

SAMA INSIDER

NOVEMBER 2018

**Cannabis
decriminalised –
what does this mean?**

**SAMA comments on Tower
Psychiatric Hospital report**



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

Taking responsibility?

In this, the penultimate *Insider* for 2018, we grapple with a number of contentious issues.

The recent Constitutional Court (CC) ruling “has only partially decriminalised the use, cultivation and possession of cannabis,” state Shelley McGee and Hanneke Verwey in their article on page 5. “Ultimately, SAMA is very concerned about the CC’s ruling. The implications are far reaching, and we will be spending more time engaging our membership on the multiple issues that are likely to arise as a result.”

Dr Abdul Domingo, a member of the SASOP Special Group on Addictions (page 6) says, “Any change to the legislation regulating cannabis use should have been undertaken in consultation with the relevant stakeholders.”

On page 7, SAMA’s comments on the Tower Psychiatric Hospital report reflect their “deeply troubled” concerns, which include the “pivotal role and importance of whistleblowers”. These concerns are reflected in the chairperson of the Eastern Cape Technical Task Team, Prof. Zuki Zingela’s, article on page 8. “Are we up to the challenge of taking on the towering responsibility of ethical whistleblowing, for the sake of our professional integrity?”

In 2015, then-president of the WMA, President Dr Xavier Deau, said, “Regrettably, there is still widespread evidence of torture being used around the world. Physicians are helping victims, often despite threats to their own life, and the WMA is committed under its Declaration of Hamburg to support physicians facing pressure to become involved in any inhuman procedures.” On page 9, Prof. Ryan Blumenthal discusses how a GP should react when a patient says, “Doctor, I was tortured.”

In her article on page 12, Dr Maria Phalime looks at the role that workplace environment plays in doctor burnout: “We need to acknowledge that burnout is the result of an interplay between individuals and their work environment ... we need to adopt a long-term view that aims to fundamentally change the way that workplaces are organised, medical students are trained and doctors work.”

Widening our consciousness to include “the socioeconomic and political influences on our psyche, and subsequently, our practice,” says Dr Lerato Masenya, can highlight “a largely unexplored blend between the art of creative writing and the science of medicine ... Creative literature might be an antidote to the disease that disconnects the health professional from her patients, the health professional from his colleagues, the health professional from the wider SA community” (page 14). Enjoy the read.

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National SAMA valedictory



Dr Marina Xaba-Mokoena, SAMA president

I am grateful for the opportunity that I have had to serve our community. As I bid farewell as SAMA president, my head reels with topics that I would have liked to leave you with. However, for space and time reasons, I have decided to write about universal healthcare (UHC), a topic that I recently addressed at the Lesotho Medical Association AGM, tackling education, economics and our ageing population.

Our developing countries are in serious leadership crises, and this is less about the quantity of leaders than it is about their quality. We need to mature in our attitude to education – to move beyond seeing it as simply a means to acquiring a job and living a better life, to appreciating education as a culture, shaping our outlook, individually and corporately, and promoting development and progress. Administrators and stakeholders of institutions and corporates ought to put the institutions first, ahead of ego.

Education enables people to not only protect their own health, but to access healthcare when needed. This requires motivated and responsible healthcare workers located close to the populations they serve, and adequate supplies of good-quality essential medicines and technologies for diagnosis and treatment. A well-functioning referral system allowing integrated management and care supports this, as does sufficient funding for prevention and health-promotion services, so that people can enjoy the greatest attainable level of health, to live long, dignified, healthy and productive lives.

They cannot use these services if financial barriers threaten them with financial ruin each time they seek care. People want the assurance that good services are available and affordable.

Other countries have achieved UHC coverage via different paths, and with varying health systems. Nonetheless, the trajectory towards UHC regularly has three common features:

- a political process driven by a variety of social forces to create public programmes or regulations that expand access to care, improve equity and pool financial risks
- growth in incomes, and a concomitant rise in health spending, which buys more health services for more people
- increase in the share of health spending that is pooled rather than paid out-of-pocket by households.

This pooled spreading is mandatory, mobilised as taxes that are channelled through governments that provide subsidies, or in the form of insurance schemes. All people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, and these are of sufficient quality to be effective without exposing the user to financial hardships. No-one is prioritised because of having personal connections.

As it stands, rural communities, indigenous people and other marginalised groups do not have the same access to healthcare that educated urban people do. The reasons for this are complex.

Income is related to health in that it allows people to purchase the things that are necessary to survive and thrive, such as nutritious food and safe shelter. Income also affects health indirectly, through its effect on social participation and the ability to control one's life circumstances. **Poverty** limits people's choices in their social networks, employment opportunities and sense of control over their destinies.

The biggest disease that needs to be cured is poverty. We need to understand what makes people sick, and so address the root cause of illness. This is illustrated by the wise Canadian family physician, Dr Danielle Martin:

"You are standing on the edge of a river. All of a sudden, a flailing, drowning child comes floating by. Without thinking you dive in, grab the child and swim to shore. Before you

can recover, another child comes floating by, so you dive in and rescue her as well. Then another child drifts into sight, and another, and another. Everyone standing on the shore is diving into the water to rescue them. Eventually, some wise person will ask – why do these kids keep falling into the river? And they'll head upstream to find out!"

Decades of studies have demonstrated that, as important as healthcare is, it does not play the primary role in determining whether we are ill or well. Social and economic factors have a much more powerful impact on outcomes. These factors are referred to as the social determinants of health. If addressed, they can have a profound effect on the health of both individuals and communities.

The social determinants of health include income, housing, education, food security, social status, gender and race. They intermingle and interact with each other in many complex ways. Poverty leads to lower educational attainment, and vice versa, which limits people's job prospects, which are also narrowed by racism, which in turn leads to chronic stress and illness – which make it hard to keep a full-time job, which leads to worse poverty. The social determinants of health pile up, making it hard to escape a vicious cycle that inevitably leads to, among other things, poor health.

Of course, deciding whether to fish drowning children out of the water or look upstream to figure out why they keep falling in is a false choice. We need to do both. A strong, equitably designed healthcare system is one of the best ways to mitigate the effects of social inequality. If all we do is pour money into the child-saving brigade, rather than building fences around the river, we are fighting a losing battle. In particular, if we want to address the social determinants of health, we need to put an end to the biggest killer, poverty.

The children of low-income parents are in worse health than the children of higher-income parents. These differences are apparent in lower birth weights, higher rates of asthma and mental health conditions, and poorer vision, hearing, speech and mobility, as well as reflected in higher levels of exposure to toxic chemicals such as second-hand smoke, and rates of accidents and injuries. Even in countries with UHI, poor children are in worse health than richer children, and poor adults in worse health than richer – particularly in

single-parent households struggling to make ends meet.

The third problem worth analysing is the myth that our **ageing population** will drive healthcare costs through the roof. But this population will not bankrupt the health system – at least, not simply by ageing. It is true that we use more healthcare services as we age, but we are not facing a grey tsunami, but rather a very slow-moving grey glacier. The real challenge of an ageing population is not the number of people, but the increasing numbers of tests and treatments that we administer to them, without improving their health.

The biggest rise in health costs over the last decade has come not from ageing, but from increased use of hospitals, drugs and doctors. All age groups are using more healthcare services than did their equivalents 20 years ago. This includes more frequent and intensive treatment, even for healthy people over the age of 65, rather than those with chronic illnesses. Most of these costs are initiated by doctors like you and me. We are the ones who tell Mrs So-and-so to come back for a follow-up in a month, or send her for an X-ray, CT or MRI scan, and prescribe medication. Costs are going up not because

Mrs X is old or even sick, but because we are providing more healthcare to her, and to her daughter and granddaughter too. We will not do justice if we do not change the way that we deliver health services. The population will be living longer with chronic health conditions such as diabetes, hypertension, heart failure, lung diseases and HIV. These afflictions can dramatically reduce people's quality of life if they are not well managed in the community and at home, and if people bounce in and out of hospital and emergency departments for every exacerbation of a chronic illness, they will not enjoy their old age.

If, on the other hand, we can build a more robust and accessible system of home and community care, along with excellent primary care, to support older people with chronic illness, we can welcome the demographic shift. The way that we approach healthcare reform must, therefore, create new opportunities to treat patients with chronic diseases, including seniors, outside of hospital. Otherwise, it will be hard to know whether our healthcare system is giving us good value for money, because measuring the quality of a healthcare system is a complicated task. This also applies to patients with incurable conditions.

The risks of “screening tests” can cause more harm than good. We need to stop thinking only about the potential benefits of medical tests and interventions, and start talking about their potential harms, even to the healthy and young. Yes, expensive technology, early diagnosis and aggressive treatment can save lives – but only when properly applied. When misapplied, they can cause suffering and death. Often the best thing we can do for our patients is to listen – and based on their history and our physical exam, figure out the most likely diagnosis. This is sometimes misconstrued by both doctor and patient as “doing nothing”. In fact, both physician and patient are doing something – but that something isn't unnecessary tests and treatments or interventions. Factors that have contributed to the rise of over-testing and overtreatment include the redefinition of disease, the leverage of corporations, the culture of medicine, the fear of litigation, the way we train our doctors and the influence of patient expectations, to name a few. There is evidence that overexposure to tests, treatments and interventions can do more harm than good; sometimes our patients would be better off without our “help”.

