

# SAMA INSIDER

JULY 2018

**Doctors with  
depression:  
Don't wait until  
it's too late!**

**Why are mental  
healthcare users'  
rights not  
respected?**



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

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**Diane de Kock**  
Editor: *SAMA INSIDER*

## No more stigma!

**T**his month we focus on the mental health of both our doctors and their patients.

1 June was international crazy socks for doctors' day – a day that aims to raise awareness about the mental health of doctors and health professionals. Now in its second year, the day originated in Australia, and has been picked up by doctors around the world, including in SA. Australian doctor, Dr Andrew Tagg, who is open about his battle with depression, says: "There is a huge stigma surrounding mental health ... it is time to normalise, not stigmatise, the conversation."

Doctors look after other people, and are generally not too great at looking after themselves. Statistics tell us that depression among doctors is far more common than we would like to think: one in 50 doctors has committed suicide, and one in four is depressed. In his article on page 5, Dr Christoffel Grobler encourages doctors to seek help. "Because of the stigma associated with mental illness ... doctors are reluctant to seek help."

On page 7, we publish the WMA statement on physician wellbeing, a good starting point, and focus on the importance of promoting awareness among healthcare workers. "Don't wait until it's too late." More articles will follow.

SASOP president, Prof. Bernard Janse van Rensburg, writes about Tower Hospital and the perceived mental healthcare crisis in the Eastern Cape (page 10), a situation currently being investigated by the health ombud. "Mental health is one of the major challenges that the country is facing," says Sibongile Tshabalala, national chairperson of the Treatment Action Campaign (TAC), "but mental illnesses are stigmatised, and most people, including government, do not talk about them." In her article on page 11, Sibongile asks: "Why doesn't the Department of Health prioritise mental healthcare in SA ... Why are mental healthcare users' rights not respected?"

The more we talk about these issues, the easier it will be deal with them, thereby decreasing the stigma. Let's open up the conversation – we look forward to hearing from you.

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## Asthma – the importance of proper history taking



Dr Marina Xaba-Mokoena, SAMA president

**M**y interest in specialising in lung diseases began when my husband was diagnosed with asthma, in 1973, at the age of 33. It was discovered via prick tests that he had many allergies, e.g. to birch trees, grasses, dust, apples, cats and, later, penicillin. He never had eczema, but sneezed a lot, with itching, running eyes.

When our son was born, we moved to live near a lung disease hospital – in Uttran, near Huddinge University Hospital in southern Stockholm. When I considered what most people died from in our part of the world, I recognised then that even compared with all the faction fights and motor vehicle accidents put together, the cause of most deaths was lung disease. So it was decided for me! At Uppsala Academic Lung Clinic, where I had been offered a registrar's post, I found that their main interest, besides lung cancer, was bronchial asthma, with plenty of research carried out on the subject. Hence asthma became my favourite interest too, although later in Lesotho and the Transkei, I became more of a TB doctor. Still, asthma was very common too, such that many saw me as their saviour when I was running the chest clinics.

Asthma is a common, well-known condition that is reversible, but can kill a person very quickly if not treated. I recall a UCT professor, whose husband was himself an ENT specialist, who offered to come and assist us for a while in the initial stages of setting up the anatomy department during the pioneering years of the Faculty of Medicine and Health Sciences at the University of Transkei (now Walter Sisulu University). But just a week before she was to fly to Mthatha, she suffered such a severe asthma attack at home that by the time her husband had rushed her to Groote Schuur Hospital, she

was pronounced dead on arrival – a severe blow both to us and to her family.

Asthma can debut from childhood, or appear at any age. Many children outgrow it by puberty, although it can still return when they are older. I shall deal mostly with adults, as I contributed both scientifically and to the writing of a book on global strategy management of adult asthma by the National Health Lung & Blood Institute – a joint project with the WHO in 1992 - 1993.

Firstly, all that wheezes is not asthma! I shall deal with the pathophysiology and diagnosis of asthma, since space will not allow me to delve into the management and treatment of status asthmaticus. Asthma is represented by certain particular forms of cough, and the presence of hyper-responsiveness: an episodic obstruction of the lower airways with an expiratory obstructive syndrome, characterised by wheezing, and reversible with a bronchodilator. The cough is often present at night or early in the morning – often triggered by contaminated air conditions caused by, for example, smoking or air pollution, as well as by viral epidemics, exertion, stress or allergens.

The condition produces inflammation, mucosal thickening and plugs of secretions, which may be eosinophil-mediated, allowing migration of circulating leucocytes to the respiratory mucosa. Consequently, cellular infiltration results in cellular abrasion, anomalies in the neurogenic control of bronchomotor tone and mucociliary function, and the enhancement of bronchial hyper-responsiveness. Raised serum IgE helps in diagnosis.

Epidemiological studies suggest an increased risk of allergenic sensitisation associated with atmospheric pollution, enhanced by exposure to cigarette smoke, NO<sub>2</sub>, SO<sub>2</sub>, ozone, or diesel particle matter. This causes an inflammatory reaction on inhalation of these pollutants, which may initiate an allergic reaction at the molecular level. Patients with allergic asthma are more reactive to allergens to which they are sensitised if the exposure is combined with a pollutant. Passive smoking is a major risk factor for developing allergic asthma.

Asthma is a chronic disease prevalent worldwide, which can be attributed to the rise in urban pollution levels, the use of perfumes and other sprays such as Doom, overheated home environments, poor eating habits and household pets. Bronchial or ENT infections, gastro-oesophageal reflux and an unfavourable psychological environment can trigger or exacerbate the disease. It can also

be seasonal, resulting in hospitalisation in autumn or spring.

Asthma is characterised by paroxysmal cough, episodes with wheezing, chest tightness and expiratory dyspnoea. It is usually reversible, but can be severe and even fatal. Wheezing is often audible at a distance, and on auscultation, rhonchi and subcrepitant rales reflect alveolar involvement. There may also be polypnoea, and suprasternal and intercostal retraction in severe cases.

I shall not go into the X-ray and blood gas examinations done in hospitals. The peak expiratory meter is a simple and inexpensive gadget that should be in every medical practitioner's rooms.

Once diagnosis is established, a clinical, radiological, allergological and functional workup should be performed, ideally, to screen aetiological factors, and to evaluate the impact of the disease and specify its grade of severity.

Asthma-like symptoms from sources such as inhaled foreign bodies, especially in children, should be excluded before diagnosis. Asthma symptoms differ from those experienced during physical exercise. Exercise-induced asthma occurs a few minutes after the discontinuation of intense/sustained exercise, and is reversible either spontaneously or with treatment. Particularly in adults, one should consider the possible presence of drugs that affect bronchoconstriction, such as beta-blockers, aspirin and non-steroidal anti-inflammatories. One should also bear in mind, especially in a rural set-up, the potential effects of feather-filled pillows, woollen blankets in winter, chickens sleeping in the house, fireplaces on the floor or made from tins filled with wood or coal, goatskin used as décor, possible fungal growth on mielies/maize, and even thatch itself, in cases of people who react to grasses. Even a sudden change in temperature, such as from jumping into a cool pool, can be a triggering factor.

I mention all of these factors to emphasise the importance of **proper history taking**, and taking the time to talk to the patient, to explain the disease and **advise** them on what to avoid that may be triggering the attacks. Most of us doctors are in a great hurry to treat our patients, and to see the next one within a few minutes – which I regard as bad medical practice. *The 15 - 20 minutes spent on getting this history and explaining the triggers to the patient can be vital in reducing the frequency and/or severity of attacks that can lead to hospitalisation and/or other serious consequences.*

# Depression: Don't wait until it's too late!

Dr Christoffel Grobler, head of clinical unit, Elizabeth Donkin Hospital; associate professor, Walter Sisulu University

The article in the *SAMA Insider* of November 2017 in which Dr Sindi Van Zyl shared the story of her battle with depression refers. I would like to commend Dr Van Zyl for her bravery, as she acknowledged something that far too many doctors are afraid to admit: that they too may be suffering from mental illness.

In recent years, I have personally made a point of sharing my own mental illnesses, namely generalised anxiety disorder and social anxiety disorder, when giving talks – something which elicits very different reactions from colleagues v. the general public, ranging from visible cringing to appreciation for my honesty.

My motive for making this disclosure is that, if we in the medical profession can't talk about our own mental illness, how can we expect our patients to not be ashamed of theirs, considering all the stigma surrounding the subject? If we don't do this, we are projecting our own shame onto our patients.

When I set out to read up on this topic, in looking at peer-reviewed articles over the last 10 years, I was shocked to find that there seemed to be far more articles on doctors' suicides than on the prevalence of mental illness amongst doctors. The reason for this, I found, was that doctors are reluctant to share their experience of mental illness for the reasons discussed below – hence the difficulty in finding published accounts of depression in doctors. Sadly, it would appear that doctors wait until it's too late, only reporting on mental illness among our peers when it ends in tragedy.

With this article, I would like to emphasise the importance of attending to our mental health, looking at rates of mental illness and suicide among doctors, as well as the risk factors for developing mental illness, and the barriers to care.

## Mental illness among doctors

Research suggests that doctors generally have high rates of mental health problems, such as depression, anxiety, substance-use disorder and burnout. Furthermore, doctors have a higher risk of suicide than the general population.

Depression is at least as common in the medical profession as in the general population, affecting an estimated 12% of males, and up to 25% of females. It is estimated that between 10 and 20% of doctors become depressed at

some point in their career, and that 10 - 12% develop a substance use disorder.

Female doctors are possibly at higher risk than the general population for developing depression and burnout as a result of role conflicts between their career and being a mother and/or a wife. In young doctors, for example, medical students and registrars, rates of depression range between 15 and 30%.

