

# SAMA INSIDER

FEBRUARY 2019

**Let's regain the  
power that has  
been lost**

*Is the world ready for  
gene-edited babies?*



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

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

## New beginnings – 2019

As we ease into 2019, it seems that an overriding theme of the first issue of *SAMA Insider* this year is new beginnings. We open with the first message from newly elected SAMA president, Prof. Hoosen Coovadia (page 4), which calls on members to “feel free to send me, through these same columns, advice, criticism, disagreements, warnings and any other of a host of responses that you feel will improve the organisation and its contemporary or modern aims and functions.”

An interview (page 6) with Dr Angelique Coetzee, chairperson of SAMA, introduces her to our readers and touches on her vision for the organisation in the future. “We are going to try very, very hard to regain the power that has been lost. We’ve got to become the main player again.”

Prof. Ames Dhai’s article on page 9 looks at the implications of the birth of the first gene-edited babies in China: “Heritable genome editing could have significant implications for individuals and for society at large. Evidence on the safety of these procedures is not available as yet, and more research, including basic science research, is necessary,” says Prof. Dhai.

We introduce the vice chairperson of SAMA (page 10) Dr Mvuyisi Mzukwa: “A united SAMA has enormous strength and provides a great platform that allows one to fight the good fight, which will advance the betterment of the health system and benefit ordinary and poor citizens of our beloved SA.”

The #MeFirst campaign (page 12) was launched by SAMA’s Border Coastal branch on Friday 16 November, and aims to tackle issues around the mental wellbeing of doctors head on. “Speaking out is often perceived as a sign of weakness,” said Dr Anastasia Rossouw from the branch. SAMA intends to take the campaign to other provinces in the near future.

CPD points are now available via an online medical CME platform (page 17), which means that health professionals will be able to earn their CPD points by watching medical lectures online.

We would like to echo Prof. Coovadia’s appeal to readers to communicate via *SAMA Insider*. Please comment on, query, complain or compliment on any matter, topic, incident, event or issue in your particular field or with regard to general healthcare that you feel should be shared with your colleagues and fellow readers.

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## Harnessing the powerful SAMA voice



Prof. Hoosen Coovadia, SAMA president

As many of you know, I am an entirely new recruit to the leadership and the contextual world of SAMA. I have only the fuzziest ideas of what values are most important to SAMA members, and which professional responsibilities matter, and are held at the highest ethical level by them, and which health policies excite their greatest interests. The ebb and flow of social currents, especially those which bear on the health system of the country, have fluctuated between many peaks and downturns, and it is inevitable that the most prominent of these would affect policies within SAMA at these moments in time. It follows that my own attitudes to these issues have varied, and, at their greatest distance from prevailing currents, been quite at odds with the leadership of the organisation then. For example, during the quite virulent arguments about SAMA's position and responsibilities to society on the murder of Steve Biko, and similar atrocities by the security branch and its lackeys, I

would have, like many others, participated in widespread public condemnation of the health professionals and the security police who were incriminated in his killing. And there will have been divergences of opinion and action on other similar instances of gross injustice and brutalities. That is the past.

So feel free to send me, through these same columns, advice, criticism, disagreements, warnings and any other of a host of responses that you feel will improve the organisation and its contemporary or modern aims and functions. I would really value these opinions or suggestions, as I have little idea of the issues and subjects which are of immediate interest to the general membership. You have very generously asked me to be the president of this medical/health organisation, and so you need to know which values of society and the health sector are dear to me. I have no intention of burdening you with the full weight of my beliefs, which are not of direct importance to my role in SAMA, so, as I am not risen without a substantial social, economic and political past, I will illustrate the values I hold dear by indicating to which organisations I have belonged: the National Medical and Dental Association (NAMDA), the United Democratic Front (UDF), the Medical Association of SA (MASA) and the Natal Indian Congress (which was part of the alliance with the ANC, Communist Party, the SA Congress of Trade Unions (SACTU), Cosatu, etc.); I have also belonged to a number of health-related international organisations. To cut to the absolute minimum of the things I hold dearest to my heart and mind, these are: democracy (in brief, my basic ideas on this are contained in those of economics

Nobel laureate Amartya Sen), and, specifically for SAMA today, I believe in equity, a national health service that is based on need rather than wealth, and fairness in all institutions of society and populations, especially education, peace and security, and a common nationhood for SA. So the current educational system, which rewards the powerful and rich, and is hopelessly weak in its implementation, is anathema to me. This does not mean that I will abandon my fundamental trust in the scientific method, which has been a dominant influence in my professional and personal life. I will avoid rigid arguments within SAMA, to arrive at conclusions within any differences of opinion, and try to be realistic – some prefer the term pragmatic, which I don't – in the proposals for the reorganisation of our troubled SA society.

I must acknowledge SAMA and its great strengths that I see before me now. Many of the staff members I have met are superb individuals, with a high sense of purpose and unfailing efficiency. It is truly a powerful voice for the health and medical professions in democratic SA. But this essential voice should not remain mute in the face of unforgivable violations of the trust with which we are bound. My recollection is that we once had a critical role to play in international affairs, and we were held in high regard for our decisions by many organisations in the world. I now detect a narrowing affiliation, rather than to worthy global causes, at a time when the industrialised countries appear to be abandoning this internationalism for more parochial loyalties. There are too many examples of this, from the USA, to Latin America, to India, to Europe, to record here, and we may discuss them in the future.

## Letters to the Editor

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

Please note that letters:

- should be no longer than 500 words
- can be published anonymously, but writer details must be submitted to the editor in confidence
- must be on subjects pertinent to healthcare delivery
- should be submitted before the 6th of the month in order to be published in the next issue of *SAMA Insider*.

Please email contributions to: Diane de Kock, [dianed@hmpg.co.za](mailto:dianed@hmpg.co.za).



# Strengthening the SA health system: The Presidential Health Summit

SAMA Knowledge Management and Research Department

The Presidential Health Summit was held on 19 and 20 October 2018 at Birchwood Conference Centre, Johannesburg. The summit brought together various stakeholders from diverse constituencies in the health sector, to deliberate and craft possible solutions to address the challenges facing the SA health system. Participating sectors in the summit included government, civil society, labour, health services users, business, academia, health professionals and allied health workers.

The summit focused on challenges that pose a threat to the achievement of universal health coverage (UHC) in both the public and private health sectors. There were five goals for the summit, which revolved around collective efforts by all players, and the identification of specific actions to solve system challenges, including corruption.

There were nine commissions set up to provide a basis of discussions, namely: human resources for health (health workforce); supply chain management, medical products, equipment and machinery; infrastructure plan; private sector engagement; health service provision (delivery); public sector financial management; leadership and governance; community engagement; and information systems.

Some of the notable speakers at the summit were Mr David Mabuza, Deputy President; Dr Nkosazana Dlamini-Zuma, Minister in the Presidency; Dr Gwen Ramokgopa, MEC, Gauteng Department of Health; Dr Aaron Motsoaledi; and two representatives from the WHO.

At the end of the summit, it was resolved that the key sectors mentioned above must collaborate in crafting a presidential health compact based on the summit's deliberations. The timelines set were that between the presidential summit and the first week of December 2018, the sectors must consult their constituencies on the interventions to be implemented, and craft a plan, including clear objectives, methods, timelines, milestones and indicators, as well as financial resources, to address the interventions. This would culminate in the signing of a presidential health compact by 10 December 2018.

