SAMA INSIDER
MARCH 2018

Sick certificates: Challenges, law, ethics and reality

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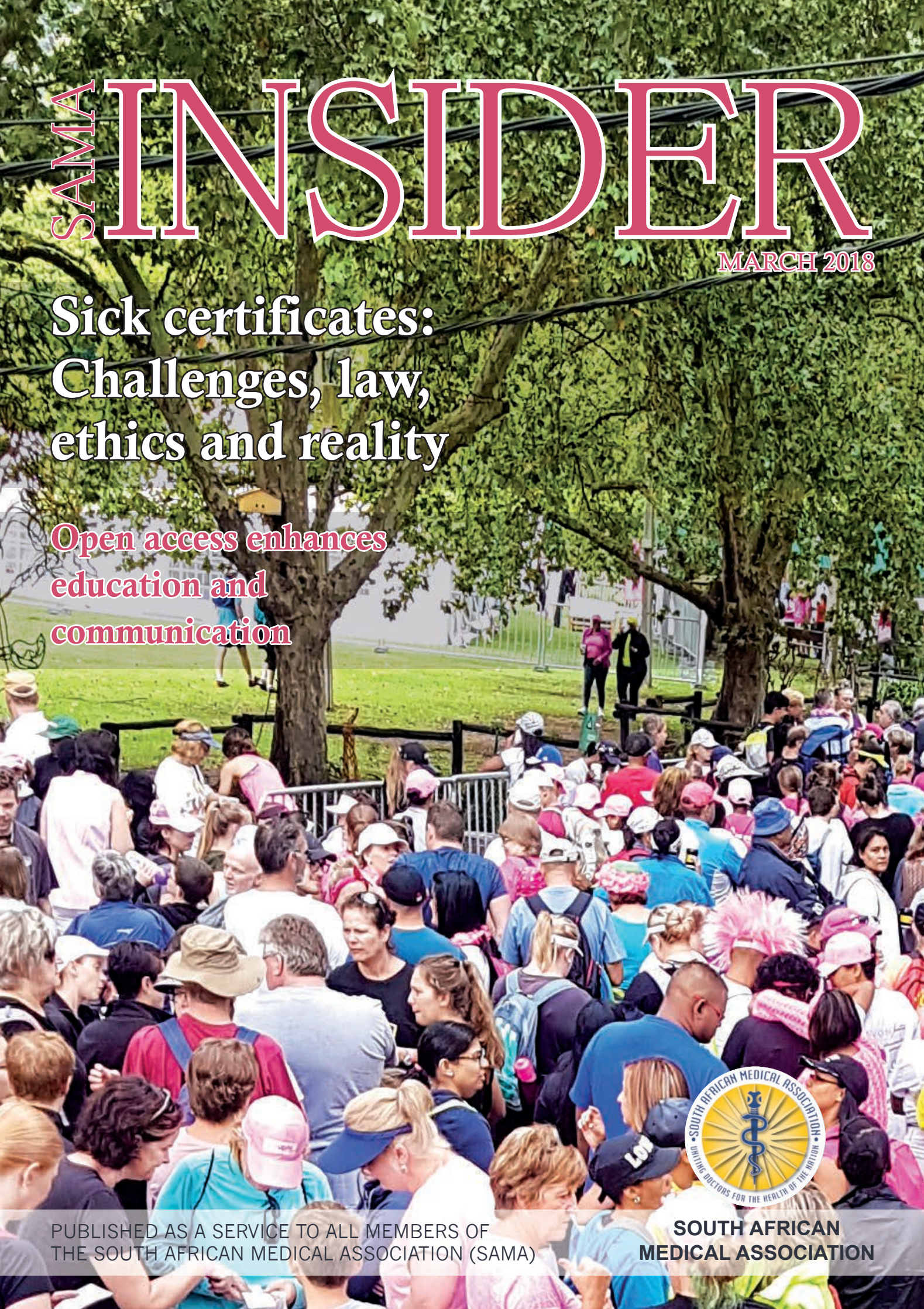

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Cancer Warrior Walk (page 19). Photograph: Jeanette Snyman

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EDITOR'S NOTE

MARCH 2018

Diane de Kock
Editor: *SAMA INSIDER*

Law, ethics and reality – a challenge of our times

The challenges of law, ethics and reality are key in SA as we move into new leadership. This reality is reflected in Yolande Lemmer and Hanneke Verwey's article on page 5 where they tackle the issuing of sick certificates in the medical profession. "Medical practitioners need to develop a deeper understanding of fundamental ethical principles," comment the authors, adding later that the trend of fraudulently issuing sick certificates "harm[s] the reputation of the medical profession".

This month we start what we hope will become a regular feature in *SAMA Insider*: a focus on the history of medicine in SA. We kick off with an article on page 14 about the impressive Adler Museum at Wits.

The theme of law and ethics in the healthcare space is continued in Prof. Dan Ncayiyana's article on page 11, where he writes about the living will and the question of whether medical practitioners have a duty to comply: "Strong arguments support the principle that the patient's wishes take precedence over the physician's discomfort."

SAMA industrial relations adviser, Modisane Lelaka, tackles dealing with disputes in the workplace, and their resolution, on page 13.

We have no doubt that our readers deal with the challenges of law, ethics and reality on a daily basis. Please write to the editor – dianed@hmpg.co.za – and keep your colleagues informed.

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Teenage suicidal tendencies

Dr Marina Xaba-Mokoena, *SAMA president*

There is no doubt that depression, which is a mental illness, is now virtually an epidemic. Sufferers lose their joy in living and the desire to live, and suicide is an all-too-frequent outcome. It can be admitted that everyone probably becomes depressed at some point in life – it would surprise me if anyone could indicate that he or she has escaped this problem – but not everyone may be so despairing as to attempt or to even think of suicide. One can think of a light stage of depression, commonly called "the blues" or "having the weeps" (especially in women), but all this means is that one is unhappy. Obviously, there is a great difference between unhappiness and mental illness. However, even the mildest form of depression dulls the keen edge of life.

Depression is not only universal, but it is also no respecter of persons. The poor suffer from it as much as the rich. All people are susceptible to it. Lately, depression is invading the young. It sweeps through college campuses. It would appear that more people are unhappy today than ever (particularly children from troubled families), and consequently, cases of depression, and even suicide, have increased. Although increasing at an alarming rate, however, depression is not new; it is as ancient as man.

Many fear that confessing that they are depressed is tantamount to acknowledging they have some mental deficiency. It has nothing to do with IQ. If anything, people with higher IQs are more vulnerable to this malady.

Depression, however, presents in many forms. Life itself is unpredictable, and every human being will necessarily experience unhappiness. Whenever a person is unhappy, (s)he has a tendency to feel depressed to some degree. Time and space will not allow me to discuss in detail why some people are more depressed than others, and the true causes of depression. Some common causes are disappointment, lack of self-esteem, making unfair comparisons, ambivalence, sickness, biological malfunctions, rejection, hyper-mental activity, unattainable goals, post-partum depression, etc. Suffice to say that many things can affect our moods, even those such as the weather, time of the year, politics, social events and a host of other things. One can be affected by colour, music, grey days, long nights. Even most well-adjusted personalities suffer the pangs of the "holiday paradox" at one time or another – with uneventful recovery. But for those predisposed to depression, holidays can be tragic, even fatal – especially at the time just after Christmas or New Year.

It is important to recognise depressive symptoms early, in the form of erratic sleep behaviour, apathy, lethargy, loss of appetite or weight, unkempt appearance or many physical ailments. They might be a loss of affection, sadness, "weeps", hostility, irritability, anxiety, fear, worry and feelings of helplessness or hopelessness. I used to think that suicide was unknown among our black African youth – but to my surprise, as I worked as a consultant in medicine in our SA hospitals, I realised how mistaken I was: at any given time in our ICUs, there were at least one, two or three attempted suicide cases, while others were in the general medical wards. Many who attempt suicide are rescued, but some do succeed.