Globally, the following has been found:

- A survey of a UK-based doctors' support network found that 68% of 116 respondents had depression.
- A Canadian study found that 80% of doctors were suffering from burnout, and 23% of practitioners had significant depressive symptoms, with female doctors twice as likely to be depressed as males.
- In New Zealand, mental health problems are nearly three times as prevalent in general practitioners and surgeons than in the general population.
- In the USA, a prospective study found a significant increase in depressive symptoms during internship, with more than 25% of participants meeting the criteria for depression, compared with just 3.9% before the internship.
- Studies from Finland, Norway, Australia, Singapore, China, Taiwan, Sri Lanka and others have shown increased prevalence of anxiety, depression and suicidality among students and practitioners of medicine.

## Risk factors for mental illness unique to doctors

Our job is a high-pressure one, with many stressors involved in our daily grind. Risk factors can generally be divided into two categories: occupational risk factors and individual risk factors (personality traits).

**Occupational risk factors:** There are numerous factors that can place doctors at higher risk of mental health problems than the general public. These include:

- the emotional demands of working with patients – breaking bad news, and being potentially confronted every day with patients' unrealistically high expectations, illness, anxiety, aggression, suffering and death
- the heavy workload, long shifts and unpredictable hours, and the associated sleep deprivation
- interpersonal relationship difficulties, for

example, workplace bullying and poor relationships with colleagues

- lack of support and teamwork: it is not uncommon in SA to hear interns and community-service doctors complain about a lack of supervision and support from senior colleagues. A supportive team with a strong *esprit de corps* is protective against mental illness
- access to prescription drugs: the misuse of prescription drugs is common; doctors are in regular contact with a wide variety of drugs, and possess the knowledge of how these drugs work, what they do and how to administer them.

**Individual risk factors:** Our occupation self-selects driven, perfectionistic, type-A personalities – people who expect a lot from themselves. Unfortunately, these traits also contribute to controlling behaviour and an aversion to admitting to mental illness, which is still frequently seen as a "moral weakness".

These obsessive-compulsive traits also make us highly self-critical, and this predisposes us to excessive worrying, rumination and anxiety.

Other psychological traits common in doctors include an excessive sense of responsibility, a desire to please everyone, guilt for things outside of one's own control, and self-doubt.

Some practitioners may also have unhelpful coping strategies, for example, using emotional detachment, rather than actively dealing with stressors.

## Barriers to care

Because of the stigma associated with mental illness, which seems to be greatly magnified among medical practitioners, doctors are reluctant to seek help. Although we seem to heed our own advice about avoiding medical risk factors for early mortality, we seem decidedly reluctant to address depression, a significant cause of morbidity and mortality that disproportionately affects us. Relative to the general population, doctors have a lower mortality risk from cancer and heart disease (doubtless related to knowledge about self-care, and access to early diagnosis), but they have an ominously higher risk of dying from suicide, the end stage of a treatable disease process.

Some reasons why doctors may not seek help for mental health problems are discussed below.

**Professional implications:** Doctors may have concerns about how their professional future might be affected by seeking help for mental health problems. For example, they may be worried about having to take time off work; they may feel guilty, and that they are letting people down by taking a day off sick and leaving their patients to someone else. Studies have suggested that doctors tend to take very little time off work, even when unwell; hence doctors are known to have high levels of “presenteeism”, attending work even when not feeling well enough to do so.

They may fear that the medications prescribed for mental illness will affect their performance, putting their patients at risk. There may also be concerns about the implications of disclosing an illness, particularly when substance misuse is involved. It is important to note that medicine is a regulated profession, where doctors’ health is of interest to the regulators. Doctors may hide illness to avoid potential disciplinary action or HPCSA involvement.

**Difficulties with disclosure:** It is common for doctors to self-diagnose, self-treat and self-prescribe. Although everyone knows that a doctor who treats him- or herself “has a fool for a patient”, we also know that most doctors treat themselves anyway, at least on occasion. This is especially likely when the doctor believes that the consequences of seeking treatment may subject him or her to stigma, shame, or worse, making self-prescription look like the only option left.

Doctors tend to be secretive and reluctant to disclose mental health problems. They may be worried about confidentiality, and rather seek treatment from someone they know in a professional context. A study of doctors’ attitudes to becoming mentally ill asked respondents who they would disclose to if they were to become mentally ill, and what factors might influence this; 73.4% said they would disclose a mental illness to a friend or family member rather than a professional, with most suggesting that career implications were their biggest concern regarding seeking help, as well as professional integrity and stigma. The researchers concluded the stigma surrounding mental health is prevalent among doctors.

Many doctors cite this issue of stigma, coupled with difficulties in ensuring privacy, fear of deregistration and the desire to continue helping patients, as major barriers in accessing care.

**Psychological barriers:** The perception among doctors that mental illness is a sign of weakness causes them to feel that they are

letting down themselves, their patients and their colleagues by becoming ill, having to seek help and taking time away from work. This can lead to feelings of shame and embarrassment.

It seems to be hard for a doctor to become a patient, with many resisting the “role reversal” involved. Worth mentioning is the fact that doctors are notoriously difficult patients, and the doctor treating the “doctor-patient” should not over-identify with the patient, and should be cognisant of boundaries.

**Lack of knowledge about where to find help:** Many doctors do not know where to go to seek help. Should they go to see a GP, a psychiatrist or a psychologist? Very few even seem to have their own GP. A doctor whose thought processes are darkened by depression and the anticipated consequences of seeking treatment for it, may believe that self-treatment is the only safe option.

Once they do seek help, doctors sometimes find that the help they need is remarkably difficult to obtain.

## Suicide

Year after year, doctors and dentists remain among the occupations with the highest suicide rates in the USA. The National Institute for Occupational Safety and Health (NIOSH) draws up a yearly list of the professions that are believed to have the highest suicide rates. Medical doctors top the list, evidence suggesting that doctors are approximately 1.87 times as likely to commit suicide as those in other occupations.

The top 11 professions with the highest suicide rates, according to NIOSH data (in descending order, with odds ratio in brackets), were medical doctors (1.87), dentists (1.67), police officers (1.54), veterinarians (1.54), people in financial services (1.51), real estate agents (1.38), electricians (1.36), lawyers (1.33), farmers (1.32), pharmacists (1.29) and chemists (1.28).

It was estimated in 1977 that on average, the USA loses the equivalent of at least one small medical school to suicide per year. Although it is impossible to estimate with accuracy, the number most often used is approximately 300 - 400 doctors/year, or “a doctor a day”. Male and female doctors are equally as likely to commit suicide; however, in comparison with women in other occupations, female doctors are 2.78 times as likely to commit suicide.

Doctors are, obviously, knowledgeable regarding doses of medications and combinations that can be fatal. Evidence suggests that doctors are nearly 4x as more

likely than the general population to use drugs as a suicide method, in an attempt to overdose.

Factors believed to contribute to doctors committing suicide include long working hours and sleep deprivation, demanding patients, bullying by colleagues, ease of access to medications and malpractice lawsuits.

Fast and efficient diagnosis and treatment benefit not only the sick doctor, but also those they treat; untreated mental health problems in doctors may lead to poor performance, professional misconduct and inadequate quality of care for their patients. In order to ensure patient safety, and sustain the public’s confidence in doctors, it is essential to identify and treat mental health problems in doctors as quickly and efficiently as possible, so that their quality of care is not compromised.

The number of people potentially involved, for example, supervisors, occupational health teams, academic staff and regulating councils, may increase the doctor-patient’s anxiety further. Therefore, interventions should be straightforward and efficient, to make the treatment process as effective as possible.

In many countries, specialist services have been set up where practitioners can get support and treatment in an environment designed specifically for doctors. I am not aware of any such service for doctors in SA, and I believe it is time that we seriously consider the creation of such a service, as a matter of urgency.

In the absence of such a service, though, I would like to make the following suggestions if you find yourself suffering psychologically and mentally:

- Find yourself a trusted GP who is not a friend, and make an appointment.
- Start seeing a clinical or counselling psychologist as well.
- Accept the sick role in this instance.
- Do not resist being referred to a psychiatrist.

In Australia, the #crazysocks4docs day campaign, where doctors wear crazy socks to raise awareness of mental illness in the medical profession once a year, has taken on a high profile, and sparked a lot of debate on social media and in other publications. The campaign was started by cardiologist Dr Geoff Toogood, who has championed mental health support for doctors since his own battle with mental illness. Incidentally, I am finishing this article today on 1 June, and I am about to put on my crazy socks. My therapist would call that synchronicity...

# Take care of your own mental health – it's vitally important

SAMA Communications Department

In the November 2017 issue of *SAMA Insider*, we published an article about Dr Sindi van Zyl, who suffered from depression. She appealed to doctors and healthcare workers to acknowledge the signs of depression in themselves and to get outside help.

At a recent SAMA Human Rights Law and Ethics Committee (HRLE) meeting, the wellbeing and mental health issues affecting doctors were discussed with concern. The committee took a decision to promote awareness of mental health in practitioners, a decision which prompted the publication of the *WMA Statement on Physician Wellbeing* printed below, and the article by Dr Stoffel Grobler on page 5.

## WMA statement on physician wellbeing

*Adopted by the 66th WMA General Assembly, Moscow, Russia, October 2015*

Physician wellbeing refers to the optimisation of all factors affecting biological, psychological and social health, and preventing or treating acute or chronic diseases experienced by physicians, including mental illness, disabilities and injuries resulting from work hazards, occupational stress and burnout.

Physician wellbeing may have a positive impact on patient care, but more research is needed. The profession should therefore encourage and support ongoing research on physicians' health. Evidence that already exists should be implemented in policy and practice. While physicians tend to have healthy habits, it is essential to enhance their health as a way to improve health for the whole population.

Physicians and medical students at all career stages are exposed to both positive experiences and a variety of stressors and work injuries. The medical profession should seek to identify and revise policies and practices that contribute to these stressors, and collaborate with national medical associations (NMAs) in order to develop policies and practices that have protective effects. Like all human beings, physicians experience illness, and they also have family obligations and other commitments outside

their professional lives that should be taken into account.

