

SAMA INSIDER

FEBRUARY 2018

SAMA chairman ushers in 2018

Budding expert
witnesses, step this way



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

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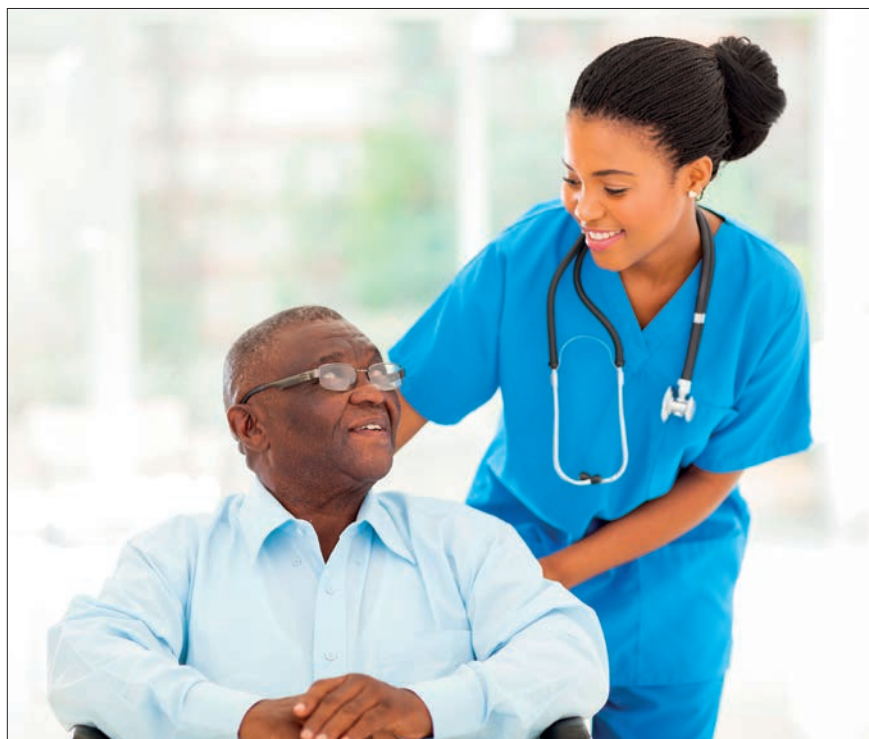
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Diane de Kock
Editor: SAMA INSIDER

Starting “right”

As we launch into 2018, a year that promises to be better than 2017, keeping in mind an overall theme of this issue – aiming to start out doing things right – could be helpful.

A glittering occasion marked the inauguration of new SAMA president Dr Marina Xaba-Mokoena, who emphasises in her president's message (page 4) the importance of doctor/patient relationships: “Isn't it time we change our attitude and do some introspection, and put ourselves in the place of the patient?”

In his message on pages 5 and 6, Dr Grootboom says: “The dawn of a New Year ... bring[s] with it a sense of hope, an opportunity to reflect on the year that was and the will to do things differently.”

On page 8, Prof. Mergan Naidoo encourages members to nominate peers, patients or communities who they think have made significant contributions in bringing health to the nation. As has been proved in previous years, there are many in our communities who are doing things right. This is an opportunity to recognise the often-unsung heroes.

According to David Bayever (page 11), “doing it right” involves an awareness of the misuse of opioid pharmaceuticals – an emerging global public health concern: “We in SA need to be aware that opioid-use disorder has become pervasive.”

On page 14, Ashley Dee discusses the fact that HPCSA complaints and clinical negligence claims largely turn on the expert evidence. She highlights some of the common pitfalls and the critical role that witnesses play: “Cases quite literally fall apart at the 11th hour, due to U-turns by experts or to poor expert preparation or performance.”

“Doing it right” also involves looking after yourself, as highlighted in the review (page 16) of Dr Chris Ellis' book *Out of Chaos Comes a Dancing Star* – Notes on Professional Burnout.

Dr Malikah van der Schyff's article on professional courtesy and “doing it right” in the December/January 2018 issue of *SAMA Insider* seems to have hit a nerve for many of our readers. It prompted Dr Lingham to send us an email plea (page 17) requesting that colleagues “all get back to that level of professional courtesy.”

The *SAMA Insider* team would like to hear your opinions on current issues in the profession. See Letters to the Editor on page 17 for format requirements and contact details. We look forward to hearing from you, and wish our readers a happy and fulfilling 2018.

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Doctor-patient relationships



Dr Marina Xaba-Mokoena, SAMA president

During my student days, as we were doing surgery rounds, my classmates and I felt that the bedside manner of colleagues or surgeons left much to be desired. I could give many examples of what I mean. The topic was eventually discussed in various medical forums, associations and meetings of the Swedish Medical Council.

The discussion culminated in the decision that all doctors who were to specialise in Sweden would be compelled to undergo 3 months' extra training in psychiatry before qualifying as specialists. They even had to sit for an examination on the subject. It did not matter if one was to be a neurologist, surgeon, obstetrician or GP (in Sweden, GPs are specialists though their training time is generally a year shorter than that for the other specialist categories).

This of course helped the Psychiatry departments because not many doctors wanted to work in psychiatry. In this system doctors worked in the psychiatry wards for at least three months thereby helping departments, which usually lacked registrars, to have personnel. At the same time doctors also learnt about human nature and behaviour.

It came to my mind to write about this topic as I feel that I have witnessed enough of this with some SA colleagues, and heard remarks about some who might need or could benefit from this extra training. It is my considered opinion that no matter how clever or gifted one is in one's work, it is human beings that doctors are dealing with – not just cases. What's more, while many a patient nowadays is not only knowledgeable, but also able to google their conditions and

their management, in such cases, this is often resented by some colleagues to the extent of telling the patients off, or to go and seek another doctor. As well as this, some patients have relatives who are doctors or nurses who are able to discuss, and advise them on, their condition. The kind of doctor who feels (s)he either owns the patient or knows it all gets infuriated, and refuses to be questioned or even reveal plans or notes to the patient, yet seeing these notes is a patient's right, if (s) he so wishes. It is also the opinion of some colleagues that "it is the culture of Africans to involve relative medics," which I feel there is nothing wrong with. After all, it is the patient's life that is concerned. While there is usually a requirement for professional confidentiality, there is no need for secrecy if the patient wishes to divulge details.

No-one knows it all, and without looking down on or doubting the colleague's integrity, it is a fact that two brains and opinions are better than one. Patients are entitled to a second or third opinion, especially in the case of complicated or difficult ailments that might be life-threatening.

No-one knows it all ... it is a fact that two brains and opinions are better than one

As well as these issues, some doctors on rounds speak about the patient above their heads only, without providing any explanation – sometimes they just look at the notes, write and go. For heaven's sake, imagine when one has been waiting a whole day and night for the doctor to come, but after the doctor has been, ends up having been ignored by the person entrusted with one's life/care. Some may deliver unpalatable news about a patient's condition without the slightest regard for his/her feelings, and even do so in front of neighbouring patients. Imagine if the doctor was the one lying on that bed.

I have been a patient myself. In the past, one would be seen by an anaesthetist in the ward preoperatively, but nowadays, one only meets them in the operating room when they are ready to push in the needle to put one to sleep, and never sees them again unless there

has been some complication. I suppose they can claim to be busy – maybe some even run two theatres simultaneously. But then, usually, in the medical aid claims, a preoperative assessment is included, when one knows that it had never been done.

It would be wise for our registrars to go through a course in psychiatry before qualifying as specialists

I do not mean to generalise and say that all specialists are like that. But you will understand when I recommend that it would be wise for our registrars to go through a course in psychiatry before qualifying as specialists. Yes, I do know of some caring doctors, who even follow up on patients with a phone call after discharge. I can quote the example of Dr Kevin Rivett, an ophthalmologist in East London, who after cataract operations always rings in the evening to hear how the patient feels, and is ready to give advice and even to see the patient the day after. How marvellous it would be if all of us took this trouble. It costs a few minutes, but is appreciated by the patient. Meanwhile, many patients leave hospital without even knowing their diagnosis, or future treatment plans. Isn't it time we change our attitudes and do some introspection, and put ourselves in the place of the patient – as we shall one day be?

I read with interest in the last issue of *Insider* the article by Dr Malikah van der Schyff on professional courtesy, and how it has been lost. There is a lot of truth in what was written, and we need our colleagues to consider this. During the time of my late father, a GP at Willowvale, this professional courtesy still applied; doctors did not charge their colleagues and their direct family (yes, there are still some colleagues who do this without exploiting them for their precious consultation times – for example, my cardiologist Dr David Kettles, whom I admire).

I wish to end by making a strong recommendation that the HPCSA looks into and takes into consideration the question of extra psychiatric training for all specialists before qualifying, and in particular our "clever" surgeons.

Inauguration of Dr Marina Xaba-Mokoena as president of SAMA

Dr Simonia Magardie, SAMA marketing and communications manager

On 24 November 2017, Prof. Dan Ncayiyana handed over the reins as SAMA president to Dr Marina Xaba-Mokoena, during a gala dinner at the Southern Sun OR Tambo Hotel in Boksburg.