Suicide is an alarmingly real occurrence and tragedy, leaving devastated family, friends and teachers behind. It leaves pain, hurt, self-doubt and questions, which remain forever. There is shame – it is frowned on by finger-wagging religions, and having a child who commits suicide is viewed as parental failure by society. The problem is huge worldwide – figures keep skyrocketing as families fall apart, teenagers are placed under pressure at school by their peers and their parents, and crime rates increase. Sometimes a suicide attempt is a desperate "cry for help", as may be talking about dying or threatening to kill oneself, while some mutilate themselves, e.g. by starving, overeating or hacking their flesh with razor blades or the points of compasses. More than 80% of successful suicides are preceded by a threat or a previous suicide attempt.

Intervention

When someone says they want to die, take it seriously. They are not joking when they talk about death. Of those who unsuccessfully try to kill themselves, 15% will try again. Don't minimise their feelings; take them seriously. You may think someone is being melodramatic. Don't dare call their bluff. That may be the impetus needed to push a suicidal soul over the brink.

Girls are three times more likely than boys to attempt suicide, but boys are three times more likely to succeed, because men tend to use more violent methods, e.g. a gun in the mouth, hanging or carbon monoxide poisoning. Girls are more likely to take sleeping tablets, e.g. an overdose of barbiturates, or their mother's medication, or organophosphate, which lately is easily accessible on the streets.

The depressed teenager needs someone important in their lives, someone they can rely on – be it a teacher, parent, close friend, or youth or social worker. A supportive, caring family abounding with love and warmth is great for morale. They need understanding and excellent lines of communication. Time counts. Learn to **listen**, not just dictate. Don't hand out advice without actually hearing their problems. Help them to find their own solutions. Those from broken homes may need a sturdy network of emotional support outside the family to buoy them, and this is where religious groups and support groups such as LifeLine come in. Group activities such as Girl Guides or Boy Scouts, hobbies and sports teams are great ways to relieve stress. Do not, of course, hesitate to seek the help of professionals – be they social workers, psychologists, or whoever else can intervene. Emphasise that **help is available**. Encourage them to talk to a professional. Don't be judgemental, and don't trivialise their emotions or problems. Show **love**, **acceptance** and **affection**. They want to be assured that someone cares, and that they won't be abandoned. Don't get angry. Make sure that obvious means of suicide such as drugs, guns, or ropes are not readily accessible – it is better to be overcautious. This is a matter of life and death.

Sick certificates: Challenges, law, ethics and reality

Yolande Lemmer, *SAMA company secretary, HOD governance and legal department;* **Hanneke Verwey,** *legal advisor, governance and legal department*

The challenges of the sick certificate in the SA workplace are numerous and varied. For employers, it is all about money: the costs of absenteeism, the abuse of sick leave and how to prevent such abuse. For employees, it is also about money – they risk unpaid leave if they do not produce a sick certificate when required, and most employees can simply not afford to lose a single day's salary. For some of those who provide sick certificates, it is unfortunately also all about money: there are doctors and others who provide fraudulent sick certificates in return for a healthy additional income, and thereby contribute to the sick-leave-abuse problem. In this regard, ethics and morals often fall by the wayside. The media contains regular tales of fraudulent medical certificates being sold to healthy employees, either by doctors or by agents on behalf of doctors.

For some of who provide sick certificates, it is unfortunately also all about money

The problem is real. In January 2017, the HPCSA investigated more than 50 doctors for issuing fraudulent sick certificates. A "first offender" doctor who is found guilty of issuing false sick certificates is liable to pay a R10 000 fine for each fraudulent sick certificate, and he or she will also be criminally charged.

According to Occupational Care SA and Statistics SA, false sick certificates contribute to the bleeding of a struggling economy – illness-related absenteeism costs the country between ZAR12 billion and ZAR16 billion per year. It has also been shown that a single day of absence can cost a company up to 3 days of an employee's salary in lost productivity. On average, between 15% and 30% of staff are absent on any given work day, and two-thirds of employees who fail to show up at work are not physically ill.

The legal framework

The law, the HPCSA ethical guidelines and other ethical principles must be carefully considered against these realities.

Dr *(initials and surname in block letters)*
MBChB *(full qualification)*
MP number
Physical address

Certificate of illness

Date and time of examination:		
Patient's name:		
Patient's employee number:		
As a result of: ***Tick whichever is applicable***	my personal observations during an examination on the date of this certificate,	
	information which has been received from the patient and which is based on acceptable medical grounds,	
It is my professional opinion that: ***Tick whichever is applicable***	the patient is totally indisposed for duty	
	the patient is only able to perform less strenuous duties in the work situation	
for the period of: ***Provide exact dates***		

Delete whichever section is not applicable:

Please note that the patient has consented to a full description of the illness/injury on this certificate indicated by his/her signature hereto.

Description of the illness/injury:

Signed patient:

Patient initials and surname:

Please note that the patient has NOT consented to a full description of the illness/injury; however, in my opinion based on an examination of the patient, the patient is unfit to work.

Signed patient:

Patient initials and surname:

Signed doctor:

Section 23 of the Basic Conditions of Employment Act No 75. of 1997, as amended, is entitled "Proof of incapacity", and stipulates as follows:

- An employer is not required to pay an employee in terms of section 22 if the employee has been absent from work *for more than 2 consecutive days or on more than 2 occasions during an 8-week period* and, on request by the employer, *does not produce a medical certificate stating that the employee was unable to work* for the duration of the employee's absence on account of *sickness* or *injury*.
- The medical certificate must be issued and signed by *a medical practitioner or any other person who is certified to diagnose and treat patients and who is registered with a professional council established by an Act of Parliament*.

Medical practitioners need to develop a deeper understanding of fundamental ethical principles

Section 22, referred to in subsection (1), provides details of an employee's entitlement to sick leave and sick-leave cycles, and is not relevant for the purposes of this article.

Section 23 therefore requires that an employee must have a sick certificate (under the conditions specified) to avoid unpaid leave, and that an employer does not have to pay this leave, in terms of section 22, if such a sick certificate is not provided.

Furthermore, the sick certificate must be legally valid, which means:

- It must state that the employee was unable to perform his or her normal duties *as a result of illness or injury*.
- It must be based on the *professional opinion* of the medical practitioner or other person defined in subsection (2).

"Medical practitioner" as referred to in subsection (2) refers to graduated doctors who are registered with the HPCSA in terms of the Health Professions Act (HPA) No. 56 of 1974. Other healthcare professionals who, in terms of their scope of practice guidelines, are permitted to diagnose and treat patients and who are registered with the HPCSA, as established in terms of the HPA include, *inter alia*, dentists and clinical psychologists. Individuals who are not registered with the HPCSA may issue sick certificates provided that they are permitted to diagnose and treat patients in terms of their scope of practice guidelines and, furthermore, that they are registered with a professional council established by an act of parliament. The aforementioned include professional nurses registered with the SA Nursing Council in terms of the Nursing Act No 33. of 2015, as well as allied health professionals such as acupuncturists, Ayurveda practitioners, Chinese medicine practitioners, chiropractors, homeopaths, naturopaths, osteopaths and physiotherapists who are registered with the Allied Health Service Professions Council in terms of the Health Service Professions Act No. 63 of 1982, as amended.

In addition to the legislative provisions referred to above, medical practitioners should also have regard to Rule 16 of the HPCSA's *Ethical Rules of Conduct*. The aforementioned rules prescribe the form and content of medical certificates. Medical practitioners are encouraged to carefully review Rule 16 and to ensure that the layout and content of their sick certificates comply with the listed requirements. In this regard, sick certificates must be issued in the correct format (see page 5) and personally signed.

What about traditional healers?

