

SAMA INSIDER

JUNE 2018

**The “sugar tax” –
what it means for
public health and
healthcare in SA**

**Is eLearning the
future of doctor
education?**



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Diane de Kock
Editor: *SAMA INSIDER*

Forging ahead

Welcome to the June issue of *SAMA Insider*, which highlights the huge developments in medicine over the last 100 years, from Dr Peter Gordon's article on the Nagin Parbhoo anaesthesia museum (page 17), to the groundbreaking launch of a simulation centre (page 13) at UCT this year.

SAMA councillor Dr Michael van Niekerk jets off to Geneva (page 5) to attend the World Health Assembly as part of the WMA delegation, for the second year running. The gathering is attended by delegations from all WHO member states, and each year focuses on a specific health agenda prepared by the executive board.

On page 6, Bernard Mutsago looks at the impact of the recently implemented sugar tax on public health and healthcare in SA, and the article on page 10 asks whether eLearning is the future of doctor education.

Medicine in SA is continuously adapting to change, and the needs and requirements of our particular society, while at the same time remaining at the cutting edge of developments. The contrast between the equipment exhibited in the Nagin Parbhoo museum and the concepts of the simulation ward and eLearning highlight the exciting developments that have occurred over the last 100 years.

Please keep us informed of developments and news in your field of interest. As always, we welcome news from all SAMA members.

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Sleep apnoea: An underdiagnosed condition



Dr Marina Xaba-Mokoena, SAMA president

Sleep apnoea is a condition that causes one to stop breathing while asleep. It is a fairly common condition in the USA – there could be up to 10 - 12 million people affected by it – but in SA, it is certainly underdiagnosed, in that very few people, comparatively speaking, undergo the necessary tests. I myself have friends who have been diagnosed with sleep apnoea, and now sleep with the aid of continuous positive airway pressure (CPAP) machines, but it seems that in general, in SA, very few practitioners consider the condition as a possible cause of symptoms, and so do not test for it.

Sleep is one of the most important healing processes your body has, and so is getting enough oxygen, either awake or asleep. But with sleep apnoea, breathing comes to a pause while one is asleep: snoring or gasping occur, resulting in reduced or absent breathing. Breathing just stops for a few moments, and one may wake suddenly, gasping for air. Usually, a spouse will notice these lapses of breathing, or the snoring. Not everyone who snores has sleep apnoea, however, and an evaluation by a doctor is recommended.

The pauses in breathing can occur three times or more in an hour, and according

to the US National Heart, Lung and Blood Institute, can have deadly consequences if left untreated. Sleep apnoea can lead to heart attacks, diabetes, cancer or cognitive or behavioural disorders.

The causes can include obesity, large tonsils, endocrine disorders, neuromuscular conditions, heart or kidney failure, genetic syndromes or premature birth.

Many patients report feeling tired all the time, despite spending 8 - 9 hours in bed every night. A patient may feel like a "sleep zombie", when memory problems occur. Sufferers can even be troubled by leg cramps while asleep.

Signs and symptoms

- **Obesity:** Heavy fat deposits around the neck and upper chest can cause a shift in the trachea when lying down. Extra weight can affect one's inner mouth structures, such as the tongue, which can fall back over the trachea during sleep, and partially or completely block air entry – resulting in snoring or cut-offs to air flow, which make one wake up gasping.
- **Blocked sinuses/deviated septum:** If one has a dust allergy that causes sinuses to congest badly, this can be aggravated when one goes to sleep, making it difficult to breathe, and leading to sleep apnoea.
- **Mouth breathing:** One wakes up during the night with a parched, dry mouth and throat, needing a glass of water.
- **Waking up gasping:** This is one of the most common signs of sleep apnoea, and can be caused by any of the above-mentioned. How frequently it occurs can determine a diagnosis of sleep apnoea.
- **Frequent night urination:** If one does not get enough air while sleeping, the body releases adrenaline to speed up its metabolism; the heart beats faster, and this leads to more frequent trips to the bathroom.
- **Daytime sleepiness/clumsiness:** Fatigue and clumsiness are noticeable; one might even fall asleep while driving, resulting in accidents.
- **High blood pressure:** Low oxygen levels lead to adrenaline secretion, resulting in raised blood pressure in a "fight-or-flight" response.
- **Morning headaches and/or muscle aches:** These may be misdiagnosed as symptoms of fibromyalgia, rather than sleep apnoea.

- **Depression/irritability:** Among other notable symptoms are cognitive and concentration problems, and even sexual dysfunction.

In SA, very few practitioners consider the condition as a possible cause of symptoms

The evaluation that is required to diagnose sleep apnoea is a **sleep study**. Many things can wake someone in the middle of the night, e.g. pets, unfamiliar noises, feeling cold or hot, or a bad dream – but these are all external causes. There are also internal causes to look for, and these can be confirmed with a sleep study, in which breathing and other bodily functions are monitored overnight during sleep. This can be performed in a sleep laboratory.

Treatment or management

The recommended treatment or management course will depend on the cause and severity of the condition. Lifestyle changes are common forms of treatment. For instance, if your sleep apnoea is a result of obesity, you can work on this by attempting weight loss. Elevating the head by using more pillows, or turning to sleep on your side, are also behavioural changes that can help.

There are also mandibular repositioning mouthpieces that can be used, or tongue-retaining devices, to hold the tongue in a forward position that prevents it from blocking the upper airway.

For chronic sufferers, breathing devices such as CPAP machines may be necessary. Generally, once one needs the machines, it becomes a lifetime management issue. Nevertheless, treatment and management are possible – but only once the condition has been tested for, and diagnosed.

SAMA councillor off to Geneva as part of WMA delegation

SAMA Communications Department

Dr Michael van Niekerk, SAMA Cape Western branch (CWB) councillor, has been selected as one of the delegates of the WMA, a body representing physicians worldwide as an international and independent confederation of professional medical associations, of which SAMA forms a part.

As part of his new appointment, Dr van Niekerk will attend the 71st World Health Assembly (WHA71), the supreme decision-making body of the WHO, on 21 - 26 May. The WHA takes place annually at the Palais des Nations in Geneva, Switzerland. The gathering is attended by delegations from all WHO member states, and each focuses on a specific health agenda prepared by the executive board.

“The main functions of the WHA are to determine the policies of the WHO, appoint the director-general, supervise financial policies and review and approve the proposed programme budget,” explains Dr Van Niekerk.

He says the WMA sends a delegation to the WHA every year, and that the delegates are chosen after a rigorous process that includes an extensive evaluation, their experience within the Junior Doctors Network of the WMA, their advocacy experience and their understanding of the WHA.

“This is the second year I have been selected. Last year I attended the 70th WHA [WHA70], when the new director-general of the WHO, Dr Tedros Ghebreyesus was elected, after the conclusion of Dr Margaret Chan’s 10-year term,” he says, adding that two of his key interests are global health and health advocacy, including building resilient health systems to form the foundation for all efforts to improve and protect health.

He says that as a result of his experience within SAMA – as the Junior Doctors Association of SA national secretary-general and SAMA branch councillor (CWB) – the International Federation of Medical Students Associations and the Junior Doctors Network (JDN), the WMA has had a significant impact worldwide in terms of its representation in public health, human rights, ethics, access to health systems and advocacy.

“Access to health systems and advocacy, specifically, are areas that lie very close to



Dr Michael van Niekerk, seen here at the 70th World Health Assembly in 2017

my heart, and a component within my own medical career and life that I spent a considerable amount of time on. With the WHA being the world’s highest health policy-setting body, it is an immense privilege for me to join the WMA delegation,” he says.

According to Dr van Niekerk, the WHA71 will have a packed agenda, focusing on non-communicable diseases, financial policies, review and approval of the proposed programme budget and, hopefully, a further review of the influenza pandemic, taking into account the massive surge in morbidity and mortality associated with influenza recently.

He says that one of the main issues of our time, antimicrobial resistance (AMR), especially in terms of national action plans in combatting AMR, will also again be an important topic.

The JDN and WMA will have to follow certain specific issues being addressed at the WHA71 pertaining to doctors and healthcare professionals worldwide, including non-communicable diseases, social determinants of health, the lifelong promotion of health and universal access to healthcare and health systems.

“[The issue of] attacks on healthcare is something that received considerable attention from a number of member states at WHA70. This year we have, unfortunately, seen another aspect to it – attacks on the integrity of healthcare leaders in countries from their own governments, specifically the recent arrests of leaders of the Turkish Medical Association.