Dr Mzukisi Grootboom, chairperson of SAMA, thanked Prof. Ncayiyana for his hard work, dedication and leadership during his term in office.

Dr Xaba-Mokoena is a respected academic with a career of almost six decades in the health sector. She has previously served as the Dean of the Faculty of Health Sciences at the University of Transkei, and Minister of Health for the Transkei government.

Prof. Ncayiyana and Dr Xaba-Mokoena retold stories of how they first met at the then University of Transkei. At the time, Prof. Ncayiyana had returned from exile, and Dr Xaba-Mokoena offered him a job as a specialist gynaecologist in the Transkei health system.

Three years later, the new medical school was established at the University of Transkei, and Prof. Ncayiyana was appointed professor of gynaecology and obstetrics, while Dr Xaba-Mokoena became the Dean of the Faculty of Health Sciences.

Subsequently, Dr Xaba-Mokoena became Minister of Health in the Transkei



Dr Xaba-Mokoena with, left to right, daughter-in-law Amanda Nkunjana-Mokoena, son Kwame Mokoena, nephew Phumlani Moholi, niece Pinky Moholi and her husband Elliot Mokoena



Prof. Dan Ncayiyana with Prof. Zimitri Erasmus

government, and Prof. Ncayiyana took over from her as dean. As fate would have it, the tables have again turned, and this time Dr



Outgoing president Prof. Dan Ncayiyana congratulates Dr Marina Xaba-Mokoena

Xaba-Mokoena is taking over where Prof. Ncayiyana left off, as president of SAMA.

SAMA chairman ushers in 2018

Dr Mzukisi Grootboom, SAMA chairman

On behalf of the national council and the board of SAMA, I would like to wish all our members a successful 2018. SAMA is and will remain the representative association for all medical doctors in SA. We are appreciative of and honoured for the opportunity to represent and serve the nation's doctors.

In short, we face a crisis due to financial constraints

As we begin to look ahead to 2018, and as we make or having made our New Year's

resolutions, it is the perfect time for us to reflect on the past year. 2017 has been a challenging year for all at SAMA and to the profession at large, including the communities we serve. Exactly a year ago, in my welcoming message, I highlighted some of the hurdles that we as a profession were facing at the time. In broad terms, these ranged from poor working conditions, human resources for health, healthcare reform, medicolegal litigation, increasing burden of disease and trauma, postgraduate training, regulatory issues, alternative reimbursement models in the private sector, increasing healthcare costs and the health-market inquiry, to disunity within the medical profession.

Your organisation, SAMA, has been intimately involved in addressing the above challenges, with some measure of success. I am happy to report that the National Health Council has accepted that, as pointed out by SAMA, the 2017 draft commuted-overtime policy was unworkable. They have also acknowledged that the working conditions of doctors cannot be changed ad hoc without consulting those affected. As a way forward, they have agreed to and formed a task team which comprises of the technical teams from the National Department of Health and SAMA. The plan is to develop a document that is underpinned by a set of principles, and acknowledges several practicalities and allows for the ultimate

document to be developed based on proper data. To this end, SAMA will commission a study looking at the worth of the doctor.

A significant matter affecting employed doctors in the public sector is the issue of eDisclosures. The directive is a consequence of the Public Service Act No. 103 of 1994 and new regulations issued in terms of this legislation. The act is to be amended and replaced with new legislation, but either way, provision is made for public servants to disclose their financial matters to their employer, viz. government. SAMA has experienced various challenges with the proposal, and in some provinces, members have been threatened with disciplinary action if they don't eDisclose. SAMA has had several meetings with the Department of Public Service and Administration, taken an opinion from Senior Counsel Adv. Willem Trengove and taken the matter back to the Public Sector Co-ordinating Bargaining Council. In December 2017, the matter was resolved to be returned to the chamber for discussion, and this process will continue in 2018.

One of the most vexing matters in 2017 that will persist and intensify into 2018/19 is the matter of the placement of interns and community-service doctors. In short, we face a crisis due to financial constraints. Our country has done very well in increasing our doctor production, but we face major fiscal constraints and insufficient funded posts to accommodate them all. The SA government took a decision not to appoint any non-SA citizens to internship posts in 2018. This in itself is problematic, as these individuals were trained at SA institutions at the taxpayer's expense, only to now no longer be accommodated. In the second week of January 2018, more than 100 interns and community-service doctors are unplaced, and the problem will intensify when the bulk of

the Mandela-Castro students return. We face three options – to:

- find the money through the fiscus and through innovative means, e.g. private funding;
- cut internship by 1 year; or
- scrap community service. SAMA believes that funding must be found, failing which community service should be terminated.

In the private sector, discussions about quality of care and outcome-based reimbursement models have been ongoing, with most of the proposals emanating from the funding industry. The HPCSA has issued advice through the media, urging doctors not to sign contracts without referring these to them for further scrutiny and advice. They have further advised that the contracts should adhere to the current HPCSA ethical rules, and should not be implemented in such a way as to result in poor patient care. The best interests of the patient should always come first.

We would like to add that all these interventions by the funders are part of managed care, and in most cases the aim is to limit expenditure that is to the detriment of patient, and also to shift the risk to the doctor. For these interventions to work, there needs to be input from the profession from the outset, and there must be mutually agreed terms of engagement and not the imposition of a contract on a doctor/practice. We further advise that no practice should agree to take any risk. Most medical practices can ill afford such impositions by the funders, who actually do have the resources to mitigate all the risks.

The work of the health-market inquiry is ongoing, and we have recently been informed that the Competition Commission has made some preliminary analyses of some of the trends from the data and the inputs that have been made so far. The analyses are available on their website, and stakeholders

have been asked to contact the commission if they would like to respond.

There needs to be input from the profession from the outset

In a related matter, SAMA has decided to commission another investigation into the current costs of running a private practice. A consortium of three companies, viz. HealthMan, PPO Serve and Medical Practice Consulting (MPC), has been engaged.

The issue of the high costs of medical litigation is receiving attention at the highest level in government, and the South African Law Reform Commission has recently sent out an issue paper outlining the current problems, with a request for comments. We at SAMA have made our input, and I would refer you to our website for details thereof.

At the level of the Council for Medical Schemes, the SAMA GPs and specialists, together with other stakeholders, were involved in the prescribed minimum benefits review process across a whole spectrum of diseases.

The dawn of the New Year does not necessarily bring an end to the difficulties that we have faced as a profession. It also does not diminish the uncertainty that we have faced in the past few years. It does, however, bring with it a sense of hope, an opportunity to reflect on the year that was and the will to do things differently.

I would like to thank you for the privilege of serving you, and would like to encourage all of you to continue showing interest in your organisation, SAMA.

New SAMA general manager appointed

SAMA Communications Department



Dr Manivasan Thandrayen

The chairman of the board is pleased to announce that Dr Manivasan Thandrayen has been appointed as the general manager of SAMA as of 2 January 2018. He has been a SAMA member since 2000, and brings vast experience from both the public and private sectors.

He served as president of the SAMA KZN Coastal branch in 2007, and since 2011 has been branch treasurer. He has been industrial relations advisor to branch members, and a national councillor since 2009. He also served on the

various SAMA committees during his tenure. Dr Thandrayen graduated from JSS Medical College, Mysore University, in 1999, and has an MBA from Regent Business School in Durban. He has also held leadership positions outside SAMA, which include chairperson of the South African Society of Medical Managers forum (KZN Province 2010 - 2012) and acting CEO of Eshowe and Ngwelezane hospitals. He has worked in the private sector running an emergency unit and a GP practice, and served as a healthcare consultant.

Recognising masked depression

Maurice Silbert

I am a GP/family doctor, recently retired. In 1968, I published an article in the *South African Medical Journal* of 10 February titled "Masked depression and the general practitioner", the aim being to alert colleagues, primarily healthcare providers in primary care, to depressive disorders which frequently present as physical or somatic symptoms. These symptoms could mask an underlying major depressive disorder or a depression due to unendurable stress (at the time referred to as "endogenous and reactive depression").

An article published in the health supplement of the *Mail and Guardian* of 19 - 25 May 2017 titled "Suicide and the violence of our words", written by Lizette Rabe, chairperson of Stellenbosch University's Department of Journalism and editor of the book *Hope: Consolation for the Inconsolable*, prompted me to revisit my article and adapt it to a broader readership. In so doing, I hope to alert families and acquaintances to the atypical ways which depression can present. A recent suicide and attempted suicide that were brought to my attention reinforced my decision to do so, particularly as in both these cases, it was alleged that there were no indications of pre-existing depression.