One reason physicians delay seeking help is their concern about confidentiality, and feeling ill-at-ease in the patient role. They experience feelings of responsibility towards their patients, and are sensitive to external expectations about their health. Therefore, physicians must be assured the same right of confidentiality as any other patient when seeking and undergoing treatment. The healthcare system may need to provide special arrangements for the care of physician-patients, in order to uphold its duty to provide privacy and confidentiality. Prevention, early assistance and intervention should be available, separately from any disciplinary process.

## Threats, barriers and opportunities for physician wellbeing

**Professional roles and expectations:** The medical profession often attracts highly driven individuals with a strong sense of duty. Successfully completing the long and intense educational requirements often confers upon physicians a high degree of respect and responsibility in their communities.

With these high levels of respect and responsibility, physicians are subject to high expectations from patients and the public. These expectations can contribute to prioritising the care of others over self, and feelings of guilt and selfishness for managing their own wellbeing. There is a direct relationship between physicians' and patients' preventive health practices. This relationship should encourage healthcare systems to better support and evaluate the effects on patients of improving physician and medical student health.

**Work environment:** Working conditions, including workload and working hours, affect physicians' motivation, job satisfaction, personal life and psychological health during their careers.

Physicians are often perceived as being immune to injury and diseases as they care for their patients, and workplace health and safety programmes may be overlooked.

Physicians who are employed by small organisations, or who are self-employed, may be at even higher risk for occupational diseases, and may not have access to health and safety programmes provided by large healthcare establishments.

As a consequence of their professional duties, physicians, including those in postgraduate education, often confront emotionally challenging and traumatic situations, including patients' suffering, injury and death. Physicians may also be exposed to physical hazards such as radiation, noise and poor ergonomics, and biological hazards such as HIV, TB and hepatitis.

Some healthcare systems may exacerbate stress, because of the hierarchies and competition inherent in them. Medical students and physicians in postgraduate education may be victims of harassment and discrimination during their medical education. Due to their position within the medical hierarchy, they may feel powerless to confront these behaviours.

Physician autonomy is one of the strongest predictors of physician satisfaction. Increasing external regulatory pressures, such as undue emphasis on cost efficiencies, and concerns about consequences of reporting medical errors, may unduly influence medical decision-making and diminish a physician's autonomy.

**Illness:** Even though medical professionals recognise that it is preferable to identify and treat illness early, physicians are often adept at hiding their own illnesses, and may continue to function without seeking help until they become incapable of carrying out their duties. There are many potential obstacles to an ill physician seeking care, including: denial, confidentiality issues, aversion to the patient role, practice coverage, fear of disciplinary action, potential loss of practice privileges, loss of performance-based payment and the efficiencies of self-care. Because of these obstacles, doctors are often reluctant to refer themselves or their colleagues for treatment.

Illnesses can include mental and behavioural health problems, burnout, communication and interpersonal issues, physical and cognitive problems and substance-use disorders. These

illnesses and problems can overlap, and can occur throughout the professional lifecycle, from basic medical education to retirement. It is important to acknowledge the continuum of physician wellbeing, ranging from optimal health, through minor illness, to debilitating illness.

Substance abuse may disrupt a physician's personal life, and may also significantly affect his or her ability to care for patients. Easy access to medications may contribute to physicians' risk for abuse of recreational drugs and prescription medications. Assistance prior to impairment in the workplace is protective for physicians, their professional credentials and their patients.

Improved wellness promotion, prevention strategies and earlier intervention can help mitigate the severity of mental and physical illnesses, and help reduce the incidence of suicide in physicians, physicians in postgraduate education and medical students.

### Recommendations

The WMA recommends that NMAs recognise and, where possible, actively address the following:

1. In partnership with medical schools and workplaces, NMAs recognise their obligation to provide education at all levels about physician wellbeing. NMAs should collaboratively promote research to establish best practices that promote physician health, and to determine the impact of physician wellbeing on patient care.
2. Physician wellbeing should be supported and provided within and outside the workplace. Support may include, but is not limited to, referral to medical treatment, counselling, support networks, recognised physician health programmes, occupational rehabilitation and primary prevention programmes, including resiliency training, healthy lifestyles and case management.
3. NMAs should recognise the strong and consistent link between physicians' and

patients' personal health practices, providing yet another critically important reason for health systems to promote physician health.

4. Physician health programmes can help all physicians to proactively help themselves via prevention strategies, and can assist physicians who are ill via assessment, referral to treatment and follow-up. Programmes and resources to help promote positive psychological health should be available to all physicians. Early identification, intervention and special arrangements for the care of physician-patients should be available to protect the health of physicians. Fostering a supportive and accepting culture is critical to successful early referral and intervention.

5. Physicians at risk for abuse of alcohol or drugs should have access to appropriate, confidential medical treatment, and comprehensive professional support. NMAs should promote programmes that help physicians re-enter medical practice with appropriate ongoing supervision at the completion of their treatment programmes. More research should be conducted to determine best practices in preventing substance abuse among physicians and physicians in postgraduate education.

6. Physicians have the right to working conditions that help limit the risk of burnout and empower them to care for their personal health, by balancing their professional medical commitments and their private lives and responsibilities. Optimal working conditions include a safe and reasonable maximum number of consecutive and total working hours, adequate rest between shifts and appropriate number of non-working days. Relevant organisations should constructively address professional autonomy and work-life balance problems, and involve physicians in making decisions about their work lives. Working conditions must not put the safety of patients or physicians at risk, and ultimately physicians should be engaged in establishing optimal workplace conditions.

7. Workplaces should promote conditions conducive to healthy lifestyles, including access to healthy food choices, exercise, nutrition counselling and support for smoking cessation.

8. Physicians, physicians in postgraduate education and medical students have the right to work in a harassment- and violence-free workplace. This includes freedom from verbal, sexual and physical abuse.

9. Physicians, physicians in postgraduate education and medical students have the right to a collaborative, safe workplace. Workplaces should promote interdisciplinary teamwork, and communication between physicians and all other professionals in the workplace should be offered in a spirit of co-operation and respect. Education on communications skills, self-awareness and team-work should be considered.

10. Medical staff should undergo training in recognising, handling and communicating with potentially violent persons. Healthcare facilities should safeguard against violence, including routine violence risk audits, especially in mental health treatment facilities and emergency departments. Staff members who are victims of violence or who report violence should be supported by management and offered medical, psychological and legal counselling.

11. Medical schools and teaching hospitals should develop and maintain confidential services for physicians in postgraduate education and medical students, and raise awareness of and access to such programmes. Workplaces should consider offering medical consultations to physicians in postgraduate education in order to identify any health issues at the outset of their medical education.

12. Workplace support for all physicians should be easily accessible and confidential. Physicians evaluating and treating their medical colleagues should not be required to report any aspects of their physician-patients' care in any manner not required for their non-physician patients.

## JUDASA AGM a huge success

Dr Diale Mahlako Maepa, *outgoing national executive committee, JUDASA*

The year is 2015, and nestled in beautiful countryside is a hotel where members of the Junior Doctors Association of SA (JUDASA) have converged to attend the JUDASA annual general meeting (AGM).

This well-attended AGM, in April of that year, appointed nine members to the national executive committee (NEC).

In February 2016, the SAMA Trade Union was disestablished; then, in September, the

interim employed doctors committee (iEDC) was established bilaterally, with the tactical resignation of a few members from the NEC of JUDASA. The remaining NEC members were undeterred, and resolute in stabilising JUDASA

and continuing to ensure that junior doctors are well represented. There was a call in February 2017 for an extraordinary general meeting to address the proposed changes in the memorandum of incorporation (MOI) and company rules, and the special interest groups (SIGs) were called upon to provide input from their memberships regarding the rules. This process delayed the convening of the JUDASA AGM.

Due to the slowly fading-away and near-superfluous JUDASA NEC structure, the remaining members from the 2015 NEC, Dr Danny Mokumo, Dr Nkateko Mnisi, Dr Zahid Badroodien and I, took the opportunity to initiate efforts to revive JUDASA. In January 2018, we co-opted Dr Farah Jawitz from the Western Cape provincial executive committee (PEC), forming a five-member National Working Group (NWG)

The aims of the NWG were to organise an AGM, where we could handover a JUDASA with functional provincial structures, and to enhance our online presence. We set out and managed to successfully elect PEC structures in all provinces, with the exception of Limpopo and the Western Cape, who had already established PECs. The NWG also was successful in establishing a partnership with the South African Medical Students Association (SAMSA) in the medical schools of five more universities. We cannot emphasise enough the importance of representation and relevance at the student level in the development of the junior doctor. JUDASA cannot afford not to take medical students under its wings, and we have welcomed the channels of partnership with SAMSA. It is our hope that due to the channels this NWG has facilitated, the new leadership will nurture and better define this relationship.

## The JUDASA 2018 AGM

A well-organised, well-attended and successful JUDASA AGM was in May this year, 3 years after the last one. Junior doctors from all PECs, as well as SAMSA chairpersons from the seven medical schools, attended the AGM, which was held at the Southern Sun OR Tambo International Airport Hotel.

The theme of the AGM was “The role of regulators and associations in a time of public health crisis.”

Speaking to the theme, I would like to start off with the words of Dr Pali Lehohla, former Statistician-General: “Population is not simply a problem of numbers. The growth in Africa’s population in the last decade has not been accompanied by



*The newly elected JUDASA committee, from left: secretary, Malose Marakalala (Mpumalanga); deputy chairperson, Farah Jawitz (Western Cape); international relations, Refilwe Lekalakala (Limpopo); deputy secretary, Lerato Masenya (KwaZulu-Natal); chairperson, Theresa Mwesigwa (Gauteng); additional member, Bridged Tshutshu (Limpopo); public relations, Michael Cloete (KwaZulu-Natal). Absent: treasurer, Redwaan Marais (North West) and student liason, Boitumelo Mooi (Gauteng)*

the necessary structural transformation, nor has it translated into equitable human development and improved livelihoods.”