“Violence toward healthcare workers is an issue that still needs serious deliberation and action planning, with resource allocation. The title speaks for itself. A multitude of healthcare workers are losing their lives or ability to continue their careers as a result of violence during armed conflicts. The Turkish example is one; another is the destruction of ambulances and assault of EMS [emergency medical service] personnel in SA,” says Dr van Niekerk.

Dr van Niekerk currently works as an emergency doctor at sea. He also serves on the board of directors of the South African Medical Students Association (SAMSA). He was selected as one of the 100 Brightest Young Minds in SA, received his university’s Dux award and attained his medical degree and Diploma in Primary Emergency Care with distinction.

The “sugar tax” – what it means for public health and healthcare in SA

Bernard Mutsago, health policy researcher and analyst, SAMA Knowledge Management and Research Department

On 8 July 2016, the Department of National Treasury released for public comment a policy paper entitled *Taxation of Sugar-Sweetened Beverages*. The policy suggested the introduction of what has come to be commonly known as the “sugar tax”, although this is a misnomer as the tax is not levied on solid sugar or sugary substances, but rather on sugar-sweetened beverages (SSBs). These are beverages that contain added caloric sweeteners such as sucrose, high-fructose corn syrup or fruit-juice concentrates. The WHO has backed SA’s sugar taxation breakthrough.

The burden of chronic diseases in SA related to unhealthy eating is enormous

In response to the call for comments, SAMA made two successive submissions to the National Treasury, followed by an oral presentation in Parliament on 31 January 2017. SAMA’s comments were similar to those of several other organisations supporting a proposed SSB tax rate of 20%, against ferocious pressure from the beverage industry, which is beholden to commercial interests. From the outset, SAMA and other proponents of the sugar tax sent a categorical message to the government that the tax revenue should be channelled towards health-promotion initiatives.

Despite the widely confirmed effectiveness of a 20% tax on SSBs – based on scientific evidence and the experiences of many countries, including Mexico – the government instead approved a watered-down level of the tax, equivalent to a levy of about 11% on a can of Coca Cola, which was implemented with effect from 1 April 2018. The designation of the sugar tax as a “health promotion levy” generates hope for its possible linking to health-promotion activities, although sceptics have shrugged off this possibility.

An 11% tax is undoubtedly too small to capably turn back the enormous obesity tide in the country; studies demonstrate that at this rate, the reduction in obesity prevalence hardly surpasses 2%. Nevertheless, the 11% is widely seen as a step in the right direction that still offers significant advantages to public health. Continuing efforts are now focusing on monitoring the use of the tax revenue, promoting complementary strategies for obesity reduction (e.g. more physical exercise, food labelling, etc.) and monitoring the impact of the tax.

The Healthy Living Alliance (HEALA)

A key driving force behind the sugar-tax campaign has been the Healthy Living Alliance (HEALA), a body comprising a number of local organisations. HEALA was formed in 2016, with a Constitutionally driven commitment to creating a healthy food environment in SA. Tracey Malawana, the HEALA co-ordinator, and her team members have been at the forefront of HEALA’s national campaign activities, which have included, among others, presentations in Parliament, mass media campaigns, and providing nutrition education in schools and clinics. SAMA is solidifying its relationship with HEALA, with the aim of formalising the collaboration.

SA’s abiding determination to harness the power of fiscal policies for public health ends is predominantly demonstrated by the decades of gradual success in reducing tobacco consumption through tobacco taxation, which has been followed by more environmental as well as health taxes that bear significant health co-benefits.

The burden of chronic diseases in SA related to unhealthy eating is enormous. South Africans consume alarming amounts of sugar and carbohydrates, putting SA in the global top 10 for soft drink consumption. Scientific evidence has convincingly demonstrated the association between the consumption of dietary sugar and a range of chronic diseases, although non-dietary factors also play a role. In SA, obesity is one of the top five risk factors for early death, and years lived with disabilities. A total of 43% of deaths in

the country are attributed to obesity-related chronic diseases such as heart disease, diabetes, stroke, osteoarthritis and some cancers. Forty percent of SA women and 11% of men are obese. This gives SA the highest obesity rate in sub-Saharan Africa.

SA has become the first African country to implement a sugar tax, following the lead of several other countries that have or have had such a tax, including Mexico, Denmark, Finland, France, Hungary, Ireland, Mauritius, Norway and more recently the Philippines (introduced in 2017) and the UK (2018). SA’s intensifying commitment to combatting lifestyle diseases is reflected in the Department of Health’s *Strategic Plan for the Prevention and Control of NCDs 2013 - 2017*, and *National Strategy for the Prevention and Control of Obesity 2015 - 2020*. The introduction of a health-related sugar tax by a non-health government department (National Treasury) demonstrates SA’s march towards the WHO’s “health in all policies” philosophy, or the “whole of government” approach.

South Africans consume alarming amounts of sugar

Evidence suggests that taxation on foods high in sugar is comparatively more cost-effective than other measures when it comes to addressing poor diet and obesity. Public health advocates hope that SA’s sugar tax, in addition to generating revenue, will reduce obesity rates, just as tobacco taxes have successfully reduced smoking rates. To what extent – as well as how soon – the 11% tax will be practically effective and begin to lower obesity rates remains to be seen. However, when Mexico introduced a 10% sugar tax in 2014, a 6% decline in sugary-drinks purchases was evident in the first year, mainly among lower socioeconomic groups. The tax-attributable reduction in disease burden has yet to be assessed.

The implementation of the sugar tax perfectly aligns with the National Development

Plan's health goals, as well as the **prevention** spirit that underpins the current health system reform project in SA. The ongoing health system reform has also focused on the **social determinants of health** – the conditions in which people are born, live, work and age that affect their health. The sugar tax is only one measure that will address the economic, social and environmental determinants of unhealthy beverage consumption and associated ill health, especially in informal settlements. Comprehensively addressing

all structural determinants of health requires multisectoral, interdepartmental, co-ordinated and complementary efforts. The projected decrease in sugar consumption will ultimately result in fewer sick people, immense reductions in the costs of lifestyle-disease treatment, and less pressure on the already overburdened health system. SAMA's pursuit of formal partnerships with key public health organisations, namely HEALA and the Public Health Association of SA (PHASA), is a real demonstration that the medical profession

is serious about the national prevention agenda, increasingly challenging itself to exercise "upstream medicine", i.e. keeping people healthy and out of hospitals.

In conclusion, although the 11% sugar tax is a somewhat weak compromise, and makes achieving the Department of Health's target of reducing the number of people who are obese or overweight by 10% by 2020 highly unlikely, 11% does not equate to nothing; it is still significant and should be celebrated, as we continue pressing for a higher tax rate in the years to come.

SAMA president honoured for her role in SA medicine

SAMA Communications Department

Prof. Marina Xaba-Mokoena is a remarkable woman. Looking beyond her considerable academic achievements, the many articles she has written and her commitment to developing medicine, one quickly realises that all of this is done to support her one true love: helping others.

Prof. Xaba-Mokoena, currently the president of SAMA, was recently recognised for her contribution to society when she was awarded an honorary doctorate from Nelson Mandela University (NMU), in the Eastern Cape, during its graduation ceremony held on Wednesday 18 April.

Born in 1938, Prof. Xaba-Mokoena was educated at Healdtown Missionary Institution, before training as a general nurse and midwife at the King Edward VIII Hospital in Durban. In 1960 she was awarded the South African Nursing Council's gold medal for the best marks in SA.

In 1964, she trained in orthopaedic nursing in London, UK, and passed in 1965 with the highest marks in the whole of England and Wales. She was awarded both the Royal National Orthopaedic Hospital and the British Orthopaedic Association prizes.

Prof. Xaba-Mokoena then went on to study medicine, in Stockholm, at the Karolinska Institute. She registered as a medical practitioner in 1973. She stayed in Sweden, and in 1978 completed her postgraduate studies, qualifying as a pulmonologist.

She performed in various medical capacities from then until 1984, when she was

appointed as founding Dean of the Faculty of Medicine and Health Sciences at the University of Transkei (now Walter Sisulu University).

Prof. Xaba-Mokoena has been, and still is, involved in plenty of community work. She was an executive member of the South African Council of Churches, and for the last 4 years has been a part of the governing council of the Seth Mokitimi Methodist Seminary, which trains ministers.

Although retired, Prof. Xaba-Mokoena continues to contribute as a board member of Frere Hospital, a position she has held for the past 3 years.

In accepting her honorary doctorate, Prof. Xaba-Mokoena reflected on the journey she has travelled to reach this point.

She mentioned how difficult it was for her father to get his medical education, as there were no facilities for black South Africans in the 1930s, when he studied medicine. He eventually graduated in 1936, becoming the 23rd non-white medical practitioner in SA at the time (all of whom had graduated abroad).