Dr Jean Usdin, in her book *Practical Lectures in Psychiatry for the Medical Practitioner*, published in 1966, states that the vast majority of depressed patients are seen by a medical practitioner. The inference to be drawn is that many such patients consult a doctor, be it a general practitioner or specialist, for physical symptoms, to the exclusion of any psychiatric ones. Common symptoms that underlie and mask a depressive disorder include fatigue, weight loss, loss of appetite and gastrointestinal symptoms. Invariably, there is accompanying anxiety that is often disproportionate to the presenting symptoms. The physical symptoms are often so typical of organic illness that the doctor is obligated to thoroughly investigate the patient, and when necessary, refer him/her for special investigations, not only as a diagnostic tool, but also as reassurance for the patient.

Should no organic illness be diagnosed, further clues for depression should be sought. These include sleep disturbances, restless sleep and early awakening, feeling worse on awakening and often improving as the day goes by. Recurring visits to the doctor for anxiety unresponsive to repeated trials of tranquilizers, and recent onset of agitation in the elderly, frequently mask

underlying depression. There is often a morbid exaggeration of normal concerns, alteration in mood, difficulty in making decisions, disinterest and apathy. The patient shows an inability to "pull him/herself together" in spite of inappropriate demands from family and friends to do so. The existence of a family history of a depressive disorder is also a vitally important clue as to diagnosing or suspecting depression, as is the postpartum state.

A recent article in a supplement to the *South African Medical Journal* of April 2017 under the title "30 days in medicine", and originally reported in the *British Journal of Psychiatry*, suggests asking two simple questions to predict depression in the elderly: "Have you been troubled by feeling down, depressed or hopeless?" and, "Have you experienced little pleasure in doing things?"

Should a depressive disorder be suspected, your family doctor is ideally placed to guide you with appropriate medication or referral for psychiatric opinion, depending on its urgency.

As stated in my introduction, I have, in response to Lizette Rabe's compassionate article, attempted to identify symptoms other than those of overt depression that could alert family members and acquaintances to seek appropriate assistance for their loved ones.

2018 Electronic Medical Doctors Coding Manual now available

Zandile Dube, senior medical coding consultant, SAMA

The first licence for the 2018 Electronic Medical Doctors Coding Manual (eMDCM) is **free** to SAMA members in private practice (including limited private practice). As a SAMA member, you must please log on using your username and password to qualify for this free licence. Only the first licence is free; additional licences will be charged for.

The 2018 MDCM book will only be published during the first quarter of 2018. Please go to the SAMA website, www.samedical.org/products, to purchase the 2018 eMDCM.

The 2018 updated programme includes:

- all the procedural codes for medical doctors
- easy-to-use search functionality

2018 eMDCM prices for additional licences for SAMA members and for non-SAMA members

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- functionality available within the browser to calculate own fee for each code
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The eMDCM programme has a 1-year licence period, valid from 1 January 2018 to 31 December 2018.

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For any computer/IT-related queries, please contact SOSi on 087 550 1715, or email support@sositi.co.za.

Calling for nominations

Prof. Mergan Naidoo, acting chair, SAMA Education, Science and Technology Committee

The Education, Science and Technology subcommittee of SAMA would like to invite members and the public to nominate doctors/other individuals who they think have made significant contributions in bringing health to the nation. We are looking for individuals who are recognised by their peers, patients and communities as having made a difference to science, the healthcare environment, communities and individuals. These outstanding individuals will be honoured at the national SAMA conference and merit awards ceremony, which will take place from 17 to 19 August 2018 at Sun City.

For nominations to be valid, one needs to complete the nomination form that is available on the website (www.samedical.org). This nomination form requires the following details to be provided:

- A motivation not exceeding 500 words supporting the reason for nomination. Submissions must be in English to avoid key elements being lost in translation. **This is the most important element in determining the placement of candidates into categories.**
- The motivation should entail a crypt, concise extract from the candidate's CV, which should contain:
 - His/her special area of interest: research, publications, awards, community involvement.
 - Other personal details, **including a photograph**, such as name in full, professional status, personal contact details and address.
 - The name and contact details of the person/branch submitting the nomination form.

The CV may be provided as additional information, but the nomination form is essential. Nominations received after the due date (31 July 2016) will NOT be considered.

The following are awards that are open for nominations under specific categories:

Human Rights and Health Medal of Honour

This is the most prestigious of the SAMA awards, and is reserved for an individual who

has displayed the very best in human effort and personal sacrifice (which may include a forfeiture of freedom), and dedicated their life in the cause of humanitarian service. One would expect this individual to show an iconic international footprint. It is not uncommon to have such an individual being subjected to detention, interrogation, torture, incarceration or even death in their pursuit of his/her ideals.

Previous recipients of this award include Dr Fabian Ribeiro and Prof. Marian Jacobs.

Medal of Transformation Equity and Justice

This nomination must show evidence that this individual has taken up the fight for transformation, justice and equity even in the face of personal sacrifice, material loss or threat to security. The nominee should be a campaigner for justifiable changes within the medical fraternity, which may include activities that promote unity within SAMA, or for fights for equal opportunity across the race or class divide in academia, industry or state structures. The individual could also be someone who champions the cause for equity in the delivery of medical and healthcare services, especially to the poor, needy, indigent and disabled.

Medicine awards Fellowship in Art and Science of Medicine

The nominee should display an iconic international footprint by obtaining international acclaim for excellence in the practice of medicine both as an art and a science. This award is generally reserved for an exclusive group of members who have been endowed with the special privilege of moving the frontiers of medicine forward, or widening the horizon in achieving a greater understanding of medicine. The nominee should embrace the philosophy and the ethical constraints of the profession as a whole and may champion the cause of healthcare despite obstacles. This award is equal in prestige and status to the Heroes in Medicine Award (Canada) and the Member of the Institute of Medicine (USA).

Previous awardees included Prof. Machaba Michael Sathekege and Prof. Bongani Mayosi.



Extraordinary Service to Medicine Award

This individual should display an outstanding contribution to medicine in a dedicated field. The incumbent should have pursued with single-minded purpose a chosen area of interest in medicine, and have made a substantial contribution in the research, promotion and advancement of that field. The work must extend beyond the ordinary terrain of medicine and extend into the wider community and nation. Publication of work in internationally accepted medical journals is a prerequisite.

This award was previously conferred on Prof. Jagidesa (Jack) Moodley.

Lifetime Achievement Award

The nominee must have dedicated his/her life to the single-minded pursuit of medicine as a career, with distinction. This is awarded to individuals who have given a productive lifetime of distinguished service to medicine, making the profession proud. His/her loyalty, dedication and professional conduct should be worthy of emulation.

Previous awardees include Prof. Andrew Argent, Prof. Andries Stulting, Dr Joseph Teegeer and Dr Helen Rees.

The Spirit of Medicine Award

This award recognises the contribution made by an individual who has provided extraordinary service to his/her community or nation, extending beyond the field of medicine. (S)he should have distinguished him/herself both in the field of medicine and also in areas beyond in creating an enabling environment and/or living habitat, or working in the wider interest of mankind, championing the cause of the poor, the indigent and dispossessed within a given ecosystem/community; provided selfless service to medicine that includes community health without a view to material gain or personal recognition; displayed through practice that medicine is a "calling"; and be recognised by his/her peers as a role model.

Previous recipients of this award include Dr Geoff Govender, Dr Stephen Grobler and Prof. Robert Golelele.

Young Leader Award

This award is made to a doctor under 35 years of age at the time of nomination who is making a difference to his/her community/healthcare environment. This colleague may be in a research-oriented environment and be making significant contributions. The nominee should be endorsed by an accredited research institute or university. The award may also be made, on the recommendation of the public sector doctors representative body, to an individual who has shown extraordinary service to his/her community or healthcare environment.

This award was previously given to Dr Vuyane Mhlomi.

Community Service Award

This is awarded to an individual who has rendered outstanding service over a sustained period of at least 20 years. Any of three criteria may apply: the nominee may have taken a leadership role in managing a specialised field of medicine in the community e.g. caring for physically and mentally challenged patients; the nominee may have rendered humane, innovative care under extreme trying conditions,

be they in the face of poor or a lack of facilities, or conditions calling for personal sacrifice; or the nominee may have taken an educative and mentorship role in adding value to the health of a community, such as empowering communities to grow their own food, maintain good health, or improve sanitation.

Emerging Scientist Award

This new award recognises outstanding research done by a registrar attached to any SA university who publishes his/her MMed research as partial fulfilment of his/her degree in the calendar year preceding the award ceremony and is judged by his/her peers to have performed outstanding work in the field of medicine. The requirements for this award will involve completion of the nomination form as well as the providing the committee with the following:

- an electronic copy of the publication
- evidence that the manuscript has been published in a peer-reviewed scientific journal
- a letter from the university confirming that the registrar is/was registered as an MMed candidate

- article metrics may also serve as supporting documentation.

Journal standing, such as the current impact factor of the journal, may be serve as supporting documentation.

Service Excellence in the Private Sector

This is a new award for private-sector doctors who have been making a difference in their area of practice. The doctor must have been a practicing medical doctor for at least 10 years. Evidence of making a difference in his/her community must be submitted with the nomination. The doctor must show compassion and empathy towards patients.