The Constitutional Court has decriminalised cannabis for personal use – what does this mean?

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

The Constitutional Court (CC) recently confirmed a High Court ruling that several sections of the Drugs and Drug Trafficking Act No. 140 of 1992 and Medicines and Related Substances Control Act No. 101 of 1965 are inconsistent with the section 14 right to privacy entrenched in the Constitution, and therefore invalid to the extent that they make the use, cultivation or possession of cannabis in private by an adult person for personal consumption a criminal offence. The operation of the order of invalidity has been suspended in order to allow the Legislature 24 months to amend the legislation in order to rectify the constitutional defects. In the interim, certain provisions will be read into the legislation, thus effectively giving the judgement immediate effect.

Legal implications

The judgment has only partially decriminalised the use, cultivation and possession of cannabis. The order does not apply to persons under the age of 18. Furthermore, the order is limited to personal use in a private space. It is also still a criminal offence to purchase or sell cannabis. The CC noted that a purchaser of cannabis would typically be purchasing it from a dealer. If the CC were to declare invalid the provisions that prohibit the purchase of cannabis, it would, in effect, be sanctioning dealing in cannabis. The CC was not willing to go that far.

The judgment has created a number of legal uncertainties that will have to be addressed by the Legislature and potentially tested in court pending the finalisation and

amendment of the legislation. The CC did not define “personal use”. The police will therefore have a discretion in determining the quantity of cannabis that an adult person may use, possess or cultivate for purposes of “personal use”, as opposed to “dealing” in cannabis. The quantity of cannabis found in a suspect's possession will likely be determinative in this regard. The CC also chose not to define “private space”. It is unclear how authorities will define “private space” over the course of the next 24 months, although the CC held that the right to privacy extends beyond the home or one's private dwelling. As the purchase and sale of cannabis remains illegal, it is unclear how individuals will actually obtain cannabis, including seeds, for its use, cultivation or possession.

Concerns for the medical profession and public health

The CC judgement in no way detracts from the potential clinical and public health impacts of cannabis use. Although SAMA has supported further research into potential medical uses of cannabis, we have not supported the initiatives to legalise or decriminalise cannabis for recreational use. Evidence as to whether recreational use of cannabis has increased in other countries where it has been legalised for this purpose, is still limited. However, it stands to reason that the court ruling could result in a more positive perception of cannabis, including the assumption that cannabis use is safe.

Unfortunately, recreational cannabis use is associated with harms and can lead to severe health consequences, particularly in the long term. It must be conceded, however, that a good deal of evidence of both positive and negative impacts remains relatively weak.

Recreationally, cannabis is sought after for its tetrahydrocannabinol (THC) content, and the plants have been selectively bred over the years to increase the THC content. While the cannabis plant contains over 100 cannabinoid compounds, THC is the principle psychoactive compound.

It would be naive to claim that recreational cannabis use was not widespread in SA, even before the court ruling. SA does not have up-to-date and reliable statistics on substance abuse, but data on admissions to substance-abuse related treatment centres in SA from 2008 to 2010 suggested that the use and abuse of cannabis was common. Anything from 11.2% (in the Western Cape) to 50% (Mpumalanga/Limpopo) of people who were admitted to treatment centres in

the period, cited cannabis as their primary substance of abuse.

The SA Community Epidemiology Network on Drug Use reports that during the second half of 2016, cannabis was the most common primary substance of abuse for persons younger than 20 years presenting to treatment facilities in all areas across SA, except for the Free State, Northern Cape and North West provinces. It is estimated that 1 in 6 teenagers who experiment with cannabis will become addicted to it.

The interest in cannabis for potential medicinal uses has resulted in a number of recently published reviews of the positive and negative potential for the plant. A 2016 report by the WHO examined the short- and long-term impacts of recreational use of cannabis.

The most obvious short-term health effect of cannabis is intoxication, marked by disturbances in the level of consciousness, cognition, perception, affect or behaviour, and other psychophysiological functions and responses. Cannabis acutely impairs several components of cognitive function, with the most robust effects on short-term episodic and working memory, planning and decision-making, response speed, accuracy and latency. Some studies also report increased risk-taking and impulsivity. Recent cannabis smoking is associated with substantial driving impairment, particularly in occasional smokers, and cannabis users who drive while intoxicated double their risk of a car crash. In a country already battling against the negative impacts of alcohol use in road accidents, this could be particularly problematic. There is no roadside test for cannabis intoxication.

Recent epidemiological studies of cannabis use and general injury risk have produced mixed findings, and more research is necessary to establish if any increased risks exist.

In the long term, evidence points to a modest contributory causal role for cannabis in schizophrenia, and a consistent dose-response relationship between cannabis use in adolescence and the risk of developing psychotic symptoms or schizophrenia.

Longitudinal studies in other countries have also shown that early initiation of heavy cannabis use is associated with lower income, lower college-degree completion, a greater need for economic assistance, unemployment and use of other drugs. Case-control studies have consistently found deficits in verbal learning, memory and attention in regular cannabis users. These deficits have usually been correlated with the duration and frequency of cannabis use, the age of initiation and the estimated cumulative dose of THC. It remains unclear whether cognitive function fully recovers after cessation of cannabis use, with studies producing conflicting results.

There is no conclusive evidence that cannabis use alone is responsible for higher population rates of chronic lung diseases, cardiovascular disease and cancers. In most reported studies, cannabis-only smokers have been more likely to have reported cough, sputum and wheezing, but no more likely to report shortness of breath, than controls who do not smoke cannabis. A common finding in video bronchoscopy studies in cannabis-only smokers is swelling and oedema that block and partially occlude the bronchi. This is consistent with a modest increase in airway resistance that is of unclear clinical

SASOP – legalising cannabis

In response to the recent legalisation of cannabis for personal use, the SA Society of Psychiatrists (SASOP) notes with concern the growing public perception of cannabis as a “harmless” plant, and the fact that few measures have been instituted to address this.

According to Dr Abdul Kader Domingo, member of the SASOP Special Group on Addictions, any change to the legislation regulating cannabis use should have been undertaken in consultation with all the relevant stakeholders, be based on good quality

scientific evidence and take into consideration the availability and accessibility of current drug addiction prevention and treatment resources in SA.

“SASOP concurs with the executive committee of the Central Drug Authority (CDA) of SA that the approaches to combat the use and abuse of psychoactive substances should include harm reduction (interventions aimed at reducing the harmful consequences associated with substance use), supply reduction and demand reduction/preventative strategies.

“We agree with the Executive Committee of the CDA that there is currently insufficient evidence to predict the long-term consequences of the legalisation of cannabis.

“The ease of accessing an intoxicating substance may have an underestimated impact on the initiation, frequency and amount of use, and the subsequent risk of developing a substance use disorder. Legalisation should therefore not have been considered at this point.”

He concludes that “SASOP commends the Medical Control Council’s decision to limit the use of cannabis for medicinal purposes to registered prescribers, and for individuals in which an acceptable justification is provided.

“We support ongoing research on the use of cannabis for medicinal purposes, to ensure that its purported and potential benefits can be scientifically measured against medical and societal risks.”

significance. The WHO has recommended further research be conducted in all of these non-communicable disease areas.

Currently, very little is known about interactions resulting from the concurrent use of cannabis and pharmaceuticals, and most existing information comes only from case reports. Concerns exist regarding contraindications in which cannabis use may interfere with the mechanisms of other medicines, either by dampening or facilitating their effects.

Concerns for employers and labour law

The judgment will have far-reaching implications for several areas of the law, including labour law. The use of cannabis in the workplace will no doubt still be illegal to the

extent that it does not qualify as “private” use. Disciplinary codes and workplace policies will, however, have to be put in place in order to deal with the effects of personal cannabis use, especially with regard to issues such as the operation of motor vehicles or heavy machinery, decreased work performance, attendance, the definition of impairment, drug-testing protocols and disciplinary procedures.

Difficulties may arise in proving that an employee is under the influence, or, more importantly, impaired. Cannabis remains in one’s system for a number of days, long after the intoxicating effects have worn off. A drug test, in the absence of further evidence, such as obvious impairment, would likely be insufficient evidence of intoxication. As far as impairment is

concerned, cannabis also differs from alcohol as there is no current consensus on safe limits for consuming cannabis, nor are the effects of cannabis on one’s ability to safely and efficiently perform work duties as clear. A zero-tolerance policy in respect of private use outside the workplace would likely be problematic, as it might result in discrimination against employees who use cannabis to treat or relieve the symptoms of a medical impairment, which an employer is also obligated to reasonably accommodate.

Ultimately, SAMA is very concerned about the CC’s ruling. The implications are far reaching, and we will be spending more time engaging our membership on the multiple issues that are likely to arise as a result.

References are available on request.