Notwithstanding the fact that the Traditional Health Practitioners Act No. 22 of 2007 has been promulgated, and that a Traditional Health Practitioners Council has been established in terms thereof, this council had not, at the time of writing (January 2018), registered any traditional health practitioners. It follows that certificates from traditional health practitioners still do not have to be accepted by employers, unless collective agreements are in place in certain employment sectors binding employers to accept such certificates. The reasons for the lack of registration are numerous, but mainly revolve around the fact that the proposed regulations in respect of training and classification that have been developed by the council have not yet been implemented.

Contrary to popular belief, the Kiviets Kroon case (Kievits Kroon Country Estate (Pty) Ltd v MMoledi & others [LAC] JA78/10) did not in fact set a precedent that employers can no longer refuse a traditional healer certificate. In this case, the employee's request for an extended unpaid leave of absence in order to complete a traditional healer's course to heed the calling of her ancestors was considered against the question of whether she was justified in disobeying the employer's instruction to return to work. Although a certificate from a traditional healer was part of the evidence, the court's principle decision related to the fact that the Constitution recognised traditional beliefs and practices, and that employers had to take these into account before disciplinary action was considered.

Certificates of medical attendance

Sick leave is only applicable when an employee is medically unfit to perform normal duties. Routine check-ups, examinations, tests, collecting medicine from the pharmacy and visits to optometrists, gynaecologists and physiotherapists do not qualify as sick leave. A distinction should therefore be drawn between medical certificates that recommend a period of sick leave, and certificates of medical attendance. A certificate of medical attendance merely serves as confirmation that the medical practitioner saw the patient – it is not considered to be a valid sick certificate.

Backdated sick certificates

In respect of sick certificates issued after the fact, i.e. during a subsequent consultation with the patient, it must be kept in mind that a certificate only stating that the practitioner "saw the patient" or "was informed by the patient" is not valid, since the practitioner did not declare, in his or her *professional opinion*, that the employee was unable to perform his or her normal duties *as a result of illness or injury*. "Backdated" certificates can, however, be valid if the certificate stipulates that the employee was, in the professional opinion of the practitioner, unable to perform his or her normal duties during the backdated period. For example, the practitioner can express such an opinion when (s)he diagnoses a virus that would have showed earlier symptoms. It is essential that the medical practitioner should indicate whether the certificate is being issued as a result of personal observations by such a practitioner during an

examination, or as a result of information that has been received from the patient and is based on acceptable medical grounds.

When to refuse a sick certificate

There is no obligation on the part of a medical practitioner to provide a medical certificate in the absence of a consultation. The medical certificate must be an original document. Extending sick leave telephonically, having the patient amend the original medical certificate, or faxing or emailing medical certificates is unethical and could lead to a finding of unprofessional conduct. Medical certificates should therefore not be issued unless a doctor has had a physical consultation with the patient and has satisfied him/herself that the patient is (or was) not fit to work. This is also applicable when an extension of sick leave is required.

Medical practitioners may also decline to provide a medical certificate if they feel it is inappropriate to do so – for example, where there is, in their professional opinion, insufficient evidence of illness or injury. It can be difficult at times to refuse to comply with a dubious request for a sick certificate from a patient with whom you have an established relationship, particularly if such a patient, or his or her family, has been with your practice for many years. Medical practitioners should, however, resist these pressures, and issue medical certificates strictly on merit and clinical indication at all times. It must be kept in mind that sick certificates are *prima facie* legal documents based on clear and relevant evidence, and should be written promptly, honestly, accurately and objectively.

Although not specifically mentioned in the HPCSA guidelines, doctors should also be careful not to issue medical certificates in respect of medical conditions that fall outside their scope of practice and expertise. In these circumstances, medical practitioners are advised to rather refer the patient to the appropriate specialist.

Confidentiality issues

From an ethical perspective, one of the primary responsibilities of medical practitioners is their duty to act in the best interests of their patients (including recognising and respecting their patients' human rights). The universally recognised doctor-patient confidentiality principle (respect for the privacy and confidentiality of the patient's personal information) derives from the above, and includes the responsibility to protect personal information from unauthorised access, disclosure, use, loss or theft.

Based on the aforesaid, doctors *do not have to disclose a diagnosis on a sick certificate*, even when pressured by the employer to do so, unless the patient's specific consent has been obtained. The only exceptions to the doctor-patient confidentiality principle are when a doctor is forced to disclose a diagnosis by court order, or if disclosure is considered to be in the public interest – for example, where a serious or contagious condition is involved. With regard to the latter, the recent listeriosis outbreak serves as an appropriate example. In ordinary circumstances, however, the only information that doctors can share with employers is a confirmation of the identity of the patient/employee, the date of the patient's appointment, and the fact that they did indeed issue a sick certificate.

Stolen or misplaced stationery

Medical stationery must be safeguarded at all times. It is advisable that medical practitioners keep all medical stationery in a locked drawer, and that they always lock their rooms, even when only leaving the room momentarily. If a patient misappropriates a pad of medical certificates negligently left lying around in a doctor's office, the doctor may be found guilty of professional misconduct. In the unfortunate event of a doctor becoming aware of fraudulent medical certificates being issued in his/her name, the matter must be reported to the SAPS.

It is advisable that medical practitioners maintain a sick-note register to record the details of all issued sick notes. This will ensure that a record is easily available, should explanations to employers or the HPCSA have to be provided, and, from an ethical perspective, doctors would be able to "red flag" patients who are requesting sick notes on a continual basis over relatively short periods for less serious illnesses.

Conclusion

Increasing levels of fraudulent activity by medical practitioners, and the media attention relating to these activities, has led to an increased demand by the public to hold healthcare providers liable for unprofessional conduct – hence an increase of complaints with the HPCSA. This rise in sick-leave abuse by employees has also made it increasingly common for disgruntled employers not only to institute disciplinary action, but also to lodge complaints with the HPCSA against medical practitioners for issuing medical certificates that do not strictly comply with the provisions of the HPCSA's *Ethical Rules of Conduct*, and/or being too generous in issuing medical certificates.

These trends harm the reputation of the medical profession

These trends harm the reputation of the medical profession. It is therefore essential that they are addressed and remedied. Unfortunately, the current system of fines, suspensions and/or criminal sanctions imposed by the HPCSA for those found guilty of professional misconduct does not adequately address the problem. Medical practitioners need to instead develop a deeper understanding of fundamental ethical principles. Rather than adopting a purely punitive approach, compulsory ethical training should therefore perhaps be imposed as an additional sanction. A deeper and more nuanced understanding of ethical principles will not only to protect the reputation of the profession and the interests of individual medical practitioners, but also improve quality of care, thereby ultimately benefiting patients.

Medical practitioners face a wide range of ethical issues and dilemmas in day-to-day clinical practice. It is not always easy to navigate the complex relationships that exist between ethics, professionalism in practice, the law and reality. Furthermore, certain contexts, such as patient insistence or professional reservations, make ethical decision-making even more challenging. Although codes of ethics (such as the HPCSA guidelines) help members of the profession to make responsible ethical choices, encourage self-regulation and ensure high levels of professional integrity, the codes in themselves do not prevent unethical behaviour. It is ultimately personal and professional integrity that motivates doctors to maintain high levels of ethical professional conduct. Medical practitioners should therefore continually remind themselves that to be a good healthcare practitioner requires a lifelong commitment to sound professional and ethical practices, and an overriding dedication to the interests of one's fellow human beings, and society.

UN Environment and WHO agree to major collaboration on environmental health risks

World Health Organization

In January, the UN Environment and the WHO agreed to a new, wide-ranging collaboration to accelerate action to curb environmental health risks, which cause an estimated 12.6 million deaths a year.