Her mother, she said, was a teacher, a leader in her church and a Girl-Guider, and died as president of the Zenzele ("do it yourself") Women's Association.

"I mention these narratives to illustrate where I inherited the traits of wishing to help others," Prof. Xaba-Mokoena noted.

And help others she has. It is this commitment to aiding others – most often the poor and downtrodden – that is highlighted as one of the reasons NMU conferred the



Prof. Marina Xaba-Mokoena with her proud husband

honorary doctorate on her. In awarding the degree, the university noted that it was being bestowed, in part, because of service to others.

The statement reads, "For her incredible advocacy in involving communities in the training of health practitioners that would later serve them, and addressing inequalities in our society, it is an honour for Nelson Mandela University to confer the degree of Doctor of Philosophy (*honoris causa*) on her."

Prof. Xaba-Mokoena was quoted in the *Saturday Star* as saying that the honorary doctorate from NMU is particularly important to her.

"It is my greatest joy to be bestowed with this honorary doctorate, and to see so many health sciences students graduating from this wonderful university named after Nelson Mandela," she said.

Kenyan seminar and conference address key issues

Dr S Mametja, SAMA Knowledge Management and Research Department, Dr L Shange, SAMA Health Policy Committee

The Kenya Medical Association (KMA) celebrated its 50-year anniversary in April this year with a conference, themed “Universal health coverage”. The conference coincided with a recent SA presidential announcement that universal health coverage would become one of the four main government priorities.

KMA also hosted a pre-conference symposium on the social determinants of health. Addressing social determinants of health is a WMA priority, and African medical associations have agreed to conjointly work on the determinants of health in Africa. The first social determinants of health symposium was hosted by SAMA in 2017.

Kenya's sociodemographic profile

Kenya is a country on the eastern coast of Africa with a tropical climate and an estimated 50 million people.

The top burdens of disease and causes of mortality are:

- diarrhoea
- HIV/AIDS
- lower respiratory tract infections
- ischaemic heart disease
- cerebrovascular disease
- TB
- neonatal encephalopathy
- neonatal preterm births
- meningitis
- protein-energy malnutrition.

The reproductive rate is four children per woman, with a high burden of teenage pregnancy. Access to contraceptives remains a major challenge. The maternal mortality rate is 362 per 100 000 births, neonatal mortality 22 per 100 000 births and under-5 mortality 52 per 1 000 births.

Social determinants of health symposium

Social determinants of health are defined as the conditions in which people are born and which determine their health outcomes. As observed from the burden-of-disease profile, Kenya's population suffers predominantly from infectious diseases, with an emerging burden of cardiovascular diseases. The

determinants of infectious disease include access to water, sanitation, housing and malnutrition. The conditions affecting these determinants were clearly visible on the drive from the airport. Although injuries do not make it into the top 10 causes of mortality, the Kenyan transport infrastructure poses a risk for morbidity and mortality.

The symposium agenda focused on access to water, hygiene, sanitation, nutrition and access to healthcare. The following statistics were highlighted:

- In Kenya, 64% and 47% of households in rural and urban households, respectively, are without sanitation
- A total of 55% of the population is without water
- Kenya experienced four cholera outbreaks last year, and has had one Chikungunya virus outbreak this year.

Nutrition

Access to food remains a problem for households that do not have access to land. In households that have access to land, food preparation methods and micronutrient deficiencies remain a problem. Kenya has a broad food-security policy that includes food supplementation and education about food preparation methods, including macronutrient balance. More work needs to be done on educating communities on food preparation and poverty eradication.

Some families with access to food do not have good feeding practices, resulting in malnutrition in children. Often children are fed only starch, their diets consisting mainly of soft porridge and/or potato. This diet lacks macro- and micronutrients.

Housing

Many Kenyans are without adequate housing. Kenya needs to facilitate and promote access to housing for its population.

Access to healthcare

Despite the problems caused by social determinants of health in Kenya, those who are sick and vulnerable often cannot access healthcare, due to a lack of funds. Universal health coverage is seen as a means of enabling access to healthcare, focusing on primary healthcare.

A human-rights approach to addressing social determinants of health

The right to healthcare necessitates addressing social determinants of health. Two case studies were used to highlight this link:

- Two male siblings from a squatter camp were arrested and quarantined for non-compliance with TB treatment. Social determinants of health had created barriers to healthcare access for these men, such as poor housing, poverty and lack of money. The patients were quarantined without a proper investigation or understanding of, or attempt to address, the factors that may have contributed to non-compliance and defaulting of treatment.
- A middle-aged man died in an ambulance after 18 hours in transit. No hospital would admit him because there were no beds. This highlights a system failure to enable access to emergency care.

The relationship between human rights and healthcare was outlined:

- The violation of human rights can increase vulnerability, burden of disease and avoidable mortality.
- The protection of human rights and dignity can promote healing, by making resources available.
- A health system can either violate or promote human rights.

In order to advance human rights, it is imperative that healthcare be recognised as a right, be made accessible to all and be of good quality. Privacy and confidentiality must be upheld, and respect for personal dignity and autonomy shown. Most importantly, there ought to be accountability and participation.

Conference recommendations

- Kenya should focus on water, sanitation and hygiene (WASH), in particular safe water, adequate sanitation and proper hygiene education, which can reduce illness and death, and also affect poverty reduction and socioeconomic development.
- Government should focus on food security.
- Instead of these programmes being funded



Dr Lindi Shange and Dr Selaelo Mametja at the conference

by developmental partners, government should prioritise and allocate resources for addressing social determinants of health.

- The training of health workers needs to include a human-rights approach.
- Human rights should be integrated into laws.
- Kenyan citizens need access to justice.

Universal health coverage conference

Healthcare financing in Kenya currently comes predominantly from three sources: out-of-pocket (32%); government and insurance (31%); and donor funding (35%). Healthcare services are provided by self-funding organisations, which include non-governmental organisations and the public sector. Some communities, such as Makueni, have a community financing mechanism.

Keynote addresses

The WMA secretary general, Dr Otmar Kloiber, alluded to the four WMA universal health coverage (UHC) streams:

- advocacy for UHC
- a global health workforce
- inequality in health, and attending to the impact of social determinants of health
- emergency and disaster preparedness.

During his keynote address, Prof. Abdallah quoted the late Jomo Kenyatta on how Kenya has come full circle in fighting three ills:

- poverty, by means of economic development and enterprise;
- ignorance, by means of education; and
- ill health, by providing comprehensive healthcare.

He further stressed that UHC, as a goal and a challenge, is also an economic, social and political issue.

The reasons for the rising healthcare costs in Kenya include: an ageing population, epidemiological transition, medicalisation of social problems, rising expectations of

the public, and healthcare awareness. New technologies, such as MRIs, organ transplants, renal dialysis, ICU care, life support and palliative care, have also increased health costs significantly. Inefficiencies created by a lack of proper cost-control mechanisms have also increased expenditure.

Trends that continue to undermine the improvement of health outcomes globally, according to the 2008 WHO *World Health Report*, are:

- hospital-centrism, which has a strong curative focus and is costly
- fragmentation in approach to programmes or service delivery
- uncontrolled commercialism, which undermines the principle of health as a public good.

Prof. Abdallah further argued that health reform is difficult because there are competing interests, institutions have different approaches, ideologies are variable and while health is a social good, it is heavily commercialised.

The basic requirements for sound UHC (the 8 As and 3 Cs) are: appropriateness, availability, adequacy, accessibility, acceptability, affordability, accountability, completeness, comprehensiveness and continuity.

KMA has seen that it is the sustained investment in education that has helped Kenya move from least-developed-country to lower-middle-income status. If investment in healthcare had also been sustained, Kenya would probably have reached upper-middle income status.

National Health Insurance Fund

The National Health Insurance Fund (NHIF) is a voluntary government insurance scheme, which was first implemented 50 years ago. NHIF's focus is on infectious diseases, diarrhoeal diseases and primary healthcare. Its responsibilities include:

- pooling resources
- purchasing resources
- accreditation of hospitals
- protecting the beneficiaries
- advising the government on matters of health policy.

The Kenyan health system currently covers those who can afford the insurance and the co-payment at point of care. The focus is mostly on hospitalisation and high-cost

healthcare, with no focus on primary or preventative care. Participating in NHIF is voluntary, and there are co-payments. Only 20% of the population is currently covered by NHIF. A community financing scheme for primary healthcare is available in some communities, e.g. Makueni.

Priority setting for universal coverage

This session was kick-started by comparison of traction and open reduction internal fixation (ORIF) for fractures. It was shown that not only was ORIF cheaper, but its outcomes were three times better than those of traction. However, it would seem ORIF is not offered to 75% of patients, as patients have to pay for instruments upfront.