SAMA: Tower Psychiatric Hospital report

SAMA Communications Department

SAMA has now had the opportunity to reflect on the report on patient mismanagement and patient rights violations at the Tower Psychiatric Hospital by the Office of Health Standards Compliance and its accompanying media statement, issued by the health ombud, in respect of the above. In this regard, the matter was fully discussed at the most recent meeting of SAMA’s Human Rights, Law and Ethics Unit.

SAMA is grateful to the health ombud, to the extent that the report provides a comprehensive account of the systemic problems and poor-quality service delivery for mental healthcare users in the Eastern Cape Province (EC), in particular at Tower Psychiatric Hospital. SAMA furthermore supports several of the recommendations contained in the report, including that regarding the appointment of an administrator with respect to mental health services in the EC Department of Health (ECDoH).

SAMA is, however, deeply troubled by the fact that the report, in SAMA’s considered view, places undue emphasis on the allegedly unethical conduct of the complainant, Dr Kiran Sukeri. Although SAMA agrees that it is unethical to release confidential patient information, including information relating to deceased patients, to the media without

the necessary consent, SAMA is of the view that the allegedly unethical conduct on the part of the complainant in reporting the matter to the media is an ancillary issue. It should not have formed the focus of the ombud’s report. Having regard to the fact that Dr Sukeri’s report, by the ombud’s own admission, “was just the needed lightning rod, and representative of broader systemic and prolonged poor-quality service delivery for mental healthcare users in the EC”, SAMA is furthermore of the view that the ombud was unnecessarily critical of Dr Sukeri insofar as it relates to discrepancies in the patient death toll, as initially reported by Dr Sukeri.

In its attempt to discredit and ostensibly to humiliate Dr Sukeri, the health ombud has done a disservice to both Dr Sukeri and the healthcare profession as a whole. Healthcare practitioners have an ethical duty to act as advocates for their patients, which encompasses the duty to expose injustice and human rights violations committed against patients. In this regard, SAMA calls into question the ombud’s conclusion that the issues highlighted by Dr Sukeri primarily related to “chronic systemic failures and neglect of the ECDoH on mental healthcare services with pernicious systemic effects, and the power struggles for change”, as opposed to

true human rights violations. Chronic system failures may very well lead to unacceptably poor patient care, which will result in the violation of patients’ human dignity and right of access to healthcare, thereby constituting a violation of patients’ human rights.

SAMA is furthermore troubled by the fact that the report of the health ombud, in its treatment of Dr Sukeri, has created a climate where other healthcare professionals may be dissuaded from coming forward in similar circumstances in the future. The pivotal role and importance of whistleblowers, in a democratic society that is based on the values of human dignity, equality and freedom, cannot be overemphasised. It takes enormous courage to be a whistleblower, and to stand up against injustices and human rights abuses. It is for this reason that the Protected Disclosures Act No. 26 of 2000 provides whistleblowers with wide protection, to which Dr Sukeri is also entitled.

SAMA extends its support to Dr Sukeri and all healthcare practitioners who raise their voices in good faith to protect the most vulnerable members in our society from abuse and neglect. SAMA confirms its commitment to achieving a climate where healthcare practitioners do not need to fear that their advocacy will be used against them.

The towering responsibility of whistleblowing: Are we up to it?

Prof. Zuki Zingela, *chairperson, Eastern Cape Technical Task Team*

In February 2018, the medical fraternity was galvanised into determined action to advocate against human rights violations reported to be taking place in our midst. Tower Hospital, tasked with providing care for people living with mental illness, was fingered as culpable in the maltreatment of our most vulnerable.

Fast forward to late August, when the health ombud released the report on the Tower Hospital allegations. The contents of the report were far from anything most expected. Instead of the predictable tale of good and evil, the report has left an impression of devils with halos and angels with horns. The unexpected discordant note has been introduced by questions raised regarding the whistleblower's own conduct.

More questions than answers

Whistleblowing is the act of telling the public and authorities about something immoral, unethical or illegal that the organisation you work for is doing. What is the duty of the whistleblower with regard to holding up ethical principles while raising the alarm about health system failures? If the whistleblower's actions are dubious, does the medical profession turn a blind eye to this for the sake of exposing these failures? Will potential whistleblowers remain forever silent after the Tower Hospital report? Has the report gone far enough in exposing health system failures that have led to the neglect of those living with mental illness by the Eastern Cape Department of Health (ECDoH)?

The dilemma in the Tower Hospital case is captured by Bolsin, Faunce and Oakley (2005), who describe healthcare whistleblowing – where the complaints are reasonable, made in good faith, in the public interest and not vexatious – as an obligation of professional conscience, which forms the basis for virtue-based medical ethics. Ray (2006), who looks at organisational ethics in the context of external whistleblowing after all internal whistleblowing through the hierarchy of the organisation has failed, argues that an organisation that does not support whistleblowers because of perceived violation of professional standards is indicative of a failure of organisational ethics. The description

of the Tower Hospital complaint in the health ombud's report as a “coy complaint which was primarily about chronic systemic failures and neglect of the ECDoH and the power struggles for change” asks us to consider whether the complaint was “reasonable, made in good faith, in the public interest and non-vexatious”. The implication is that in this instance, there was a power struggle at play, which influenced the actions of the whistleblower, actions which in themselves are described as flawed. Several of the whistleblower's missteps are described, ranging from violation of patient confidentiality to misquoting of death statistics and “falsification of data”. The report does, however, also say: “This does not detract from nor diminish the importance and uniqueness of the whistleblower's complaint.”

“My name may be Tower Hospital but my surname and *isiduko* (clan name) is the ECDoH.” It is clear from the subtitle that significant and severe system failures in the ECDoH resulted in the neglect of people with mental illness. The Minister of Health has been tasked with appointing an administrator to address these failures, because the correction required “cannot be done from and with the current staff.”

“The major stumbling block to effective mental health service delivery can be located from the level of the Chief Director: Health Services downwards at the ECDoH.”

These statements must prompt us, as the medical fraternity, to ask the following questions:

- Since the release of the report, have there been any actions taken against all ECDoH staff who failed, through action or inaction, in their duty of care towards patients with mental illness? Genuine consequence management demands an honest and open examination of the failures in mental healthcare service delivery in the province, and a rooting out of all inept officials who are responsible. The report provides names or positions of those who must be held to account.
- Is the public health sector in SA an intolerant environment when it comes to whistleblowing in general?
- Has the medical fraternity risen to the challenge of scrutinising the ethical aspects of actions taken by one of our own in the process of drawing justified

attention to health system failures within the ECDoH?

- What is our responsibility as doctors when faced with failing health systems that pose a risk to patients? How do we address this while safeguarding professional ethical boundaries?

Guidance towards ethical whistleblowing

In every organisation, there are internal systems that employees may follow to address system failures. It is the employer's obligation to ensure that new employees are inducted into these systems when they first join the organisation. This does not happen automatically in the SA public health system. Line management and hierarchical responsibilities within the organisation must be outlined clearly for all employees, including within the National DoH. When junior doctors join, it is imperative that they request such pertinent information through their representatives, if it is not provided automatically. When confronted with system failures that pose a risk to patients, then the first step is to alert your line manager, ideally in writing. Should this fail, then getting the support of colleagues within the organisation is also advisable. A unified approach may have better success than a lone ranger. The issue may be escalated through line management structures, documenting each step taken and response received. Doctors' associations such as SAMA or the SA Society of Psychiatrists (for mental health issues) may also be approached. There are also formal processes built into the country's constitution and laws. These include oversight bodies such as the health ombud's office and the health portfolio committees at provincial and national level.

Conclusion

The fault lines identified by the health ombud's report in the Tower Hospital complaint represent an opportunity to provide guidance to doctors, who are continually grappling with how to deal with failing health systems and the risks posed to patient care. Are we up to the challenge of taking on the towering responsibility of ethical whistleblowing, for the sake of our professional integrity?

References are available on request.

The torture victim and the GP

Prof. Ryan Blumenthal, *associate professor/senior specialist forensic pathologist, Department of Forensic Medicine, University of Pretoria*

"Doctor, I was tortured." What does one do in these circumstances, and what is considered the reasonable approach to such a claim? This article will consider an approach to the situation.

A forensic investigative approach is considered in respect of the situation where presented with limited scientific evidence of possible abuse, or where such abuse may be suspected from evidence or information, or may need to be considered and investigated.

How does this evidence typically manifest? I will briefly introduce some of the underlying basic definitions, and standard operating procedures for the GP.

A workshop on the application of forensic skills to the detection and documentation of human rights violations took place in Durban, SA, from 3 to 5 July 1998. This topic has not been thoroughly addressed in SA since then. Human rights monitors have documented, over many years, the inadequacy and inconsistency of medicolegal investigations of suspected human rights violations. Concerned professionals have made clear the need for the strengthening of both technical skills and ethical awareness among medical practitioners involved in the investigation of suspected torture cases.

Questions and challenges posed

There are many legal questions and challenges posed with regard to the claim of possible torture or abuse. There are also many constraints and challenges from the medical and/or evidence perspective.