The comprehensive documents related to the summit are available at SAMA head office, namely the concept note, commission presentations, summit outcomes, key health policy literature and the summit's final report.

Although SAMA was able, in the end, to attend the summit, the organisation almost did not, after – for unknown reasons – SAMA was not among the invitees. After vigorously engaging the Presidency, SAMA was eventually granted seats for 40 SAMA doctors.

## Health Professionals Summit

One of the resolutions from the Presidential Health Summit was that each sector needed to identify a sector leader, and organise adequate consultations of its constituencies. In this regard, SAMA volunteered to co-ordinate the health professionals sector. Therefore SAMA led the arrangement of the Health Professionals Summit, which was held on Saturday 17 November 2018 at Premier Hotel O R Tambo, to bring all health professionals registered with the Health Professions, Nursing and Pharmacy Councils of SA together to deliberate, although allied health professionals were not included in this summit. About 109 health professions' organisations were invited to the Health Professionals Summit, and although not all were able to attend, over 80 delegates from over 60 organisations attended. A report of the summit is available from the authors.

In her opening remarks, Dr Angelique Coetzee, chairperson of SAMA, extended SAMA's gratitude to the Presidency, especially for committing funds to address some of the country's human resource gaps, and shortages of key supplies in health facilities. She underlined the importance of healthcare professionals as part of the health system, in advancing the country towards the progressive realisation of access to quality healthcare in the country. Dr Coetzee highlighted the fact that health professionals as a distinct group are very important and a key determinant in the delivery of healthcare. It would have been a great mistake to assume that the voice of health professionals could be adequately represented by labour or business. Dr Coetzee was emphatic that our main

mandate and identity as health professionals – who are bound by our various professional ethics – takes pre-eminence over business or labour interests. The sacrifice by each of the delegates present at the Health Professionals Summit, Dr Coetzee noted, was a great gesture towards *thuma mina*, and a humble response to the presidential call.

Prof. Olive Shisana, from the Office of the Presidency, presented highlights from the Presidential Health Summit, making reference to the document *Guidelines for Preparing the Input into the Presidential Health Summit Compact*. She emphasised the action-oriented approach of the presidential summit and the Health Professionals Summit, pointing out that as a collective, health professionals must build upon and pinpoint exactly where they are able to act, and precisely where change is needed, based on the summit outcomes. The summit was structured into three breakaway groups, to discuss the issues critically. These groups were:

- private sector; leadership and governance; community engagement; quality of health services
- human resources; quality, including supply chain and infrastructure; leadership and governance
- information systems; supply chain management; infrastructure; leadership and governance.

Potent ideas from the breakaway sessions were subsequently used to compile a list of implementable actions for the short, medium and long term. Prof. Olive Shisana has repeatedly underlined the fact that each sector needs to indicate what it can immediately achieve. As a result, various health professionals submitted their suggestions for immediate actions.

The Health Professionals Summit generated two pertinent outcomes: first, delegates unanimously adopted a motion demanding 4 months' extension before signing the presidential health compact. This was to allow professional organisations to adequately negotiate or consult with their constituencies. Recognition was given to the fact that health professionals

cannot sign a binding compact without the necessary thorough input and consideration, and the full mandate of professionals' constituencies. The extension would also allow time to bring as many professional organisations into the process as possible, so as to enable the whole industry to participate. Subsequently, a meeting between leaders of various sectors and the Presidency was held on 23 November 2018, where the health

professionals sector's request for an extension was discussed, and the meeting decided that 4 months' extension was too long. Therefore, as patient groupings said that they would be able to submit by 30 January 2019, the health professionals sector was requested to align with this and submit by the same date, to allow planning for implementation from 1 March 2019, in alignment with the government financial year.

Secondly, there was unanimous agreement on establishing a truly representative task team from among the health professions, to co-ordinate the work of the health professions sector. Sixteen individuals from various organisations and diverse professions were duly appointed to constitute this task team. Dr Angelique Coetzee is a member of the task team, and was nominated by the Presidency to be the health professions sector leader.

## Let's regain the power that has been lost

SAMA Communications Department

Newly elected chairperson of SAMA, Dr Angelique Coetzee, is geared to face many challenges in the next few years. A Pretoria-based GP, she is a long-serving member of SAMA, at both branch and executive level. Meet Dr Coetzee.

### Where and when did your medical career start?

I qualified in 1985 at UP. In those years we still did "*huisdokter jaar*", and I did mine at Kalafong. I had a bursary that I started to work off at Mamelodi Day Hospital in 1987, and in January 1988 I went into solo private practice in the Moot area. I have practised as a private family practitioner for the past 30 years.

### Tell us a bit about your background?

I attended Sentraal Hoerskool, Bloemfontein, as a boarder. I then went to Pretoria to study, in 1978. I first did my BMedSci, and then started my 3rd year MBChB. I was the first in my family to graduate.

### When and why did you decide to join SAMA?

I joined SAMA as part of their student campaign, as that was the "cool" thing to do. I was a passive SAMA member at that time. In 2006, I wanted to emigrate, and secured a very lucrative deal, but unfortunately my husband refused to go at the last minute. This was a turning point for me, as I had already done some overseas work, and realised that we are excellent doctors and in high demand.

I vowed to become involved in the politics of medicine, doing something to change the situation, and not be one of the doctors always complaining but not doing anything. A colleague and I, in the times of Dr Kgosi

Letlape, met with him, and he advised us to join our branch as a start, and the rest is history.

### What is your field of specialisation/interest?

Family medicine, for me, is medicine. I have a special interest in non-communicable diseases, and believe that putting the patient first in his or her disease profile will lead to better outcomes. Medicine is not at present outcomes driven, but rather fee-for-service driven, irrespective of outcomes.

### Please tell us about your family? And how do you spend your free time?

I am married with three children, all grown up. My children keep me on my toes, and they are also my fiercest critics. I have realised that young people have different ideas of how the world works, in essence preparing me to lead and understand a primarily young board of directors, guiding them into the realities of the outside world, which most of the time are out of sync with what the young people expect.

I love reading sci-fi books, but don't always get the time. At my age the most favourable pastime is falling asleep in front of the TV...

### What is your vision as chairperson of SAMA?

As I have heard and actually remember, there was a time not that long ago when SAMA, and of course MASA [the Medical Association of SA] before it, was more powerful than even the Department of Health when it came to the daily wellbeing and interests of the country's doctors. We're going to go back to that. We are going to try very, very hard to regain the power that has been lost. We've got to become the main player again. That's my vision. There's no reason why it shouldn't be.



I want a united SAMA that is there for doctors, addressing their professional interests and remuneration issues but not least, also their emotional wellbeing. There is currently little in the space about the wellbeing of the doctor, and we tend to forget that doctors are people first, with needs and dreams. They have loved ones who most of the time will be second to the needs of the patient, unconsciously putting a lot of strain on the doctor as a real person.

We would like to unite doctors, with SAMA as the flagship, and regain that force again. SAMA should have a pivotal role in representing both our public and private doctors in an NHI environment. No other body has that ability. It won't be an easy task, marrying the two (public and private), but SAMA can and must do it, on the important understanding that each sector has to have its own space under NHI.

