operational and ethical guidelines be developed by the governing bodies or associations of the various clinical disciplines, using information and communication technologies in the provision of healthcare, with the aim that a regulated telemedicine environment would ensure improved access, service delivery and quality of

care for rural communities in SA. The HPCSA has since released its *General Ethical Guidelines for Good Practice in Telemedicine – Booklet 10*, which were compiled in 2014. These will be discussed in more detail below.

Current position

The HPCSA has provided circumstances under which telemedicine may be utilised, in line with the ethical rules. The guidelines state: “The objective of the SA Telemedicine System as established by the National Department of Health is to deliver healthcare services at a distance to SA communities in under-served areas.” The need for telemedicine has increased over the past few years, leading to the implementation of the guidelines. The guidelines stipulate who bears the primary responsibility when it comes to telemedicine, and state that

before the servicing practitioner can provide treatment or issue electronic prescriptions using telemedicine, the consulting practitioner must provide a medical history, as well as any other necessary information, with the patient’s consent, to the servicing practitioner. Therefore, mere treatment or issuing of prescriptions will not suffice without being accompanied by a report from the consulting practitioner.

Furthermore, detailed informed consent from the patient must be given in writing to the consulting practitioner. It is important to note that there must be an existing doctor-patient relationship in place, which would enable the servicing practitioner to reach a well-informed decision about the diagnosis, treatment or recommendation for the patient.

Conclusion

Medical practitioners, when employing telemedicine, should ensure that they act in the best interest of the patient, and that they do not contravene any of the ethical rules. Telemedicine is relatively new in SA, and as such, medical practitioners should, as far as possible, adhere to Booklet 10. Medical practitioners using telemedicine must advise their patients to have a face-to-face consultation with and/or examination by their primary medical practitioner, or to attend at a clinic. It should be stressed that the patient’s confidentiality should be protected at all times, and that the requirements for informed consent are met. In summation, telemedicine should be conducted by the servicing practitioner, in conference with the consulting practitioner.



Legal reform would have the biggest impact on medicolegal claims environment

The Medical Protection Society

Legal reform is essential if we are to begin to tackle some of the problems that have contributed to the challenging claims environment in SA, the Medical Protection Society (MPS) said on 3 November 2017.

In its response to the SA Law Reform Commission (SALRC) issue paper on medicolegal claims, MPS said that over the 6-year period from 2011 to 2016, there was a 35% increase in the number of claims being made against healthcare professionals in SA. Large claims in particular are on the rise. MPS has seen an increase of 121% in medical and dental claims valued at over ZAR1 million.

MPS said there are a multitude of complex factors that are contributing to the current claims environment, such as the lack of a patient-centred and robust complaints system, which is leaving many patients with litigation as the only viable avenue for redress. The lack of an efficient and predictable legal process for handling clinical-negligence claims contributes to the delays, with the cost of settling a claim increasing as time goes on.

MPS believes whole-system legal reform is essential and would have the biggest impact. The reforms it recommends include

the introduction of a prelitigation resolution framework, and the development of a patient-centred complaints process that allows for local resolution. In a legal system that can at times be unduly complex and potentially inaccessible, MPS said there is value in exploring alternative dispute resolution, such as the SA Dental Association's effective mediation process.

Dr Graham Howarth, head of medical services, Africa, at MPS said: "The SALRC are to be commended for tackling this issue so comprehensively – significant reform is needed across a range of issues that are addressed in their paper on medicolegal claims. This is a subject in which MPS takes a considerable interest, and we are keen to be part of the debate. In 2016 we wrote our policy paper, "Challenging the costs of clinical negligence; the case for reform," where we set out our proposals.

"We believe that the clinical negligence litigation system does not currently facilitate the efficient and fair resolution of disputes, and is unnecessarily adversarial. Additionally, it lacks transparency and is time-consuming and expensive.

"MPS is deeply concerned by the unsustainable increase in the cost of clinical negligence. It means that the state is diverting a significant amount of its funding away from frontline patient care towards claims. It is important that there is reasonable compensation for patients following clinical negligence, but this must be balanced against society's ability to pay.

"Legal reform could help to make the system faster and more efficient for patients and their families, highlighting the importance of a patient-centred complaints system to address concerns without the need to resort to litigation."

The Medical Protection Society Limited (MPS) is the world's leading protection organisation for doctors, dentists and healthcare professionals. They protect and support the professional interests of more than 300 000 members around the world. Membership provides access to expert advice and support, together with the right to request indemnity for complaints or claims arising from professional practice.