In Nairobi, Mr Erik Solheim, head of UN Environment, and Dr Tedros Adhanom Ghebreyesus, Director General of the WHO, signed an agreement to step up joint actions to combat air pollution, climate change and antimicrobial resistance, as well as to improve co-ordination on waste and chemicals management, water quality, and food and nutrition issues. The collaboration also includes joint management of the BreatheLife advocacy campaign to reduce air pollution for multiple climate, environment and health benefits.

This represents the most significant formal agreement on joint action across the spectrum of environment and health issues in over 15 years.

"There is an urgent need for our two agencies to work more closely together to address the critical threats to environmental sustainability and climate – which are the foundations for life on this planet. This new agreement recognises that sober reality," said UN Environment's Solheim.

"Our health is directly related to the health of the environment we live in. Together, air, water and chemical hazards kill more than 12.6 million people a year. This must not continue," said the WHO's Tedros.

He added: "Most of these deaths occur in developing countries in Asia, Africa and Latin America, where environmental pollution takes its biggest health toll."

The new collaboration creates a more systematic framework for joint research, development of tools and guidance, capacity building, monitoring of the Sustainable Development Goals, global and regional partnerships and support to regional health and environment forums.

"Together, air, water and chemical hazards kill more than 12.6 million people a year. This must not continue."

The two agencies will develop a joint work programme and hold an annual high-level meeting to evaluate progress and make recommendations for continued collaboration.

The WHO-UN Environment collaboration follows a Ministerial Declaration on Health, Environment and Climate Change calling for the creation of a global Health, Environment and Climate Change Coalition, at the UN Framework Convention on Climate Change COP 22 in Marrakesh, Morocco in 2016.

Just last month, under the overarching topic "Towards a pollution-free planet", the UN Environment Assembly, which convenes environment ministers worldwide, adopted a resolution on Environment and Health, calling for expanded partnerships with relevant UN agencies and partners, and for an implementation plan to tackle pollution.

"Our health is directly related to the health of the environment we live in"

The collaboration aims to advance the goal of sound lifecycle chemicals management by 2020, a target set out at the 2012 UN Conference on Sustainable Development.

Priority areas of co-operation between the WHO and UN Environment include:

- Air quality – more effective air-quality monitoring, including guidance to countries on standard operating procedures; more accurate environmental and health assessments, including economic assessment; and advocacy, including the BreatheLife campaign promoting air-pollution reductions for climate and health benefits
- Climate – tackling vector-borne disease and other climate-related health risks, including through improved assessment of health benefits from climate mitigation and adaptation strategies
- Water – ensuring effective monitoring of data on water quality, including through data sharing and collaborative analysis of pollution risks to health
- Waste and chemicals – promotion of more sustainable waste and chemicals management, particularly in the area of pesticides, fertilisers and use of antimicrobials.

Open access enhances education and communication

SAMA Communications Department

Prof. Johan Fagan of UCT's Division of Otorhinolaryngology was one of six ear, nose and throat (ENT) surgeons recently awarded a gold medal by the International Federation of Otolaryngology Societies (IFOS) at its 4-yearly IFOS World Congress, which was held in Paris in June 2017. The award was in recognition of Fagan's contributions to ENT internationally: through his two open-access textbooks; for advancing head and neck surgery in Africa, by training head and neck surgeons through the University of Cape Town Karl Storz Head and Neck Fellowship; and by founding the African Head and Neck Society in 2016.

A few years ago, Fagan noted with dismay how the cost of printed textbooks was skyrocketing. A new set of operative-surgery textbooks may cost colleagues working in some African countries as much as 2 months' salary, he says. Much of the content in modern textbooks has limited relevance to surgical practice in a developing-country setting anyway, he adds.

After two publishers refused to allow two senior international ENT authors to make their older, out-of-print textbook available for free, Fagan wrote and self-published the *Open Access Atlas of Otolaryngology, Head and Neck Operative Surgery*. *The Open Access Guide to Audiology and Hearing Aids for Otolaryngologists* was hot on its heels. They are free texts intended particularly for surgeons in the developing world who are unable to afford textbooks. Soon, international experts were queuing up to write open-access chapters – although Fagan wrote many of the chapters, it has become a truly international project, with 100 experts from 20 countries contributing chapters to date. The textbooks are registered with *Creative Commons*; there are no copyright restrictions, and readers are encouraged to use, copy and quote text as they wish. Producing the textbooks has not cost a cent, other than the time commitment of the contributors.

By the end of 2017, chapters from Prof. Fagan's ENT textbook series had been downloaded for free almost 1.5 million times, at a rate of one every 80 seconds. Fagan says that this reinforces the effectiveness of the open-access format, which allows doctors to freely share knowledge with colleagues in the remotest places on earth.

Johan Fagan receives the 2017 OER and Project Award for best Open Textbook from Sophie Touze, board president of the Open Education Consortium

Fagan's *Open Access Atlas of Otolaryngology, Head and Neck Operative Surgery* has won acclaim around the world. It was named best Open Book in the international 2017 Open Educational Resources (OER) Awards for Open Education Excellence. The Open Education Awards for Excellence provide annual recognition for outstanding contributions in the open-education community. The awards recognise distinctive open educational resources, open projects and initiatives, and exemplary leaders in open education worldwide. Last year, the OER Awards were introduced as a new expanded category, to recognise resources beyond courses and sites fostering the wide variety of innovative OER being developed around the world.

There are other benefits to publishing via the internet. "Because we can track the number of times that individual chapters are downloaded, it is now possible to determine what topics are most popular, compared with a textbook where the content an editor includes amounts to little more than a thumb-suck of what he or she thinks the reader may wish to read," says Fagan. It also means that chapters can be modified or updated whenever the author wishes to do so; there is no expense in using colour illustrations, and the books can be accessed in most parts of the world if the user has access to a mobile device.

The French ENT Society has now translated many chapters into French, and volunteers have translated some chapters into Portuguese and Spanish.

To Fagan's surprise, the biggest users of the textbooks are not doctors from developing countries, but from the USA, followed by India, SA and the UK.

Sources: The Cape Doctor and UCT website.

The Open Access Atlas of Otolaryngology and Head and Neck Operative Surgery:
http://www.entdev.uct.ac.za/guides/open-access-atlas-of-otolaryngology-head-neck-operative-surgery.
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The living will: Do medical practitioners have a duty to comply?

Prof. Dan Ncayiyana

A living will, better known to lawyers as an "advance directive", is a document prepared by an individual in which (s)he specifies the kind of medical treatment or intervention in respect of which (s)he declines to give consent in the event of being mentally incapacitated or otherwise rendered incompetent to think and communicate rationally at the time such treatment or intervention is contemplated.

There is presently no specific SA legislation governing the validity or enforceability of a living will. However, SA law recognises the right of the patient to refuse treatment even when such refusal may hasten death. A living will is an instrument of the patient's personal autonomy, which is guaranteed in our constitution. The ethical appropriateness of withholding treatment or refraining from performing a therapeutic intervention in the absence of explicit consent and against the wishes of the patient is acknowledged by SAMA and the HPCSA.

While this may seem self-evident in the case of a conscious and mentally competent patient, some practitioners may find it offensive to their core values – notwithstanding the absence of consent – to withhold what they deem to be life-sustaining treatment in respect of a patient in a vegetative state. Such treatment may include mechanical ventilation, cardiopulmonary resuscitation and, sometimes, quite invasive (if futile) interventions to treat complications such as seizures and infections, even though the patient is irreversibly brain damaged and comatose. In that event, SAMA advises that "doctors with a conscientious objection to withholding treatment in any circumstances are not obliged to comply with an advance directive but should advise the patient [or substitute decision-maker, usually a close relative] of their views, and offer to step aside or transfer treatment and management of the patient's care to another practitioner." If such a transfer is not feasible, is it the responsibility of the physician to then comply with the patient's wishes? Abandonment of the patient is not an option. According to Michael Gordon of the Toronto Joint Center for Bioethics, "strong arguments support the principle that the patient's wishes take precedence over the physician's discomfort in living with the consequences of a medical act that favours a patient's *bona fide* and legal rights over the physician's personal moral or religious principles, and it does not appear to be an excessive price to pay for patients to feel confident that their reasonable wishes will have meaning at the end of their life."