# Nominations open for SAMA Merit Awards 2019

Prof. Mergan Naidoo, *chair, SAMA Education, Science and Technology committee*

The Education, Science and Technology subcommittee of SAMA would like to invite members, and the public, to nominate doctors/other individuals who they think have made significant contributions in bringing health to the nation. We are looking for individuals recognised by their peers, patients and communities as people who have made a difference to science, the healthcare environment, communities and individuals. These outstanding individuals will be honoured at the national SAMA conference and merit awards ceremony, which will take place from 8 to 10 August 2019 at the Tsogo Sun Hotel, Elangeni, Durban.

For nominations to be valid, one must complete the nomination form that is available on the website ([www.samedical.org](http://www.samedical.org)). This nomination form requires the following:

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

The CV may be provided as additional information, but the nomination form is essential. Nominations received after the due date (**15 June 2019**) will not be considered.

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

## Human rights and health awards

**Medal of Honour.** This is the most prestigious of the SAMA awards, and is reserved for an individual who has displayed the very best in human effort and personal sacrifice, which may

include a forfeiture of freedom, and dedicated their life to the cause of humanitarian service. One would expect this individual to show an iconic international footprint. It is not uncommon for such an individual to have been subjected to detention, interrogation, torture or incarceration, or even killed in their pursuit of his or her ideals.

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

**Medal of Transformation, Equity and Justice.** This nomination must show evidence that the individual has taken up the fight for transformation, justice and equity, even in the face of personal sacrifice, material loss or threats to personal security. The nominee should be a campaigner for justifiable change within the medical fraternity, including activities that promote unity within SAMA, or should fight for equal opportunity across the race or class divides in academia, industry or state structures. The individual may also be someone who champions the cause for equity in the delivery of medical and healthcare services, especially for the poor, needy, indigent or disabled.

Previous recipients of this award include Prof. Leslie London and most recently, Dr Perisamy Neelaphithambaran (P N) Govender.

## Medicine awards

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

Previous awardees include Prof. M Michael Sathekge, Prof. Bongani Mayosi and most recently, Prof. Gerhardus Lindeque.

**Extra-Ordinary Service to Medicine Award.** The nominated individual should display

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

This award was previously conferred on Prof. Jagidesa (Jack) Moodley and most recently, Prof. Rudo L Mathiva.

**Lifetime Achievement Award.** The nominee must have dedicated his or her life in the single-minded pursuit of medicine as a career, with distinction. This award is presented to an individual who has dedicated a productive lifetime of distinguished service to medicine, making the profession proud. His or her loyalty, dedication and professional conduct must be worthy of emulation.

Previous awardees include Prof. Andrew Argent, Prof. Andries Stulting, Dr Joseph Teeger, Dr Helen Rees and most recently, Prof. Jannie F Hugo.

**Spirit of Medicine Award.** This award recognises the contribution made by an individual who has: provided extraordinary service to his or her community or nation extending beyond the field of medicine; distinguished him- or herself both in the field of medicine and also in areas beyond, in creating an enabling environment and/or living habitat, or working in the wider interests of mankind; championed the cause of the poor, the indigent and dispossessed within a given ecosystem/community; provided selfless service to medicine, which includes community health, without a view to material gain or personal recognition; or displayed through practice that medicine is a "calling", and been recognised by his or her peers as a role model.

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

**Young Leader Award.** This award is made to a doctor under 35 years old at the time of nomination, who is making a difference to his or her community or healthcare environment. This colleague maybe in a research-oriented

environment and be making significant contributions, and should be endorsed by an accredited research institute or university.

The award may also be made to an individual, on the recommendation of the public sector doctors' representative body, who has shown extraordinary service to his or her community or healthcare environment.

This award was previously given to Dr Vuyane Mhlomi and most recently, to Dr Jayshina Punwasi.

**Community Service Award.** This is awarded to an individual who has rendered outstanding service over a sustained period of at least 20 years. This nominee may have: taken a leadership role in managing a specialised field of medicine in the community, e.g. caring for physically and mentally challenged patients; rendered humane, innovative care, under extremely trying conditions, be they in the face of poor or unavailable facilities, or conditions calling for personal sacrifice; or taken an educative and mentorship role in

adding value to the health of a community, such as empowering communities to grow their own food, maintain good health or improve sanitation.

**Emerging Scientist Award.** This new award recognises outstanding research by a registrar attached to any SA university who publishes his or her Master of Medicine (MMed) research in partial fulfilment of his or her degree in the calendar year preceding the award ceremony, and is judged by his or her peers to have performed outstanding work in the field of medicine. The requirements for this award are the completion of the nomination form as well as providing the committee with an electronic copy of the publication, evidence that the manuscript has been published in a peer-reviewed scientific journal and a letter from the university confirming that the registrar is/was registered as an MMed candidate. The standing of the relevant journal, such as its current impact factor, may be provided

as supporting documentation, as may the article metrics.

**Service Excellence in the Private Sector Award.** This is an award for private sector doctors who have been making a difference in their area of practice. The doctor must have been a practising medical doctor for at least 10 years. Evidence of making a difference in his or her community must be submitted with the nomination. The doctor must be known to show compassion and empathy towards patients.

The previous recipient of this award was Dr P J Senoamadi.

### SAMA loyalty award

**SAMA Award of the Year.** This award is given to a SAMA member who has maintained distinguished service to SAMA of an extraordinary nature, as judged by his or her peers.

Previous recipients of this award include Dr Fazel Randera, Dr Akthar Hussain, Dr Gregory Mbambisa and most recently, Dr Farah Jawitz.

## Discovery Health breakthrough: Specialist family medicine physicians private practice network

Prof. Shadrick Mazaza, SAMA Specialist Private Practice Committee



In the June 2016 issue of *SAMA Insider*, I provided an overview of the status of the discipline of specialist family medicine, and the physicians in private practice in SA. I explained how, in spite of government gazetting of the specialty and the HPCSA's opening of a register of the discipline, medical aid schemes continued to treat

specialist family doctors as GPs. The private practice committee of the SA Academy of Family Physicians has, since then, continued to engage with medical aid schemes to afford the discipline its due status, and remunerate them accordingly.

For the past 2 years, the discipline has focused its engagement efforts on Discovery Health, to address any issues that medical schemes might have. I am pleased to report that a breakthrough agreement with Discovery Health in the latter half of 2018 resulted in a draft contract for a family medicine physicians' network in private practice. Therefore, as of 1 January 2019, those on the HPCSA register of specialist family medicine, and with a Board of Healthcare Funders (BHF) practice code 015, will be eligible to apply to join the network, and be remunerated accordingly.

In this agreement, network participation benefits include:

- An increased consultation and procedure fee
- specialist referral privilege for MRI/CT scan investigations

- automatic addition to the Premier Plus disease management network
- access to chronic illness benefit specialist benefit baskets.

There remain a few issues to be addressed in this network contract with Discovery, one of which is how to deal with specialist physicians who are in a group practice with GPs. As we work on these, we will shift our main focus to the other medical schemes, to negotiate a similar network contract.

This development marks the beginning of a very exciting era in the evolution of primary care in SA. We now have GPs (family practitioners, as some prefer to call themselves) and specialist family medicine physicians making up the primary care physicians or family doctors group (World Organization of Family Doctors). Together as family doctors, we will champion quality of care, co-ordination of care and clinical governance well into the advent of NHI, should that ever come about.

# Is the world ready for gene-edited babies?

Prof. Ames Dhai, Director, Steve Biko Centre for Bioethics



On 26 November 2018, media reported that gene-edited babies had been born in China. Many raised huge concerns, because heritable genome editing could have significant implications for individuals and for society at large. Evidence on the safety of these procedures is not available as yet, and more research, including basic science research, is necessary.