SAMA Award of the Year

This award is given to a SAMA member who has maintained distinguished service to SAMA of an extraordinary nature as judged by his/her peers.

Previous recipients of this ward include Dr Fazel Randera, Dr Akthar Hussain and Dr Gregory Mbambisa.

Technical guidelines for expansion of the NAPPI code to seven digits

MediKredit

MediKredit has received several queries about the interpretation of our *Technical Guidelines for Expansion of the NAPPI Code to 7 Digits*, particularly regarding the representation of the existing six-digit NAPPI code in specific file layouts. This article is intended to clarify the interpretation of the document.

Interpretation guidelines

Specific data elements appear differently in each of two **fixed-format file layouts**: numeric and alphanumeric. A fixed-format file contains data values that start and end in fixed positions within the physical file. Both codes must be represented in a seven-positional data field: each of these layouts require seven positions to be filled. However, in filling them, the existing six-digit NAPPI codes do not themselves become seven-digit codes: rather, they are padded to appear so, to conform to the requirements of each layout type.

If the code is defined as a **numeric data type**, then a leading 0 is added to the existing six-digit code, to represent it within the seven-digit field. Extracting systems using this layout as an input source would know that when a leading 0 exists within a seven-numeric source field, then this is an existing six-digit NAPPI code.

Since the new seven-digit codes will never start with a 0, they can never be confused with an existing six-digit NAPPI code by the extracting system.

For a code defined as an **alphanumeric data type**, a "trailing space" is added to the end of the existing six-digit NAPPI code to represent it within the seven-digit-long alphanumeric field.

Extracting systems using the fixed-format file layout as an input source would know that when a trailing space exists within a seven-digit alphanumeric-defined source field, then this is an existing six-digit NAPPI code.

The new seven-digit code, in this alphanumerically defined positional field, uses up

the full seven positions, and so no such extra space is needed.

For all other **non-fixed-format file layouts**, such as XML and delimited file structures (e.g. pipe, csv), the representation of the actual NAPPI code value will not change in any way, irrespective of whether the field is numeric or alphanumeric: the six-digit NAPPI code for Panado, for example, will appear as 752274, while a new seven-digit NAPPI code, such as, 8456224, appears as is.

For further details, please refer to the technical guidelines document published on the MediKredit website: https://www.medikredit.co.za/index.php?option=com_content&view=article&id=93&Itemid=213.

Should you have any further queries, please contact:

General queries: Annelize Basson (Annelizeb@medikredit.co.za).

Technical queries: Edwyn Venkatsamy (EdwynV@medikredit.co.za), or Yvette van der Westhuizen (YvetteV@medikredit.co.za).

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Opioid misuse and abuse

David Bayever, chairperson, Central Drug Authority, Department of Social Development, SA

Misuse of opioid pharmaceuticals is emerging as a global public-health concern. There has been a 4-fold increase in the prescribing of opioid-containing medicines in the USA since 1999. Based on an international study, which included SA, conducted in 2015, there is evidence that the indicators in SA are no different. This is becoming a major public-health issue because of opioid-naïve individuals being prescribed opioids, and the relationship between the introduction to use and the risk of progressing to recurrent opioid use. Studies have shown that 17% - 21% of patient admissions to emergency clinics or hospital casualty departments have resulted in a prescription for opioids. As a result of the current opioid epidemic in the USA, there has been a change in perceptions of the face of addiction. We in SA need to be aware that opioid-use disorder has become pervasive and can impact on all ages, races, ethnicities and socioeconomic classes of our society.

The concern is further illustrated by the report that 46 people lose their life each day to a chronic disease that is misunderstood and mischaracterised, and therefore undertreated. The Centers for Disease Control and Prevention reported that 64 000 people died from drug overdoses in 2016 in the USA.

We in SA need to be aware that opioid-use disorder has become pervasive

Codeine or 3-methylmorphine, an opiate, is widely used for its analgesic, antidiarrhoeal and antitussive properties. The misuse of non-prescription codeine-containing products contributes to it being the most commonly consumed opiate worldwide. In SA, it is available as a combination analgesic without prescription. The available evidence suggests that many opioid- and codeine-dependant patients regret their dependence and reject a "drug identity" due to their continued work, functionality and social activity. They also feel reassured about its safety through it being a licit substance and either prescribed or available over the counter. The risk of

tolerance developing is increased, however, through increasing the dose for either therapeutic or non-therapeutic purposes. Physical dependency and withdrawal symptoms mimic those of morphine, and include cravings, preoccupation, insomnia, restlessness, runny nose and stomach pains.

Health professionals must stay abreast of the new drugs, and the marketing ruses used to conceal the true nature of substances

It is not only professionals calling for revised scheduling, control and increased pharmacovigilance. Greg Williaims is a typical member of society admitting that he was on other medication when he started taking small doses of Oxycontin. It eventually developed into a daily routine, and he was crushing and snorting the pills. He admits that he was naïve about what he was doing to his body. He is among the 23.5 million people in the USA in recovery, of whom 22.7 million need treatment for substance-use disorders. As he says, "People in recovery need ongoing support because addiction is a chronic illness. You don't go to five days of 'detox' or 28 days of 'rehab' or receive outpatient treatment and sail off into the sunset."

There are more people who lose their lives in the USA annually from overdoses than car crashes. It was reported by experts at a national conference in San Francisco in 2014 that prescription abuse was skyrocketing, outpacing illegal drugs and leading to more heroin addicts.

The reason for this transition may be related to difficulty in obtaining prescribed opioids once a tolerance has been developed, and the desire for long-term use at increasing doses. In some instances it may be attributed to heroin being cheaper and easier to obtain than prescription opioids. The problem stems from the inability to discern how individual differences at the level of behavioural traits, neural spasticity and genetic predisposition affect addiction liability.

The Codemisused study conducted locally illustrates the concerns of local practitioners surveyed. A total of 78.8% felt that they required more instruction on prescribing potentially addictive medication, while 21.9% of respondents acknowledged that they do not have suitable screening methods to use to help identify patients' inappropriate use of medicines containing, for example, codeine. If codeine dependence was identified, only 34.6% of the sample felt that the misuse use of codeine could be managed effectively in general practice. In SA, nearly 45% of patients who are in treatment for prescription medication dependence reported the use of opioid-containing painkillers as being their drugs of choice.

Health professionals must stay abreast of the new drugs, and the marketing ruses used to conceal the true nature of substances and new psychoactive substances, which are constantly being prepared by misguided chemists. Early recognition of and intervention regarding the drugs, and the initiation of detoxification, can make all the difference to the final outcome for the patients. In spite of the research focusing on treating the underlying addictive processes, the successes have been minimal. Withdrawal from certain classes of drugs can be life-threatening, and treatment must be gradual, structured and closely monitored. Treating the substance-use disorder to reduce the patient's dependence on the drug, in order for them to remain functional, may require substitution of another drug for the primary drug of dependence.

It would obviously be prudent rather to prevent problems. Opioids should only be prescribed for the duration of treatment that closely matches the clinical circumstances and that does not expose patients unnecessarily to prolonged use, which increases the risk of opioid addiction. This will go a long way to preventing the progression to the use of illicit drugs, including heroin. The US Food and Drug Administration (FDA) reports that in a sample of heroin users in treatment for opioid addiction, 75% of those who began abusing opioids in the 2000s started with prescription opioid products.

References available on request.

Looking at the World Medical Association

Otmar Kloiber, WMA secretary general, Clarisse Delorme, advocacy advisor

At the end of World War II (WWII), medical associations from 27 countries met at British Medical Association (BMA) House in London to prepare the foundations for a new global association. Its predecessor, the *Association Professionnelle Internationale des Médecins* (APIM), had stopped functioning at the beginning of WWII. At the London conference in 1945, consensus was reached that the APIM should be discontinued. Finally, on 18 September 1947, the new World Medical Association (WMA) was inaugurated in Paris, 1 month after verdicts convicting Nazi doctors of the crimes they had committed in the name of medical research were handed down in Nuremberg.

The new global association has since developed a strong focus on the ethical rules of the profession, the deontology of medicine, but also on the social environment in which physicians work. Over time, the WMA has become the global platform for national medical associations to work together and develop medical ethics. The constituent membership of the WMA is currently made up of 114 national and territorial associations.

In addition to national medical associations, individual physicians can also join the WMA as associate members. As such, they have voting rights at the Annual Associate Members Meeting and the right to participate in the General Assembly through their chosen representatives.

The WMA also has a dynamic Junior Doctors Network (JDN), made up of junior doctors who join the WMA independently as associate members. The JDN was formed in Vancouver in October 2010 as a platform for junior doctors worldwide to ensure that their voice is heard, both within the WMA and globally.

The WMA addresses policies covering all aspects of medicine, from antimicrobial resistance to medical research, from ethical questions in reproductive medicine to end-of-life issues, from core medical issues to health and healthcare aspects of intellectual property laws and international trade agreements. Recognising the magnitude of the worldwide health inequalities generated by social, political, environmental and economic factors, the WMA is also engaged in supporting physicians and national medical associations to take action for the social equity necessary to empower all persons to claim their right to health.