We live in a country where the number of skilled professionals is largely outweighed by the population that they need to serve, a country where healthcare is in a monumental predicament and on the brink of collapse, a country where hospitals and clinics are in dire need of doctors and our rural healthcare facilities are in shambles – and a country where our profession is being undermined and undervalued.

This is a country in a **public healthcare crisis**.

The continued training and supervision of junior doctors in some of our facilities leaves a lot to be desired. Our marginalised healthcare centres in mostly rural areas are understaffed, under-resourced and neglected – yet we are instructed to continue as usual, year in and year out.

The roles of our regulators, the HPCSA, the National Department of Health cannot be overemphasised. It is time we as a profession take the conversation from the boardrooms and act; otherwise we risk losing the integrity of our profession. If we do not protect our profession, if we do not protect our work environment, we risk having those with little knowledge of the profession governing us. Our association, SAMA, needs to continue to robustly protect the doctor and the doctor’s work environment.

We acknowledge that there is a crisis in our profession, the nursing fraternity and allied healthcare workers, not only in SA

and SADC, but across the entire continent. Fewer and fewer of us yearly remain in the public sector as medical practitioners, or even specialists. The deficit of specialists throughout our healthcare facilities not only compromises patient care, but also hinders junior doctor supervision and education. Furthermore, our healthcare system has not yet reached a state where we can say that it is equitable; one only needs to take a brief look at our rural community healthcare facilities. The WHO currently states that over 45% of its member states have less than 1 doctor per 1 000 population; SA is not exempt from this, and the figure is, shockingly, even lower than that.

I do acknowledge that we find ourselves in an economically difficult time; however, we should never allow our government to compromise on healthcare and education. We are in dire need of doctors, and there are junior doctors available to work, yet they are unemployed as a result of frozen posts and lack of funding.

## The future of JUDASA

A nine-member NEC was elected at the AGM, with Dr Terry Mwesigwa becoming the new national chairperson of JUDASA. This team is ready to take on the issues discussed at the AGM, namely, mental-health issues among junior doctors and medical students, creating safe working environments and engaging with various stakeholders on finding solutions to the current unemployment crisis, and putting preventative measures in place for the future.

### A message to the incoming NEC, and to all junior doctors

You should continue to hold yourselves accountable to your members and the organisation, and the organisation accountable to your members. You should continue to advocate for the rights of all junior doctors, for improved working conditions, for improved healthcare facilities for our patients and improved training facilities and better supervision. You should continue to advocate for equitable healthcare. In terms of professionalism, this does not mean wearing a medical coat or carrying a stethoscope; rather, it means conducting oneself with responsibility, integrity, accountability and excellence. It means communicating effectively and appropriately, and always finding ways to be productive. You should aim to uphold this standard. The process of transformation requires profound and radical change that focuses an organisation in a new direction, and

aims to take it to an entirely different level of effectiveness. True transformation should bring about a change that results in an organisation with little or no resemblance to the past configuration or structure.

Aim to move and propel JUDASA forward positively, productively and proficiently, together with the other SIGs, our partner SAMSA, the HPCSA and the SAMA leadership.

In this time of Youth Month, history has shown us the inherent power of the youth, and our capability to harness and optimally utilise this power in a conscious manner, to bring forth radical changes to the benefit of the majority.

The time is NOW.

The time is now to take back our profession.

The time is now to advocate for our profession.

The time is now to protect our profession.

If we do not do so, in years to come we will have only ourselves to blame.

I would like to express my gratitude for the opportunity to have served junior doctors for the past 3 years, in various portfolios in the national structure. It has not been an easy task, yet it has been highly rewarding. I am grateful, too, for the team that I have served with, especially over the last few months. We must never underestimate the invaluable contribution we have made and the time that we have given to this organisation.

Many thanks to the following persons for a successful AGM: in the iEDC, Dr Y Baldeo, Dr M Sonderup and Dr M Thandrayen; the SAMA marketing department, Bokang Motlhaga and Alfred Chumu; the conference organisers, Dabchick Conference and Events; the NWG members; and all the delegates who attended the AGM.

It gives me great pleasure to hand over the reins to a highly motivated, eager and energised generation of junior doctors, under the leadership of Dr Terry Mwesigwa.

## SASOP: Tower Hospital and the perceived mental healthcare crisis in the Eastern Cape

Prof. Bernard Janse van Rensburg, *SASOP president*

Our awareness of the problems started with a media question received by the SA Society of Psychiatrists (SASOP) in January 2018, following a discussion in the Eastern Cape (EC) Provincial Executive Committee in December 2017 on the deaths of patients over the past 5 years in EC psychiatric facilities. Following that, Dr Kiran Sukeri, a local psychiatrist, reported specific concerns about conditions at Tower Hospital to SASOP's board, who assisted him in preparing submissions to institutions such as the Human Rights Commission of SA and the Office of Health Standards Compliance. Following the sudden resignation of Dr Sukeri, a visit to Tower Hospital was made by the SASOP board and EC subgroup representatives, with representatives of Treatment Action Campaign and the SA Federation of Mental Health, on 6 March 2018. The meeting was approved by the EC surgeon-general (SG), and it was arranged to meet with the hospital management about the concerns raised by Dr Sukeri. A report was subsequently compiled. It was released on 19 March 2018, and submitted to the MEC for Health and the SG's office, while a media statement was

made by SASOP on 22 March. Although certain limitations of the report were highlighted, the findings were of such a nature that SASOP urged the EC Department of Health (DoH) to investigate the situation at Tower Hospital further, as well as the whole mental healthcare system in the EC, in order to prevent further possible violations of patients' rights.

### SASOP report

The report indicated problems in the following areas:

- Multidisciplinary team (MDT), Dr Sukeri and hospital management (HM) relations: There appear to have been differences between the MDT and the rest of the HM team about clinical decisions taken regarding the admission, leave-of-absence and discharge of patients.
- Deaths, death records and record keeping: Accurate record-keeping and proper documentation is a significant challenge in the institution, while significant discrepancies and inaccuracies existed regarding the hospital's available information on the number and nature of deaths of inpatients

that have occurred over the last 5 - 8 years.

- Seclusion room: The current seclusion rooms at Tower Hospital should be regarded as very high-risk areas and should not be used, while inadequate implementation of existing policies and procedures occurred to ensure the safe and legal seclusion of any mental healthcare user.
- Patients' physical health: Significant improvements could be made in terms of procedures, protocols and physical capacity, to ensure that the physical health of patients is properly monitored and maintained.

### Recommendations

The report made the following recommendations:

- Infrastructure challenges related to the single seclusion rooms must be addressed urgently, and the current rooms must not be used.
- Reconciliation of the death register of the hospital with the actual number of deaths is urgently required, while discrepancies must be appropriately investigated and any misconduct accounted for.

- The hospital's entire information management system must be investigated, and more evidence should be gathered on possible misconduct.
- More evidence must be obtained and considered on pre-existing problems with the food and clothing of patients, while irregularities must be investigated, and misconduct accounted for.
- Measures and procedures are required to ensure that the physical health of patients is properly maintained and monitored, while comorbid medical conditions should be adequately managed.

## Developments

In addition to the SASOP report, the EC DoH also instructed a provincial task team to investigate the concerns. This team completed their report towards the end of March 2018, and was also submitted to the national Minister of Health.

In addition to the problems at Tower Hospital, reports raising more concerns about services, facilities and training were also received regarding other facilities in the EC,

e.g. Cecilia Makiwane Hospital. These were received by another senior psychiatrist and SASOP member, who also subsequently resigned after years of service in the public sector. On submitting the SASOP report on Tower Hospital to the SASOP board and national council on 24 March 2018, it was endorsed by these structures, who advised that the health ombud must be approached, with not only a request to investigate circumstances at Tower Hospital, but also the recommendation that the entire system of mental healthcare services in the EC must be investigated.

Such a submission was made in the beginning of April 2018, including details of SASOP's and SASOP members' track record of engagement with officials of the EC DoH, as well as the national DOH, about concerns on conditions in the EC, some of which date back for several years. The health ombud is currently investigating conditions at Tower Hospital, and it is anticipated that this will provide more clarity on what measures and interventions may be appropriate.

## Dr Grootboom responds

In light of the recent Life Esidimeni tragedy and the Eastern Cape mental healthcare crises, the chairman of SAMA, Dr Grootboom, would like to remind doctors of ethical issues relating to the management of mental health patients, and affirm the ethical foundations for the treatment of patients with mental illness.

Doctors should protect and promote the dignity and human rights of patients with mental illness. It is our responsibility as doctors to raise awareness on mental health, and advocate for sufficient allocation of resources. As a voice for our patients, we have an obligation to report poor-quality healthcare and human rights violations to the Office of Health Standards Compliance and the Human Rights Commission, respectively.

# Why are mental healthcare users' rights not respected?

Sibongile Tshabalala, *national chairperson, Treatment Action Campaign*

Mental health is one of the major challenges that the country is facing, but mental illnesses are stigmatised, and most people, including in government, do not talk about them.

The Eastern Cape has nine psychiatric hospitals, but over 90 people with mental illnesses are being held in various prisons in the province, instead of being looked after in hospitals. They are state patients – people declared unfit to stand trial or found not criminally responsible because of their illness or “mental defect” (the state's term). This is despite the courts having ordered that they be placed in mental health facilities. According to the Mental Health Care Act (MHCA) No. 17 Of 2002, if a court orders a patient to be transferred to a mental health institution, this must happen within 28 days.

However, the situation in the psychiatric hospitals is not much better. On 22 May 2018, News24 reported that patients are

being abused in Tower Hospital (<https://www.news24.com/SouthAfrica/News/visit-to-eastern-cape-psychiatric-hospital-gives-a-very-different-picture-from-reports-department-20180307>). According to the statement issued by the SA Society of Psychiatrists (SASOP), “Dr Kiran Sukeri, the psychiatrist involved, reported several matters that seemingly have been infringing the human rights of mental healthcare users at Tower Hospital over an extended period of time, as well as being indicative of entrenched management and governance problems at the hospital. These included a poor standard of food and clothing, unlawful seclusion of patients, as well as inaccurate figures on deaths occurring at the hospital.”