Medtronic conducts a Total Laparoscopic Hysterectomy workshop

Bokang Motlhaga, *junior marketing officer*

On 13 and 14 October, Medtronic conducted an interactive Total Laparoscopic Hysterectomy (TLH) workshop at the Ahmed Kathrada Private Hospital, Lenasia. In the opening address, Andre Laas, business unit manager at Medtronic, summarised Medtronic's mission as being to contribute to human welfare by the application of biomedical engineering to the research, design, manufacture and sale of instruments or appliances that alleviate pain, restore health and extend life. This workshop was a true practical reflection of Medtronic's mission statement. SAMA was invited



The operating team, from left: Dr Nana, Dr Laher and Dr Vallabh



Some of the attendees participating in the Stitching simulation

to witness this epitome of clinical CPD, which consisted of four live cases of the TLH theatrical procedure led by Dr Satish Vallabh, a gynaecologist and obstetrician at the Ahmed Kathrada Private Hospital, who was assisted by Dr Yahya Nana and the rest of the efficient team that works with Dr Vallabh regularly in theatre. The attendees watched the whole theatrical procedure unfold, while interacting with Dr Vallabh through questions and answers.

In his article titled "A single surgeon's experience in Total Laparoscopic

Hysterectomy", which aims to assess the benefits of TLH and to introduce it as a routine alternative to total abdominal hysterectomy, Dr Vallabh raises the concern of a need for more studies with better designs to investigate TLH. This workshop made a significant contribution towards such studies.

Medtronic showcased a few of their latest innovations within the medical equipment landscape, which included an effective stitching simulation which the attendees participated in practically.

In informal encounters with some of the attendees, many of them raised how impressed they were with this workshop; moreover, it could not have happened at a better place than the Ahmed Kathrada Private Hospital, an entity named after a phenomenal revolutionist – and that is what Medtronic is aiming for, to bring revolution to the medical fraternity while relieving the plight of patients, and diminishing health inequalities through innovation, using highly effective medical technology.

Undescended testis

The Medical Protection Society shares a case report from their files

Baby L M was taken to see his GP, Dr E, for his 6-week checkup. During this examination, Dr E noted that his left testis was in the scrotum, but his right testis was palpable in the canal. He asked LM's mother to bring him back for review in a month.

Two weeks later, his mother brought him to see Dr E because he had been more colicky and had been screaming a lot in the night. As part of that consultation, Dr E documented that both testes were in the scrotum.

LM was brought for his planned review with Dr E after another 2 weeks. Both testes were noted to be in the scrotum although this time the left testis was noted to be slightly higher than the right. His mother was reassured.

When L M was 16 months old, he appeared to be in some discomfort in the groin when climbing stairs. His mother was worried, so she took him back to Dr E for a check-up. Dr E examined him carefully and documented that both testes felt normal and were palpated in the descended position. He also noted the absence of herniae on both sides. He advised some paracetamol, and for mother to bring him back if he did not improve.

When L M was 15 years old he noticed that one of his testicles, felt different to the other. At that time he was found to have a left undescended testis, which was excised during surgical exploration.

L M's mother felt that Dr E had missed signs of his undescended testis when he was younger. A claim was brought against Dr E, alleging that he had failed to carry out adequate examinations, and that he should



have referred L M to a paediatrician. It was claimed that if Dr E had referred him to a paediatrician, then this would have resulted in a left orchidopexy, placing the testis normally in the scrotum before the age of 2 years, and so avoiding its later removal.

Expert opinion

The Medical Protection Society (MPS) obtained expert opinions from a GP and a consultant in paediatric surgery. Both were supportive of Dr E's examination and management. The consultant in paediatric surgery thought that L M had an ascending testis. This is a testis which is either normally situated in the scrotum or is found to be retractile during infancy, but later ascends.

He thought that even if L M had been referred in infancy, it would have been likely that examination would have found the testes to be either normal or retractile, and he would have been discharged with reassurance.

He explained that it is thought that testicular ascent occurs around the age of 5 years. Therefore, on the balance of probabilities, referral to a paediatrician before the age of 4 would not have led to a diagnosis of an undescended testis.

This claim was dropped after MPS issued a letter of response to the claimant's legal team that carefully explained the expert opinion.

Learning points

- MPS was able to defend Dr E in light of his appropriate clinical management, good note-keeping and the expert advice.
- Good documentation helped MPS to defend Dr E's care. Doctors should always document the presence or absence of both testes in the scrotum at the 6-week check-up.

Congratulations Dr Rossouw

Neurologist Dr Stacy Rossouw, vice chairperson of the Border Coastal branch, and her Frere Hospital colleagues who drive the stroke-management programme, recently received the Spirit of Excellence award. The award was made at the 5th National Angels Conference, held recently in Gauteng, for her commitment to excellence in stroke care at Frere Hospital.



Dr Stacy Rossouw at the National Angels Conference



Dr G T T Buthelezi and Dr N L P Nkosi with SAMA chairperson Dr Mzukisi Grootboom

KZN Midlands hold annual CME

The KZN Midlands branch hosted their 46th annual CME session on Sunday 29 October, at the Victoria Country Club in Pietermaritzburg.

The topics discussed were:

- Training in emergency care
- Approaches to breast cancer
- Paediatric immunisation
- Recent controversies in managing dyslipidaemia
- An approach to stroke management
- Mastering difficult interactions with patients
- Prevention rather than cure.

The academic programme was designed to be of interest to all doctors, especially specialists and doctors working in both the private and public health sectors.

The CME session was well attended, by doctors from throughout KwaZulu-Natal, and the feedback was excellent.