While all members can propose new policies or amendments to existing ones, the annual General Assembly meeting, which usually takes place in October, makes the final decision on their adoption or rejection. The work of the General Assembly is prepared by a Council with elected representatives from the six WMA areas (Africa, Asia, Europe, Latin and North America and the Pacific). The council sessions were originally rather closed, but have now opened up to the active participation of all WMA members. Although only council members have formal voting rights, all members can take part in discussions.

In 1974, the WMA moved its office from New York to Ferney-Voltaire, a French town just across the border from Geneva. This brought the WMA close to the WHO headquarters in Geneva, enabling day-to-day contact. The UN Geneva campus not only hosts the WHO, but is home to the International Labour Office, the International Organization for Migration, the World Trade Organization and the offices of UNESCO and UNICEF, as well as the High Commissioner for Refugees and the Human Rights Council. The close proximity of these and other international bodies and associations provides the WMA with access to a unique forum for bringing forward the views of physicians at the global level.

In addition, its location close to Geneva and the UN campus allows liaison with other healthcare associations. In 1999, the World Health Professions Alliance was formed

together with the International Council of Nurses, the International Pharmaceutical Federation, the International Dental Federation and the World Confederation for Physical Therapy.

Independently and together with its partners, the WMA advocates for the interests of physicians and their patients, is engaged in promoting human rights related to healthcare and medicine and provides advice to governments and intergovernmental bodies, as well as to international organisations. It also supports the campaigns and activities of UN agencies, especially the WHO.

Although the WMA was not set up as a service provider, it now offers a variety of services to its members as well as directly to physicians. These include, in particular, online learning courses on topics such as the treatment of TB and multi-drug-resistant TB, prison medicine, health issues related to second-hand smoking, antimicrobial resistance and healthcare in the context of emergencies. From the beginning of 2018, the WMA will offer a service portal for online education, which will allow national medical associations to present their own online educational material under their own name.

For many years, the WMA has offered leadership courses in collaboration with the *Institut Européen d'Administration des Affaires* (INSEAD), one of the world's largest graduate business schools, to address the emergent need for the development of physicians' advocacy and leadership skills. These Caring

Physicians of the World Initiative courses first took place at the INSEAD campus in Fontainebleau (France), and then in Singapore. Since last year, the courses have been held in Jacksonville, Florida, USA, with the kind support of the Mayo Clinic. The courses now have a focus on communication strategies and techniques, including the use of social and public media. They are open to physicians who have been nominated by the leadership of their national medical association.

The WMA negotiates upon request with partners of national medical associations, especially national governments, on contentious issues. This often helps to restart

stalled talks, or to draw public attention to a particular issue, which otherwise may not be achievable. However, the WMA does not unilaterally interfere with the internal matters of member countries, except in evident cases of human-rights violations.

Likewise, the WMA receives support from partnered academic institutions, usually on scientific matters or where specific expertise is required, on areas ranging from medical diplomacy to policy development and medical ethics. The academic body usually supports the WMA by providing expert advice, conducting studies or surveys, or hosting discussions or consultations. One of the five

WMA academic co-operation agreements is with the Steve Biko Centre for Bioethics at the University of the Witwatersrand in Johannesburg, SA.

With the essential participation of its constituent members, the national medical associations, the WMA has been successful in consolidating the development of medical ethics over the past 70 years and building trust and confidence in the medical profession. We are a dedicated partner to major human-rights organisations on health and human-rights matters, and foster professional autonomy and clinical independence against the growing influence of commercialisation.

SAMA welcomes 2018 new intern doctors

Dr Mzukisi Grootboom, SAMA chairman

On behalf of SAMA National Council and Board, I would like to welcome all the new interns who have joined the ranks of our noble profession. You all are very privileged to be part of a profession whose goal is to advance the science of medicine and to improve the health of our fellow human beings, and to prevent illness and death.

Being a doctor in SA has its own challenges, as there are not many of us

Most of you will have taken the Hippocratic Oath or the Declaration of Geneva in your different universities, and we hope that you will adhere to it and treat human life with the utmost respect. It is also important to note that our noble profession is not only a calling, but the ultimate gift from humanity to the profession, to allow us to learn from them, not only when they are alive but even from their dead bodies. Humanity in turn expects nothing less than your commitment to putting the best interests of your patients first in all your decisions in the practice of your profession. You will be held in high esteem by society, but it is important to always maintain your humility, and always have time to talk to your patients and their relatives. Your advice and recommendations must be discussed with them, and the decisions taken about any intervention should always be made with their consent and full



An intern orientation took place at the Border Coastal branch on 1 January 2018, attended by administration secretary Stella Kaschula, Dr Kim Harper (immediate past chairman) and Dr Stacy Rossouw (vice chair)

understanding. You must remember that particularly in the environment that we are currently practising in, with the high levels of litigation, communication is not only an ethical obligation, but your best defence.

The respect of the public for the medical profession is arguably unsurpassed by any other profession, and that privilege depends on respect and mutual trust. Always remember to treasure that trust and your professional life will be most rewarding, and you will experience immeasurable satisfaction.

Some of you, if not many, might have had anxious moments when you did not know whether you would find an internship placement this year at all, let alone where. It is a sad indictment on the health authorities in this country when they are not able to execute a simple plan that they themselves



Welcome packs were made up and distributed to the new interns, which included SAMA information, application forms, pens, tourism information, street maps and entertainment/restaurant information



Dr Hanno van Zyl delivering the SAMA presentation at the Border Coastal intern orientation

had committed to. What makes it even worse is that this problem has been going on for the last 3 years. Worse still, this is despite the advice and assistance of the Junior Doctors' Association of SA (JUDASA) and the senior leadership of SAMA. Internship and community service are statutory requirements in this country, and every year for the past 3 we have been informed that there are not enough funded posts in the provinces. The blame is laid at the door of national Treasury, and we are expected to accept such excuses. It is clear to me that this is downright incompetence and utter lack of an understanding by the powers that be of how to manage a simple task that requires proper planning, given that each and every year they know how many medical students will be completing their studies at various medical schools, and how many posts are accredited for internship training in each province. It always intrigues me that the public pronouncements and the many commitments made in many of the meetings we have with some of these officials and their political principals never measure up to the experiences of many of our colleagues in the employ of the state.

Being a doctor in SA has its own challenges, as there are not many of us. Some of you may work long hours, even despite the recent negotiated changes, and under challenging conditions, because of SA's high burden of disease. You will find satisfaction in knowing that your senior colleagues will always be available for advice and to offer a helping hand. You will also find that in facing adversity, you will experience the proudest moments of your career.

Remember that internship is your first opportunity to learn medicine hands-on. There is no substitute for experience in

medicine. You must also remember to regard your internship as another step towards lifelong learning. You will, without any doubt, find more growth and fulfilment the more you make use of the opportunities that are presented to you.

As interns you may find some challenges that you may regard as not compatible with good working conditions, and maybe some unfairness. Remember your medical association is there to look after your interests, and never hesitate to call and discuss your issues. You may find your local representative in the hospital you work in, the closest SAMA branch or a senior colleague who is a SAMA member. If all fails, please do not hesitate to contact the SAMA head office at 012 481 2000.

Medicine is well known for the collegiality that exists among members of the profession. You must take advantage of that, as you are likely to develop and nurture some of the best relationships in your life. You must never shy away from discussing with colleagues the challenges that you may come across, whether of a professional or personal nature.

We sincerely hope you will continue to play an active role in the affairs of your profession by taking part in the activities SAMA is involved in. As a junior doctor, you will also find a home in the Junior Doctors Association of SA (JUDASA, a special interest group of SAMA), if you are not a member already. You are joining the profession at a time when SA is undergoing a series of healthcare reforms; some of them will have a positive impact while some may have the opposite. By being part of your professional



KZN branch president, Dr G T T Buthelezi, welcomes interns to the presentation

association, you have a unique opportunity to influence the outcome of some of the policy decisions. Remember also that you not only will be able to advocate for your profession, but you will also be in a position to advocate for your patients and the community at large. SAMA wishes you the best of luck with your internships, in the hope that you will become the kind of diligent, conscientious, disciplined, compassionate and ethical doctors that our country requires you to be.



KZN Midlands intern orientation at Grey's Hospital on 29 December 2017

Budding expert witnesses, step this way

Ashley Dee, medical protection claims lead for Southern Africa, Medical Protection Society

It should not come as a surprise that HPCSA complaints and clinical-negligence claims largely turn on the expert evidence. Experts are a critical part of investigating and defending these types of cases, and this work is incredibly important to both medical protection and our members.

It can be rewarding and interesting work, but it is also demanding: experts need to appreciate the commitment involved, and to understand the high standards expected in terms of report writing, preparation and giving evidence in court or at a hearing.