A panel discussion focused on how NHIF should prioritise coverage. The following key issues emerged from the discussion:

- protecting members against poor health outcomes
- financial protection
- addressing the major burden of disease
- primary healthcare orientation
- the need for evidence-based care
- achieving cover for all, but not for everything (with the progressive inclusion of diseases to be covered)
- concurrent addressing of social determinants of health.

Conference recommendations

- The successful and efficient implementation of UHC will require redress of the social determinants of health.
- A primary healthcare approach, although costly, ought to be prioritised, as it yields better outcomes and is cost-effective.
- Politicians need to be made aware of the social determinants of health, as political will is key to addressing the issue.
- Inadequate financing mechanisms can result in bad health outcomes.
- UHC must be inclusive for all, with a progressive increase of disease coverage.
- An agency model should be adopted, where the government or state contracts with an outside organisation.
- The community health workers' network should be activated.
- Legal reforms are needed to align NHIF with UHC.
- NHIF should be redefined to include multi-tier benefit packages.
- NHIF should be digitised.

Is eLearning the future of doctor education?

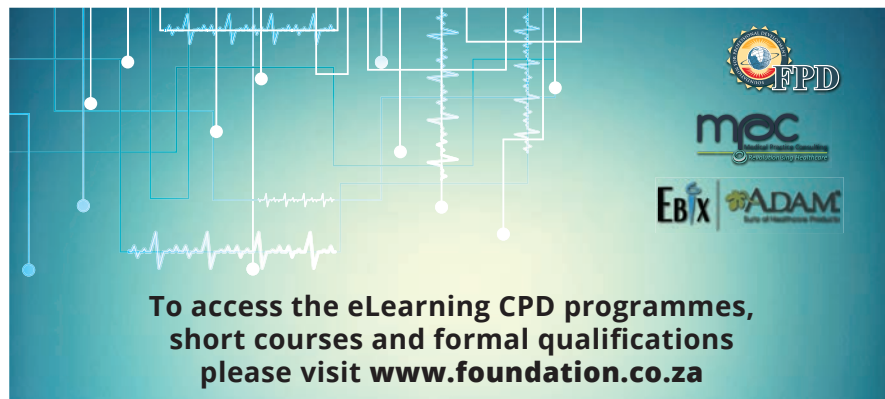
Gustaaf Wolvaardt, Grace Makgoka, School of Health Sciences, FPD, Werner Swanepoel, Medical Practice Consulting

According to the International Telecommunication Union, the internet user base in SA has grown rapidly, from 2.4 million users in 2000, to 30.8 million in 2017. This represents 54% of the SA population and positions information communications technology (ICT) as potentially the biggest game changer or leapfrogging technology in the health sector. The WHO says that “eLearning has an underexploited potential to support health workforce capacity-building in different contexts, and can empower health workers to take charge directly of their own competency development, to enable them to play a full role as change agents in addressing the challenges we will face in the 21st century.” ICT therefore offers promising new modes of professional development for doctors, either through purely online or eLearning courses, or through blended learning models that combine online learning with short classroom sessions.

This does, however, raise the question of whether eLearning is as effective as traditional classroom-based learning. In 2015, the WHO answered this question by conducting a systematic review of the role of ICT in health professions education, following the methods recommended by the Cochrane Collaboration initiative. Overall, 209 studies were identified that met the inclusion criteria for this systematic review. The findings of the systematic review suggest that *both computer-based and web-based eLearning are no better and no worse than traditional learning with regards to knowledge and skills acquisition.*

The conclusions reached by the WHO systematic review panel were that eLearning:

- helps to reduce the costs associated with delivering educational content
- facilitates the development and scalability of educational interventions
- breaks down the geographical and temporal barriers that limit access to, and the availability of, education
- improves access to relevant experts and novel curricula
- allows for personalisation of eLearning based on learner behaviour
- facilitates “immersive learning” through augmented-reality and 3D learning environments
- facilitates ubiquitous learning through mobile learning and cloud learning environments.



Students reported the following advantages of eLearning interventions:

- ease of access to content, and flexibility to access content when convenient to them
- portability of content, due to the fact that the content was not restricted to presentation in a physical classroom environment
- improved student-teacher contact and discussions through support forums
- more frequent discussions with peers through discussion forums.

However, some of the most common disadvantages reported by students were:

- the time-consuming nature of eLearning
- a lack of student-teacher interaction and tutor support, due to not physically being in contact with teachers
- feelings of isolation due to the lack of human interaction
- an inability to clarify doubts with a tutor directly
- a lack of in-depth group discussion, which might have been limited by the types of discussion forums used.

FPD started exploring eLearning programmes as early as 2012, by launching the first eLearning HIV and TB short course in Africa, on the Medical Practice Consulting (MPC) platform. Since then, more than 29 500 users have registered on this platform. The success of this initiative has generated a progressive increase in the types of FPD eLearning offerings to different user segments. In addition to clinical courses, FPD now offers free management short courses for medical students, free clinical courses for community service officers and more recently, a regional programme for teachers that has

reached almost 5 000 teachers in 9 countries in Africa.

Responding to requests from medical specialists, FPD in May launched the first of a series of leading internationally developed eLearning CPD programmes for specialists and registrars. Over the next 6 months, FPD will release courses developed by leading international experts in disciplines such as:

- disability assessment
- family medicine
- neurology
- ophthalmology
- orthopaedics
- pathology
- psychiatry
- public health.

Other specialities will be added in 2019.

The first of these offerings is on gastrointestinal pathology, as part of our Master of Pathology series, and focuses on the major changes in the practice of gastrointestinal pathology that stem from the progressive incorporation of immunohistochemical and molecular genetic techniques into the realm of surgical pathology. Led by a renowned Johns Hopkins pathologist, the course is designed to significantly enhance diagnostic skills in all areas of gastrointestinal pathology. The course is divided into neoplastic and nonneoplastic pathology of the tubular intestinal tract, with major emphasis on interpreting biopsies. Fifteen state-of-the-art lectures are designed to advance participants' knowledge in this rapidly evolving subspecialty.

References available on request.

Disclosure of HIV status to a sexual partner without patient consent: Ethical implications

Hanneke Verwey, *legal advisor, SAMA Governance and Legal Unit*

There is nothing shameful about suffering from HIV/AIDS; HIV is a disease like any other. However, due to the social construction of and associated stigma around the disease, fear, ignorance and discrimination continue to pose barriers to prevention and treatment. There is also increasing recognition that the HIV epidemic intersects with the epidemic of violence against women and girls. Studies among women in sub-Saharan Africa have shown that fear of a partner's negative reaction, including violence and abandonment, often prevents women from undergoing testing or from disclosing their HIV status to intimate partners. It is therefore not surprising that doctors often find that patients are extremely reluctant, or even refuse outright, to disclose their HIV status to sexual partners. This often poses a dilemma to the doctor, who owes patients a duty of confidentiality, but also owes certain obligations to broader society, including endangered third parties.

Confidentiality

The Hippocratic Oath requires of a doctor "to keep silence" about information relating to a patient that is acquired in his or her professional capacity, "counting such things to be as sacred secrets". The existence of a special relationship between a doctor and a patient therefore entails that information disclosed between them in such context remains confidential, whereas the information would not be considered confidential had it been exchanged outside of such a relationship.

Doctors have to balance the conflicting interests involved

Confidentiality in medicine serves two purposes. Firstly, it is essential to protect patient privacy. Secondly, without assurances about confidentiality, patients may be reluctant to furnish doctors with the information they need in order to provide

good clinical care. Confidentiality therefore also secures public health, performing a public-interest function. The application of the principle of confidentiality is of special importance when a patient is HIV-positive. A patient's HIV status deserves the highest level of protection against indiscriminate disclosure, due to the nature of the disease and the negative social context, as well as the potential intolerance and discrimination that could result from its disclosure. Ethical Rule 13 of the HPCSA recognises the importance of the confidentiality duty, and provides that a doctor may divulge information regarding a patient only if this is done in terms of legislation, at the instruction of a court, in the public interest, with the express consent of the patient, with written consent of a parent or guardian in the case of a child under the age of 12 years, or with the written consent of the next of kin or executor of the deceased estate in the case of a deceased patient.