What does this mean? It means that mental healthcare users' constitutional rights are being violated. Chapter 2 section 9(3) of the SA Constitution states that “the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds,

including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.” The conditions at Tower Hospital show that patients' rights are being violated, indirectly: they are being treated unfairly because of their disability.

According to the provincial chairperson of the Treatment Action Campaign (TAC) in the Eastern Cape, Mziwethu Faku, “The situation in the two hospitals that TAC and SASOP [visited] was horrible – patients [wear] torn-apart clothes, even their private parts are exposed [and a] poor standard of food is provided to patients.” Furthermore, he said, “Last week it was reported that another patient had died due to eating expired food,” which is a violation of the Constitution's chapter 2, section 10: “Everyone has inherent dignity and the right to have their dignity respected and protected.” Patients' human dignity is not respected, and moreover,

chapter 2, section 27(1)b states that “every-one has the right to have access to sufficient food and water.”

The MHCA, in chapter 3 section 8, states that (1) The person, human dignity and privacy of every mental healthcare user must be respected. (2) Every mental healthcare user must be provided with care, treatment and rehabilitation services that improve

the mental capacity of the user to develop to full potential and to facilitate his or her integration into community life. (3) The care, treatment and rehabilitation services administered to a mental healthcare user must be proportionate to his or her mental health status, and may intrude only as little as possible to give effect to the appropriate care, treatment and rehabilitation.

The Department of Health, both provincially and nationally, should take responsibility for the state of the mental healthcare crisis in the Eastern Cape.

So the big questions are: Why doesn't the Department of Health prioritise mental healthcare in SA, especially the Eastern Cape? Why are mental healthcare users' rights not respected?

## Legislative provisions regulating informed consent and minor patients

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

It is a fundamental principle of medical ethics and law that informed consent must be obtained from a patient before proceeding with treatment or surgery. The same holds true in the case of minor patients and/or their parents. The law governing minors and consent to medical treatment is contained in several pieces of legislation, and the consent requirements differ depending on the type of treatment involved. Given the possible serious consequences of non-compliance, it is essential that doctors familiarise themselves with the legislative framework. The purpose of this article is to provide a brief synopsis of the most important legislative provisions pertaining to minors and informed consent.

Informed consent in general is regulated by the National Health Act No. 61 of 2003. In terms of section 7 of the Act, a health service may not be provided without the patient's informed consent. Section 6 details the scope of the information that should be provided to patients when procuring consent. These requirements also apply when obtaining consent from a minor, or the parent or guardian of the child. Section 6 stipulates that a doctor should inform a patient of:

- the patient's health status, except in circumstances where there is substantial evidence that the disclosure of the patient's health status would be contrary to the best interests of the patient
- the range of diagnostic procedures and treatment options generally available
- the benefits, risks, costs and consequences generally associated with each option
- the patient's right to refuse health services,

and the implications, risks and obligations of such refusal.

The doctor must, where possible, inform the patient, as described above, in a language that the patient understands, and in a manner that takes into account the patient's level of literacy.

### Legislative provisions: Intervention

**Surgery and treatment:** Section 129 of the Children's Act No. 38 of 2005 provides that a child between the ages of 12 and 17 years may consent to his or her own medical treatment, provided that (s)he is of sufficient maturity and has the mental capacity to understand the benefits, risks, and social and other implications of the treatment. The same requirements apply to surgical operations, except that the child must then also be assisted by his or her parent or guardian during the decision-making process.

For children under 12 years old, or children over 12 of insufficient maturity to consent, the following individuals may consent to medical treatment or surgical operations: (a) the parent, guardian or caregiver of the child; (b) in emergencies, the superintendent of a hospital, or the person in charge of the hospital in the absence of the superintendent; (c) if the parent or guardian unreasonably refuses to give consent or assist, is incapable of doing so, cannot be readily traced or is deceased, the Minister of Social Development; and (d) in all instances where another person who may give consent refuses or is unable to give such consent, a High Court or a children's court. If the

child unreasonably refuses to give consent, the Minister of Social Development may consent to treatment on behalf of the child.

In cases where children do not have the legal capacity to consent to treatment or surgery, their preferences should nevertheless be taken into account when decisions are being made. Section 10 of the Children's Act provides that every child that is of an age, maturity and stage of development as to be able to participate in any matter concerning him or her has the right to participate in an appropriate way, and views expressed by the child must be given due consideration. Where possible, a minor patient's assent to treatment should therefore be sought.

**HIV tests:** In terms of section 130 of the Children's Act, no child may be tested for HIV except when it is in their best interests and consent has been given. An exception to the aforementioned rule is where the test is necessary in order to establish whether a health worker or any other person may have contracted HIV from contact in the course of a medical procedure involving contact with any substance from the child's body that may transmit HIV, provided that the test has been authorised by a court.

The Children's Act furthermore provides that consent for an HIV test may be given by the child if (s)he is 12 years of age or older, or under the age of 12 years and of sufficient maturity to understand the benefits, risks and social implications of the test. If the child is unable to consent, consent may be given by the provincial head of social development, a designated child protection organisation arranging the placement of the child or the

child's parent or caregiver. The superintendent or person in charge of a hospital may provide consent if the child has no parent or caregiver and there is no designated child protection organisation arranging the placement of the child. A children's court may also be approached if consent is unreasonably withheld or if the child, parent or caregiver of the child is incapable of giving consent. In all instances, if the child is of sufficient maturity to understand the benefits, risks and social implications of such a test, pre- and post-test counselling should be provided. Counselling should be provided to the child's parent or caregiver, if the parent or caregiver has knowledge of the test.

**Contraception:** Section 134 of the Children's Act provides that no person may refuse to sell condoms to a child over the age of 12 years, or to provide a child over the age of 12 years with condoms on request where such condoms are provided or distributed free of charge. Contraceptives other than condoms may be provided to a child on request by the child and without the consent of the parent or caregiver if the child is at least 12 years of age, proper medical advice is given to the child and a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided. A child who obtains condoms, contraceptives or contraceptive

advice is entitled to confidentiality in this respect.

**Circumcision:** In terms of section 12 of the Children's Act, circumcision of male children under the age of 16 is prohibited, unless the circumcision is performed for religious purposes in accordance with the practices of the religion concerned and in the manner prescribed, or is performed for medical reasons, on the recommendation of a medical practitioner. Circumcision of male children aged 16 years and older may be performed if the child has given consent to the circumcision, after proper counselling of the child, and in the manner prescribed. Taking into consideration the child's age, maturity and stage of development, every male child has the right to refuse circumcision. Female circumcision is illegal at any age.

**Sterilisation:** In terms of section 2 of the Sterilisation Act, a person may only be sterilised if he or she is capable of consenting and at least 18 years old. Sterilisation may only be performed on a person who is under the age of 18 years if failure to do so would jeopardise the person's life, or seriously impair his or her health. In such cases, the minor may furthermore only be sterilised if consent is given by a person who is lawfully entitled to give consent (usually the parent or guardian), and an independent medical practitioner has consulted with the patient and has provided

a written opinion to the effect that the sterilisation is in the best interest of the patient.

**Termination of pregnancy:** In terms of section 5 of the Choice on Termination of Pregnancy Act No. 2 of 1996, notwithstanding any other law or the common law, no consent other than that of the pregnant woman is required for the termination of a pregnancy. The Act defines "woman" as any female person of any age. In the case of a pregnant minor, a medical practitioner or a registered midwife or registered nurse shall, as the case may be, advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated. The termination of the pregnancy may, however, not be denied because the minor chooses not to consult anyone.

Where doctors are unsure whether a minor patient may in fact consent to treatment, it is recommended that they first approach their professional association, attorney or indemnity provider for legal advice before proceeding. When dealing with minors, the best interest of the child is of paramount importance. Extra care should therefore be taken to ensure that consent is informed, comprehensive and voluntary. It should be kept in mind that informed financial consent will still have to be obtained from the person (usually the parent) responsible for payment.

## Submission of research protocols for ethical review

Lisa Reid, CPD accreditation officer, SAMA

In the execution of its responsibilities in evaluating the ethics of research protocols, the SAMA Research Ethics Committee (SAMAREC) is guided by the relevant SA law, research and ethics guidelines, professional standards, international standards and guidelines, and codes of practice. Health research ethics committees (RECs) must be established by every institution, health agency and health establishment at which health research is conducted, or they must have access to a health REC that is registered with the National Health Research Ethics Council (NHREC).

All submissions to SAMAREC can be done electronically. For new applications, the following **documents** relevant to the proposed study need to be submitted:

- covering letter
- protocol summary/synopsis
- SAMAREC checklist
- patient information and informed consent document (PID)
- investigator's brochure
- letters of information
- questionnaires (if any)
- copy of the insurance certificate
- SA Health Products Regulatory Authority (SAHPRA) approval or notification or letter of submission
- proof of NHREC registration
- details and breakdown of financial arrangements with study doctors
- information pertaining to patient recruitment, e.g. advertisements, bulletins and information placed on the internet
- justification for the use of a placebo
- CVs of all study personnel, in the SAHPRA format
- declarations by trialists
- proof of personal malpractice indemnity cover of study doctors, nurses and pharmacists
- GCP (good clinical practice) certificates
- dispensing licences (if applicable).

All documentation should be properly indexed, with the protocol number clearly visible on all sections of each document.

For further information on submitting a protocol for ethics review please contact Adri van der Walt at [samarec@samedical.org](mailto:samarec@samedical.org).

# Government Gazette: New COID fees now applicable

SAMA Private Practice Department

The scale of fees for medical aid, as published by the Department of Labour in respect of the Occupational Injuries and Diseases Act No. 130 of 1993 (also known as injury on duty), was published on 25 April 2018 in the Government Gazette No. 41596. These compensation for occupational injuries and diseases (COID) fees are applicable from 1 April 2018.