This article highlights how to avoid some of the common pitfalls – and is written after seeing cases quite literally fall apart at the 11th hour, due to U-turns by experts or to poor expert preparation or performance.

Accepting instructions

You do not have to agree to act as an expert if asked; you should not do so if you feel that you are not sufficiently experienced in the subject matter to express an informed opinion, or if you have a conflict (or potential conflict) of interest and/or cannot express an objective opinion.

You may have a conflict of interest if you:

- have been involved in the patient's treatment
- are a friend and/or close colleague of the clinician being investigated
- are a friend or relative of the patient
- have accepted instructions to provide a report for one of the parties (e.g. the patient or another defendant). If you do agree to proceed, your agreement creates a contract. As with any contract, you need to be sure of the terms, particularly as to the identity of the other contracting party (client or attorney), the timing for your input and, importantly, the specific issue(s) on which you are asked to provide your opinion.

Your fee

The expert should specify their fee structure and rates (including court attendance and cancellation fees) at the outset, and ensure these are accepted by the instructing party.

Scope of opinion

Generally, an expert is asked to provide an opinion in one of four possible categories:

- **Negligence:** Did the clinician fail to exercise the degree of skill and care that a reasonable practitioner of that experience/

specialty would have exercised in the same circumstances? The degree of skill and care to be expected of a reasonable practitioner in the same circumstances must be logical and stand up to scrutiny.

- **Causation:** Did any failures identified above probably (with a greater than 50% chance) cause or contribute to some injury, damage, harm or loss for the patient?
- **Apportionment:** If there are several care providers, you may be asked for your view on the appropriate apportionment (as a percentage) between the various parties.
- **Condition and prognosis and/or life expectancy:** This usually requires an assessment of the patient in person, as well as a review of the clinical records.

For all of the above, you will be expected to provide relevant references from any scientific literature at the time you provide your report.

Existing investigations

An expert may him/herself be the subject of regulatory or disciplinary problems or complaints – if so, this should be disclosed to an instructing attorney at the outset, or as soon as they arise.

Your report

Experts instructed by the Medical Protection Society (MPS) are provided with guidance on report-writing – this should be read fully and carefully. When you receive the documents regarding the case, inform your instructing attorney if there are further records/information you need to provide a meaningful opinion. Do not start your report until the further information has been provided, unless your instructing attorney tells you otherwise.

Remember – while you are being instructed and paid by one of the parties to the claim, you are preparing your opinion *for the court*. Your role is to assist the court.

Send your report to your instructing attorney.

Scope of your expertise

You should be sufficiently experienced in the relevant area of medicine to give an authoritative view. The HPCSA would likely take seriously a complaint that an expert expressed an opinion beyond the scope of his/her expertise.

Withdrawal of your services

You are entitled to withdraw your services as an expert if you so wish. However, you can be criticised for doing so, if you do so in breach of your contractual obligations, or you do not have good reason, particularly if you withdraw at a late stage.

Impartiality

Your role is to present the court with your impartial opinion, soundly based. You must, at all costs, not be persuaded, or tempted, to withhold material information in order to maintain your initial opinion. There is no immunity for experts in SA. If an expert acts in a way which is negligent, then they can be sued.

Meetings between experts

You may be required to discuss the differences of opinion between you and other experts of the same discipline after you have seen their reports. These discussions may be in person or by telephone, and are usually arranged by you directly. You will be required to produce for the court a note of the discussion.

Giving evidence

The simple rule is to listen to the specific question and, after reflecting on it, answer it succinctly and honestly. Do not rush or be rushed. Answer in your own time.

Points to note

- Due to the crucial role of experts in investigating and defending claims and HPCSA complaints, MPS is always keen to hear from clinicians who are interested in expert witness work, so get in touch at southafrica@medicalprotection.org.
- Acting as an expert is an important and challenging role – don't underestimate the time commitment.
- Read papers and instructions thoroughly; ask questions if anything is unclear – and provide an open, honest and objective opinion.

MPS is running two expert training courses on the professional obligations of being an expert: Durban: Saturday 3 March 2018
Johannesburg: Saturday 10 March 2018.

For more details and to register, please visit medicalprotection.org.

This is an edited version of an article that first appeared in the MPS journal Casebook.

Chris Ellis – the doctor and author who forgot to go home

SAMA Communications Department



Dr Chris Ellis

Dr Chris Ellis is a family practitioner who will next year celebrate 50 years as a clinician in SA.

Born and raised in England (where he obtained his medical qualification at the University of London), Dr Ellis arrived in SA in 1969 to work at Edendale Hospital in Pietermaritzburg. He fell in love with the country and the Natal Midlands and then, he jokes, he forgot to go home.

Dr Ellis is a prolific writer, with *Out of Chaos Comes a Dancing Star* being his sixth published book. He contributes monthly columns to several publications, including one in *Diversions* magazine on gardening. In 1995, he started writing about burnout among medical professionals, and the seeds for *Out of Chaos Comes a Dancing Star* were sown.

"In the early 1990s, burnout was a relatively new topic, and I intended to only write one column about it," he says. However, this turned into more reading and lecturing on the subject, and holding workshops as well.

The experiences of the courses and workshops, which he facilitated, inspired him to write this book.

Dr Ellis says the book is a blend of theory, practice and the experiences of other doctors and participants in the workshops.

"It is a book, I hope, that people can pick up and read, and get something useful to help with the management of burnout in both their patients and themselves," he says.

Married with four sons, Dr Ellis continues to practice family medicine in KwaZulu-Natal.

"I'm very fortunate," he says, "as I still enjoy my medical practice, as well as the creative aspects of writing in my spare time."

Out of Chaos Comes a Dancing Star – Notes on Professional Burnout

Chris Ellis. Pp 95. Oasis Open Books. 2014. ISBN 978-0-620-55803-7

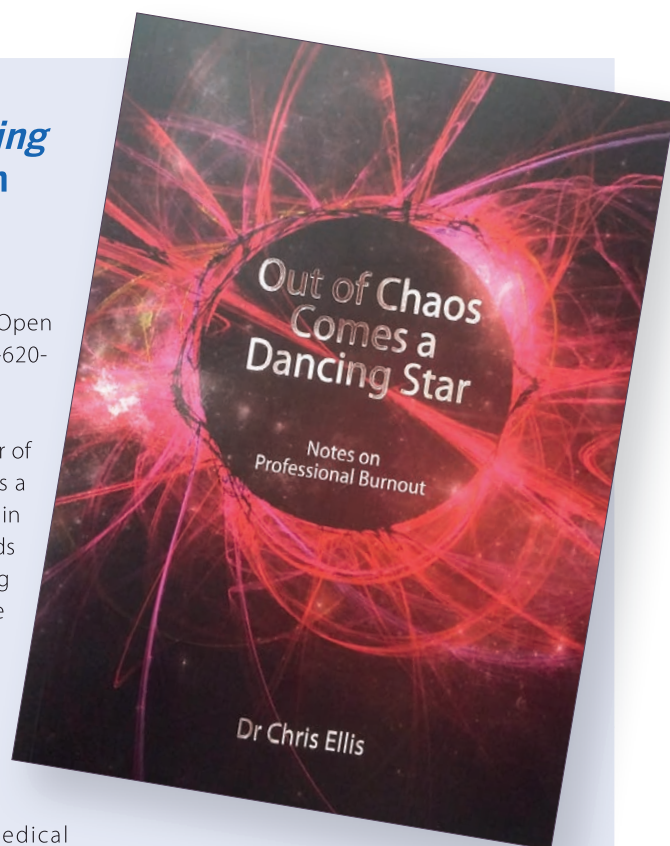
Chris Ellis, the author of this little book, was a family practitioner in the KwaZulu-Natal Midlands for many years before going into "semi-retirement". The older readers of the *South African Medical Journal* will recall Dr Ellis' occasional essays, published in the journal in years gone by, in which he shared anecdotes from his medical practice, for their wit and humour. This little book, based on his notes as facilitator at workshops and courses on burnout, mirrors the same style.

Although this booklet is billed as "Notes on Professional Burnout", the content is in fact much broader, touching on a wide variety of situations that may stand in the way of a fulfilling medical career and can serve to undermine the psychological wellbeing and professional performance of practitioners. The hurdles include loneliness, stress, depression, family and spousal relationships, money issues and so forth. The book further references situations where the doctor may be his or her own worst enemy. These are explored in chapters on the doctor as a patient, the "wounded healer", the "Mr God Complex", the angry doctor, the impaired physician and other traits. Other chapters contain quotable passages (or poems) from classical literature, such as the Prayer of St Francis of Assisi.

Burnout may result from long hours and no sleep, poor working conditions, an uncaring hospital administration, "neglect, inefficiency, departmental politics and staff who do not share the same goals", overwork and demanding patients. One suggested means of escaping burnout is titled "Downshifting, choosing quality of life and voluntary simplicity", which may involve "accepting a lower level of income and lower level of consumption, resulting in more time with the family and restraint in the use of luxuries".