Definition of torture

Torture is conceived by many as a weapon used to extract confessions and/or information. Sometimes torture may be used to destroy a political opponent or enemy. Torturers may use innovative methods. Human rights violations do not only take place in the context of war; sometimes they occur in times of peace, as authorities can violate the rights of citizens. Violations may happen in both democracies and dictatorships. The treatment and rehabilitation of torture victims are not described here, as this would be within the domain of other specialities. What will be discussed here are some of the medico-legal perspectives, and the role of the GP in such cases.

According to the Declaration of Tokyo (Japan 1975), "For the purpose of the Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason."

Torture methods

It must be emphasised that the full list of torture methods is extensive. It must further be stressed that the GP only rarely has the opportunity to examine a victim of torture shortly after it has been meted out. Usually, survivors are examined weeks, months or years after the torture, when the lesions have healed.

It is suggested that the medical examiner research the political background of, and the most common torture methods in, the area and other relevant facts, before the examination.

Important legislation

- Article 3 of the European Convention on Human Rights
- The Istanbul Protocol (1999)
- The Minnesota Protocol (2017)
- The Tokyo Declaration adopted by the World Medical Association (1975)
- Resolution 37/194 of the General Assembly of the United Nations (1982).

These documents represent essential reading, especially if one is dealing with alleged torture cases.

There are many methods of torture and/or other cruel treatment: beating and kicking; being forced to watch or listen to the torture of loved ones; burning; dental torture; electrical torture; exposure to bright light; extreme sensory deprivation; falanga; forced feeding (for example, of excrement); genital or anal trauma; isolation; mock execution; mutilation; pharmacological torture; prolonged forced standing; sexual humiliation/violation; showers with icy cold water or hot oil; sleep deprivation; starvation/dehydration; submarino – wet (immersion of head in dirty water) or dry (placing of plastic bag over head); suspension by wrists, ankles or knees; telefono (simultaneous beating of ears with flat hands); threats to family.

The medical examination of alleged torture victims

When presented with such a claim, what is the best approach for the medical practitioner? GPs may be asked to assess individuals claiming torture or human rights abuse. Such assessments may be complex, and it may be necessary to assess and interpret physical findings for which there may be a number of explanations. The doctor's role is to assess these findings impartially.

In order to make an assessment for physical evidence of torture, a structured examination must take place, which involves the history, the medical history and then the physical examination. First and foremost, all acute and/or life-threatening injuries must be treated.

The physical examination must involve a thorough examination. The history-taking should include direct quotes from the victim, establishing a chronology, and where possible backing it up, for example, with old medical records and photos.

Attention should also be paid to the psychological status of the victim, and this may require specialist assessment.

Sometimes the victim is an asylum seeker, for whom the granting of asylum may depend on the medical confirmation of torture. Prejudice should never be expressed against a government, a politician or a group of people, as this will compromise the independence of the examiner.

It is important to recognise that there may be no physical evidence of torture. Usually, there is testimonial evidence and/or allegations. One cannot leap to conclusions in these cases.

Steps to be taken

- Enlist the help of an interpreter, if necessary.
- Consent for examination must be obtained.
- Thoroughly complete the J88 form, a typed report creates a better impression.
- Take all such claims seriously.
- It is important to treat all information with scientific scepticism. There is a difference between bias and a well-informed scientific approach.
- Teamwork is often necessary, and a multi-disciplinary approach may be advised.
- Human rights associations, such as Amnesty International, may also wish to be present, to collect evidence for the purposes of documentation.

- Physical lesions may have healed, but the mental scars may remain.
- Document the “pre-torture state of health” of the victim.
- Many victims do not reveal their story right away, and may only disclose portions of it (these patients need sympathetic listening and questioning).
- A thorough physical examination needs to be performed. The entire skin surface and all body orifices must be examined. All scars must be measured and described in detail.
- Photographs and diagrams are essential. Victims may be referred to other specialists for more detailed examinations (rheumatologists, dermatologists, orthopaedic surgeons, cardiologists and psychiatrists).
- Complications may need to be referred, such as peptic ulcers, a deformity of a leg, etc.
- The main purpose is documentation. The non-forensic expert must be as objective as the forensic expert.
- Women from some countries and religions will need to be examined by a female, and this request must be respected. This may also happen with men who refuse to be examined by women.
- Mental symptoms such as post-traumatic stress disorder, flashbacks, and avoidance may be present. Look out for sleep disturbance, depression, fear, irritability, aggressiveness, sexual problems and suicide ideation.

A formal psychological and psychiatric consultation may be required.

- Where scars or marks are present, it is important for the credibility of the examination to distinguish between alleged torture scars and injuries and non-torture scars and injuries.
- Skin surfaces must be carefully examined, because the lesions are not often easily discernible.
- Special investigations may need to be carried out.
- X-rays/CT scans/MRIs may be needed.
- The decision to biopsy recent lesions to prove their origin is controversial, although probably advisable.
- Lactate dehydrogenase, creatine kinase, neuron-specific enolase, cardiac markers and muscle markers may be drawn, should there be an indication.
- Other blood tests as indicated.
- Security of information must be ensured.

Consult with other experts as appropriate. Remember your role in briefly four points:

- Observe all findings, and overlook nothing.
- Preserve all information in written and photographic records.
- Maintain the chain of evidence, accounting for the whereabouts and security of all relevant materials.
- Provide a professional, objective, typed report without prejudice, advocacy or theory.

Interpretation of scars or marks

Do your findings correspond with the version of the victim? You cannot give your own opinion unless it is specifically asked from you.

Finally, if asked for your opinion, try to answer using one of the following five descriptions:

- Not consistent: The lesion could not have been caused by the trauma described.
- Consistent with: The lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes.
- Highly consistent: The lesion could have been caused by the trauma described, and there are few other possible causes.
- Typical of: This is an appearance that is usually found with this type of trauma.
- Diagnostic of: This appearance could not have been caused in any way other than that described.

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References are available on request (Ryan. Blumenthal@up.ac.za).

Is a wheelchair just a wheelchair?

Megan Giljam, occupational therapist, Shonaquip

A wheelchair is just a wheelchair, right? A seat on wheels, to get from A to B. Well, not exactly. According to the WHO, it's not quite this simple. The *Guidelines on the Provision of Manual Wheelchairs*, developed by the WHO in 2008, specify that a wheelchair needs to be not only well suited to both the person's physical and functional needs, but also their environment. It also needs to fit them properly, and provide comfort and support.

Now how do we go about this? Just as much as I wear different shape and size shoes from yours (and I always prefer to wear flat shoes, due to the physical nature of my work) how can we possibly know which type,

size and features of a wheelchair would be suitable to an individual? A person who uses a wheelchair and lives in rural KwaZulu-Natal needs a very different wheelchair and support package from a wheelchair user who works in an office in Gauteng. Luckily, the WHO guidelines can help us out here too. They have specified eight essential steps that every wheelchair service provider should follow to make sure that the wheelchairs ordered or made are well suited to the person who will be using it. These eight steps take you all the way from the beginning of the process, when you meet the person (referral), through the individual assessment and measurement,

choosing the correct device in partnership with the user, ordering that device and preparing it when it does arrive at your service. Once the device is ready, the user will come in to collect the device, and have it fitted to their body. They should also receive training on how to use the device, how to care for it and where to go when they need help. The last step is follow-up, which is extremely important – just as with servicing your car, a wheelchair lasts much longer when it is well looked after and maintained.

So that's the theory, and the international documents that we use as advocacy tools to start conversations around how not just any

wheelchair is good enough. But what does this mean for the people who are using the wheelchairs? What does it mean for them, to have the appropriate wheelchair? Having the appropriate wheelchair could be the difference between going to school and staying home. It could be the difference between getting a job or staying home and receiving a grant. For children with more severe disabilities, the appropriate wheelchair can not only prevent them from developing life-threatening secondary complications, but it also positions them with such a good upright posture that they are better able to make eye contact, breathe, communicate, eat their food and use their hands for play or school activities.

The little boy in the photograph lives in a rural area of Southern Africa. He is looked after by his loving granny, who does her best to include him in all of their family and community activities, but his body is very floppy and he can't hold his head up on his own. So he rests his head on granny's

shoulder and looks at the world at an angle. It means that he spent most of his time inside the house, lying on a bed.

WHO guidelines ... have specified eight essential steps

He received an appropriate wheelchair after a thorough assessment, and not only does this wheelchair provide him with the full-body support he needs to sit upright with good posture, but it will also ensure that as he grows, he will continue to grow straight, preventing him from developing life-threatening secondary complications. Now, when granny is working in the yard, cooking, or washing clothes, he can sit in his buggy and join her, and be included in family and community life.

The provision of an appropriate wheelchair has given this young boy the opportunity to



live to his full potential and be as independent as he needs to be, and ensures that he does not develop any future complications as he grows. A little bit more than getting from A to B, I hope you would agree?

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Doctor burnout: Resilience training isn't enough

Dr Maria Phalime, author of the award-winning memoir, *Postmortem – The Doctor Who Walked Away*

In a recent two-part article series published in *The Daily Maverick* titled “The canary and the coal mine – The state of public health”, the SA Medical Research Council’s Glenda Gray, Debbie Bradshaw and Leonard Gentle use the metaphor of the canary in the coal mine to highlight the dire state of public health in SA, and its relationship to the overall wellbeing of the nation.