Basic science research is unquestionably vital to advancing biomedical science. The same applies to such research involving genome editing. Genome editing research and understanding the molecular processes that control disease development and progression using somatic cells are already at an advanced stage. There is great potential for somatic-cell genome editing research to facilitate the ability to develop better interventions for people who are affected by certain diseases. Gene therapy in which genetic changes are made to somatic cells is already an established modality of treatment, and genome editing for somatic applications would not be dissimilar. Somatic genome editing could be performed either outside of or directly within the body. While the latter could pose technical challenges, in that the gene-editing tools may not find their target genes efficiently, or may inadvertently affect germline cells, clinical trials using this technology for some diseases have already begun in some countries, according to the US National Academy of Sciences.

Prevention of disease transmission using prenatal and pre-implantation genetic diagnosis has been in use for some time already. However, these technologies do not work in all cases, and where they do work, they may result in the discarding of affected embryos, or in selective abortion, giving rise to age-old beginning-of-life debates. Germline genome

editing, when safe for use, could assist some families by providing the most appropriate option for preventing disease transmission. Moreover, the resulting genetic changes would then be passed down the generations. However, this shift beyond individual-level effects is viewed as contentious by some. Social and ethical concerns, including those involving the social acceptance of children with disabilities, the risk of inheriting off-target genome effects, equitable access, and slippery-slope cautions in the contexts of enhancement and eugenics, are being debated. Genome editing for enhancement purposes would involve both somatic and germline processes. Enriching traits and capacities beyond levels considered adequate for health is a realistic possibility, and invokes considerations around fairness, social norms and the need for both public debate, and regulation.

## Heritable genome editing could have significant implications for individuals and for society at large

Following broad consultation, the US National Academy of Sciences has recommended that heritable genome editing clinical trials be permitted within a framework of due care and responsible science, which entails that the following criteria must be satisfied:

- absence of reasonable alternatives;
- restriction to preventing a serious disease or condition;
- restriction to editing genes that have been convincingly demonstrated to cause or to strongly predispose to the disease or condition;
- restriction to converting such genes to versions that are prevalent in the population and are known to be associated with ordinary health with little or no evidence of adverse effects;
- availability of credible preclinical and/or clinical data on risks and potential health benefits of the procedures;

- ongoing, rigorous oversight during clinical trials of the effects of the procedure on the health and safety of the research participants;
- comprehensive plans for long-term, multigenerational follow-up that still respects personal autonomy;
- maximum transparency consistent with patient privacy;
- continued reassessment of both health and societal benefits and risks, with broad ongoing participation and input by the public; and
- reliable oversight mechanisms to prevent extension to uses other than preventing a serious disease or condition.

Seven principles for the governance of human genome editing are proposed by the Academy: promoting wellbeing, transparency, due care, responsible science, respect for persons, fairness and transnational co-operation.

On the ethical acceptability of genome editing in the context of reproduction, the Nuffield Council has proposed that two principles need to be satisfied:

**Principle 1: The welfare of the future person.** Gametes and embryos that have been subject to genome editing procedures (or are derived from cells that have been subject to such procedures) should be used only where the procedure is carried out in a manner and for a purpose that is intended to secure the welfare of a person who may be born as a consequence of treatment using those cells. Moreover, the intervention must also be consistent with the welfare of such a person.

While principle 1 is necessary for heritable genome editing interventions to be morally permissible, it is not morally sufficient, hence the need for principle 2.

**Principle 2: Social justice and solidarity.** The use of gametes or embryos that have been subject to genome editing procedures (or that are derived from cells that have been subject to such procedures) should be permitted only in circumstances in which this cannot reasonably be expected to produce or exacerbate social division or the unmitigated marginalisation or disadvantage of groups within society.

The United Nations Educational, Scientific and Cultural Organization (UNESCO) reacted to the media reports on the birth of gene-edited babies by cautioning against the reckless application of gene editing. It reiterated the need

to heed internationally agreed principles that affirm the values of human rights and human dignity as the prime concerns for any medical research and intervention on human beings. While there is promising scientific advancement

with the potential to benefit humanity in the latest developments in genome editing techniques, UNESCO advises member countries, SA included, to exercise caution when it comes to gene modifications that will pass onto future

generations. The UNESCO International Bioethics Committee has called for a moratorium on genome engineering of the human germline for as long as the safety and effectiveness of these procedures remain unproven.

## A united SAMA has enormous strength

*SAMA Communications Department*

**S**AMA Insider interviews Dr Mvuyisi Mzukwa, newly elected vice-chairperson of SAMA.

### Where and when did your medical career start?

I studied medicine at the UKZN Nelson R Mandela School of Medicine over a 6-year period, from 2000 to 2005. This was the period in which the two universities (University of Natal and University of Durban Westville) merged. I did my internship at the Nelson Mandela Academic Hospital in Mthatha, Eastern Cape, in 2006. My community service happened at Prince Mshiyeni Memorial Hospital in 2007. I thereafter worked at Osindisweni Hospital in Verulam, KwaZulu-Natal. Lastly, I worked at Wentworth Hospital, until I left for general private practice at Malvern Medicross. Later on, I started Isipingo Healthcare Centre, where I work now.

### Tell us a bit about your background?

I grew up at Flagstaff (not the one in the USA), a small rural town in the eastern part of the Eastern Cape, under strong rural and traditional values of ubuntu. I am very familiar with the game of stick fighting, which introduced me, as it were, to politics and an understanding of the struggles facing an African child. My rural village is called eMangquzu.

I come from a family of eight children, five boys and three girls (two twin girls). Our clan name is Amaxesibe. I have had the privilege of living in both rural and urban settlements. Rural life was excellent, not in resources but in ubuntu, which came out of it. In urban areas, I find myself caged behind heavy burglar guards and an alarm system, on top of my urban life. I don't have any significant, meaningful relationship with my neighbours; it's just too individualistic. My dad, Mzwandile Mzukwa, passed away on 19 February 2018, at the age of 86. My mom is still alive and healthy. I did my schooling at Fama Junior Secondary school and Ndaliso Senior Secondary School, respectively.

I am an ordained resident pastor at Isipingo, south of Durban. I am an orthodox, unapologetic Christian, who believes firmly in the prescripts of the scriptures. I alternate between Indwedwe, north of Durban, and Isipingo to minister to our church branches based in those two areas. I fully understand the right to choose your own religion, and respect those rights. I have learnt to live happily with colleagues from other religions.

### What about your family, and how do you spend your free time?

I got married in 2007 to Nokuthula, from KwaZulu-Natal. We are blessed with two boys: Esihle, 10, and Skhuselwe, 8. I spend time with family on weekends, playing soccer with the boys at Amanzimtoti beach, and going out for drives along the south coast. We spend time also going deep into Christianity, searching for the meaning of scripture and how it relates to our lives. I am very grateful to my wife for the unconditional support she gives me. I'm blessed to have had a very stable family life for the past 12 years.

### What is your field of interest?

I am currently practising as a general medical practitioner and an occupational health practitioner. Occupational health has stimulated my love for public health, which is my next project. This will fit well my purpose of being a health activist. There is a lot going on regarding health policy reforms in SA. I believe that I will spend the rest of my life on public health, and this is why I yearn for more in-depth knowledge.