This booklet is not a *vade mecum* on burnout or any of the other personal challenges that may confront doctors in medical practice. It does not pretend to provide answers and solutions. Written in short, one- or two-page chapters, it will serve splendidly as a bedside manual for daily reflection and meditation.

Prof. Dan Ncayiyana



Letters to the Editor

The Letters to the Editor page aims to give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare, which you feel should be shared with your colleagues and fellow readers.

Please note that letters:

- should be no longer than 300 words
- can be published anonymously, but writer details must be submitted to the editor in confidence
- must be on subjects pertinent to healthcare delivery
- should be submitted before the 10th of the month in order to be published in the next issue of SAMA Insider.

Please email contributions to: Diane de Kock, dianed@hmpg.co.za. Our thanks to Dr Lingham for the contribution printed below.



Has professional courtesy been lost?

The Editor,

Dr M van der Schyff, in the December/January 2018 issue of *SAMA Insider*, has succinctly captured the sad level to which many of our newer graduates have sunk. Fortunately, many of the older generation still practise in this noble profession, and with that, practise professional courtesy. In the past, it was also the standard ethical response [when a colleague treated your or your family without charge] to donate to an organisation, on behalf of the colleague rendering the service, citing his or her name *in lieu of services rendered* to whomever (recipient of service: mother, father, sibling spouse, etc).

Colleagues, the late Mr R Shar did a total gastrectomy on my late Dad 30 years ago and refused to take a cent for the procedure: can we all get back to that level of **professional courtesy**? Below is an article I submitted for publication in the September 2015 issue of *SAMA Insider*. I invite comment from colleagues.

Professional ethics – have we lost it?

I wish to refer readers to the September issue of the *SAMA Insider* and Prof. Mazwai's article titled "Medico-legal litigation: Do we have the solution?"

The professor succinctly captures salient points that need attention and correction in the way in which we practice medicine;

however, I wish to add another spin to his article with particular reference to the ethics and staff attitude. Two critical factors:

Professional ethics: In the seventies and eighties, when general practitioners referred cases to specialists, specialists would review the case and advise the referring general practitioner on his findings and his proposed management plan, the specialist would further indicate a treatment plan in generic terms. It was the responsibility of the general practitioner to institute and to continue follow up as may be required. Similarly, for patients admitted to hospital and if the specialist required an opinion from a second specialist, the referring general practitioner would be advised, and the specialist would also ask the general practitioner whether the second suggested specialist was acceptable or whether the general practitioner wished to propose another specialist.

Today professionalism has changed drastically.

Patients referred to a specialist are oftentimes sent on a round-robin circuit of specialists, with no report-back letters to the referral general practitioner, and all subsequent follow-ups are done by the specialist – in essence, the patient is lost to the specialist until medical aid source funding is depleted.

The point I am making is that professionalism, professional ethics, compassion, care and empathy have been lost out of the equation

– the drive for monetary gain is paramount. Once medical insurance funding is exhausted, the patient then lands at the general practitioner's door.

May I ask why is there such a reluctance, particularly with the more recently qualified specialists, not to commit their findings and management plans to writing by way of a simple report-back letter to the general practitioner? Is this a lack of professionalism or fear of revealing their incompetence?

A second point: If a patient is admitted to hospital under a specialist, and as a general practitioner you visit the patient, what is the ethical norm in inspecting the test results and various investigations – do you inform the specialist of your intention and/or request of the specialist permission, or is requesting the sister in charge's permission sufficient? What about the PAIA (Promotion of Access to Information Act)?

Lastly, say a patient under specialist care in a private facility falls out of bed and sustains a head injury – cot sides not raised by the nursing staff (clearly a nurse omission). The patient is medically assessed and a CT scan is ordered. For whose account will the CT scan be? What about follow-up management costs for any injury or complication sustained in the fall?

I invite comment from colleagues and healthcare funders.

Yours sincerely,
Dr P Lingham

Lost opportunity

The Medical Protection Society shares a case report from their files

Ms C, a 43-year-old smoker who was otherwise well, presented to her GP, Dr Q, complaining of a few days' discoloration to the tip of her right index finger. She explained that her fingers have always felt cold, and often turn white and go numb when she is outside.

When Dr Q examined the finger, there was purplish discoloration of the tip and it felt cold. He noted the presence of good peripheral pulses. Dr Q advised her to stop smoking and made a non-urgent referral to the vascular team.

Nine days later, the patient consulted a second GP, Dr P, as the fingertip had become painful. The records of this consultation were limited, but he diagnosed cellulitis and prescribed flucloxacillin, with an appointment for review in 10 days.

When Ms C returned for review, her finger was much better, but she now complained of tiredness, with some back pain, which she thought was related to her periods. Dr P arranged some investigations, including a full blood count, urea and electrolytes (U and Es), liver and thyroid function tests, and planned a further review with the results.

The next day, the results were available, and alarmingly, revealed some abnormalities. Her estimated glomerular filtration rate (eGFR) was just 22, urea 14 (2.8 - 7.2); creatinine 211 (58 - 96); albumin 33 (35 - 52). The results were reviewed by a third doctor, Dr B, who arranged to see Ms C the next day. As there were no previous U and Es, Dr B arranged for a repeat set of bloods, including an erythrocyte sedimentation rate (ESR). He also arranged an urgent renal ultrasound scan.

The repeat bloods showed creatinine 216, urea 10.7 and ESR 104. These were reviewed by Dr P, who took no action as the renal ultrasound scan was to be carried out 3 days after that, and the patient was due to be seen by Dr B for review thereafter.

At that review, 8 days later, Dr B noted that the U and Es were still abnormal, and decided to await the results of the ultrasound scan. The ultrasound result was delivered the next day, and stated that "both kidneys demonstrate slight increase in cortical brightness; otherwise both kidneys are normal size, shape and morphology with no pelvicalyceal dilatation." The results were filed by Dr P, as no major abnormality was demonstrated.

One-and-a-half months later, Ms C was admitted to hospital with a subarachnoid haemorrhage. On admission, her Glasgow Coma Scale (GCS) was 11, blood pressure 175/103, and the creatinine 573, urea 50 and albumin 29. The patient was referred to a neurosurgeon, who organised a CT scan, which confirmed blood in the intraventricular systems. An angiogram was performed, which revealed a left pericallosal aneurysm, which was successfully embolised. There were also noted to be other aneurysms. Ms C was initially aphasic with significant neurological impairment after the first procedure.

Ms C was also seen by a nephrologist in light of her significant renal impairment. She was found to have proteinuria and blood in her urine. Further investigation revealed raised inflammatory markers, mild anaemia and the presence of antinuclear antibody. A repeat renal ultrasound showed two normal kidneys. A renal biopsy was performed, which revealed acute necrotising glomerulonephritis.

A potential diagnosis of systemic vasculitis was made. She commenced peritoneal dialysis, high-dose oral prednisolone and cyclophosphamide. Ms C eventually required renal transplantation, 3 months after the presentation with subarachnoid haemorrhage. Her kidney function stabilised thereafter.

In conjunction with renal support, Ms C was successfully treated for the multiple aneurysms and recovered from her aphasia. Her neurological deficit improved, such that she was able to mobilise, albeit with assistance.

Following discharge from hospital, Ms C brought a claim against Dr P and Dr B, alleging they failed to refer her to a renal specialist when the abnormal U and E results were initially found.

The Medical Protection Society (MPS) instructed experts in general practice, nephrology, neurology and radiology to assist in managing the claim.

Expert opinion

The GP expert opined that a reasonably competent GP should have checked the patient's urine on the first consultation after the increased creatinine was noted, as proteinuria and blood in the urine would more than likely have been present. Urgent referral to a renal

specialist would have been appropriate at that stage. He was critical of Dr B for waiting for a second blood sample and ultrasound. Furthermore, when the second set of blood results was reviewed, and then the ultrasound report received, Dr P should have referred the patient.

The nephrologist expert considered that end-stage renal failure would have been deferred, but not avoided, if the patient had been appropriately diagnosed and treated earlier. As there was no evidence of polycystic renal disease, he did not consider there to be any connection between the kidney disease and the cerebral aneurysms. However, it is noted that although the pre-subarachnoid-haemorrhage blood pressure was not available, the blood pressures at the time of the haemorrhage were elevated. It was felt that if Ms C had been referred earlier, any hypertension would have been treated aggressively. The neurologist expert considered that strict control of blood pressure would have been sufficient to prevent the subarachnoid haemorrhage.

On the basis of the critical expert reports, the case was settled for a substantial sum.

Learning points

- Seeking specialist advice or referral early may be appropriate in certain situations. Good communication is essential for continuity of care between primary and secondary care.
- Correlation of investigation results with the clinical picture is essential, and could have avoided the renal ultrasound being filed in this case without further action being taken.
- Carrying out simple tests in primary care, such as urine analysis and blood pressure, should always be considered, and may affect a patient's management and the eventual outcome.
- Ultrasound scans can be falsely reassuring and need to be correlated with the clinical features. In this case, the cause of the renal failure was not clear and warranted further investigation, rather than the ultrasound scan alone offering reassurance.