The compliance dilemma

Withholding life-sustaining treatment (also called non-initiation) is one thing; withdrawing treatment that is already underway is another. A patient admitted to the emergency department with life-threatening injuries will immediately be hooked up to mechanical life-support systems as a matter of course. If the patient is subsequently deemed to have sustained severe brain injury sufficient to result in a permanent vegetative state requiring continuous artificial life support, and if a living will then emerges in which the patient declines consent to heroic life-sustaining measures in these specific circumstances, some physicians may well find themselves on the horns of a dilemma. Does the living will render it ethical to withdraw treatment that is ongoing, and pull the ventilator?

This calls to mind the groundbreaking case in the 1970s of Karen Ann Quinlan that started the debate and rattled the percepts of moral theology and bioethics around the world. Twenty-one year old Quinlan was admitted to hospital in a comatose state with cardiopulmonary collapse after she had consumed a combination of alcohol and tranquilisers at a party, while on a crash diet. Upon admission, she was immediately connected to a respirator and was fed artificially by nasogastric tube. After some months of persistent unconsciousness on life support, the doctors determined that she was in a permanent vegetative state. The parents then requested – on compassionate grounds – that the respirator be disconnected and to allow her to die a dignified death. The doctors demurred, and the case went to court.

In their suit against the state, the parents asked the Supreme Court of New Jersey for authority to order the "discontinuance of all extraordinary procedures for sustaining Quinlan's vital processes". The argument in the case revolved around the state's inherent interest in preserving life versus Quinlan's constitutional right to privacy, which includes the right to make her own life decisions. The court affirmed Karen Ann's constitutional right to privacy, and recognised Karen Ann's father as the substitute decision-maker. The court ruled that he – and not her doctors or a court – was the authority in deciding her fate on her behalf. In ruling in favour of the Quinlans, the Court declared, among other things, that "the state's interest [in preserving life] … weakens and the individual's right to privacy [that] grows as the degree of bodily invasion increases and the prognosis dims. Ultimately, there comes a point at which the individual's rights overcome the state's interest."

Doctors have a standing duty to recognise and respect the lawful terms of a living will

An important principle to emerge out of the Quinlan case was the ruling that no one could be held criminally liable for removing the life-support systems, because the woman's eventual death "would not be homicide, but rather expiration from existing natural causes". The ruling thus served to indemnify healthcare providers, as well as to distinguish the act of voluntary withdrawal of artificial life support from euthanasia. This decision had a huge impact on bioethical thinking globally. Indeed, SAMA's position that the "late discovery of an advance directive after life-prolonging treatment has been initiated is not sufficient grounds for ignoring it" has its origins in the Quinlan case.

Formulating a living will

The signatory of a living will must be of age and fully mentally competent. The document must contain the full particulars of the

signatory: full names, address and identity number. It must be properly dated. It must be witnessed by two individuals, preferably not the signatory's family members or intimate partner, or potential beneficiaries of his/her deceased estate. Both must be present at the signing. If the signatory has a personal doctor, it is a good idea to include him/her in the drafting of the document.

"Strong arguments support the principle that the patient's wishes take precedence over the physician's discomfort …"

Ideally, the document should identify at least one substitute decision-maker, such as a life partner or family member, to represent the signatory and to assist the doctors in the interpretation and implementation of the living will. This proxy must be thoroughly familiar with the wishes and intentions of the signatory as expressed in the document, and must have knowledge of its location and ready access to it. According to David McQuoid-Mason, law professor and medicolegal specialist at the University of KwaZulu-Natal, "The National Health Act … allows for proxy decision-making on behalf of incompetent patients, by allowing such patients to mandate a person in writing to make decisions on their behalf when they are no longer able to do so."

The document must specify as closely as possible the types of treatment in respect of which the signatory is withholding consent. SAMA cautions that "if an advance directive is specific to a particular set of circumstances, the directive will have no force when these circumstances do not exist. If a directive is so general that it applies to all possible events that could arise, it could be viewed a too vague to give any definitive direction to the doctor."

SAMA suggests wording to the effect that: "If there is no reasonable prospect of my recovery from physical illness or impairment expected to cause me severe distress or to render me incapable of rational existence, I do **not** give my consent to be kept alive" by means of artificial life-support measures, including by way of mechanical ventilation and pacemakers. The advance directive can also include things that the signatory gives consent to. Thus, he or she may also wish explicitly to consent to or to refuse being fed and hydrated artificially (tube feeding), and similarly with regard to drugs and intravenous fluids being administered as necessary to remain free from pain.

Doctors' standing duty

It will be clear from the foregoing that doctors have a standing duty to recognise and respect the lawful terms of a living will. The WMA's Declaration of Venice directs doctors to "recognise the right of patients to develop written advance directives that describe their wishes regarding care in the event that they are unable to communicate, and to designate a substitute decision-maker to make decisions that are not expressed in the advance directive".

Source: The Cape Doctor.

Stop the world I want to get off

Gert Viljoen, *VPROF*

Our lives seem to become more stressful every day, and the barrage of "urgent" emails and social media messages that we are subjected to certainly doesn't help.

Why do we feel compelled to check our emails so often? What happens if we train ourselves to reduce the number of times we look at our emails to, say, three times a day? How does that affect us personally? How does it impact on our productivity and on our interactions with colleagues?

We live in times of immediate responses and instant gratification. A survey done on emails showed that people check their emails up to 18 times per hour.

Apart from emails, we are distracted by smartphones that deliver us endless messages from Facebook, Instagram, WhatsApp, Twitter and so on. Not forgetting that you can keep proactively checking these media as well.

Picture John Twit who has to analyse and report on a new brand strategy that he has just received from the firm's advertising agency. His boss wants the report in 3 hours so that he can give feedback at a board meeting.

John starts going through the report but continues to frequently check his emails. Many of them are urgent and require a swift response. As the 3-hour deadline looms, John becomes increasingly stressed, and finds it difficult to focus on the report. By the time he emails it to his boss, he is exhausted and mentally drained.

What's happening to John?

The human brain is wired to focus on only one important task at a time. So when John tries to respond to urgent emails while working on his report, he struggles to focus on the brand report.

Also, every time he switches from emails back to his report, he has to reset his brain to focus on the report. John feels mounting frustration as the deadline for the report looms and he faces ongoing pressure from the emails coming through.

Research shows …

The *New York Times* did a study on 124 people. Half the people were allowed to only view their emails three times a day. The other half were allowed to check their emails with no limit placed on this process.

Within a week, the people who looked at their emails only three times a day showed **markedly lower stress levels.** Other research has revealed that people communicated more with fellow staff members, and remained more focused, when they reduced the number of times they checked emails.

Productivity has been sluggish for more than a decade, so it is doubtful that the trend of responding instantly to emails has had a major economic effect. In fact you will probably find that many of the "urgent" emails have been resolved by the time they are opened several hours later.

Breaking habits is never easy to do, but checking your emails only two or three times a day will be good for productivity and ultimately, for your mental health.

Dispute resolution in the workplace

Modisane Lelaka, *industrial relations advisor, SAMA*

A dispute is regarded as disagreement between parties over an opinion, or over an issue arising in the workplace. A dispute maybe either a dispute of rights or a dispute of interest.

Disputes of rights

These are disputes in which employees acquire rights from the contract of employment and policies of the employer. If employees feel that their rights are being encroached upon, they can declare a dispute in terms of an unfair labour practice.