Limitations

The principle of confidentiality and the doctor's corresponding duty are not absolute. When considering whether or not to disclose a patient's HIV status, doctors therefore have to balance the conflicting interests involved. A doctor may be justified in disclosing a patient's HIV status to a patient's sexual partners where the doctor's obligations to society or need to protect endangered third parties outweigh his or her obligations to the patient. It is generally agreed that the obligation to protect a third party from serious harm or death outweighs the patient's right to confidentiality. It could therefore be argued that if there is a real risk for the patient's sexual partners (for example, where despite thorough counselling, the patient indicates that (s)he will not disclose his or her HIV status and will not practise safer sex), the breach of confidentiality would be justified. This, however, does not detract from the fact that the merits of each matter must be assessed on a case-by-case basis, considering all relevant factors and balancing the parties' competing interests. The ethical guidelines published by the HPCSA and SAMA provide doctors with guidance regarding the factors

that should be considered during this balancing exercise, as well as the procedure that should be followed before and after undertaking the disclosure.

SAMA guidelines

SAMA's guidelines provide that doctors may only disclose a patient's HIV status to the patient's sexual partners if all of the following conditions are met:

- The doctor has counselled the patient regarding the importance of disclosing his or her status to his or her sexual partner(s), yet the patient nevertheless refuses to disclose the information.
- The patient's sexual partner(s) are known to the doctor, and clearly identifiable. A general suspicion that people may be at risk is not sufficient.
- The patient's sexual partner(s) are at real risk of being infected. This means that the patient has refused to disclose their status or take the necessary precautions, and the doctor has reason to believe that the patient is posing a risk to the sexual partner(s). The doctor may be required in court to show that he or she was acting on substantial information, and not on mere suspicion. There should be no other way to protect the partner(s).
- The patient should be advised that the doctor is going to breach the confidentiality duty. The patient should then be permitted a specified period of time to tell the partner(s) him- or herself.
- Once these steps have been followed the doctor may disclose the HIV status to the patient's partner(s). Pretest counselling and/or referral of the partners to a counselling, support and/or treatment facility should be offered.

It is important to remember that a doctor should only disclose the patient's HIV status to partners if the patient's refusal to do so him- or herself is unreasonable. For example, the patient may be justified in withholding the information based on a legitimate fear of violent retaliation. The SAMA guidelines provide that where the patient firmly believes that there is a risk of harm if his or her HIV

status is disclosed, the doctor's primary duty is to protect the life of the patient and act in his or her best interest. Doctors should therefore use their discretion when deciding whether or not to disclose information to sexual partners, taking into account the risks involved to both the patient and the partner(s).

HPCSA guidelines

The HPCSA's guidelines are similar to those of SAMA. The guidelines recommend that doctors must counsel patients on the importance of disclosing their status to their sexual partner(s) and taking measures to prevent HIV transmission. Doctors must also offer support to patients in disclosing their status to their sexual partners. If a patient still refuses to disclose his or her HIV status, or refuses to take measures to prevent infection, the doctor should counsel the patient on the doctor's ethical obligation to disclose such information. If the patient persists in his or her refusal, the doctor should disclose the information to the partner(s) and ensure access to voluntary counselling, testing and treatment where necessary. Following disclosure, the doctor should then follow up with the parties to determine whether it has resulted in adverse consequences or violence

for the patient, and, if so, intervene to assist the patient appropriately.

Unlike SAMA's guidelines, the HPCSA's guidelines do not explicitly provide that the patient's partner(s) need to be clearly identifiable, that a real risk to the partner(s) should exist or that there should be no other way to protect the partner(s). The guidelines do, however, provide that if a patient refuses consent, the doctor should use his or her discretion when deciding whether or not to divulge the information to the patient's sexual partner(s), taking into account the possible risk of HIV infection to the partner(s) and the risks to the patient (e.g. through violence) that may follow such disclosure. The guidelines further provide that the decision must be made with great care, and that consideration must be given to the rights of all parties concerned. SAMA's guidelines can therefore be read together with the HPCSA's, in the sense that a prudent exercise of discretion should involve the consideration of various factors, including whether or not there is an identifiable partner, and evidence of real risk to the partner that cannot be otherwise prevented. The guidelines should not be abused, and doctors should not act freely without giving

thought to less intrusive alternatives. For example, if it is possible to warn an endangered partner without identifying the patient, this would obviously be preferable. The aforementioned option will, of course, not effectively preserve confidentiality if the patient and his or her partner are in a monogamous relationship.

Conclusion

Based on the above discussion, it is clear that there is no simple answer or single approach to be followed. The decision on whether or not to disclose a patient's HIV status should be made on a case-by-case basis, following a careful consideration of the particular circumstances. Although a discussion of the possible legal (as opposed to ethical) consequences of a breach of privacy in the context of the disclosure of a patient's HIV status to a sexual partner falls beyond the scope of this short article, similar factors would be considered when determining whether or not the breach of privacy was justified. Doctors are therefore encouraged to approach their professional indemnity provider, an expert in medical ethics or an attorney before making such a disclosure.

Early dispute resolution should be encouraged

Medical Protection Society

Mediation is becoming more and more widely used in resolving clinical-negligence disputes, and can be an effective alternative to litigation as part of a package of wider legal reforms, says the Medical Protection Society (MPS).

As part of the "Championing co-operation and collaboration in clinical negligence claims" roundtable discussion, MPS will be calling for all parties involved in the clinical negligence process to work towards resolution prior to court proceedings.

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

Legal reform could help to make the system faster and more efficient for patients and their families. Among a number of reforms that

MPS recommends are the introduction of a prelitigation resolution framework, and the development of a patient-centred complaints process that allows for local resolution.

In a legal system that can at times be unduly complex and potentially inaccessible, MPS says that there is value in exploring alternative dispute resolution processes, such as the SA Dental Association's effective mediation process.

"MPS welcomes alternative dispute resolution such as mediation, and we would particularly like to see mechanisms put in place that facilitate the early resolution of meritorious claims," says Dr Graham Howarth, head of medical service, Africa, at MPS.

"While mediation is no guarantee of avoiding conflict, there is an emphasis on bringing disputing parties together in agreement. One of the most powerful outcomes of the mediation process is that

a patient is able to receive an apology or an acknowledgement that harm has been caused.

"Unfortunately, the lack of a patient-centred and robust complaints system is leaving many patients with litigation as the only viable avenue for redress, which then has an impact on the current claims environment.

"MPS has experience of mediation across our cases, and we will be helping to drive forward the debate to make the clinical-negligence resolution process more efficient and effective, as part of our wider work on legal reform. There is certainly an argument to be made that we need to strike a balance between appropriate compensation in clinical negligence cases, and what is affordable for society.

"Avoiding litigation and court appearances, which can often be drawn out, means that patients, their families and healthcare professionals all benefit."

Innovative simulation centre heralds new era for safety training

SAMA Communications Department

Workers in healthcare facilities across the world daily face the challenges and threats of maintaining safe healthcare practices. These include the risks of contracting TB and other airborne pathogens, and HIV and hepatitis through needle pricks. Exposure to these risks is common, even though many of the safety protocols are taught in medical schools.

"Despite students passing their procedural skills exams well, statistical feedback from the workplace on, for instance, the occurrence of needlestick injuries, suggests that technical competence (knowledge and skills) does not necessarily translate into safe clinical practices," explains Dr Rachel Weiss, director of UCT's Clinical Skills Centre.

And, says Dr Weiss, while the protocols and training are academically excellent, they are sometimes out of sync with those used in surrounding hospitals.

"Students seem to need more repetition and critical framing in different contexts, and we realised that rather than technical competence, students need to develop an attitude – a lifelong culture – of safety that will endure beyond the confines of the skills lab."

With this vision of instilling a sustained culture of safety in medical students, and other workers in the healthcare environment, the Clinical Skills Centre (a division of the Department of Health Sciences Education at UCT) refurbished a learning space at Groote Schuur Hospital (GSH) into a dedicated Safety in Health Simulation Centre.

While there are similar simulation wards around the world, including in other countries in Africa, a unique feature of the UCT Safety in Health Simulation Centre is its cross-sectoral approach, involving other healthcare workers and not only medical students.

"Interprofessional learning is critical to maintaining safety; for us, involving only medical students is futile if safety is your goal. For this reason, our centre also involves hospital managers, nurses, interns, rehabilitation workers, cleaning staff and other support services personnel who are exposed to the threats," says Dr Weiss.

This learning is performed in the centre under simulated conditions, using life-like

models of patients who are "waiting" to be resuscitated, opened up for emergency surgery, or have catheters, or other intravenous therapies, administered to them. With these "patients", students and staff are able to practise a range of skills, including aseptic nursing techniques, sharps procedures and team communication.

The practical learning is supported by a safety curriculum delivered by trained experts, an outline of methods for testing policies and protocols related to sharps and infection prevention, and a digital library with multimedia educational resources.