In the early days of coal mining in Britain, miners would take caged canaries with them down the mine shaft. The yellow songbirds were more susceptible than the miners to the effects of noxious gases such as methane and carbon monoxide, and therefore served as an early warning system for the miners. When the birds stopped singing, the miners knew to quickly evacuate to safety above ground.

In their article, the authors liken the state of SA’s health to the canary. “Today the canary giving us advance warning of a serious crisis if we do not respond appropriately, is the state of SA’s health – both the social determinants of health, and the state of healthcare.” They further assert that the state of the nation’s health “is a direct measure of our existence, and frames whatever political and economic choices we may make. And yet current policies and economic orthodoxy are taking us in the opposite direction to that required to address what the reports are signalling.”

I borrow this metaphor to illustrate the relationship between doctor burnout and the healthcare system. If the state of SA’s health is a warning sign of a national crisis, doctor burnout is a warning sign of a healthcare system in crisis.

By now, many of us are aware of the scourge of burnout in the medical profession. Recent studies have shown a high prevalence of burnout among doctors in both rural and urban settings, and articles in the mainstream media have helped to draw attention to the challenges many face in our beleaguered system.

However, when we talk about burnout, the focus is often only on the syndrome, as described by Prof. Emerita at the University of California at Berkeley, Christina Maslach, and her colleagues, and characterises burnout as a syndrome consisting of the three dimensions of emotional exhaustion (“I’ve got nothing left to give”), depersonalisation (“I don’t care

anymore”) and low sense of accomplishment (“What difference does it make?”).

While this characterisation describes how burnout manifests in individuals, it only provides a partial understanding of what burnout is.

Burnout doesn’t happen in a vacuum; it happens in workplaces that predispose doctors to burning out. Therefore, a fuller understanding of burnout must necessarily include the workplace environment in which burnout develops and festers.

In addition to their work on defining workplace burnout, Prof. Maslach and her colleagues have also conducted extensive research into the workplace factors that drive and perpetuate it. They have identified what they term the six areas of work life that are most associated with burnout:

- **Workload.** In medicine, this factor is a given. It relates not only to the volume of work, but also the intensity. This area of work life is particularly important in the development of burnout. When job demands exceed human limits, emotional exhaustion begins to set in, and triggers the other manifestations of burnout.
- **Control.** Perceived control is an important predictor of wellbeing. To what extent do you feel you have control over where, when and how you work? Do you have the resources available to be effective in your work? And to what extent are you equipped to fulfil the level of responsibility you are given, and to make the kinds of decisions that you are required to make? A sense of control can act as a buffer against workload demands. However, if the workload is excessive and there is a low sense of control over it, burnout is a likely consequence.
- **Reward.** Reward doesn’t only have to do with financial reward, though this can be an important factor when one’s expectations aren’t met. More significant than financial reward is acknowledgement and recognition of one’s contribution, particularly from more senior doctors. This recognition has a reinforcing effect on behaviour, and if it doesn’t happen, there is a sense of being out of sync with the values of the institution, which negatively impacts work engagement and performance. Reward also refers to

intrinsic reward – the inner sense that what one is doing is meaningful.

- **Community.** As humans we are social beings, and the quality of our social interactions at work is important. What contributes to burnout in this area is low levels of support, toxic work relationships and poor teamwork dynamics. It’s not only toxic relationships that are a problem. Even when we have good connections and positive relationships at work, the reality of rotating between different hospitals or working in remote locations may make it difficult to nurture these relationships, leading to feelings of isolation. Work also often affects our non-work relationships; being away from loved ones and our support network takes away a valuable support mechanism in times of strain.
- **Fairness.** How are decisions made in your place of work? Are policies and decision-making processes clear and equitable? To what extent do personalities play a role? When errors occur, are they dealt with openly and constructively, so that they become opportunities for learning and improvement, or are they dealt with from a position of blame and shaming? All of these factors contribute to the extent to which people feel that they are treated fairly at work.
- **Values.** When people feel that there is a mismatch between their values and the values of their organisation, engagement suffers. Also, when the organisation says “We care about you,” but what actually occurs on a daily basis communicates the exact opposite, people become less engaged, and job performance is affected.

These areas of work life are important contributors to burnout. Whenever there is a mismatch between people and their work environment, their energy, engagement and effectiveness are lowered, which correlates to the burnout dimensions of emotional exhaustion, depersonalisation and low sense of accomplishment.

Resilience training is often proposed as a solution for doctor burnout. It’s understandable why this is the case, given the way our medical training teaches us to approach wellbeing issues. Through the process of history taking,

clinical examination and special investigations, we arrive at diagnoses which inform the kinds of treatment we prescribe to alleviate symptoms and restore health.

Resilience training attempts to address doctor burnout in the same way – as a “disease entity” for which a definitive treatment can be prescribed.

This approach is problematic for a number of reasons:

- It focuses purely on the individual, and ignores the workplace context in which burnout occurs.
- It implies personal failing or weakness which must be “fixed” by toughening doctors up for the job. In this way, the approach contributes to the stigma associated with burnout.
- Resilience training also sends the wrong message – that employers bear no responsibility for addressing the drivers of burnout in the workplace; instead, doctors

need to be equipped to better cope with that environment.

- Doctors are already resilient; it takes a lot to withstand the rigours of medical training, the long working hours and the often harsh conditions in which doctors work. They don’t need to be toughened up any further.

Resilience training effectively says that doctors need to be “tougher canaries” in order to survive the mines of our healthcare system, which countless reports have shown to be toxic. It doesn’t take much to see that this approach does little to address the wellbeing of the hardworking professionals who are at the coalface of patient care.

We need to acknowledge that burnout is the result of an interplay between individuals and their work environments; it is an ever-present risk of working in the high-pressure, high-stakes environments that characterise

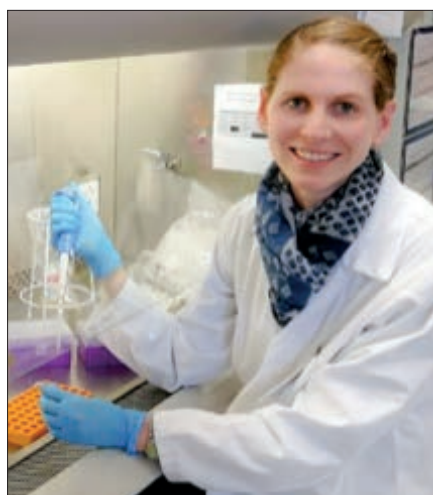
the practice of medicine. Therefore, if we are going to deal with it effectively, our approach needs to be:

- to reduce the risk, by addressing the drivers of burnout in the workplace,
- **and** to promote a culture of wellbeing, in order to enhance the capacity of individuals to perform effectively in these high-pressure environments.

There are no quick fixes. We need to adopt a long-term view that aims to fundamentally change the ways that workplaces are organised, medical students are trained and doctors work, and to create a culture that recognises the critical role that doctor wellbeing plays in patient wellbeing. For this to happen, leadership is key, both in terms of a commitment to a fundamental change in the way things are done, as well as in driving interventions forward.

SAMA scholarship helps to answer questions

Dr Kate McMullen



The Division of Neurology at Groote Schuur Hospital has long maintained a special research interest in young stroke in HIV, with particular focus on the role of HIV itself as an independent risk factor for stroke.

As a medical officer at Groote Schuur Hospital in 2016, I had already completed my Diploma in HIV Management, and knew I wanted to specialise in neurology. However, I decided that I wanted to embark upon a year of full-time research before furthering my clinical training. Prof. Alan Bryer, head

of the Division of Neurology, and principal investigator of a study into HIV infection and stroke, offered me the opportunity of doing a Master of Science (MSc) that encompassed both of my special interests in HIV and neurology.

While a registrar training post also requires the completion of an MMed, to ensure that all SA-trained specialists have some research experience, I felt that doing an MSc would give me a greater depth of training in critical thinking and appraisal, scientific methods and scientific writing and independent thinking. I therefore took the decision to resign from my post to do the degree full-time, with the aim of completing the master’s degree by dissertation in a period of 18 months, before re-entering clinical medicine.

Taking the plunge into full-time research after being a salaried clinician was daunting, but I was fortunate enough to receive funding to support this project from the SAMA Research Masters Supplementary Scholarship, the Discovery Foundation Academic Fellowship Award and the Division of Neurology Research Fund.

Stroke and HIV are both important contributors to the disease burden and mortality in SA. Even in the current antiretroviral era,

people with HIV have a higher risk of stroke than the general population. The current hypothesis is that this increased risk is due to HIV-related endothelial dysfunction, as well as comorbid cardiovascular risk factors. However, HIV is now recognised as an independent stroke risk factor. Although endothelial dysfunction in HIV is multifactorial, recent research has focused on viral protein toxicity. Secretion of viral proteins may be unaffected by antiretroviral therapy, and thus contribute to ongoing endothelial damage, even in effectively treated individuals. The transactivator of transcription (Tat) protein and the viral protein R (Vpr) protein have been explored in relation to HIV-associated neurocognitive disorders, but not in relation to stroke. It has been shown that viral protein variants, products of the error-prone replication of HIV, have potential for neurotoxic effects. The Tat protein, which has demonstrated pro-inflammatory properties in vitro, had never been explored in relation to endothelial damage and stroke in a clinical context.