Section 186(2)(i) of the Labour Relations Act No. 66 of 1995 (the LRA) states that an unfair labour practice means an unfair act or omission by the employer involving unfair conduct relating to promotions, demotion, probation (excluding disputes about unfair dismissal based on probation), or training of an employee, or relating to the provision of benefits to an employee. Section 186(2)(ii) addresses the unfair suspension of an employee or any other unfair disciplinary action short of dismissal in respect of an employee. Section 186(2)(iii) deals with the failure to or refusal by an employer to reinstate or re-employ a former employee in terms of any agreement. It also refers to an occupational detriment other than dismissal, in contravention of the Protected Disclosure Act No. 26 of 2000, on account of an employee having made a protected disclosure as defined in that act.

The Commission for Conciliation, Mediation and Arbitration (CCMA) was established in terms of the LRA to resolve disputes. However, its powers are limited in resolving the following disputes:

- those regarding the disclosure of information (sections 16 and 89 of the LRA)
- those relating to organisational rights (chapter III, part A of the LRA
- agency shop disputes (section 25 of the LRA)
- closed shop disputes (section 26 of the LRA)
- those about the interpretation or application of a collective bargaining provisions (section 63(1) of the LRA)
- workplace forum disputes (sections 86 and 94 of the LRA)
- unfair discrimination disputes (section 6 of the Employment Equity Act No. 55 of 1998).

Following the establishment of the CCMA, the bargaining councils were created. The councils were established to resolve disputes of rights through conciliation and arbitration within the respective sectors. Additionally, they are tasked with negotiating issues affecting employees within relevant sectors. For example, the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) assists employees working within the health sector.

However, before a dispute is referred to either the PHSDSBC or CCMA, internal processes should have been exhausted. Disputes of unfair labour practices should be referred to the council within 90 days.

Disputes of interest

These are disputes wherein the employer and the unions, on behalf of the employee, seek to establish a new right. An example would be higher wages and improved conditions of service. The establishment of these rights is attempted through negotiations, and if parties fail to agree, conciliation may be the ideal, if parties agree to it. However, employees not engaged in essential services can resort to strike action after following the required processes, and the employer in return can resort to a lockout.

Unfair dismissal disputes (s186) arise when an employer has terminated employment, with or without notice.

There are three grounds for fair dismissal:

- Conduct of the employee: An employee would have to be subjected to a disciplinary hearing. The employee, if found guilty, may be dismissed as a result of misconduct. The employee would be required to appeal, and if unsuccessful, declare a dispute within 30 days to the bargaining council.
- Capacity of the employee: These disputes relate to an employee's ill-health, which may impinge on his or her ability to render services.
- Operational requirements (retrenchment): These are defined in section 213 of the LRA as "requirements based on the economic, technological, structural or similar needs of the employer". However, the employer is required to consult the employees before terminating their services; this would further require the employer to explore alternative ways of accommodating the employee.

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.

A medical walk through the ages – the Adler Museum offers an enriching experience

SAMA Communications Department

The Adler Museum of Medicine at Wits is an important cultural and academic institution, for a variety of reasons. Chief among these is that the museum preserves the history of the health sciences in southern Africa.

"It is also unique in that it supplements the educational activities of Wits, especially those of the Faculty of Health Sciences, by means of collections, research, teaching, exhibitions and publications," says the museum's acting curator, Mr David Sekgwele.

The museum, founded in 1962, was, at the time, situated in the grounds of the SA Institute for Medical Research in Johannesburg. It is named after its cofounders, Drs Cyril and Esther Adler, who handed the museum to Wits in 1974.

In the intervening years, the museum has relocated to the Wits Medical School campus in Parktown. In 2012, the Adler Museum celebrated its 50th anniversary with an exhibition on the history of the museum.

In addition to having the museum named after them, the Adlers were also heavily involved in its running. Until her death in 1982, Dr Esther Adler served as the museum's honorary curator, while Dr Cyril Adler acted as honorary director of the museum until his death in 1988.

The frontage of the museum in the foyer of the Medical School consists of an early 20th century apothecary, Reynolds Optometry Shop and Dr Greathead's Surgery, all of which are donations which have been made to the museum

A 20th century operating theatre

"The museum contains a lot of valuable pieces [that] show the history of medicine, dentistry and pharmacy through the ages," says Mr Sekgwele.

Apart from the hundreds of items of medical historical interest on display, there are also documents, sculptures, pictures, videos and philatelic and medallion collections relating to medical history and the history of allied health sciences.

In addition, the Adler Museum houses a library of rare books, and a significant history-of-medicine reference library. It is also has an archive, arranged by subject matter, which is housed in the library, and biographical

The museum's acting curator, Mr David Sekgwele

Draeger iron lung used in the 1950s poliomyelitis epidemic

information relating to thousands of medical and allied health professionals is available to students, researchers and interested members of the public.

There are reconstructions of an African herb shop and a patient consulting a *sangoma* (traditional healer); a reconstructed early 20th century Johannesburg pharmacy, doctor's consulting room, dental surgery and operating theatre; and an optometry display of the same period.

A history of scientific medicine is augmented with displays of several alternative modalities. Other attractions range from a

An important stream of medicine in Africa, traditional healing, is showcased in the museum – here, a reconstruction of a sangoma (traditional healer/diviner) consulting is depicted

reconstruction of a patient being treated by the famous Persian physician Avicenna to an exhibition of early electromedical equipment.

A showcase containing new acquisitions to the collection is constantly changed as donations are received. The objects displayed provide insight into the range and diversity of the collection.

In the foyer outside the museum are the shop fronts of a 19th century apothecary and an optometrist, as well as a doctor's surgery and operating theatre.

Panels relating to the history of the Cradle of Humankind (Sterkfontein and environs) and a display of replicas from the site give visitors a fascinating glimpse into this world heritage site.

The museum arranges regular public lectures, tours for students of all ages, film shows and exhibitions, and provides excellent facilities for medical historical teaching and research.

The museum is situated in the foyer of Wits Medical School, 7 York Road, Parktown, and is open from Monday to Friday, 09h00 - 04h00. It can be contacted on 011 717 2018.

"The museum contains a wealth of material and sources that are relevant to the Revised National Curriculum Statement, and is therefore an excellent resource for educators. The hundreds of fascinating exhibits on display are of interest not only from a historical point of view, but also in demonstrating technological advances in the field of medicine and healthcare. Using evidence is a major feature of the curriculum, and by visiting the museum learners will be able to view authentic or replica sources and to interpret evidence," concludes Mr Sekgwele.

Your financial health

Gert Viljoen, *VPROF*

VProfessional Services (VPROF) is a medical practice administrator, medical bureau and professional accounting firm that is dedicated to supporting the business activities and patient care of independent medical practices around SA. Gert Viljoen keeps us up to date on developments.

Watch your liquidity and solvency

There is nothing more demoralising than running into financial difficulties. Suddenly, all your energies are focused on survival rather than on growing the business. The fun goes out of the organisation, rumours of retrenchment flourish and if management aren't careful, the rumours can become self-fulfilling.

The importance of liquidity and solvency ratios

Since the "new" Companies Act (Act No. 71 of 2008) came into force, there has been a change of emphasis. The "old" Act (Act No. 61 of 1973) considered the cornerstone of sustainability to be "capital adequacy" – acceptability amounted to your equity being positive (share capital plus retained profits).

Globalisation and technology have speeded up business cycles, and have shifted modern thinking to liquidity and solvency as determinates of a company's viability. The new Companies Act adopted this philosophy.

What are liquidity and solvency?

Liquidity measures an organisation's ability to meet its short-term liabilities over the next 12 months, i.e. paying all creditors and any debt that is due in that period.

Solvency measures whether an organisation's assets are greater than its liabilities over the next 12 months. If your liabilities exceed your assets, then you have usually taken on too much debt or you are trading at a loss.

There are ratios that you can use to determine liquidity and solvency, but probably the best approach is a detailed cashflow that looks to at least the next 12 months – but usually for longer periods, depending on how much confidence you place in the reasonable accuracy of the cashflows.