Please go to the SAMA website, <https://www.samedical.org/private-health/coid> to download the complete Government Gazette. Please note that the amounts published in the Government Gazette are VAT exclusive.

See unit values (below) for the various groups and sections as from 1 April 2018.

Contact SAMA Coding Unit, Private Practice Department, for more information: [coding@samedical.org](mailto:coding@samedical.org), or 012 481 2073.

|    | Symbol | Description                                                                                                               | VAT inclusive | VAT exclusive |
|----|--------|---------------------------------------------------------------------------------------------------------------------------|---------------|---------------|
| 1a | V      | Section I: Consultative services: Items 0173 - 0175, 0177 - 0179, 0190 - 0193, 0109, 0129, 0151 - 0153, 0130 - 0136, 0199 | R 27.53       | R 23.94       |
| 1b | VC     | Consultation services codes 0181 - 0186, 0151 (COID only)                                                                 | R 28.05       | R 24.39       |
| 2  | CL     | Clinical procedures                                                                                                       | R 27.53       | R 23.94       |
| 3  | A      | Anaesthetics performed                                                                                                    | R 128.64      | R 111.86      |
| 4a | RA     | Section 19: Radiology                                                                                                     | R 28.80       | R 25.04       |
| 5a | RO     | Section 20: Radiation oncology                                                                                            | R 30.29       | R 26.34       |
| 5b | ROTC   | Section 20: Radiation oncology: Technical component                                                                       | R 30.29       | R 26.34       |
| 6  | U      | Section 19.11: Ultrasound                                                                                                 | R 27.20       | R 23.65       |
| 7  | CT     | Section 19.9: Computed tomography                                                                                         | R 27.67       | R 24.06       |
| 8  | CP     | Section 21: Clinical pathology                                                                                            | R 28.65       | R 24.91       |
| 9a | AC     | Section 22.1: Anatomical Pathology: Cytology (items 4561 - 4566)                                                          | R 28.28       | R 24.59       |
| 9b | AH     | Section 22.2: Anatomical pathology: Histology (items 4567 - 4595)                                                         | R 28.28       | R 24.59       |
| 4b | MR     | Section 19.15: Magnetic resonance imaging (MRI)                                                                           | R 28.80       | R 25.04       |
| 10 |        | 5 digit radiology (SP)                                                                                                    | R 187.77      | R 163.28      |



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# Tackling adverse events in the SA health sector

Dr Ayodele Aina, SEDASA national chairperson

The newly elected leadership of the Senior Employed Doctors Association of SA (SEDASA) had their first contact meeting with Sanlam financial representatives on 2 June 2018 at the SAMA head office in Pretoria, to tackle serious adverse events that are currently a cankerworm in the SA health sector.

This article describes some of the highlights of the meeting deliberations.

## Definition

Serious adverse events (previously known as serious and sentinel events) are events that have generally resulted in harm to patients, led to significant additional treatment, are life-threatening or have led to an unexpected death.

We have a highly professional and dedicated health workforce, but harm does occur. Not all of it can be prevented, but some can. It is the responsibility of all of us who work in health to provide the safest care possible.

## Common types

The types of serious adverse events that can occur in the healthcare sector can be grouped into categories.

### Maternal and child management care:

- Patient death or serious disability associated with a medication error
- Patient death or serious disability associated with a haemolytic reaction due to the administration of ABO-incompatible blood or blood products
- Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility.

### Patient protection events:

- Infant discharged to the wrong person
- Patient death or serious disability associated with patient disappearance for more than 4 hours
- Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility.

### Surgery events:

- Surgery or other invasive procedure performed on the wrong site
- Surgery or other invasive procedure performed on the wrong patient
- Wrong surgical or other invasive procedure performed on a patient
- Unintended retention of a foreign object



Front row, left to right: Mr S Van der Watt (Sanlam), Dr O Udeagha, Dr A Aina (SEDASA national chairperson), Dr A Mir, Ms S Harris (Sanlam), Dr M Thandrayen (SAMA general manager)  
Second row, left to right: Dr J Ngundu, Dr T Muyembe, Dr B Malumane, Dr C Mojapelo, Dr F Konso, Dr W Selfridge, Dr T Smit

(e.g. scissors or swabs) in a patient after surgery or another invasive procedure

- Intraoperative or immediately postoperative death in a normal healthy patient.

### Infrastructure-related events:

- Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility
- Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility
- Patient death associated with a fall while being cared for in a healthcare facility.

### Criminal events/safety and security problems:

- Sexual assault on a patient within, or on the grounds of, a healthcare facility
- Death or significant injury of a patient or staff member resulting from a physical assault (e.g. battery) that occurs within or on the grounds of a healthcare facility
- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed healthcare provider.

## Reporting of serious adverse events

**Regulations:** National regulations vary considerably in their requirements for reporting of adverse events. For serious events, however, accelerated reporting is required.

National regulations may require the sponsor and/or the investigator to report certain types of adverse events or reactions (e.g. serious, previously unknown) to the drug regulatory authority and the ethics committee. If required, all such reports should be accompanied by an assessment of causality and possible impact on the trial and on the future use of the product. In reporting, measures should be taken to avoid unnecessary duplication.

The national reportable-event policy includes a standardised form, known as a reportable event brief (REB), which is used to report events and to advise the Commission of the outcome of the review.

## Labour union management intervention

- Put a monitoring team in place, incorporating different trade union representatives, to review contributing factors and possible intervention points, with the aim of preventing such an event in future. Create

and implement an action plan in line with SMART (specific, measurable, agreed, realistic and time-scaled) principles.

- Request to regularly review and update relevant policies (remunerative work outside of public service (RWOPS), commuted overtime).
- Encourage open channels of communications at all times in the multidisciplinary care approach.
- Lobby for budget, and ensure its appropriate use.
- Avoid litigation from all angles, and where unavoidable, pay early cognisance to it.

### SANLAM presentation

Sanlam representatives Selmie Harris and Stephan van der Watt advised the SEDASA

leadership on financial planning – how best to manage finances through tax reductions, proper budgeting in line with income and expenses, risk management, and creating wealth and a legacy – in an exemplified, practicable manner. Sanlam's financial products were discussed with passion and a great sense of humour. Stephan's presentation was highly interactive, informative, participatory and a great eye-opener to the SEDASA leadership.

The expertise displayed by both Stephan van der Watt and Selmie Harris, in the absence of Ms Madeleine Van Wyk, was hugely appreciated and rated "outstanding" by the SEDASA leadership.

The meeting concluded with a discussion about the importance of ongoing dialogue with heads of government departments in the health sectors.

The importance of lobbying for health budget and its appropriate use as a tool for labour union management interventions is critical in order to prevent a reoccurrence of the Life Esidimeni scandal in SA. SANLAM also advised members that successful businesses take risks, not chances.

Each SEDASA leader at the contact meeting received a SEDASA/Sanlam branded jacket from Sanlam. The leaders undertook to continue to work as a team with Sanlam to "tackle the cankerworm" (serious adverse events) in our health sectors.

Vernon Kinnear, senior marketing officer, SAMA, played a tremendous role in organising the meeting from the preparatory stages, and ensured a successful meeting outcome.

## Doctors need management and leadership skills

Dr Gustaaf Wolvaardt, *managing director, FPD*, Pie-Pacifique Kabalira-Uwasa, *head, FPD Business School*

Practising medicine is increasingly becoming a daunting affair. The public sector seems to be plagued by a daily litany of disasters, while in the private sector financial pressure, litigation risk, practice complexity and stress translates into doctors abandoning independent practice altogether.

The reality is that the business environment in which medical practice takes place is becoming increasingly complex, and often hazardous. Expert clinical skills are no longer a guarantee for successful practice, and managerial skills have become a requirement, to anticipate and manage the impact of major trends such as changing funding models (e.g. National Health Insurance), a litigious practice environment, complex labour relations, artificial intelligence and mobile health, to name but a few.

It is increasingly accepted that the traditional medical school curriculum does not fully prepare doctors for the reality of medical practice in the 21st century. At both national and international level, this understanding is informing a debate on what the role of a doctor should be. The World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA) and the WHO have both adopted the concept of 5-star doctors, in which the following roles are recognised:

- care provider
- decision-maker
- communicator
- community leader
- team member/manager.

This expanded view of the role of a doctor now influences the design of medical school curricula both locally and abroad. CanMEDS 2015, an educational framework designed to ensure that future doctors effectively meet the healthcare needs of the people they serve, has been adapted for SA, and identifies the following roles:

- medical expert
- communicator
- collaborator
- leader/manager
- health advocate
- scholar
- professional.

Although there is general consensus that doctors need managerial skills, developing such skills at an undergraduate level is often challenging, as the training environment offers limited opportunities for students to engage with basic managerial skills such as developing strategic and operational plans, compiling budgets, using management information, marketing and human resource

management. As a result, the majority of healthcare professionals are not prepared for the realities they will face when they are, inevitably, required to assume a managerial and leadership role.

The phenomenon of amateur managers is not exclusive to healthcare, and is still the norm in technical areas where contextual subject-matter knowledge is seen as a prerequisite for managers. However, not supplementing this subject-matter expertise with managerial training was shown to translate into poor organisational performance, in a 25-year study of more than 40 000 managers by Rook and Torbert, which categorised managers by their worldview (called action logic). They found that the majority of professionals appointed to managerial positions without additional management training operated from what they defined as an "expert" action logic. This action logic was generally associated with poor performance, due to various internal factors such as a rigid conviction that their views are always right, an inclination to view collaboration as a waste of time and a tendency to treat the opinion of people they view as less qualified with contempt. Fortunately, this study showed that action logics can be transformed through management training.