### When and why did you decide to join SAMA?

Dr Jacob Mpatshwe, former chairperson of SAMA KZN Coastal branch and the General Practitioners Private Practice Department, respectively, introduced me to SAMA. I met him at King Edward hospital, and he was very humble and knowledgeable. He pleaded with me to attend branch council meetings. Prof. Mergan



Naidoo was then the branch chairman. The branch council allowed me to participate fully in discussions on issues affecting service delivery. I was not allowed to vote, though. I was very impressed by their dedication to the branch and the quality of the discussions that came up. They were all knowledgeable, with great articulation of the struggle facing healthcare professionals and patients. I was later on co-opted as a branch councillor. Little did I know that I would be taking over from Prof. Mergan Naidoo in the next term. I enjoyed full support from all branch councillors, and we collectively achieved more. I am so grateful to all of them. What I enjoyed most in the branch was the presence of both quorum and decorum in our meetings. Late last year, 2018, I was elected as the national vice-chairperson.

### What is your vision as vice-chairperson of SAMA?

I see SAMA as being a united, credible voice for healthcare professionals, and a think-tank in its own right, due to its commitment to research-based views and articulation. I believe that no collision of opinions may interrupt our progress on the right path. A united SAMA has enormous strength and provides a great platform that allows one to fight the good fight, which will advance the betterment of the health system and benefit ordinary and poor citizens of our beloved SA.

# It is time to move from awareness to action in mental health

Dr Margot Uys, Technical Assistance Department, Foundation for Professional Development

October 2018 was declared Mental Health Awareness month in SA, with the objective of not only educating the public about mental health, but also reducing the stigma and discrimination that people with mental illness are often subjected to. As such, various talk shows, television programmes, newspapers and magazines all allocated space and time to increasing mental health awareness among the public. It does, however, raise questions regarding our ability as healthcare providers to respond to the expanding mental health epidemic facing SA.

Mental illness, which accounts for 14% of the total disability adjusted life years (DALYs) lost due to all diseases and injuries in the world, is a complex group of conditions, which probably affects most families in SA in some way or another. According to the SA Depression and Anxiety Group (SADAG), as many as one in six South Africans suffer from anxiety, depression or substance use disorder. In a study by the London School of Economics across eight countries, published in 2009, the lifetime prevalence of depression in SA is 9.7%, or 4.5 million, and a 2016 study showed that absenteeism (absence from work) or attending work while unwell (presenteeism) due to workplace depression cost SA at least USD2 billion, and USD17 billion in lost productivity. It is estimated that neuropsychiatric disorders will increase to account for more than 15% of DALYs by the year 2020, with 5 of the 10 leading causes of disability and premature death worldwide attributed to psychiatric conditions.

Mental disorders represent not only an immense psychological, social and economic burden to society, but also increase the risk of physical illnesses. It is estimated that approximately one-third (17 million) of South Africans suffer from some form of mental disorder, according to an SA Stress and Health study conducted in 2003/4, and ratified in 2014 by Profs Dan Stein and Soraya Seedat in the psychiatry departments at the University of Cape Town and Stellenbosch University, respectively.

The media daily confronts us with the reality that we can and must do more to promote preventive mental health services and increasing access to care. SA has a severe shortage of healthcare workers trained

in mental health. It is estimated that we require at least 10 - 20 full-time equivalent mental healthcare staff/100 000 population, according to the workforce gap analysis for low- and middle-income countries. The SA ratio of mental health workforce staff to general population is at a rate of <1/100 000 (this includes psychiatrists, child psychiatrists, other medical doctors, nurses, psychologists, social workers, occupational therapists and other paid workers working in mental health), compared to some of the first-world rates of >70/100 000. This highlights the urgency of expanding the mental health knowledge base of all mental health practitioners.

Suicide is haunting our academic institutions. The tragic death of a Wits student, shortly before the start of final examinations in October 2018, has again highlighted the need for psychological support to help students to cope with all the demands of student life. This is the third incident of a student suicide over the last 12 months at Wits, according to the dean of student affairs, Mr Jerome September, in an interview on eNCA on 30 October 2018. In terms of the suicide rate globally, Africa ranks among the highest, at 12.5/100 000 population, compared to the global rate of 10.5/100 000.

A few months ago, the tragic death of the dean of health sciences at UCT, an A-rated National Research Foundation researcher, cardiologist and family man, Prof. Bongani Mayosi, alerted South Africans and the world to the issue and management of depression in an era of increased life stressors in general, academic burden and political demands, digital access and information overload.

What these examples highlight is the urgent need to rapidly increase awareness and ability among primary care providers to recognise, treat and refer patients presenting with mental health conditions.

The Life Esidimeni tragedy, where 144 institutionalised mental healthcare users lost their lives when transferred to mostly unregistered community based organisations, emphasised the need for an urgent overhaul of the whole mental health service provision platform.

In recent years, SA has taken some important steps forward in strengthening its mental health systems. Mental health legislation has been reformed, and there is

some level of policy commitment to mental health. An important step forward was taken in July 2013, when the National Health Council adopted the Mental Health Policy Framework for SA, and the Strategic Plan 2013 - 2020. They identified eight key objectives: (i) district-based mental health services and primary healthcare re-engineering; (ii) building institutional capacity; (iii) surveillance; (iv) research and innovation; (v) building infrastructure and capacity of facilities; (vi) mental health technology, equipment and medicines; (vii) intersectoral collaboration; and lastly, (viii) human resources for mental health, advocacy, mental health promotion and prevention of mental illness. However, SA still has ongoing challenges, largely related to implementation.

Some of the recommendations urgently needed are to develop an overarching national mental health policy, lobby for mental health on national policy agendas, include mental health in poverty alleviation programmes, conduct a greater number of educational and awareness-raising campaigns, begin standardised evidence-based training of health staff and develop community-based mental health services.

FPD is responding to this need by launching a number of new training initiatives for primary care providers as online, distance, open-enrolment and sponsored blended-learning options. As part of this initiative, FPD and the National Department of Health, in collaboration with pharmaceutical companies Sanofi and Janssen, and Vula Mobile, will be embarking on a project to address some of the knowledge gaps identified, and thus lead the way to improved mental health services for uninsured South Africans at all levels of the healthcare system.

The proposed interventions will be aimed at developing the capacity of providers at larger community health centres (professional nurses) and district hospitals (medical officers) to manage common mental health issues, and simultaneously, to develop an effective referral system. This will address the urgent need for improved mental health services at the coalface, and should also relieve the current pressure and the long queues for formal assessments at tertiary mental health institutions.

*References available on request.*

## Border Coastal tackle doctors' mental wellbeing head on

SAMA Communications Department



At the successful launch of the #MeFirst campaign in East London

The #MeFirst campaign was launched by SAMA's Border Coastal branch on Friday 16 November, in Berea, East London, and also happened to coincide with National Doctor's Day. The launch saw about 75 Eastern Cape doctors converge on the BMW Autohaus Monti premises, where Border Coastal branch partnered with Harvey World Travel, Standard Bank, BKR Attorneys and East London Insurance Consultants to launch the #MeFirst campaign, with the aim of tackling issues around the mental wellbeing of doctors head on.

Branch vice-chairperson Dr Anastasia Rossouw, the only female neurologist in the province, said that SAMA's core function is to care for doctors' needs. "We decided to look further than just fighting for doctors' salaries, and include in our focus doctors' physical and mental wellbeing. This is particularly relevant after the untimely death of Prof. Bongani Mayosi, as a result of a 2-year struggle with depression, in September 2018, which shook the medical fraternity. We hear of colleagues who struggle to cope with feelings

of burnout, exhaustion and anxiety on a daily basis, yet we continue to suffer in silence, as speaking out is often perceived as a sign of weakness," Rossouw said.