Part of the cashflow process is to consider all known risks and to measure the potential impact they will have on cashflow if they materialise. In this way, you can plan for any contingencies and how you will respond to them. You can, for example, keep cash reserves to cover potential risks occurring.

Many best-practice businesses do cashflows as part of their monthly financial procedures. If the cashflows or ratios show that the business is getting into cash difficulties, then you have time to react. This time is crucial, as it is the difference between controlling the process or being controlled by it.

What the Act requires, and the risk of personal liability

In terms of the new Companies Act, if it is likely that the company will not be able to meet its short-term liabilities or will become insolvent in the next 6 months, then the organisation needs to consider:

- going into insolvency if the situation is unsalvageable; or
- commencing business rescue proceedings.

Remember that directors risk personal liability if they could have foreseen financial losses but failed to initiate business rescue proceedings or to declare bankruptcy.

The bottom line – be prudent

Keep yourself informed and ensure that you are checking that liquidity and solvency tests are being performed. Ask your accountant for advice at the first sign of trouble!

Sugar tax: Is it good for us?

Tax increases are on the way, and Treasury has signalled that a sugar tax (more correctly, a "Health Promotion Levy") will be levied from 1 April 2018. As with all new taxes, emotions have been running high.

Much of the debate centres on whether the tax is simply a revenue-generating exercise, or whether it will bring medium- to long-term health benefits to SA.

Recent tax increases have come mainly from an increase in the personal income tax rate and the fuel levy. Spreading the tax net wider will help Treasury to raise additional revenue.

The tax will be levied at 2.1 cents per gram of sugar content that exceeds 4 grams per 100 mL.

The passing of the legislation follows exhaustive negotiations and public hearings that included the National Economic Development and Labour Council (NEDLAC).

How will prices rise and what does the sugar industry say?

The proposed tax is estimated to add up to 11% to the cost of sweetened soft drinks such as Coca-Cola. This is in contrast to the initial proposal, which was for a 20% increase, and included items such as 100% pure fruit juice that have now been excluded.

The sugar industry, which opposed the levy, has been under pressure since the turn of the century, and 20 000 jobs have been lost, with the industry saying now that another 3 129 jobs will be under immediate threat and 20 000 more in 5 - 7 years. There have also been predictions that companies like Coca-Cola will cut investment, leading to further job cuts.

What does the health industry say?

- A sugar tax is one of the cornerstones of the National Department of Health (NDoh)'s determination to reduce non-communicable diseases (NCDs) such as obesity, diabetes and heart disease.
- The NDoH sees a clear link between NCDs and sugar consumption, although this supposed correlation is strongly disputed by opponents of the levy.
- NCDs are the leading cause of death in low-to-middle-income countries.
- SA has the highest incidence of obesity in Africa.
- We are among the top 10 consumers of soft drinks in the world.
- Diabetes alone killed 25 000 people in 2015, while diabetes, strokes, heart disease and other obesity-related conditions cause 55% of deaths in SA.
- India, Portugal, Saudi Arabia and Thailand

introduced taxes to combat NCDs in 2017. More than 30 countries have sugar-tax legislation in progress.
- Key research in these countries shows that there were minimal job losses (Mexico), and it reduced the consumption of sugar-sweetened drinks by 10%.

In conclusion

Treasury forecasts an additional ZAR1 billion - ZAR 1.5 billion in annual revenue from the levy. The licensing and registration of manufacturers of sugary beverages will take place from February 2018. On balance, the consensus seems to be that a sugar-sweetened beverages tax will bring in revenue to the fiscus (potentially limiting income-tax increases), and is likely to have health benefits.

Parliament is aware of potential retrenchments, and will be monitoring the impact of the tax on the sugar industry.

IGBA launches a biosimilar-medicines information campaign

SAMA Communications Department

On 1 February, the International Generic and Biosimilar Medicines Association (IGBA) launched an information campaign on biosimilar medicines. The foundation of this campaign is the IGBA biosimilar-medicines public slide deck. Access to well-referenced information is fundamental to improving worldwide understanding and acceptance of biosimilar medicines, which support patient access to life-saving treatments, enhance competition and contribute to healthcare system sustainability by offering savings for the same medical outcome.

The expiry of patent protection on a host of biological medicines in many parts of the world has paved the way for more affordable versions, or "follow-on" medicines, to be produced. These medicines, called "biosimilar medicines", are biological medicines that are highly similar to another that has already been approved (the "reference" medicine). While SA has just registered its first biosimilar medicine, Europe and the USA already have a number of these treatments approved and in use.

Because biosimilar medicines are usually less expensive than the reference medicine, IGBA estimates that biosimilar medicines could produce cumulative savings of nearly USD107 billion, in Europe and the USA combined, between 2015 and 2020.

Biosimilar medicines, like their reference medicinal products, help to treat many complex diseases, including cancers, rheumatoid arthritis, psoriasis, inflammatory bowel disease, growth disorders and diabetes.

The European Union (EU) has approved the highest number of biosimilar medicines worldwide, and has acquired considerable experience in their use and safety. There is real-world experience available of over 700 million patient days from EU-licensed biosimilar medicines alone, and "over the last 10 years, the EU monitoring system for safety concerns has not identified any difference in the nature, severity or frequency of adverse effects between biosimilars and their reference medicine." IGBA believes that this accumulated wealth of clinical experience with biosimilar medicines can become a worldwide game-changer for access to medicines for certain complex medical conditions.

The slide deck, developed to be shared for educational purposes with any stakeholder, is complementary to the extensive information on biosimilar medicines that has already been made available, for example, in the USA and the EU.

The IGBA biosimilar medicines public slide deck may be accessed via the Generic and Biosimilar Medicines Southern Africa (GBMSA) website at www.gbmsa.org, or from http://www.igbamedicines.org/committees/biosimilars-committee/communication-on-biosimilar-medicines.

The International Generic and Biosimilar Medicines Association (IGBA) was founded as the International Generic Pharmaceutical Alliance (IGPA) in March 1997, to strengthen co-operation between associations representing manufacturers of generic medicines from around the world. Its membership includes AAM (USA), CGPA (Canada), GBM Southern Africa (South Africa), IPA (India), JAPM (Jordan), JGA (Japan), Medicines for Europe (Europe) and TGPA (Taiwan), while the associations from Australia (GBMA), Brazil (ProGenericos), Mexico (AMEGI), and Malaysia (MOPI) are associate members. IGBA is at the forefront of preserving sustainable competition within our industry by stimulating competitiveness and innovation in the pharmaceutical sector, thereby ensuring that millions of patients around the world have access to high-quality, procompetitive medicines. Through its constituent member associations, IGBA maintains constant dialogue with government authorities around the world, as well as with international institutions such as the World Trade Organization, the World Intellectual Property Organization and the WHO.

For more information, visit www.igbamedicines.org.

Calling for nominations

Please note that the due date for nomination forms to be submitted for the SAMA Education, Science and Technology subcommittees awards is 31 July 2018 NOT 31 July 2016 as stated in the February issue of *SAMA Insider*.

Caught by consent: A private neurosurgeon faces questions

The Medical Protection Society shares a case report from their files

Mrs P, a 40-year-old nurse who lived in the platteland, attended her GP complaining of back pain, and was prescribed simple analgesia. After a month, the pain was no better, so she consulted a neurosurgeon in a nearby city, Dr S, who advised conservative measures.

One month later, Mrs P phoned Dr S to tell him that her back pain had not improved and that she now had left-sided sciatica. This was confirmed by her GP, who arranged an MRI scan, which showed the disc bulge responsible for it. Overall, her condition was worse, and she had been off work for over a month.