High tea at Gauteng North branch

Bokang Motlhaga, junior marketing officer

The Gauteng North branch recently hosted a high tea at Rozenhof Guest House, Pretoria. The branch invited their life members to a sunny breakfast in celebration of their long commitment to SAMA, and to making the branch the active entity it is today.

Dr Tshilidzi Sadiki, chairperson of the Gauteng North branch, in his opening address, enlightened the attendees on the objectives of the event, pinpointing the most significant of them as countering the generational barrier that exists between the senior or retired medical practitioners and the current generation of practitioners, in order to allow the senior medical practitioners to impart their knowledge to the current medical practitioners.

Dr Jacobus Bekker was awarded the SAMA Life Membership Award, in recognition of his long service to the association.

In closure, Dr Sadiki encouraged the life members to continue their support of the association and the branch, despite their current status of non-employment. The high tea was a good social encounter for the attendees to meet their former colleagues and to indulge in sharing memories.



Dr Sadiki (left) handing over the SAMA Life Membership Award to Dr Bekker

Goldfields focus on eye care and polio

The Goldfields branch, in collaboration with the Goldfields Society for the Blind, recently facilitated an information and training session at the Round Table community hall in Welkom. Topics discussed included eye care, glaucoma, macular degeneration and cataract blindness.

The branch and Rotary were also involved with a polio awareness drive in October. Polio is a paralysing and potentially fatal disease. The virus invades the nervous

system and can cause total paralysis in a matter of hours.

It mainly affects children under the age of five, but can strike at any age. Polio is incurable, but can be prevented by vaccination.

In 1985, Rotary took the momentous decision to tackle polio eradication worldwide through the vaccination of children. Approximately 2.5 billion children in 122 countries have been immunised, with money raised by Rotary worldwide.

CWB attend shop-steward training

Representatives from SAMA Cape Western branch attended a shop-steward training workshop at the Congress of SA Trade Unions (Cosatu) offices on Thursday 12 October 2017. They were: Ceninne Gericke, Emily Nel, Dr Jonathan Oettle, Dr Farah Jawitz, Dr Monique Visser and Dr S A Craven.

Approximately 50 people from various unions attended the excellent training course.



At the training workshop

CPD on SEMSDA diabetic guidelines

Border Coastal held a CPD meeting on 18 October in the conference room at St Dominic's Hospital. The speaker was Dr Tersia van Heerden, who spoke about the latest Society for Endocrinology, Metabolism and Diabetes of South Africa (SEMSDA) diabetic guidelines.

SEMSDA is a scientific society open to all persons interested in endocrinology, metabolism and diabetes.

The society aims to:

- further the clinical practice of endocrinology, metabolism and diabetes
- promote both clinical and scientific research into, and publications on, all branches of endocrinology, metabolism and diabetes

- promote acceptable standards for training in the professional practice of endocrinology, metabolism and diabetes
- advise, where necessary, regarding the academic standard of individuals and training units
- promote access to and the provision of healthcare services and adequate treatment for all affected by diseases related to endocrinology, metabolism and diabetes, particularly the poor and needy
- provide support to those who are training in the field
- promote, maintain and protect the honour and interest of the discipline of endocrinology, diabetes and metabolism as a medical subspecialty for the benefit of all.



Lyn Rielly and Scott Gordon, representatives from MSD, the pharmaceutical company who kindly sponsored refreshments for the event

Branch enable visit to the zoo

West Rand branch recently made a cash donation to the Rant-en-Dal School for learners with autism in Gauteng West, to enable one of the teachers to take her class to the Johannesburg Zoo on an outing.

The school relies on community involvement to provide learners with a quality education, a hostel for those who are disadvantaged and food for those in need. More than half of the 150 children experience serious socioeconomic challenges.



The children from Rant-en-Dal school enjoying their outing to the Johannesburg Zoo

Heartburn during pregnancy I recommend Uri-ALK

Effervescent, effective and rapid relief



If you suffer from gout, heartburn or bladder infections while pregnant! There is now a product called Uri-Alk, a pleasant lemon/lime tasting alkalizing agent which will give you quick relief. Uri-Alk is an effervescent tablet that dissolves into a clear liquid when added to water. It will not fizz over. In addition, one table gives you the exact dose required. Each tube of Uri-Alk has 12 effervescent tablets (two more than the usual quantity of other fizzies.) Uri-Alk has four active ingredients for effective and rapid relief from excess acid.

Visit your local pharmacy and ask for Uri-Alk.
Email: medchem3@gmail.com

Uri-Alk effervescent tablets: Reg. No. 31/18.3/1414 Not scheduled
Per effervescent tablet: Sod. Citrate 2H₂O: 615mg, Tartaric Acid 860mg,
Sod. Bicarbonate 1362mg, Citric Acid Anhydrous 700mg

Plasmoquine, for the treatment of rheumatoid arthritis

Rheumatoid arthritis is a chronic condition mainly caused by inflammation in the joints of the hand, wrist, elbows, shoulders, hips, knees and feet. These conditions are usually on both sides of the body.

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