A recent study by Govender *et al.* found that among medical doctors working in four hospitals of the Ngaka Modiri Molema (NMM) district in the North West province, 34 of 67 doctors (51%) were found to be stressed, while 18 (27%) were highly stressed (morbidly stressed). The rate of doctors who were morbidly stressed was higher in this study than that in a similar study in KwaDukuza, KwaZulu-Natal.

Rossouw said that the initiative was a first for SAMA, which plans to take the campaign to other provinces, with activities such as dialogues and roadshows, promoting physical wellbeing through various activities, such as fun walks and spin-a-thons, and engaging and working together with non-governmental organisations and the National and provincial Departments of Health, to ensure that the wellbeing of **all** healthcare practitioners (nursing staff, allied health professionals and



Dr Rossouw and Dr Muller at the launch

emergency medical service personnel alike) are prioritised and placed at the forefront of the health agenda.

# Alcohol use among medical students in SA

Jolene Hattingh, SAMA Knowledge Management and Research Department

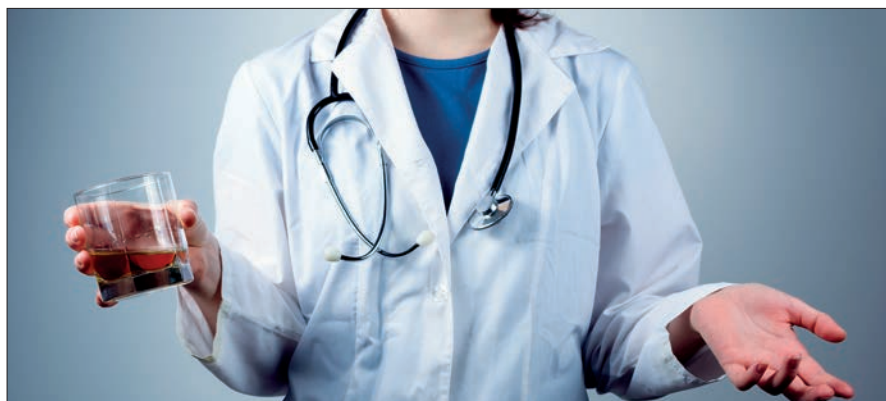
SA has a long history of alcohol use. Traditionally, alcohol was used on specific occasions, and only after the introduction of commercial alcohol was it used by the youth, women and men on a more regular social basis. The Liquor Act, passed on 23 June 1927, prohibited the serving of alcohol by Africans and Indians, also prohibiting them from entering premises licensed to sell alcohol. After SA became a democratic country in 1994, all such regulation was taken out of the statute books, and all South Africans over the age of 18 could buy, sell or use alcohol, subject to certain conditions. The breweries expanded their markets, and advertising campaigns were introduced to target previously disenfranchised groups. This increase in alcohol consumption also led to an increase in alcohol-related health problems among consumers.

Alcohol is listed as the third-largest risk factor for disease, and the eighth-largest for death, globally. An estimated 7% of all deaths and 7.1% of the burden of disease in SA in 2000 were attributed to alcohol; these are significantly higher than the global averages.

## Prevalence and risk factors

SA students have been rated as high consumers among those who drink alcohol. Studies show that students have a tendency to both use and abuse alcohol, leading to negative academic, as well as social, consequences. Both male and female users have been found to consume similar quantities and have similar tastes in beverages when they decide to go drinking. When students were interviewed, it came to light that although moderate alcohol consumption was deemed socially acceptable, they had little knowledge about alcohol and the negative effects that it might have, especially regarding their health. The students were well aware, however, that some of their peers had problems stemming from the use or misuse of alcohol.

Alcohol abuse by university students is not just an SA problem, but is reported globally. However, in the case of SA, alcohol consumption per capita is especially high, and compounded. Studies identified by Kyei *et al.* have linked students aged 18 - 26 years with both negative school performance and social problems when high levels of alcohol consumption were concerned. Although not unique to the group, psychological distress has been found to be



prominent among medical students, and it has been shown that members of this group are more prone to depression, anxiety and stress when compared to their peers.

Kyai *et al.* found that among a study population of 209 university students interviewed, over 65% used alcohol, of whom 49% abused it. The prevalence of depression among university students, in general, is weighted at 30.6%. The two main proposed schools of thought in this regard are that: (i) certain personality traits, such as conscientiousness, which enhance academic performance, could make medical students vulnerable to self-criticism, in an environment that has a high academic and/or occupational demand; and (ii) medical training in itself has been described as a major psychological stressor, considering factors such as examinations, high workload and time constraints. A diagnostic interview schedule to screen for possible depression in first- and second-year medical students confirmed these findings. In a study of 2 046 in the USA, 87.5% of medical students reported alcohol use within the month that the study took place, 88% of students had used alcohol in the month prior to the study and 9.1% of students used alcohol on a daily basis, with a number of students reporting that they used alcohol to cope with stressful situations.

In a study at the University of the Free State, situated in the province with the third-highest occurrence of alcohol use disorders in SA, a combined prevalence of hazardous, harmful and dependent drinking of 25.3% was found among students.

In a study in Egypt, in a study population of 687 students interviewed, results showed that 14.4% of students abused alcohol. In

Brazil, 23.8% of undergraduate students abused drugs. A study in Nigeria among male and female undergraduate students aged 19 - 23 years reported that multiple alcohol advertisements on television, posters, billboards and the branded fences of bars are common, on campus and around students' off-campus residential and leisure spaces, and these students showed good knowledge about alcohol brands and advertisements.

More recent focus on burnout and depression within the medical professions also leads us to consider risk factors and early warning signs of stress among medical students. Studies focusing on medical students have shown that symptoms of depression were highest among students during their first postgraduate year. Factors such as family history and personality traits such as neuroticism and self-criticism, and contextual factors such as stress, were found to be predictive of mental health problems. Levels of substance abuse and self-medication among medical students were, however, found to be similar to, and in some publications even lower than, those of other students in general. The substances of choice, however, did differ when compared to the general public. Drug use (self-medication) was found to be most common among residents working in emergency medicine and psychiatry.

## Recommendations

The following recommendations have been made regarding the use of alcohol among university students:

- Universities should initiate a policy on alcohol use at the institution, particularly in student residences. In addition, students should be given clear messages and materials regarding the policy.

- More workshops should be conducted to educate students on all aspects of alcohol use and abuse.
- Universities should forge relationships with rehabilitation centres, and invite officials and/or experts to meet with students who are identified as needing help as a result of alcohol abuse.
- Universities should make provision for student healthcare and support services, and ensure that those working in these services are properly trained in the identification and management of alcohol misuse. Students should also be taught how to manage stress in a healthy way.
- As a preventive measure, students should be given the availability and opportunity to talk to a counsellor regarding any problems experienced, whether they relate to personal experiences or their studies.
- Universities should proactively identify possible alcohol abuse and need for rehabilitation in students who “binge drink”, as some of these students could be in denial while being addicted to alcohol.
- Universities should make use of the assistance of social media forums such as Facebook, Twitter, etc. to disseminate information regarding alcohol use and abuse.
- Parents should be encouraged to visit students staying in hostels over weekends,

to keep students from destructive behaviour or bad weekend habits.