In 2017, I undertook the task of sequencing and identifying signature patterns in the Tat protein in a case-control study of young HIV-infected individuals with and without acute ischaemic stroke, while concurrently

examining both traditional and HIV-related risk factors that may also have contributed to stroke risk in these individuals.

The work has been both novel and exciting, and the laboratory work gave us the opportunity to collaborate with the Division of Medical Virology at Stellenbosch University. Thus far, we have identified two signature amino acid mutations that distinguish the Tat protein in individuals with acute

ischaemic stroke from non-stroke controls, highlighting the potential role of HIV protein-induced inflammation in the development of ischaemic stroke.

Doing an MSc has taught me a great deal about clinical research, and although it was not without its challenges, it also had many highlights. I met a wide variety of people who are all passionate about improving healthcare in SA, and also had

the opportunity to present some of the preliminary findings at the 22nd International AIDS Conference, in July 2018.

I would strongly encourage other young clinicians to apply for the SAMA Research Masters Supplementary Scholarship. Most of us have a question that we want to answer in our clinical work. Organisations such as SAMA provide funding to enable us to try and answer them through research.

Books, pills and politics

Dr Lerato Masenya

In SA, the socioeconomic and political landscape within which medicine is practised often disempowers both the doctor and the patient, and thus affects the doctor-patient relationship. This disempowerment rests heavily on the shortcomings the public health space. As SA evolves from a turbulent political past, the legacy of which inadvertently plays out in our health systems, the reinvention of the healthcare fraternity focuses on systems and infrastructure. There is, however, a largely unexplored blend between the art of creative writing and the science of medicine that can contribute to a consciousness of the socioeconomic and political influences on our psyche, and subsequently, our practice.

Tim Gillespie, of a USA-based publishing house, argues that because literature cultivates imagination and empathy, it has the capacity to offer a vision of other lives and other vistas that would otherwise be inconceivable. When health professionals switch from scientific writing, which only their academic peers can appreciate, to creative literature, which anyone in the general public can appreciate, they open up to creatively telling stories that unearth themes that can serve as paracetamol for the pain of living in a society where ill health is often the result of sociopolitical determinants. When novels, short stories, biographies and memoirs are written through the pen of a health professional, a pen that has written in patients' case files, a fresh perspective is brought to the table, and therein lies the power of literature to be a healing balm for the aches of the healthcare service, to the doctor, to the patients, to the SA community.

Deena Padayachee, a bachelor of medicine and bachelor of surgery alumnus from UKZN, writes in his book *What's Love Got To Do With It* about the experience of living in the polarised post-apartheid SA. Through the stories, Padayachee unravels identity, social status, culture, success and justice. Although stories are an author's creation, they have the potential to give the reader, who at some point may become a patient, a level ground on which to relate on human terms. Relatability and representation foster a sense of confidence that health professionals understand the background and the political history of the patients who knock on their consultation door.

In her novel *Period Pain*, Kopano Matlwa, an SA-qualified medical doctor, builds a story around the protagonist Masechaba, who is a medical doctor in SA. Through the eyes of Masechaba, the doctor introduces the themes of gender, class and xenophobia. The story invites the reader to reflect on the state of the country and the period it is in, marred by its many difficulties. Matlwa ventures into the experience of medical doctors working in the public sector, and through her characters, health professionals may find areas that they relate with, and that allow them to understand their colleagues better.

The patient-centred approach advocated in the practice of medicine requires a willingness to become involved in the full range of difficulties that patients bring to their doctors, and not just their biomedical problems. The themes of governance, slavery and corruption interrogated by Mtutuzeli Nyoka, an ENT surgeon, in his book *A Hill of Fools*, show consideration of large-scale issues that have

implications for the poor and marginalised. Although the book is not about the practice of medicine, and is instead a fictional work depicting life in a fictional country, Doma, and the effects of slavery on this country, one can extract from it points that can be extrapolated into the healthcare sector. It opens stakeholders up to consideration of how their power contributes negatively or positively to the health of the nation.

The enlarged outlook offered by creative literature is an important part of our national ethos, to encourage a culture of communication through creative writing and reading. When health professionals write, they introduce their field of view into the public domain. Their narratives, be they fictional or biographical, offer a unique insight that has the potential to foster hope for a better world, and a belief in the possibility of improving situations that directly or indirectly affect healthcare. Literary work that creatively illuminates the triumphs and difficulties experienced by health professionals may inspire stakeholders' contribution to healthcare facilities. Furthermore, aspiring health professionals can absorb the experiences and themes journalled by their successors and thus have a better, more realistic expectation of the profession in the SA context.

Readers travel to different locales, to the past, the present, the future, and learn during these travels about other cultures and peoples, all in the pages of a book. Creative literature thus might be an antidote to the disease that disconnects the health professional from her patients, the health professional from his colleagues, the health professional from the wider SA community.

Endowments often overlooked

Roenica Tyson, investment product manager, Glacier by Sanlam

Decreases in cost and increases in transparency and choice regarding underlying investment options make endowments a viable option to consider for tax-efficient discretionary (non-retirement funding) savings.

No tax relief for high-income investors in the 2018 budget. Most of the hype around the 2018 budget was around increased VAT, but there was also little good news on the investment front. Interest and capital gains allowances remained unchanged, and personal income tax for investors in higher tax brackets had below-inflation adjustments. The personal income tax bracket of 45% introduced last year remains daunting for high-income earners and trusts (where the trust itself is taxed), supporting the need for investors to look for more tax-efficient ways to grow their discretionary savings.

When does an endowment make sense? There are a number of factors to consider when choosing between a pure discretionary investment plan and an endowment. These include the availability of interest and capital-gains allowances, and required access to capital within the first 5 years.

A key consideration in how to allocate between the two products is the investor's tax rate. Income-tax legislation requires policyholders of an endowment to be classified as an individual, company or untaxed policyholder, and income and capital-gains tax varies accordingly. An endowment under the individual policyholder classification, such as the Glacier Vantage Life Plan, is available to individuals and to trusts with individuals as beneficiaries. Tax is applied as follows: tax on income: 30%; and effective tax on capital gains: 12%.

Individuals in an investment plan are taxed at marginal rates up to 45%, resulting

	Endowment	Investment plan
Individuals and special trusts		
Income	30%	Up to 45%
Capital gains	12%	Up to 18%
Trusts, other than special trusts		
Income	30%	45%
Capital gains	12%	36%

in an effective tax rate on capital gains of 18%. Between the two products there is no differentiation for dividend tax, which is withheld at 20% either way.

How much can you save on tax in an endowment? For high-income earners, the endowment can offer significant tax savings. Consider an individual who has no interest and capital gains allowance available, and invests ZAR5 million for 5 years. Assume a balanced fund-type investment with 11% return per annum and 20% trading of the portfolio each year.

After 5 years, allowing for redemptions for payment of income tax annually, such an investment would have grown to ZAR7.93 million in an investment plan. An equivalent investment in an endowment would have grown to ZAR8.09 million, saving the investor ZAR161 000 over the period. This consists of:

- income tax saving (30% v. 45% marginal rate assumed)
- capital gains tax saving (on realised capital gains)
- additional return earned as a result of compounding from a higher base.

If the investor completely sells out of the investment after 5 years, the tax saving when realising the remaining capital gains would be an additional ZAR90 000 when opting for the endowment.

Do the maths. Trusts or individuals with significant discretionary savings and high marginal tax rates should consider an endowment. There are restrictions that may not make it a suitable option, but multiple benefits and the significant potential tax saving are not to be ignored.

More reasons to consider an endowment and sinking fund. In addition to tax savings, an endowment offers the following advantages:

- simplified tax administration, as tax is recovered within the endowment and taken care of on behalf of the investor
- insolvency protection – the entire value of the policy will be protected against creditors after 3 years, and the protection will continue until 5 years after the termination of the policy
- no restriction on maximum levels of equities and offshore investments, as in the case of retirement savings products
- ability to draw income upon retirement after the 5-year restricted period has ended – this can be done on an ad-hoc basis, without the investor being forced to draw income at specific intervals
- estate planning benefits, such as saving on executor's fee (up to 3.99%)
- liquidity created in the estate as payment of the death benefit, as this does not depend on the winding up of the estate, and beneficiaries will receive the proceeds relatively quickly.

Connected care – innovation at its best

Dr Kofi Okyere-Dede

Big companies with millions to spare frequently paint innovation as a complicated, tech-based solution, but in truth it is all about solving problems

simply. Doctors all over Africa are constantly faced with challenges that require innovation in the most simplified ways, and as Africans, innovation is part of our fabric.