Gauteng North celebrates a year of success

The Gauteng North branch recently hosted their year-end function at the Promenade events venue, Pretoria. This event was preceded by a year of achievement, hence a need for the members to celebrate their impeccable efforts to make the branch a success.

Dr Tshildzi Sadiki, chairperson of the Gauteng North branch, stated in his opening address that the participation of the members in branch activities was meritorious, but also that the branch council would appreciate an amplified response from members in the year ahead.



From left: Prof. Risenga Chauke, outstanding work in the field of cardiothoracic surgery award recipient, with Dr Lindiwe Shange (branch vice chairperson) and Dr Tshildzi Sadiki (branch chairperson)



Dr Eduard Johan D'Alton receiving an award for outstanding work in the field of orthopaedics

Dr Sadiki presented the 2017 overview of the branch's activities, which comprised the hosting of several successful CPD events, corporate social investment events, student support programmes, a high tea and others.

Some members of the branch were recognised for their valuable contributions to their disciplines at the healthcare institutions where they are employed, as well as their willingness to impart their knowledge in their respective fields to other healthcare workers.



Dr Elsa van Duuren (middle) receiving recognition for outstanding work in the field of rheumatology

In absentia, Dr Wilhelm Stephanus Nel was recognised for his outstanding work in the field of gynaecology and obstetrics.

Dr Lindiwe Shange reinforced Dr Sadiki's sentiments in her vote of thanks, stating that the members of the Gauteng North branch should strive to make it one of which every member of the medical association wishes to be a part.

Border Coastal year-end function

Border Coastal branch held their final branch council meeting on Monday 4 December. This was followed by a delicious meal provided by the Blue Ribbon Cooking and Hospitality School. Life St Dominic's Hospital kindly set up the conference room facility for the event and decorated the venue, which made the evening very special.



Dr Richard Makomba (specialist rep), Dr Luvuyo Bayeni (national councillor), Dr Mzu Nodikida (chairman), Dr Kim Harper (immediate past chairman/treasurer), Dr Stacy Rossouw (vice chairperson/national councillor)

KZN Midlands reach out

The Grey's Hospital children's wards outreach took place on 23 December 2017. The children each received a Christmas stocking filled with goodies donated by the KZN Midlands branch. The members involved said it was humbling, and a delight to see their little faces light up.





Dr Oscar Radebe, Dr Coceka Mnyani, Dr Candice Fick and Dr J A Kunzmann (branch council honorary secretary)

Hosting HIV and TB CPD event

The Gauteng North branch held a full-day CPD event in Erasmuskloof. The opening address was delivered by Dr Sadiki, chairperson of the Gauteng North branch council, and Dr Kunzmann introduced all the guest speakers, who were from the Southern African HIV Clinicians Society. Speakers and topics included:

- TB manifestations as an AIDS-defining illness – Dr Francesca Conradie
- Comprehensive TB treatment guidelines, including MDR and XDR-TB – Dr Francesca Conradie

- Treatment optimisation and dosing with TB – Dr Sarah Stacey
- Adult HIV treatment guidelines – Dr Oscar Radebe
- Treatment optimisation and dosing in pregnancy – Dr Coceka Mnyani
- TB treatment and prophylaxis in children – Dr Candice Fick.

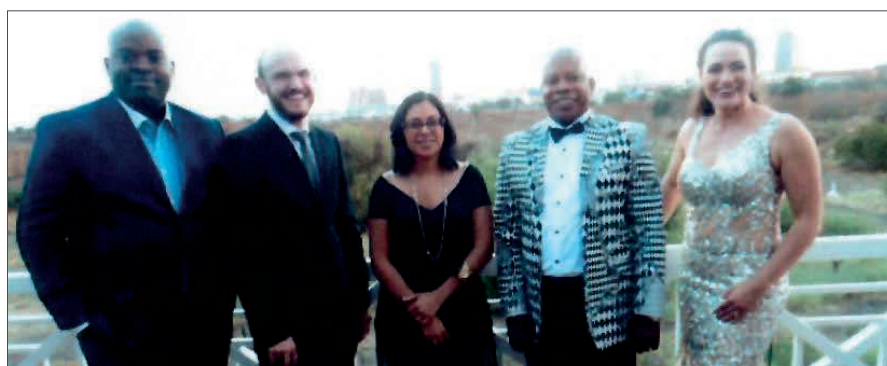
After each talk there was a question-and-answer session, and many interesting questions were put forward, which led to fruitful discussions between doctors and the lecturers.

Griqualand West hold annual branch dinner

At the end of 2017, the Griqualand West branch hosted an annual branch dinner at the Protea Hotel next to the Big Hole in Kimberley.

The branch invited their members to a lovely dinner party in celebration of their commitment to SAMA, and of making the branch the active entity it is today.

Dr M J Ngundu, chairperson of the branch, in his opening address, enlightened the attendees on the objectives of the event, saying that the dinner was a good social encounter for members to meet and indulge in sharing memories.



Griqualand West branch council members, left to right: Dr T F Konso, Dr D B Mattison, Sultana Hartzberg (branch secretary), Dr M J Ngundu (chairperson), Dr I N Blanche (vice chairperson)

Gift of sight given for free

Performing *pro bono* cataract surgeries on 22 patients at the Mediclinic Welkom was a first for the hospital group in the Free State. All the life-changing operations were performed within 4 hours by Dr Steve Steyn, a well-known ophthalmic surgeon in private practice. SAMA Goldfields branch councillor Dr Paris Daniel and his colleague Dr Etienne Marais performed the eye-pain blocks *pro bono*.

The procedures were carried out in collaboration with Bongani Regional Hospital in Welkom and the Free State Department of Health, on Wednesday 29 November 2017.

The purpose was to help alleviate the pressure on public ophthalmic surgical waiting lists at local and regional public hospital facilities.

According to Mr Basie Polelo, deputy director general of clinical health services DoH, there are more than 2 000 patients on the waiting list. The total backlog is over 5 000 in the Free State province.

The operations will radically change the lives of the patients, as they will be able to work again, and drive their own cars.

The youngest patient of the day was a 23-year-old man. Another patient was an artist, and rapidly losing his eyesight had been making his work almost impossible.

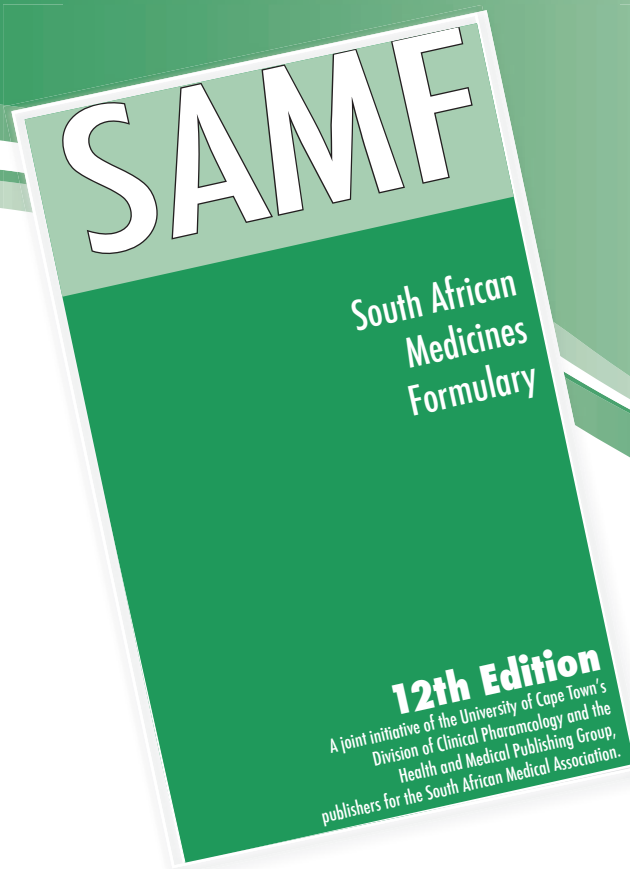
Dr Steyn, who said it was a privilege to be of assistance to the community, mentioned that more of these operations will be performed in future. The procedures on 29 November cost between ZAR20 000 and ZAR22 000.

Mr Frans van Niekerk, manager of Mediclinic Welkom, says that it is an honour for the hospital to give back to the community.

Community outreach

Since the inception of St Helena Private Hospital, under the umbrella of Africa Healthcare, a number of SAMA members have been involved in various community outreach programmes initiated within the Matjhabeng municipality. These included a visit to the Bronville old-age home on 20 December 2017 with the hospital manager to donate some groceries to the elderly on behalf of Africa Healthcare and the entire staff.

Vulnerable children who do not have parents were also present at the handover.



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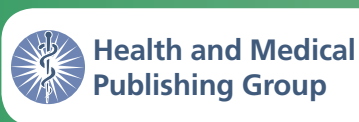
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