### Conclusion

Students, especially in the medical field, are often expected by their peers to be immune to stress and pressure. We envy their stamina, we neglect to think about them as young adults still being formed in their professions and we judge them without knowing the facts. Stressors that contribute to the use and abuse of alcohol include the pressure and stresses students experience from study workload, social and familial pressures and the pressure to succeed in life.

*References are available on request.*

## The adoption process: Leave of absence and Resolution 7 of 2000 unpacked

Phumzile Gwala, industrial relations advisor, SAMA Public Sector Department

Adopting a child in SA can be a long process – it may take months or even years for a magistrate’s court to grant an adoption order. While this may seem unfair on the adoptive parent(s), the authorities have a duty to ensure that the child is placed in a safe and loving environment.

This first process involves the screening of the parent(s) by a qualified social worker, which requires the following:

- police clearance
- medical and psychological assessments
- summary of the parent(s)’ finances
- clearance from the National Child Protection Register
- clearance from the National Register for Sex Offenders
- marriage assessment (in the case of a married couple)
- references (usually 3 per parent)
- conducting a group counselling session
- home visit from the social worker
- family profile, detailing every member of the family.

Once the parent(s) have completed these steps, the legalities commence. Usually this is the stage at which the longest delays happen, since the court must examine the following before issuing an adoption order:

- all the documents that have been submitted
- the report from the social worker (which

includes details on the citizenship, religious and cultural background of the child and his or her biological parents, and those of the adoptive parent(s)), and its recommendations

- consent from the biological parents
- information about counselling sessions that may have been given
- the financial status of the adoptive parent(s)
- whether the parent(s) have a good reputation in their community, and are able to take care of the child, financially and otherwise.

It is the sad truth that the court does not grant an adoption order unless all requirements have been met. This demands a lot from the adoptive parent(s), who have to wait patiently for this process to unfold. This brings me to Resolution 7 of 2000 (Public Service Co-ordinating Bargaining Council) and the determination on leave of absence, and its effect on the adoption process.

### Resolution 7 of 2000

Resolution 7 of 2000, the determination on leave of absence and its effect on adoption leave, deals with improvements in the conditions of service of public sector employees. In terms of clause 7.7.2 of this resolution:

- An employee who adopts a child younger than 2 years old shall qualify for adoption leave to a maximum of 45 working days.

Thereafter the provisions of 7.7.1(b) (i) and (ii) shall apply (this means that the employee can use his or available vacation leave or receive up to 184 days of unpaid leave.

- If both spouses or life partners are employed in the public service, both partners will qualify for adoption leave provided that the combined leave taken does not exceed 45 days in (a) above.

While part 4 clause 4.1. of the determination on leave of absence in the public service states that for the purposes of the interpretation and application of this provision, specific attention is drawn to section 228 of the Children’s Act No. 38 of 2005, which stipulates that a child is considered adopted if the child has been placed in the permanent care of a person in terms of a court order that has the effects contemplated in section 242.

In terms of the resolution and the determination on leave of absence, for the employee to qualify for this adoption leave, first and foremost, the child must be under 2 years old (bearing in mind that the intention to take this leave is to bond with the child while he or she is still at a tender age). Secondly, for the employee to be allowed this leave, there must be an adoption order giving the employee full parental responsibilities and rights in respect of the adopted child. Based on these factors, it seems that the Minister of Public Service and

Administration, while drafting the directive that then gave rise to the parties reaching this resolution, did not consider the possible delays in the adoption process. In addition to that, (s)he did not anticipate that there might be cases in which a public sector employee who is still waiting for the adoption process to be finalised finds him- or herself faced with

a situation in which the child is living in an unsafe environment, which could then force the employee to take custody of the child prior to obtaining a court order placing the child under his or her care. This would leave the employee with no choice but to take unpaid leave, which could not be recovered in the near future, for the purposes of bonding

with the child, due to circumstances beyond his or her control.

It is against this backdrop that I felt that it was important to draw SAMA members' attention to this phenomenon, in case any are thinking of embarking on an adoption process, to enable them to do so from an informed position.

## Divorced parents: Who may consent to treatment or surgery on behalf of a child?

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

Doctors are often unsure about how to go about procuring informed consent for the treatment of a minor patient. Consent is typically obtained from the child's parent or guardian, or from the mature minor him- or herself. In the case of divorced parents, however, one of the parents often takes responsibility for the child's medical care without necessarily involving the other in every instance. Difficulties then occasionally arise when the non-consenting parent finds out about the treatment. It is not unheard of for the non-consenting parent to lodge a complaint against the doctor in these circumstances, on the basis that (s)he was not approached for consent to treatment of his or her child. It is also not uncommon for the non-consenting parent to refuse to pay the doctor's account. In order to avoid this situation, it is essential that doctors familiarise themselves with the law on minors and consent.

### Children with capacity

When treating a minor patient, it first needs to be determined whether the minor is capable of consenting to the treatment or surgery him- or herself. In terms of the Children's Act No. 38 of 2005, a child between the ages of 12 and 17 may consent to his or her own medical treatment, provided that (s)he is of sufficient maturity and has the mental capacity to understand the benefits, risks and social and other implications of the treatment. The same requirements apply in respect of surgical operations, except that the child must then also be assisted by a parent or guardian. The Act does not define "assist", but it is unlikely that the legislature intended independent consent from the parent or guardian, in addition to the minor's consent, to be a requirement. To "assist", in

this context, therefore likely means to guide and support.

Unfortunately the Act also does not define "sufficient maturity", and it may be difficult for doctors to assess a child's level of maturity without adequate clinical guidelines. Similarly, it is not always a simple exercise to determine whether a child has the mental capacity to understand the benefits, risks and social and other implications of the treatment or surgery.

### It is essential that doctors familiarise themselves with the law on minors and consent

The matter is further complicated by the fact that capacity falls and fluctuates along points on a continuum. A minor patient may therefore be fully capable of consenting to simple and low-risk treatments or procedures, but may not have the high level of capacity required to choose between complex or high-risk treatment and surgical options. Decisional capacity must therefore be judged according to the particular decision with which the minor patient is confronted, and on a case-by-case basis.

It is required of the doctor to assess the minor patient's decisional capacity in every instance. In this regard, it is recommended that the relevant information should be conveyed to the minor in simple and understandable language. The doctor should discuss the treatment options with the minor in order to

determine his or her level of understanding, and then carefully question the minor in order to determine whether (s)he truly understands the information. It is important that the minor should demonstrate a capacity to assimilate relevant facts necessary to arrive at an informed, rational decision, and an appreciation and understanding of his or her situation as it relates to the facts. In cases of uncertainty, it is advisable to approach a senior colleague, or to involve the assistance of a child psychologist. Doctors are furthermore encouraged to make detailed clinical notes regarding the informed-consent discussions and, where possible, get the minor to note his or her informed consent in writing. According to the Regulations to the Act, the child consenting to surgery, and the parent or guardian assisting the child, must also do so in writing on a prescribed form (form 34).

In addition to making sure that the child has the necessary capacity to consent, the doctor should ensure that the consent is informed, comprehensive and voluntary. It should be kept in mind that informed financial consent will still have to be obtained from the person (usually the parent) responsible for payment.