In Kenya's Samburu County, a doctor travels more than 300 km north of the capital, Nairobi, to reach the residents in this remote area on a camel. Surely a doctor in this position will

not stop helping the last patient just because they have run out of gloves? Examples like this showcase the huge role that innovative thinking and affordable technology solutions can play in SA and beyond.

So what is innovation in the healthcare industry?

It all begins with understanding the patient experience. This is true of both the private and public sectors. A private patient goes for a consultation; if blood tests are required, the patient has to return a week later for the results before definitive action can be taken. Those are two days off their work schedule. In the same breath, a public patient experiences healthcare quite differently, an early journey to the hospital, a wait in a seemingly endless queue – with no guarantee that you will be seen, considering the many patients ahead of you in line.

Connected care can minimise these inefficiencies. Point-of-care devices, mobile applications and other forms of technology are currently at the cutting edge of innovation, and once SA healthcare providers are prepared to embrace the advantages that relatively inexpensive and readily available technology can offer, they will soon realise just how much of a positive impact it can have, for both their patients and the bottom line of their practices.

When a doctor innovates, it is always about the people – that's why the path to good customer care is complex and sophisticated,

with multiple touchpoints and sources of data. This is exactly where the concept of connected care comes into play. Connected care is mainly the ability to provide healthcare services anywhere, any time, even remotely, by harnessing the power of technology and devices to provide more flexible, intelligent ways to interact with clinicians and other healthcare team members. It can also be used to manage one's own health.

According to Statistics SA, only about 6 in 10 (55.1%) South Africans over the age of 15 have completed a secondary qualification. That leaves a total of 44.9% without education. Now imagine that individual trying to remember the names of the chronic medications they are on, or merely remembering to take their medication as required.

"Something as simple as an automated reminder to take specific medication via their mobile phone can make a world of difference to the success of their treatment. This is just one example of how connected care, even in its most basic form, can improve the experience of all patients, and how important it is that we, as healthcare professionals, spot these issues and use the opportunities to address them.

I believe that innovation is needed to improve the user experience for a wider healthcare ecosystem. Connected care can benefit doctors, nurse practitioners and pharmacists positively. It can affect every aspect of care delivery and operations,

enabling smarter choices and better utilisation of time and resources, allowing practitioners to spend more time with their patients – even if it means spending this time with them digitally.

South Africans in general are slow adopters of new technology – for a variety of reasons, and due to legitimate challenges. Yet we now find ourselves at a crossroads, where the technology exists to overcome most cost and infrastructure challenges, and can make a valuable contribution to the efficiency of our healthcare system. The question is, are we, as medical professionals, willing to lead the way and embrace the possibilities?

About Dr Kofi Okyere-Dede

"I have always wanted to be both a doctor and an entrepreneur; I have also always loved technology. For as long as I can remember, there was a disembowelled computer in our household. As soon as we could get them, my little brother and I experimented with gadgets. This and my degree in medicine meant that I would always see inefficiencies in the medical system that I felt could be solved by simple tech."

Kofi spends his time providing clinical services as a GP in KwaMhlanga, and building mobile-based solutions to help patients to manage their own health.

Enhanced pre-authorisation process for hospital benefit management – Medscheme

SAMA Private Practice Department Medical Coding Unit

Please take note that Medscheme has sent out the following notification regarding pre-authorisations with their hospital benefit management from 13 September 2018.

For **all** of the following instances, there are six mandatory fields to complete:

- in-hospital admissions
- doctor in-room (in lieu of hospitalisation) procedures
- specialised radiology
- renal dialysis
- physiotherapy benefits, if required by the scheme

- any other type of in-hospital authorisation request for all Medscheme-administered schemes.

Please complete all six of these mandatory fields:

1. Treatment date: when is the person being admitted?
2. Member **and** beneficiary number: who is being admitted?
3. Treating provider practice number: who is the treating healthcare professional?
4. Place of service practice number: where is the person being treated?

5. Relevant diagnosis and/or procedure codes: why is the person being admitted?

6. In- or out-of-hospital indicator: will the person be admitted as an inpatient or treated as an outpatient?

Important note: If any of these six basic mandatory fields are not completed, the pre-authorisation request will not be acknowledged or captured into their systems. No reference number will be generated, and no claim will be processed without the applicable authorisation number.

Oudtshoorn congress a success

Dr Wessel Vermeulen

A very successful SAMA congress was held on Saturday 8 September. It was attended by 75 doctors, mainly from the southern Cape, and lectures of exceptional standard were presented by several specialists.

The audience also contributed actively to the discussions, and a wide range of topics was covered, including the latest treatments and available medications.

The medical ladies were treated to a stylish tea, while listening to the opinion of a gynaecologist regarding hormone replacement. Thereafter all the delegates gathered for a tasty braai.

SAMA intends making this an annual event.

Statins should be added to drinking water

Dr Eyla, the first vascular surgeon to settle in the southern Cape, gave a lecture on the latest timeous and expert treatment of stroke. The most important and obvious aim is to prevent strokes by aggressively treating hypertension, diabetes, raised cholesterol, obesity and inactivity.

He emphasised that statins not only shrink, stabilise and prevent the forming of plaque in the veins, but also have an anti-inflammatory effect. In fact, he feels so strongly about their use that he wishes he could introduce the drugs into drinking water.

He pointed out that worldwide, there is indisputable proof in evidence-based medicine that statins have proven their worth, and cautions against "Google and the lay press", which have negatively influenced patients.

Control of diabetes and hypertension is just as important in the prevention of stroke. Patients who tend to become complacent can suffer a stroke, which could permanently change their lives, and those of their loved ones.

It is of the utmost importance that patients should seek medical treatment as soon as they show symptoms of a stroke. Millions of brain cells are lost literally by the minute, and the patient should have a brain scan as soon as possible to determine whether the stroke is caused by a clot or by bleeding.

If it is caused by a clot, a drug is immediately injected to dissolve the clot, avoiding



permanent damage. If bleeding is the cause of the stroke, it can be treated surgically.

New techniques to remove clots from veins without making big incisions were demonstrated, as well as modern techniques to replace narrowed arteries by means of "keyhole" methods (endoscopy).

It is very reassuring to know that these techniques are available in the southern Cape.

New vaccines

Dr Lee Baker, world-renowned pharmacologist, research scientist and academic in SA and Australia, discussed the latest guidelines and availability of preventive immunisations.

There was an interesting discussion of the vaccinations for adults against the many viruses and bacteria that cause millions of deaths annually. People over the age of 60 years should be vaccinated against lung diseases, and the latest available drugs were discussed. The necessity of vaccinating children against measles, meningitis and whooping cough was emphasised, and Dr Baker cautioned that should the percentage of the population that is vaccinated drop too low, mass epidemics could be the result. Naturally this constitutes a huge risk for any country where thousands of people from countries without vaccination programmes stream across the border in an uncontrolled manner.

Vaccination against female cancer is important

Dr Lizelle Nortje, a new gynaecologist from Mossel Bay, said that cervical cancer still

causes the death of millions of women annually, and that its incidence is increasing.

The causes are many – from genetics to early start of sexual activity, multiple sexual partners and unhygienic and promiscuous lifestyles – resulting in repeated viral infections, specifically the papillomavirus.

This specific virus is the main cause of cervical cancer, and can be avoided by the early and correct vaccination of all girls between the ages of 9 and 12 years. The vaccination is also available for adult women, and has been recommended for young boys in some countries.

Ethical dilemmas for doctors

Dr Engela Lang, well-known pathologist and academic from Pathcare, led an interesting discussion on the ethical dilemmas facing doctors. She emphasised that doctors still fulfil an important and crucial role in their communities, at all levels, and that they face many new challenges and responsibilities.

There is a concern that demands, restrictions and responsibilities placed on doctors by medical aid funds cause enormous negative ethical and medicolegal problems – the funds tend to prescribe to doctors how, when and where they should treat their patients. At the same time, doctors remain legally responsible for decisions that are forced on them.

Doctors feel that this situation manipulates, threatens and intimidates their independence and decision-making powers. One of the delegates predicted that a situation is developing where doctors and

private hospitals will consider the plans of the medical aid funds and the government as being the biggest threat to the existence of private medicine in the country. They predict that it will cause a mass exodus of mainly young doctors.

Exorbitant insurance costs drive doctors away

Doctors are extremely concerned about the unacceptably high costs of insurance that they have to pay to cover potential law suits. Examples were given of many highly qualified gynaecologists and senior experienced doctors who simply cannot afford to handle confinements. An example was given of a doctor who has to deliver at least 20 babies per month just to cover his insurance costs.

Very few claims against doctors are ever granted or proven, and doctors are of the opinion that some members of the legal fraternity are indirectly responsible for the exceedingly high costs. There are allegations that lawyers on both sides of a case could force huge increases in the legal costs – this in the full knowledge that there was no negligence.

Ultimately, cases are settled out of court, and the public may think that the doctor has acknowledged guilt, which is not true. The insurers decree that the costs are becoming too high, pay the legal team and settle the case. The irony is that the original, and often false, accusations have already been sensationally published in newspapers, with the resultant permanent damage to the doctor's career and practice.