As Mrs P now had sciatica, Dr S felt that a microdiscectomy was a reasonable approach. He discussed the options with her over the phone, and explained the operation and its pros and cons. Dr S did record the phone call in the medical records, but did not state exactly what was discussed. Mrs P was happy to proceed, and so the operation was arranged. Dr S wrote a letter to the GP informing him of the plan.

Dr S next saw Mrs P on the day of the operation as she was brought in to be anaesthetised. He had a brief conversation with her, confirming that she was happy to go ahead and that she had no questions. She then signed the consent form, which listed none of the pros and cons of the operation.

The operation was straightforward and there were no observed complications. However, 2 months after the operation, Mrs P felt that her pain was worse, and she had genital numbness and urinary symptoms. Her urodynamic investigations were normal, but she was numb in the S3 dermatome.

Mrs P brought a claim against Dr S, alleging that he had taken inadequate consent and had not informed her that the operation could make her pain worse. She also alleged that the operation had been negligently performed, damaging the left L5 root and the S2 and S3 roots bilaterally.

Expert opinion

MPS sought expert opinion from a neurosurgeon. The expert advised that although the consent form was inadequate, the overall consenting process, including the phone consultation and the brief discussion on the day of the operation, was just about acceptable.

The expert also opined that it was very unlikely that an experienced neurosurgeon, such as Dr S, would have damaged the nerves without noticing and recording it. He noted that there was no suggestion of nerve damage in the immediate postoperative period, and suggested that deterioration occurring 2 months after the operation was more suggestive of a chronic pain syndrome.

Learning points

- Being cognisant of the National Health Act No. 61 of 2003, doctors must take reasonable steps to ensure that patients are aware of any risks that are material to them, and of any reasonable alternative or variant treatments.
- In deciding whether a risk is material, doctors should consider whether a reasonable person in the patient's position would be likely to attach significance to the risk.
- It is important to make a record of the consent discussion in the patient's notes, including key points raised and hard copies of or web links to any further information provided. This is in addition to the consent form.
- It is also important to document the indications for surgery.

The case was deemed defensible and taken to trial. The judge concluded that there had been no negligence during the operation, but that Dr S had taken inadequate consent. The ruling stated that Mrs P had not been warned of a 5% risk that the surgery could make her back-pain worse, and that if she had been, she would not have gone ahead. Mrs P was awarded a moderate sum.

SAMA supports Cancer Warrior Walk

Jeanette Snyman, *senior marketing officer, SAMA*

Shelley Warner from the Gauteng branch

On 4 February 2018, thousands of cancer survivors and the families of those who have battled the fight against cancer dressed up and gathered together for a 5 km One Step at a Time Cancer Warrior Walk at the Johannesburg Zoo. The event carried the theme "I can, we can." SAMA was a visible supporter of the event.

World Cancer Day raises the profile of cancer in people's minds, in the media and on the global health and development agenda.

Cancer affects everyone in different ways, and everyone has the power to take action to reduce the impact of the disease on individuals, families and communities. Therefore, World Cancer Day gives us a chance to reflect on what we can do, make a pledge and take action. Whatever we choose to do, we can make a difference in the fight against cancer.

This family supported the woman on the left who is a cancer survivor

Supporting Saron community Christmas party

Western Cape branch councillors and the branch contributed to the Saron community's Christmas party at the end of last year. Branch chairman Dr Abbas, who had heard about the community from his patients Edward and Lucille Patience, motivated the donation. The Patiences have worked in Saron for more than 4 years, and own a house in the village. Edward's family has lived in Saron for many generations, and this is his way of giving back.

Originally a mission station at the foot of the Saronsberg in the Tulbagh district, the town is about 20 kilometres from Porterville. It was established by the Rhenish Missionary Society in 1848, and later taken over by the Dutch Reformed Church in 1945. In 2013, the historic core of the Saron Mission Station was declared a provincial heritage site.

Over 400 children from the community are assisted by Edward and Lucille's work.

The children received party packs donated by SAMA, while they wait in the lunch queue

Lowveld hold impressive CSI project

Lowveld branch President, Dr Abraham Varghese

Dr Bongi Baloi and Karen Potgieter discuss a referral patient. Congratulations to Dr Bongi Baloi (Lowveld branch council member) who was nominated as the Best GP of 2017 at the Mpumalanga Healthcare Professionals Awards (Emnotweni Arena – Nelspruit) on 8 December 2017

Matthew Greavor (Barberton Primary) assisted in patient flow at the vital sign table, Dr Ernie Valster did screening and Brandon Baumgart (Bervlam high school) assisted with record keeping

The Lowveld branch kicked off the year with an impressive first CSI project. This event took place at the Cathyville Clinic in Barberton, where eye tests, screening, blood pressure and glucose tests were performed. This is one of Mbombela's yearly projects, in partnership with the local Lions Club and several other sponsors. This year, sponsorship came from the Swift Group of Mbombela, who sponsored all the spectacles for the elderly. SAMA Lowveld did the catering for the workers, and set up a table to check vital signs, and the Lions Club sponsored food for approximately 320 patients for the day. The Department of Health (as represented by Barberton Hospital and the Cathyville Clinic) also contributed to the success of this day by sending helping hands.

Successful intern orientations held in Western Cape

Western Cape branch held an intern orientation at Groote Schuur Hospital on 28 December 2017. Prof. Mark Sonderup spoke to approximately 35 interns, and more than 25 joined SAMA on the day.

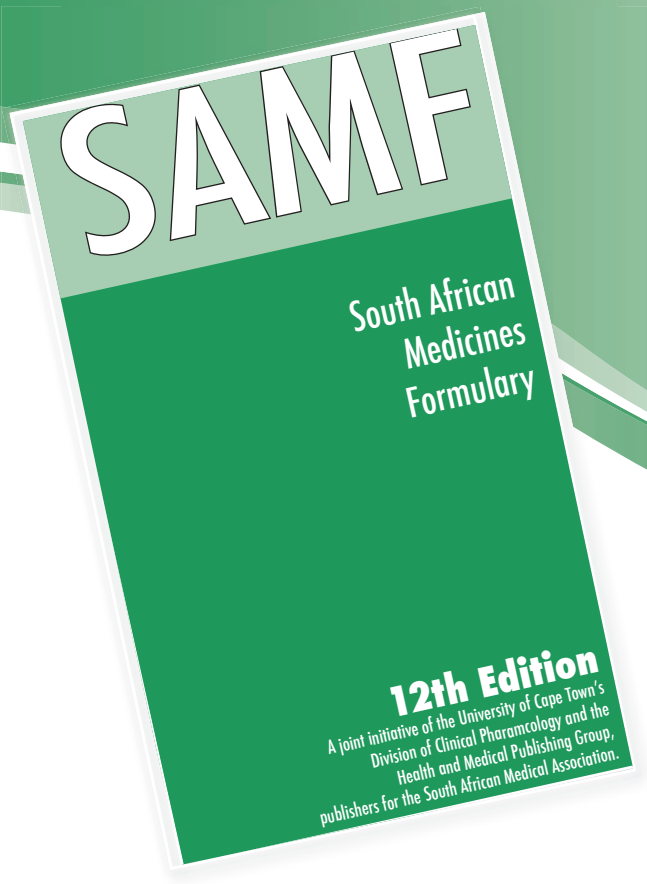
The branch also successfully visited Paarl Hospital on 18 January and Helderberg Hospital in Somerset West on Friday 2 February.

Interns at the Groote Schuur Hospital orientation

New Branch Council elected

Congratulations to the following new Free State Branch Council members elected at the last branch meeting: Dr D Hagemeister (chairperson), Dr T S Matshidze (vice chairperson), Dr C C van der Bijl (honorary secretary), Dr D Menge (employed doctors committee rep.) and Dr F C J Bester (treasurer).

Dr M C Diba, Dr T S Matshidze, Dr D Hagemeister, Dr F C J Bester, Dr D Menge, Dr C C van der Bijl



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