According to Dr Weiss, the centre will, initially, focus on three main areas:

- Multidisciplinary resuscitation and debriefing training, led by a group of simulation-trained UCT, GSH and Red Cross War Memorial Children's Hospital doctors and nurses. In this area, the focus is on communication, teamwork, the use of equipment and the accurate documentation of adverse/risk events.
- Sharps, cannulation and infusion pump training.
- Infection prevention and control (IPC). Through this area, the centre aims to bring

the authority of the GSH IPC nurses into the "classroom".

The centre was established with the support of medical technology company Beckton Dickinson (BD). Ian Wakefield, country general manager: BD Africa, says the development at GSH provides healthcare education that crosses the boundaries between professions, and among public, private, academic and provincial institutions.

"We believe in the longterm benefit of empowering all individuals involved in patient care as a crucial component of strengthening the healthcare system and ensuring that it can advance the health of all people entrusted to its care," says Mr Wakefield.

Prof. Bongani Mayosi, dean of the Faculty of Health Sciences at UCT, says the university is excited about the benefits of the centre. "It highlights how the private sector is making a difference to public health, through investment and involvement in education and training of health professionals," he says.

When fully operational, the centre will be linked to other training centres in SA and Africa, to extend its contribution to healthcare beyond GSH and the Western Cape.



Attending the launch of UCT's new Safety in Health Simulation Ward on 28 March were (from left) Mr Ian Wakefield, country general manager: BD Africa, Sr Milah Govender, GSH quality assurance manager, Prof. Bongani Mayosi, dean of the UCT Faculty of Health Sciences, and Dr Rachel Weiss, head of the Clinical Skills Centre, UCT Department of Health Sciences

Mortality rates declining, but considerable burden of NCDs remains – StatsSA

SAMA Communications Department

Mortality rates in SA are declining. That's the good news. The bad news is that overall, there is still a considerable burden of disease from non-communicable diseases in SA, and there are concerning signs that a sizable proportion of deaths are associated with diabetes mellitus, particularly in females.

These are the findings of Statistics South Africa (StatsSA)'s *Mortality and Causes of Death in South Africa, 2016* report, released at the end of March this year. The report bases its information on the findings from death notifications.

The report provides "information on levels, trends and patterns in mortality and cause-of-death statistics by sociodemographic and geographic characteristics".

The main focus of the report is on 2016 death occurrences, but, to give context to its figures, information on deaths from 1997 to 2015 is included, to show trends in mortality.

According to StatsSA, "the cause-of-death statistics in the report provide information on the leading causes of deaths, as well as comparisons between immediate, contributing and underlying causes of death."

Overall, "the general trend of registered deaths processed by StatsSA indicated an increase in death occurrences from

1997 to 2006, when the number of deaths peaked at 614 248, and a decrease thereafter. In 2016, a total of 456 612 deaths occurred, marking a decline of 3.5% from the 473 266 deaths in 2015."

And, according to the report, mortality now occurs at a greater age for both sexes, which StatsSA says is an indication of a decline in premature mortality.

"In 2016, male deaths peaked at age group 60 - 64 years (8.6%), while female deaths peaked at a much older age group: 75 - 79 years, or 8.3%," it notes. Statistically, there were more male deaths – the sex ratio was 112 male per 100 female deaths.

In line with these numbers, StatsSA finds that the median age of male deaths is 52.7 years, and 62.0 years for females, meaning females outlive males by more than 9 years.

Causes of death

Perhaps, from a clinical point of view, the more important information contained in the report relates to the causes of death, rather than the actual numbers.

The report says that 405 370 (88.8%) deaths in 2016 were due to natural causes, and 51 242 (11.2%) were attributed to non-natural causes. It notes that non-communicable diseases accounted for 57% of the deaths

in 2016, while communicable diseases were responsible for 31.3%.

"TB maintained its rank as the leading cause of death in SA, albeit with declining proportions (down to 6.5% in 2016, from 8.3% in 2014). Diabetes mellitus (5.5%) was the second leading natural cause of death, followed by other forms of heart disease and cerebrovascular diseases, both of which ranked at third place with 5.1% each," notes the report.

HIV moved up from the sixth position in 2014, and has remained at fifth for 2015 and 2016. TB, for females, moved from the third position in 2015 to the fifth position in 2016, while among males, diabetes mellitus ranked sixth in both 2015 and 2016.

The report notes that, "Overall, the results show a considerable burden of disease from non-communicable diseases and concerning signs of a sizable proportion of deaths associated with diabetes mellitus, particularly for females. SA is characterised by declining levels of mortality, declining but still high prevalence of communicable diseases, and a growing tide of non-communicable diseases."

The full report is available online at <http://www.statssa.gov.za/publications/P03093/P030932016.pdf>.

The Tshemba Foundation – a doctors' refuge

SAMA Communications Department

To say that Neil Tabatznik, founder of the Tshemba Foundation, is inspirational is a vast understatement. Not only has he led an incredible life, but he is also dedicated to making a difference in the lives of those less fortunate. A South African who spent his working life overseas, he wanted to give back to the country he loved.

"Tshemba was started about 3 years ago, and the concept was to bring medical practitioners to the most underserved areas in SA. The idea is not so much to build structures, as our experience of building structures has





led us to Tshemba. Structures are not what's needed, it's the personnel. The shortage of doctors and medical practitioners in these rural areas borders on obscene," says Neil.

The road to Tshemba started with a visit to a game lodge in the Hoedspruit area. Neil and a friend were on a game drive when the ranger asked Neil to build a school for his children. The community, at that point, had already built a room and found a headmaster, but it was nowhere near being a proper school. Neil built the school, which is now flourishing, and then sat down with the area chief to find out what the "real" community needs were. A clinic, the chief responded.

It was during the research that went into building the clinic that Neil realised that the infrastructure was already partly in place. They visited a beautiful clinic with full dental suites, but they were unused – there were no dentists.

"It is the most tragic thing. Imagine, someone gets sick and dies of something that if it had been in an urban area, it would not have occurred to anybody that their lives might be at risk."

Hence the Tshemba Foundation was formed, to bring volunteer healthcare professionals to the area to work and teach in the local health facilities. The Tshemba Volunteer Centre was built as a refuge for the volunteers.

"It's built for doctors who have a wealth of knowledge and experience; this is their chance to give back. We built this stunningly beautiful and comfortable lodge in a Big Five conservation area where doctors can rest, relax and take in the peaceful wonders around them, while being safe. Our idea is to provide doctors with a refuge after they've spent the day working in gruelling and obstacle-ridden conditions. Practising medicine without the necessary equipment is much more challenging than what they are used to," comments Neil.

"We have an MOU [memorandum of understanding] with the Mpumalanga Department of Health, who allow us to place our doctors and nurses in their hospitals and clinics. However, we must stay cognisant of the number of volunteers we accept at a time, as the Tintswalo Hospital only has six permanent staff doctors. Hence we look at what we do as organised volunteering that you don't have to pay for to attend," he continues.

The Tshemba Foundation is not only about servicing less fortunate people in dire need of medical attention, but also about helping doctors to find their love for medicine again, and pass their legacies on to the next generation.



About Tshemba

The Tshemba Foundation (a non-governmental organisation) was founded by Neil Tabatznik, a philanthropist with a heart of gold. Its sole mission is to improve access to healthcare in low-income communities in Limpopo and Mpumalanga, by encouraging voluntourism in the area. They recruit both SA and international healthcare professionals who volunteer their time to provide lifesaving medical care to the local community, while also training the local healthcare practitioners based at the Tintswalo Hospital and surrounding clinics. The medical professionals are housed in the newly built, 5-star luxurious Tshemba Doctor's Refuge in the Moditlo Private Game Reserve. The centre offers:

- Luxury accommodation and a uniquely African bush experience
- A tranquil, beautiful space where the volunteers can unwind, and spot wild-life such as elephants and antelope, to name a few
- Spectacular views of the majestic Drakensberg Mountains.

Notable achievements of the Tshemba Foundation to date:

- A women's clinic built at Hlokomela Clinic
- A mobile dentist programme in collaboration with Colgate and The Dental Warehouse treated 6 500 children.
- A visiting dentist recently screened ~400 children in 3 days, and handed them each a dental kit.

Pledge your services to the Tshemba Foundation, and help both those in need and yourself. Contact Barbara McGorian, barbara@tshembafoundation.org, or visit www.tshembafoundation.org for more information or to schedule your visit.

Disciplinary hearings: What are your rights?