The Minister of Health has repeatedly been asked to intervene in these excessive and exaggerated claims by setting restrictions and guidelines. The medical profession has no problem with patients making justified claims for negligence, but currently only the insurance and legal companies benefit, leading to high premiums and increases in medical costs for all patients.



Well-known orthopaedic surgeon Dr Perry van Rooyen and his wife, Lucky

Doctors despondent with funds

Across the board, doctors have become despondent with the increasing regulations, demands and obligations imposed on them by medical aid funds, and predict that doctors will increasingly ask for direct payment from patients. The structures of the medical aid funds are too complicated, and members as well as doctors cannot keep up with the various funds, saving plans and very confusing regulations. It would be preferable to have fewer medical aid funds, with each fund having at most three uncomplicated plans.

Initially, all funds managed their own administration, and funds were not-for-profit by law. Over the past few years, funds have begun employing fund administrators, which has pushed up administrative costs to a huge extent. Three weeks ago, the administrator of one of the biggest funds announced a profit of ZAR2 147 billion – this after the recovery of billions of rands for expenses and capital projects. This is the money that according to many doctors and members has been derived from premiums paid by patients, and it should be used to lower premiums and improve benefits.

There is also a concern that too high a proportion of members' premiums is spent on managed healthcare and fund brokers. The opinion has also been expressed that the big fund administrators (many of them from the same stable as the funds themselves) are very keen to administer the planned NHI plan – hence the attempted control by the medical aid funds and the government of the private medical industry.

Doctors are of the opinion that they will have to stand together to secure their future, especially now that the government is again considering implementing the so-called "certificate of need". Besides the compulsory 2-year community service, government intends to regulate where doctors can work by only allowing practices to open where there is a sufficient need.

Private practitioners expressed the opinion that the way in which government intends to initiate the NHI plan, as well as certain restrictions on private practice, will constitute a serious risk for the medical profession, and many doctors will leave the country. It will also result in fewer young people choosing a medical career.

GastroFoundation presents festschrift to Prof. Kew

SAMA Communications Department

On 20 September, the GastroFoundation [Gastroenterology Foundation of SA] presented Prof. Michael Charles Kew with a festschrift, also part-

funded by the UCT Department of Medicine, published in a special issue of the *SA Medical Journal*. The festschrift was the outcome of a Festschrift Symposium held at the SAGES

[SA Gastroenterology Society] Congress in August 2016, where colleagues and mentees of Prof. Kew, both local and international, presented the papers now published in



Prof. Kew with Assoc. Prof. Chris Kassianides

honour and celebration of his illustrious career and lifelong influence on hepatology.

At the presentation, held at Groote Schuur Hospital and attended by colleagues from UCT and the GastroFoundation, Assoc. Prof. Chris Kassianides, GastroFoundation founder

and chairman, spoke of Prof. Kew's many achievements over his long career. This began with his graduation in 1961 at the top of his class at Wits, where he went on to spend most of his working life, as a physician, hepatologist and professor in the Department of Medicine at the Johannesburg Academic Hospital Complex, though he also spent short periods at the Royal Free Hospital in London, and the National Institutes of Health in Bethesda, USA.

It is his work on hepatocellular carcinoma and its association with the hepatitis B virus for which he has become internationally renowned, establishing himself as the foremost authority on this form of cancer, and "one of the best-known hepatologists of his era".

On his retirement from Wits, at the age of 68, Mike Kew continued his academic career as honorary professor of medicine at UCT, keeping up his prodigious research and publication output. Over the course of his career, he authored close to 600 articles, 75 book chapters and a textbook on liver

cancer, and received numerous national and international awards and honours. The foreword to the festschrift describes the academic esteem in which he was held as stemming not only from his contributions to research, but his "insatiable sense of curiosity, his passion, his persistence, his determination and his dedication".

As well as his academic record, tributes from former colleagues attest to his skills as a teacher and mentor. As Prof. Ntobeko Ntusi writes, "While his influence as a great physician-scientist, teacher and role model is unquestionable, Mike's enduring contribution will be the role he has played as mentor to countless generations of medical students, physicians and hepatologists ... without exception, every former student regards Mike with awe, admiration and gratitude."

Prof. Kew was presented with a hard copy of the festschrift, and a framed image of the publication cover, in celebration of his sterling career.

A child makes an allegation of sexual abuse

The Medical Protection Society shares a case report from their files

Mrs X asked her GP to refer her 8-year-old daughter, Child F, to be assessed by a specialist psychiatrist in child and adolescent mental health. The GP referral letter stated that Child F had reported to her teacher that her father frequently touched her genitalia. The child's parents had recently separated acrimoniously, and the mother had reported the matter to the police.

The consultant psychiatrist, Dr B, obtained a history from Mrs X, who confirmed these details. She then took a history from Child F, and wrote a report based on these discussions. The report detailed that Child F had reported numerous incidents of touching by her father, and the descriptions provided by the child indicated that the father was sexually abusing his daughter.

The police investigated the allegations, but no charges were brought against the father, Mr X. However, Dr B's report was used by the mother in custody proceedings, and the mother gained sole custody of Child F.

In the course of the proceedings, Mr X obtained his own expert psychiatric report. Mr X's expert concluded that Dr B had obtained an inadequate history in three

areas. The expert said that Dr B had failed to confirm the history with the school directly, had failed to seek an explanation from Mr X and had failed to consider that Mrs X may have coached Child F in giving her answers. This expert was less certain that this was a case of sexual abuse, but considered that the child was best placed with her mother, with supervised contact with her father.

Mr X brought a claim for negligence against Dr B, alleging a failure to take an adequate history from a range of sources to evidence her conclusion of sexual abuse.

Expert opinion

The Medical Protection Society (MPS) obtained further expert opinion from a psychiatrist. This expert concluded that Dr B had carried out her interview with Child F appropriately, and that there was no evidence of pressure or undue influence by the mother. She concluded that there may have been some shortcomings in failing to obtain collateral history from the school and Mr X, but that the activity that Child F had described to Dr B, if true, would unequivocally amount to child sexual abuse,

and that Dr B's conclusions to that effect were reasonable.

MPS successfully defended the claim.

Learning points

- When writing a professional report, you should take reasonable steps to check the information provided, to ensure that it is not false or misleading. A report should make clear where a patient has provided information about events or another party, and this should not be recorded as fact. You must not deliberately leave out relevant information, even if requested to do so.
- When writing a professional report, you should set out the facts of the case, and clarify when you are providing an opinion. Do not be tempted to comment on matters that do not fall within your area of expertise. In this case, Dr B was assisted by her clear and robust report-writing.
- All doctors have a duty to act on concerns about the welfare of children.



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Gauteng North held a well-attended diabetes upskilling workshop CPD at the Muelmed Medi-Clinic in September. It was presented by Dr Shaifali Joshi (above right), who discussed various interesting aspects of diabetes, including management, complications, therapy, preventative measures and practical tips, and Dr Angelique Coetzee (above left) who assisted with a discussion of case studies, and gave treatment advice.



The SAMA Gauteng North branch successfully sponsored training of students in basic life support, on 16 and 29 September. We are very proud of our students, as they all passed their exams and practical training. Branch council member Dr Lehlohonolo Majake (above right) took the time to come through to welcome the students. "A big thank you to the training company for their excellent training and presentation," said Judy Mills, branch secretary (above left).

Successful CPD at Mediclinic

Discovery Health presented a well-attended CPD at Mediclinic Muelmed on 21 August.

Darren Sweiden presented on Premier Plus, a network of practitioners partnering with Discovery Health, designed to support the development of organised disease management programmes to optimally manage the growing epidemic of chronic illness. The preliminary results of the Premier Plus Network show a pleasing and significant change in the management of diabetes. In 2018, the Premier Plus network was expanded to include HIV care. Any willing family practitioner who meets the network requirements may participate in the Premier Plus GP Network.

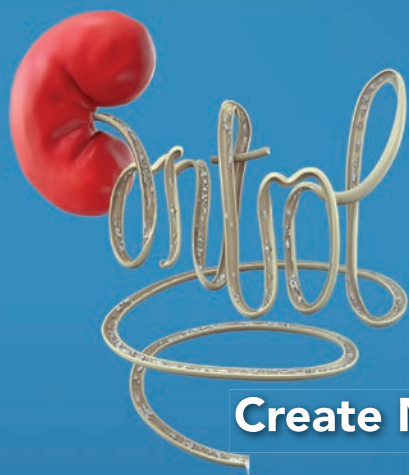
Marius Smit presented on how to prevent and deal with a forensic audit. He explained the legal framework and requirements,

common practices that may lead to fraud and abuse, examples of fraud and abuse, and the process of a forensic audit and how best to deal with it.

Lastly, there was a question-and-answer session where doctors were able to raise matters, ask questions and discuss problems with Discovery Health.



Question-and-answer session with Marius Smit, head of forensics and fraud at Discovery, and Dr Kunzmann, honorary secretary, Gauteng North branch council



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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 randomised, 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, September 2017.

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