If you are not yet convinced of the importance of good management and

leadership skills, an insightful exercise is to identify a problem that you can attribute to a lack of management or leadership skills. Now do a back-of-the-envelope calculation of the short-, medium- and long-term direct and indirect costs to the business, and/or the individuals involved, i.e. the healthcare professionals and patients. This relatively easy exercise is seldom carried out, simply because we are not trained to quantify the real cost of problems, especially those left unresolved.

Remember, the costs of unresolved problems are not only financial; they may also be emotional, reputational and so on.

SAMA acknowledged the need for health management development as far back as 1997, when it established the FPD ([www.foundation.co.za](http://www.foundation.co.za)). To date, FPD has provided management and leadership training to more than 6 000 healthcare professionals across 13 countries in Africa, and since 2015, SA medical students can access all FPD management

short courses for free on the FPD e-learning portal, <https://student.foundation.co.za>.

Whether we like it or not, doctors need to embrace the reality that surviving and thriving in this new complex environment will depend on their ability to embrace their role as leaders and managers, and that acquiring the necessary skills for this role has become a matter of urgency.

*References available on request.*

## Understanding the right to fair labour practice

Bertha Shabangu, *SAMA legal advisor, industrial relations*

The right to fair labour practice is a constitutional right, provided for in terms of section 23(1) of the Constitution of SA. This right is also enshrined in section 185 of the Labour Relations Act No. 66 of 1995 (LRA), which states that “every employee has the right not to be subjected to an unfair labour practice.” Put simply, any worker or job applicant has the right not to be treated unfairly by his/her employer.

To best answer the question of what being treated unfairly means, one needs to understand the meaning of “unfair labour practice”. An unfair labour practice is any unfair act or omission that arises between an employer and an employee, involving:

- the failure or refusal of an employer to reinstate or re-employ a former employee in terms of a court order, award or any form of agreement
- the unfair conduct of an employer relating to the promotion, demotion or training of an employee, or relating to the provision of benefits to an employee
- the unfair suspension of an employee, or any disciplinary action in respect of such an employee.

### Unfair conduct relating to promotion, demotion, training or benefits

The right to fair labour practice also means that an employee or job applicant has the right to be promoted, if such is well deserved; to not be demoted unfairly; to equally enjoy benefits that other employees enjoy; and to be trained when there's a need.

Unfair conduct relating to promotion, demotion, training or benefits usually involves cases where the employer deviates from its own policies, or when the employee alleges that promotion, demotion or training is in itself unfair. For example, the employer may be guilty of unfair conduct against an employee or employees if all employees pass a test, but all except one, or a few, are promoted. On conduct relating to promotion, the court held in *National Commissioner of SA Police Service v Safety and Security Sectoral Bargaining Council and Others* (2005) 26 ILJ 903 (LC) that it is important for the applicant to show a causal connection between the unfairness complained of and the prejudice suffered.

An example of unfair conduct based on benefits would be when all employees are given travelling allowances, but one does not enjoy the same benefits. Any conduct promoting racial discrimination or any other form of discrimination is also viewed as an unfair treatment, and therefore may constitute an unfair labour practice.

### Unfair sanction or disciplinary action

Often employers elect to suspend an employee who is facing pending disciplinary processes, or as a sanction imposed on the employee following a disciplinary action. Such a suspension may be unfair, and would therefore mean that the employer had infringed the employee's right to fair labour practice. In *Lebu v Maquassi Hills Local Municipality and Another* (2011) the court stated that suspension is a measure that has serious consequences for an

employee, and is not something that should be resorted to lightly.

Unfair suspension may be regarded as a dispute, and be referred to as an unfair labour practice if the employee is suspended for an unreasonably long period, and where there is no valid or plausible reason for the delay in finalising the disciplinary processes. An example of an unfair suspension would be a case where a manager and his/her subordinate argue, and the employer suspends only the subordinate and not the manager.

### Disputes: Unfair treatment

Any dispute about forms of unfair treatment or an unfair labour practice may be referred firstly to conciliation, conducted either by a bargaining council or, if there is no bargaining council, then by the Commission for Conciliation, Mediation and Arbitration (CCMA). If the dispute remains unresolved, then it can be referred to arbitration.

Section 191 of the LRA states that the employee has 90 days from the date of the act or omission that allegedly constitutes unfair treatment to raise the issue, or, if it is discovered at a later date, 90 days from the date on which the employee became aware of the act or occurrence. All employees must enjoy the same right to fair treatment by their employer, and they should be protected against any form of unfair treatment. Knowing and understanding one's rights remains key. Employees should be made aware that there are dispute mechanisms and forums in place, such as bargaining councils and the courts, waiting to be utilised.

# Obituary: Dr Siyolo Solombela, the people's doctor

SAMA Communications Department

The medical profession is mourning the death of one of the Eastern Cape's finest, Dr Siyolo Solombela, 67, who has died after a long illness. A SAMA member for 15 years, he served on Border Coastal branch council from 2013 - 2016.

Dr Solombela was born in 1951, the only son of Samson Ndleleni and Felicia Ndileka Nobandla Solombela (née Nguza). He entered the University of Natal Black Section (at Wentworth) at the age of 16, where he later qualified as a medical doctor. His subsequent educational qualifications include a Diploma in Forensic Medicine (College of Medicine), Diploma in Tropical Medicine and Hygiene (Wits) and Master's in Medicine (UCT).

He served his internship at Port Elizabeth's Livingstone Hospital in 1975, from where, in 1976, he went on to serve as a medical officer with Dr Mamphela Ramphele at the Zanempilo Health Centre, an alternative community healthcare service created at Zinyoka in King William's Town by the Black Community Programmes, under the leadership of Steve Biko. In 1977, he opened a private practice at Ngqeleni, while serving as district surgeon and medical officer at St Barnabas Hospital.

In 1984, he opened a private practice in his hometown of Butterworth, where he also served as district surgeon and medical officer at Butterworth Hospital until 1989. While in Butterworth, Dr Solombela became part of a programme facilitating scholarships for students, combining this with recruitment for underground political work. He also started an advice centre that assisted people with legal and other social problems, working with a team of available lawyers. In 1989, he relocated to Port Elizabeth to work as a medical officer at Livingstone Hospital. He enrolled at UCT in 1991, and worked as a registrar at Groote Schuur Hospital, finishing in 1998 with a Master's in Medicine, having qualified to practise as a specialist physician.

He worked as a specialist physician both in private and public practice, at Frere Hospital, Cecilia Makiwane Hospital and the three East London Life Private Hospitals. At Frere Hospital he created a special no-fee medical outpatients' service, for patients who could not afford private hospital attention.



As a medical student he participated in many community-based social and political activities of the South African Students Organisation (SASO). He contributed significant time to SASO community development programmes in the Phoenix area of Durban, near the Gandhi Memorial Centre. As a member of the Black Consciousness Movement he was involved in the organisation of the Black People's Convention in King William's Town. In 1976 he was detained without trial for 6 months by the apartheid government, in "preventive detention", along with others who were considered politically influential, in case they caused trouble!

Between 1979 and 1984, while practising as a doctor in Ngqeleni, he participated in ANC underground work as an MK operative, assisting with recruitment and transportation of MK operatives, as well as managing finances for MK operatives in the Mthatha area. Their unit was responsible for the bombings of the Mthatha petrol depot and Mthatha Dam, among others. He was arrested and detained twice without trial, in 1985 and 1986.

From 2012, he served on the Correctional Services Medical Parole Advisory Board that advises the Minister of Justice and Correctional Services on medical parole considerations for offenders sentenced to long-term imprisonment. This board dealt with, among others, the parole submissions of Jackie Selebi and Clive Derby-Lewis.

Dr Solombela had a profound commitment to his patients, and served them ceaselessly, with availability virtually 24 hours a day, 7 days a week. He took calls at all hours from his patients in need of care and attention, as well as from nurses consulting

him from hospitals. Nursing sisters from St. Dominic's Hospital in East London described Dr Solombela as "one of the most beautiful souls of this world and an amazing and intelligent doctor who was loved by all his patients and colleagues".

Dr Solombela was profoundly committed to the treatment of patients with HIV and AIDS, and many lives were saved through his unrelenting ethical commitment to medical intervention in this area. Provincial health spokesman Sizwe Kupelo said: "To him, medicine was not just a career, but a call to serve the nation. He continued to deliver quality services to our people, and never retired because he understood the scarcity of his skills in the field."

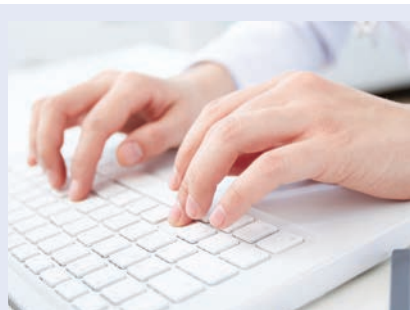
**Dr Solombela  
had a profound  
commitment to his  
patients, and served  
them ceaselessly**

Although Dr Solombela was not a gifted singer, he loved his jazz, gospel and soul music. He even enjoyed kwaito music – and often tried dancing to it. He also enjoyed travelling to new and unknown places, especially with his wife Pinky. At the same time, he was a dedicated son of emaHlubini eZazulwana, with much love for the village community, and ensured that his children identified with the village roots of the family.

Dr Solombela was married to the love of his life Pinky Solombela (née Fantisi), whom he wed in 1976. They were blessed with three boys: Fezile, Sibongile and Kwanele. He is survived by his wife, three children, daughters-in-law Asanda and Babalwa, seven grandchildren and three sisters: Welekazi, Bhadikazi and Nontando.

*Lala ngoxolo Radebe, Mthimkulu, Bhungane, Mashwabada, Ngelengele – ulufezile ugqatso lwakho!*

You honoured your calling till death. We are proud of you.



## 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 email contributions to: Diane de Kock, dianed@hmpg.co.za. Our thanks to Dr W R Bezwoda for his contribution below.