Phumzile Gwala, industrial relations advisor, SAMA Public Sector Department

An employee facing a disciplinary hearing has many rights, starting from the chance to prepare for the hearing, which is a basic right allowing the employee to defend themselves against the charges levelled. This right to defend his or her case in turn originates from the right to fair labour practices, as provided for in Schedule 8 of the Labour Relations Act No. 66 of 1995 and Section 1 of the Constitution. An employee's right to sufficiently prepare for the hearing has three components:

- **The right to ample time to prepare a defence.** This is sacrosanct. Clause 7.3 of Resolution 1 of 2003 of the Disciplinary Code and Procedure for the Public Service states clearly that the disciplinary hearing must be held within 10 working days of the notice of enquiry being delivered to the employee. This means that the period between the time the employee is notified of his or her hearing and the hearing itself is the actual time to start preparing for the case.
- **The right to fully understand the charges.** This means that the employer must ensure that the charges are not vague, and that they have sufficient details for the employee to make preparation realistically possible. This means that neither "fraud" nor "corruption" can be viewed as a charge in itself.

- **The right to documentation.** The employer has to make sure that it provides the charged employee with the documents it intends to use in the hearing, as well as other pertinent documents requested by the employee. In terms of Resolution 1 of 2003, Clause 7.1 c (i) states clearly that "the notice of the disciplinary meeting must provide a description of the allegations of misconduct, and the main evidence on which the employer may rely." In light of this clause, this means that a refusal by the employer to provide such documentation is a complete violation of the collective agreement.

In addition to the aforementioned rights are the right to be represented, the right to give evidence, the right to call witnesses and also to cross examine any witnesses called in support of the charge. When looking at the right to be represented, it is important to note that Resolution 1 of 2003 specifies clearly who should act as a representative during the hearing. Clause 7.3 f (i) states that the employee may be represented by a fellow employee or by a representative of a recognised trade union. It further states that a legal practitioner is prohibited from representing an employee, unless the charged employee is a legal practitioner, or the representative of the employer is one,

and the direct supervisor of the employee charged with misconduct, or if the hearing is conducted as a pre-dismissal arbitration under the auspices of the Bargaining Council.

We appeal to members to immediately approach the SAMA offices for representation when faced with a disciplinary hearing, to receive the necessary advice on time and also to seek representation.

Case law

In the case of NUMSA o.b.o. Masina v Cobra Watertech (2009 2 BALR 140), the employee sought clarity on the charges given to him prior to his disciplinary hearing. However, the employer refused to provide such clarity. The arbitrator therefore decided that although disciplinary hearings are not required to follow the procedures of criminal trials, charged employees are at least entitled to be informed of the charges against them. Due to the insufficiency of the information concerning the charges that had been given to the charged employee, the Commissioner ruled that the employee's dismissal was procedurally unfair, and ordered the employer to pay compensation to the employee.

JUDASA Gauteng PEC elections

Bokang Motlhaga, junior marketing officer, SAMA Marketing and Communications Department

The Junior Doctors Association of SA (JUDASA), an affiliate group of SAMA, recently hosted the Gauteng provincial executive committee (PEC) elections at the Protea Hotel Fire & Ice, Johannesburg. The event attracted junior doctors from the Gauteng region who embrace SAMA's mission: to unite doctors for the health of the nation.

In the opening address, Dr Mlekeleli Gambu, *ex officio* member of the Gauteng JUDASA PEC, stated that the Gauteng JUDASA leadership has worked very hard towards bettering the health environment in Gauteng,

and that such efforts should be continued, and increased. He described three categories that junior doctors might fall into – undertakers, overtakers and risk-takers – and urged them to enthusiastically embody traits that are associated with risk-takers. He also praised the junior doctors for continuing to maintain their professionalism despite constrained resources at their respective institutions.

Following Dr Gambu's presentation, Dr Diale Maepa, the current national chairperson of JUDASA, delivered a jam-packed presentation in which she reminded the delegates of the

nature and essence of JUDASA. Dr Maepa depicted JUDASA as providing a foundation, which needs to be solidified and nurtured in order for the health fraternity to improve, for the good of both patients and health professionals. She subsequently quoted the late Nelson Mandela: "Sometimes it falls on a great generation to be great. You can be that great generation. Let your generation blossom." One of the notable points that Dr Maepa made was that junior doctors should aspire to understand the communities that they serve, because the only way in which one can deliver



Some of the JUDASA National Working Group members with some of the newly elected members of the Gauteng JUDASA executive committee, happy to take on the role of representing junior doctors



Dr Yakish Baldeo informing the delegates on SAMA's role in uplifting junior doctors

the right healthcare to a society is through a full comprehension of that society's needs.

At a meeting held afterwards for the newly elected Gauteng JUDASA PEC, the candidates elected for office-bearer positions were:

- Dr Sinovuyo Msutu – chairperson
- Dr Boitumelo Mooi – deputy chairperson

- Dr Leonard Muhango – secretary
- Dr Malebo Kgatle – deputy secretary
- Dr Theresa Mwesigwa – student liaison officer
- Dr Chiko Kamba – public relations officer.

The other elected members are:

- Dr Caolan Abrahams

- Dr Neelo Sekwati
- Dr Luke Fletcher
- Dr Laura Kingwill
- Dr Gugu Dlomo
- Dr Kathleen Kabuya
- Dr Matthew Apostolou
- Dr Heila Barrett.

Nagin Parbhoo anaesthesia museum plays an important part in education

Dr Peter Gordon, Emeritus Associate Professor, Department of Anaesthesia and Perioperative Medicine, UCT, and honorary curator of the museum

The Nagin Parbhoo History of Anaesthesia Museum, housed in the UCT Department of Anaesthesia and Perioperative Medicine, boasts the finest collection of early anaesthesia apparatus in Africa, dating back to 1847 – only 1 year after the historic first public demonstration by Morton, in Boston, of the efficacy of ether in providing painless surgery. The museum strives to preserve artifacts from the past, to record progress in the development of the specialty, to educate medical students and registrars and to publish papers on the history of anaesthesia in SA.

History of the collection

The collection began in earnest in 1956, when the then-head of the UCT Department of Anaesthesia, Dr C S Jones, together with the first archivist and founder member of the

SA Society of Anaesthetists (SASA), Dr Jack Abelsohn, realised that they possessed early anaesthesia equipment worthy of preservation. The following year, Dr Lindsay van der Spuy donated a considerable amount of equipment of historical interest, much of it the property of Dr Royden Muir, who had emigrated to Cape Town from New Zealand after World War I, and lectured in anaesthesia at UCT. Muir made extensive visits to London and the USA in 1933 and 1938 to study advances in the specialty. On his return, he introduced cyclopropane to the UK and SA.

After Arthur Bull became head of department in 1969, the equipment that had been collected was mounted, catalogued and displayed in showcases in the Department of Anaesthesia at the UCT Medical School. Prof. Bull's successor, Prof. Gaisford Harrison, continued the search for historic anaesthetic



Display of vaporisers



Surgery by Dorothy Kay (original donated to UCT by family). Photo: Cornel de Kock



McKesson anaesthesia machine, c 1920



Clover ether inhaler, c 1877. Photo: Ashley Townner

equipment, and in 1987 appointed the SASA archivist, Dr Naginal Parbhoo, as honorary curator of the museum. Dr Parbhoo visited many hospitals in the Cape, seeking out more items of anaesthetic historic interest. In 1993, after the appointment of Prof. Michael James to the chair of anaesthesia, and the move to the new Groote Schuur Hospital, Dr Parbhoo designed and sought sponsorship for the manufacture of eight oak-and-glass display cabinets in which the bulk of the collection was housed. In recognition of his efforts, Prof. James named the museum The Nagin Parbhoo History of Anaesthesia Museum. In 2009, Dr Parbhoo died after a long fight with leukaemia, and Dr Peter Gordon was appointed honorary SASA archivist and honorary curator of the museum. Under his leadership, many old artifacts have been identified and new ones acquired, and the number of display cabinets has more than doubled.

The displays record the improvements in the design of equipment for delivering various anaesthetic agents, from early Schimmelbusch-type masks used for ether and chloroform, through the Clover ether inhaler used in the Anglo-Boer War, the first Boyle's anaesthetic machine, made in 1917, equipment used to deliver the expensive but highly explosive agents vinesthene and cyclopropane between 1930 and 1960, to the advent of halothane, which revolutionised anaesthetic practice in the 1950s. For many years, anaesthetists in private practice

had to carry all their own equipment from private hospital to private hospital. A variety of portable anaesthetic machines for this purpose are on display. Prior to the mid-1950s, ventilators were uncommon, but the history of ventilators can be followed through the collection.

SA-designed anaesthetic equipment is prominently featured, and includes the Taurus blood warmer (named after Prof. Bull), the Samson neonatal resuscitator, the Cape Town and Stellenbosch paediatric circuits, the Humphrey and Miller anaesthetic circuits and one of the smallest ventilators ever made – the Minivent, which was designed by Johannesburg anaesthetist Dr Anthony Cohen in 1965.

Various anaesthetic machines and monitors used at Groote Schuur Hospital between 1940 and 1984 are displayed, demonstrating their development from purely mechanical machines, such as Bird ventilators powered by the oxygen supply, and very limited monitoring, to the highly complex electronic machines of today.

As the official museum of the SASA, there are also displays covering the history of the society since its foundation in 1943, including its successful hosting of the World Federation of Societies of Anaesthesiologists Congress in Cape Town in 2008. Artworks relating to anaesthesia appear on the walls.

The museum plays an important role in educating registrars in the physical principles behind the development of monitors and equipment. A Draeger iron lung allows medical students to better understand the medical difficulties involved in treating victims of the polio epidemics of the 1950s, and how this led to the development of ICUs.

The collection has stimulated the publication of numerous papers on the history of anaesthesia in SA.

An Australian academic on a recent medical tour of SA had this to say about the museum:

"It is great to see that this department, which is clearly a very modern research facility with an eye to the future, also has such a dedication to preserving the past."

Visits to the museum: The museum forms part of an active department and visitors are welcome. Appointments can be made by emailing Peter Gordon at peter.gordon@uct.ac.za, or by telephoning the Department Secretary, Mrs C Wyngaart, on +27 21 404-5004.

SAMA 2018 conference chairperson steps up at UKZN

SAMA Communications Department

Dr Mergan Naidoo, the SAMA 2018 conference chairperson, and chairman of SAMA's Education, Science and Technology Committee, has recently been appointed to the position of associate professor at the University of KwaZulu-Natal (UKZN). Prior to this appointment, Prof. Naidoo was a lecturer at UKZN from 2008.

In addition to serving in his new academic position, Prof. Naidoo will continue as the head of the Clinical Unit in the Department of Family Medicine for the Department of Health (DoH) at Wentworth Hospital in Durban. Prof. Naidoo is also the Academic Leader: Teaching and Learning at the School of Nursing and Public Health, a position he has held since 2017.

An accomplished academic and mentor, Prof. Naidoo currently supervises 11 master's and 6 PhD students. He also has 12 publications pertaining to teaching and learning in DoH-accredited education and training journals, has contributed to two chapters in the *Family Practice Manual*, and to three sections of the *Oxford Handbook of Family Medicine*.

Notably, Prof. Naidoo is also the chairman of the MCQ [multiple choice questions] Committee in the College of Family Physicians, and has served as an external examiner for, among others, Wits, Stellenbosch University, UCT, the University of Limpopo and the University of the Free State.

Apart from his work locally – which is extensive – Prof. Naidoo is also working with an international team in the Acute Care for Africa Research and Training (ACART) group in KZN. He has authored or co-authored more than 30 articles for publication.

"Obviously this appointment is a huge honour for me, one I have worked hard to achieve. I believe it's important to give back and, I believe, as an academic and a professional, we have an obligation to ensure the success of future generations of doctors in our country," says Prof. Naidoo.

To ensure that he keeps his mental abilities sharp, Prof. Naidoo is a member of the Phoenix Villagers Athletic Club and has completed 10 Comrades Marathons and 8 Two Oceans ultra-marathons. He is also a member of the



Prof. Mergan Naidoo

Cycle Specialists Club in Durban and has served as the race doctor to the Pietermaritzburg Marathon for the past 16 years.

Visiting Tembisa Hospital

Sarah Molefe, junior marketing officer, SAMA Marketing Department

SAMA, in collaboration with SANLAM, steered an information session at Tembisa Provincial Hospital on 23 March 2018. Keletso Makwe, industrial relations (IR) advisor, delivered a presentation on the SAMA member benefits, and IR's role in advising and representing members in the public and private sectors.

She also elaborated on the important benefits for public sector doctors, which are:

- Assistance in unfair dismissal cases and unfair labour practices in the workplace
- Assistance with conditions of employment
- Handling complaints and representing doctors in grievance hearings, disciplinary enquiries, conciliations and arbitration hearings

- Collective bargaining at the Public Service Co-ordinating Bargaining Council, and Public Health and Social Development Sectoral Bargaining Council (PHSCBC agency fee **not** deducted from members who belong to a trade union)
- Receiving the *South African Medical Journal* (SAMJ) and *SAMA Insider*
- Direct access to the SAMA special interest groups (JUDASA, SARA, SEHDASA, and ADASA).

Selmie Harris of Sanlam gave an overview on wealth creation, i.e. tax, finance and budget, and asset and wealth protection.



Keletso Makwe, industrial relations advisor

SAMA visits Witbank Provincial Hospital

Sarah Molefe, junior marketing officer, SAMA Marketing Department

SAMA visited Witbank Provincial Hospital on 18 April 2018 for the intern monthly meeting.

Dr Chandrè Baile, member of the Gauteng North branch council delivered a presentation on the SAMA member benefits, and Mr Modisane Lelaka elaborated on industrial relations matters, including complaints and grievance processes, and emphasised the point that members are always welcome to forward their labour-related matters to the national office for urgent attention.



Modisane Lelaka, industrial relations advisor, Dr Chandrè Baile, SAMA Gauteng North branch council member, Judy Mills, SAMA Gauteng North branch secretary



Doctors at Witbank Provincial Hospital attending the intern monthly meeting

Western Cape visits Eerste River Hospital

SAMA Communications Department

Western Cape branch secretaries Chenienne Gericke and Emily Nel visited Eerste River Hospital on Friday 4 May 2018, on the invitation of Dr Steve Swartz. Three interns signed up as SAMA members, and they are expecting more signed application forms to be returned.

Western Cape branch president-elect Dr Rehaaz Adams spoke about the importance of joining SAMA, and what to do when interns have problems at their places of work. The meeting was attended by students, interns and public sector doctors.



Dr Rehaaz Adams speaking to students, interns and public sector doctors who attended the meeting



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 500 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.



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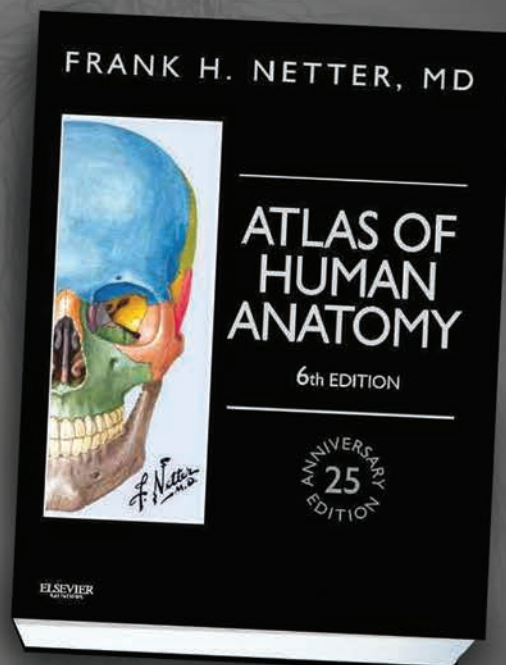
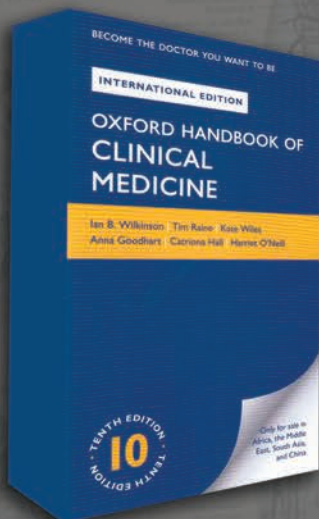
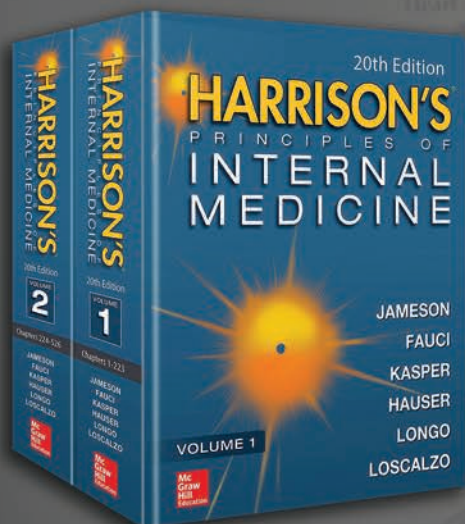
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