### Re: Supersession and medical scheme administrators

#### The Editor,

The mere fact that complaints of supersession are being made against medical directors/advisors of medical schemes is a measure of the frustration that clinicians feel when faced with an adamant refusal by schemes to take the patient's best interests into account when making their decisions. Schemes and their administrators hide behind the mantra of scheme rules and formularies, even when these cannot be applied to a specific patient. They are often oblivious to their duty of care. As a counter to merely exonerating the whole tribe of "managed care practitioners", including medical advisors and case managers, for their refusal to consider the needs of the patient as an individual, perhaps an article outlining their duties, responsibility and therefore liability for their decisions would be in order. Such decisions do impact on patient care, and when made without due consideration, are unethical and/or illegal.

Yours faithfully,  
**Dr W R Bezwoda**

## SAMA response: Medical scheme administrators

Shelley McGee, *health policy researcher, SAMA Knowledge Management and Research Department*,  
Hanneke Verwey, *legal advisor, SAMA Governance and Legal Department*

Dear Dr Bezwoda,

Thank you very much for your response to our article on supersession, with special attention brought to medical scheme administrators.

The challenges you raise have not escaped the attention of SAMA's Human Rights, Law and Ethics Committee (HRLE), and we are busy developing a research paper and position on this issue, particularly as it applied to medical ethics and the various aspects of the laws that apply in the country.

Regulation 15 of the regulations to the Medical Schemes Act (MSA) No. 131 of 1998 enables medical schemes to introduce managed care programmes as part of their administration. The regulation requires that these programmes adhere to the principles of evidence-based medicine, as defined in the MSA.

Regulation 15 (D) of the MSA also requires that managed healthcare programmes run by medical schemes, or the third parties they engage, should be administered by qualified healthcare professionals, who should oversee funding decisions. It additionally requires that the appropriateness of these decisions is evaluated periodically by clinical peers.

The HPCSA's *Policy Document on Business Practices* permits the participation of practitioners in managed care models, provided that those in both clinical and non-clinical practice (including clinical advisors) act in the best interest of patients at all times. The policy does not condone intervention from employed advisors in the clinical management of patients. If there *is* such intervention, these advisors effectively share the responsibility for the wellbeing of that patient.

The HPCSA states that liability should also accrue to the medical scheme in instances where decisions of medical schemes or managed care companies acting on their behalf are not in the patient's best interest, and the patient suffers harm as a result thereof. The aforementioned HPCSA guidelines furthermore recommend that where a provider's recommendation regarding the treatment options of a patient differs from that of the medical scheme or managed

care organisation, such recommendation(s) must be submitted to the patient in writing to enable the patient to make an informed decision as to the treatment path to be followed. Keeping a copy of this written recommendation on the patient file is also essential for the purposes of protecting the practitioner's future legal interests, as it will carry evidentiary value in the event of an adverse outcome occurring, where decisions of medical schemes or managed care companies acting on their behalf were not in the patient's best interests.

The difficulty that often arises is that medical advisors at schemes and managed care organisations do not necessarily dictate the care that patients must receive, but they *do* make recommendations on what will or will not be reimbursed by the scheme, which may often be a determining factor in the course of care. Particularly in an area such as oncology, declining to fund a particular prescribed course of action means that an alternative must be sought, as patients can seldom afford to self-fund aspects of their treatment.

Besides the position paper and articles planned, we are examining this practical state of affairs on various fronts – at the Council for Medical Schemes (who should be enforcing the provisions of the MSA), with the HPCSA itself, and through our SAMA Private Practice Committees in meetings with medical schemes and their administrators.

We are very grateful for direct member feedback, and the additional information and awareness this provides us for our projects. Where there are particular issues you would like to bring to our attention regarding the ethics and legalities of the application of managed care at specific schemes, we are very happy to hear more.

Please feel free to contact us in the Knowledge Management and Research, and Governance and Legal, Departments at SAMA, and we can ensure that these issues are driven through the correct channels to be highlighted for our membership, as well as dealt with at a legal and scheme level.

## CPD points in ethics, human rights and medical law

Lisa Reid, CPD accreditation officer, SAMA

As healthcare professionals working in SA, it is appropriate that practitioners should be familiar with the Acts, regulations and guidelines that govern our practice. Furthermore, professionals should have an understanding of the bioethical principles that determine how we perform research and interact with patients and society. Medicine is a constantly advancing field, and with these advances, conflicts often

arise within the arenas of politics, law, religion, philosophy and economics. An understanding of bioethics helps us to recognise, admit to and sometimes resolve these conflicts.

The allocation of specific CPD points to ethics, human rights and medical law is an acknowledgement of how important these issues are to our practice.

It is important, however, that CPD activities on these topics focus on issues of patient care.

Ethics talks, for instance, can cover a wide range of topics, but accreditation is generally awarded to talks concerning the principles of autonomy, beneficence, non-maleficence, justice and human dignity. Medical law activities should focus on the responsibilities of professionals and the rights of patients.

To accredit your ethics presentations, please contact Lisa Reid: [lisar@samedical.org](mailto:lisar@samedical.org).

## Dr Gerald Paris, president and “kingmaker”

SAMA Communications Department

Dr Gerald Paris, a clinical oncologist and senior lecturer at Tygerberg Hospital since 2009, is the new president of the Tygerberg-Boland branch of SAMA.

A lung and CNS tumour specialist, Dr Paris qualified at Groote Schuur Hospital in 1998. He subsequently worked in state hospitals in the Eastern Cape and Gauteng before returning to his roots.

Dr Paris has been involved in management, as well as SAMA and academic activities, for decades, e.g. as past president of SEDASA, and past chairman and president of the Border Coastal branch of the association, during which time he was on the SAMA board of directors. He is also a longstanding member

of ADASA, and served on the Wits University Senate when working there.

A dedicated teacher, Dr Paris has played a major role in registrar training and collaborated on various research projects, which have resulted in presentations in countries such as Spain, Singapore and the USA, in Chicago. He has also attended numerous training programmes and activities abroad. His personal motto is “If I cannot be a king, I can help create them. That will be my pride.”

Dr Paris is an excellent pianist who regularly gives concerts and performances, mostly for charity. He is happily married, lives in Welgemoed and is a keen Rotarian and bridge player.



New Tygerberg-Boland branch president, Dr Gerald Paris (right) with the branch chairman, Dr Wynand Goosen

## Border Coastal honour local doctor

SAMA Communications Department

SAMA Border Coastal branch held its AGM and annual dinner on Friday 11 May at the East London Golf Club. During the evening the branch honoured Dr Zuki Jafta, and nominated her for the Local Hero Award. Dr Jafta heads the oncology unit at Nelson Mandela Academic Hospital in Mthatha, and is recognised by her peers for her passion for bringing services to the uninsured population of the Eastern Cape. She aims to promote early screening, diagnosis and treatment, and is currently involved in establishing a fully fledged oncology service

at the hospital. Jafta says that being able to explain cancer to rural and elderly people in isiXhosa is what allows them to open up to her. “We want people to test early so that they can be treated early. It is sad to have patients only come in when the cancer is already at stage three or four, and not much can be done.”

Branch chairman Dr Mzulungile Nodikida said they were extremely proud of Dr Jafta. “SAMA recognises the wonderful work that Dr Zuki Jafta has done by bringing the oncology services closer to the poorest of the poor in our province,” he said



Dr Jafta with Dr Kim Harper, branch treasurer and past chairman

## Branch news



The Free State branch hosted a "Medical confidentiality and informed consent" ethical presentation at Mediclinic Hoogland on Tuesday 22 May 2018. Left to right: Jaco Verhoef (Sanlam Bethlehem), Elsabe Stofberg (Mediclinic Hoogland Doctor Relationship Manager), Vishen Singh (presenter) and Lizette du Plessis (Free State branch).



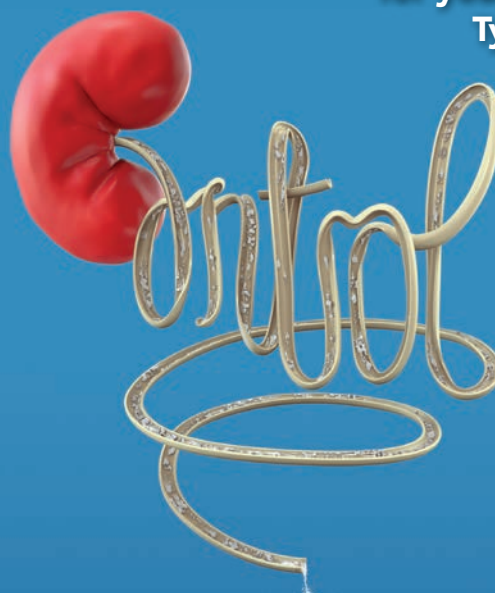
A CPD meeting was held at the Hermanus Provincial Hospital on Friday 11 May. While in Hermanus, branch secretary, Chenienne Gerike, paid a visit to Dr Steyn van Riet, Cape Town branch chairman and president for many years. He is now practising in Vermont.



The KwaZulu-Natal (KZN) Midlands branch recently conducted a membership drive, and visited doctors in Greytown, Dalton and Wartburg. Dr H Steinhagen's friendly staff in Dalton, KZN – on the far right: Mandy Hattingh, branch secretary.

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**References:** 1. Bailey CJ, Gross JL, Pieters A, *et al.* Effect of dapagliflozin in patients with type 2 diabetes who have inadequate glycaemic control with metformin: a randomised, double-blind, placebo-controlled trial. *Lancet* 2010;375:2223-2233. 2. Bailey CJ, Gross JL, Hennicken D, *et al.* Dapagliflozin add-on to metformin in type 2 diabetes inadequately controlled with metformin: a randomized, double-blind, placebo-controlled 102-week trial. *BMC Medicine* 2013;11:43. 3. Sjöström CD, Johansson P, Ptaszynska A, *et al.* Dapagliflozin lowers blood pressure in hypertensive and non-hypertensive patients with type 2 diabetes. *Diab Vasc Dis Res* 2015;12(5):352-358. 4. **FORXIGA**® package insert 2017.

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