### Children without the necessary capacity

In the case of children below the age of 12, or children who are not sufficiently mature to consent to treatment or surgery on their own behalf, consent may be obtained from the parent, guardian or caregiver of the child. Determining whether someone is the child's parent, guardian or caregiver is a factual question that can be answered with reference to official or unofficial documents, or evidence given by the

# MEMBER BENEFITS



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adult or child. A doctor is not required to act as a detective in this regard, but (s)he should be reasonably satisfied of the identity of the child's parent, guardian or caregiver.

Parents often lose sight of the fact that where both of them hold the same parental responsibilities and rights in respect of a child, either may act without consent of the other when exercising these responsibilities and rights, except where the Act or any other law or an order of court provides otherwise. There are four components to parental responsibilities and rights: care for a child, to maintain contact with the child, to contribute to the child's maintenance and to act as the child's guardian. As a general rule, the biological mother of a child, whether married or not, has full parental responsibilities and rights. The biological father of a child has full parental responsibilities and rights in respect of the child if he is married to the mother of the child, was married to the child's mother at the time of the child's conception, birth or anytime between conception and birth, was living with the mother in a permanent life partnership when the child was born, has consented to be identified as the child's father and contributes to his or her upkeep, or had full parental responsibilities and rights conferred on him by a court order.

A parent need only give due consideration to the views and wishes expressed by the co-holder before taking a decision if such decision is likely to change significantly, or have

a significant adverse effect on, the exercise of the co-holder's parental responsibilities and rights. (S)he must also give due consideration to any views and wishes expressed by the child, bearing in mind the child's age, maturity and stage of development, when a decision is made that is likely to significantly change, or to have an adverse effect on, the child's health. The implication is that only one parent needs to provide consent to non-invasive treatment or procedures (unless otherwise specified by the relevant board's ethical guidelines) and is not required to consult the co-holder, unless a court order provides otherwise. A parent is, however, required to give due consideration to the wishes of the other co-holder in a case of invasive or high-risk treatment or surgery, as such treatment or surgery could significantly change or have an adverse effect on the exercise of the other's parental responsibilities and rights.

In light of the above, doctors are encouraged to consider the following guidelines:

- Advise the consulting parent of the fact that the Children's Act encourages parents to see parenting as a shared set of responsibilities and rights. If the treatment is high-risk or invasive, advise the consulting parent that the Act provides that (s)he should notify the other parent and obtain his or her views and wishes in this regard. Obtaining the views of the other parent is the responsibility of the co-holder, not the doctor. Doctors may, however, advise the parent that a

failure to obtain and consider the other co-holder's views and wishes in case of invasive or high-risk treatment or surgery may render the decision reviewable by a court on application by the non-consenting parent.

- Keep detailed written notes regarding the aforementioned discussion.
- Enquire whether the other parent will be responsible for payment and, if so, whether (s)he might have any difficulties with this. Make it clear that if there is a specific agreement between parents, they have to sort that out between themselves, and the doctor cannot be held liable for such agreements or the enforcement thereof.
- The most important consideration should always be the best interests of the child. If you are of the view that it would be in the best interests of the child to discuss treatment with both parents or to obtain consent from both, you should indicate as much. This is more likely to be the case in cases of invasive or high-risk treatment or operations. In such cases, it is advisable to consult both parents, where practicable.
- In cases of uncertainty regarding the capacity of the child or what the best interests of the child entail, or unresolvable conflict between the parents, legal advice should be sought regarding the need to approach the Minister of Social Development, a children's court or high court for an order.

## CPD points now available via online medical CME platform

*SAMA Communications Department*

**S**A health professionals will now be able to earn their CPD points by watching medical lectures online. Medtalkz, SA's new open access library of medical lectures, has announced that its online content is now accredited with CPD points, allowing health professionals to earn their points at a time and place convenient to them.

Medtalkz founder, Dr Brian Levy believes that by providing CPD-accredited content, Medtalkz is creating greater access for healthcare professionals to learn from some of SA's greatest medical minds. "SA is privileged to have an active CME environ-

ment through conferences, lectures and refresher courses. But the valuable content delivered at these events is often lost to those who are unable to attend, and is effectively lost to the profession once it has been delivered," says Levy.

Medtalkz records, catalogues and stores this content online, thereby safeguarding it for the future and making it accessible to all SA healthcare professionals, regardless of their location.

Levy adds that the rationale behind the creation of Medtalkz was a combination of the need for health professionals to stay up

to date in a rapidly developing sphere, and the need for smarter learning methods that take into account the time pressures faced by doctors, nurses and others.

The site currently houses over 400 lectures from across most fields of medicine, including allied health disciplines. Access to the site is free, and is strictly for use by registered health professionals.

"It is important to Medtalkz, as a not-for-profit entity, to be able to offer this content free to the industry, thereby supporting greater access to medical education now and into the future," concludes Levy.

## An elusive foreign body

*The Medical Protection Society shares a case report from their files*

A child suffered recurrent episodes of pneumonia following the inhalation of a plastic toy.

Child H, a 3-year-old boy, was brought into the emergency department (ED) by his mother, with a history of having inhaled or swallowed a little building brick. They brought a similar piece with them. Child H was seen by Dr W, who documented that he appeared well, with no signs of respiratory distress and a normal auscultation. Dr W arranged for him to have a chest X-ray, which both Dr W and a radiologist considered normal.

### Taking a good history can save many mishaps in clinical practice

Two months later, Child H became unwell, with a cough and a high temperature. His mother brought him to the ED where, following a chest X-ray, he was diagnosed with right lower lobe pneumonia. Child H's mother mentioned to Dr F – the doctor who saw them – that they had been to the ED not long ago after Child H “swallowed” a little toy. All of this was documented.

During the next 2 years, Child H suffered recurrent episodes of pneumonia, and attended the local ED five times. He saw a different doctor on each occasion, and had five more chest X-rays. All of them were reported as showing “right lower lobe pneumonia with collapse and some pleural fluid”. There were no indications in the ED notes to suggest that previous cards or X-rays were looked at.

In view of the recurrent chest infections, Child H's GP, Dr W, referred him to a paediatrician for further investigation. Paediatrician Dr Q saw Child H, looked at all the X-rays and suspected the presence of a foreign body. An urgent bronchoscopy was organised, and a large piece of plastic removed. Child H required further surgery, as the foreign body had caused fibrosis of the pulmonary parenchyma, which required excision.

Child H's mother made a claim against the ED and all the doctors involved during the 2 years.

### Expert opinion

The experts commented that “a case of a possible inhaled foreign body has to be followed up closely, and even without a clear history of inhalation of a foreign body, this

should be considered a possibility in cases of recurrent pneumonia in children with persistent X-ray changes.”

The case was deemed indefensible, and was settled for a moderate amount.



### Learning points

- Taking a good history can save many mishaps in clinical practice; it is important to listen. Digging into the details of what had happened to this child could have made it clear whether the foreign body had been swallowed or inhaled. Sudden onset of respiratory difficulty, with coughing, stridor or wheezing, needs to be specifically investigated. If inhalation is suspected, careful follow-up is required to determine the need for a bronchoscopy.
- Many types of plastic are radiolucent and will not show up on an X-ray.
- Asking the radiographers to place an example of a foreign body, if brought in by the parents, next to the patient they are going to X-ray will easily determine whether it is a radio-opaque object or a radiolucent one.
- Previous attendances at an ED by a child might be relevant in a significant number of cases. Hospital note-gathering systems may be helpful in picking up previous ED attendances. Reviewing old notes is therefore always important, and might offer unexpected background to a new presentation.
- With modern computerised radiographic storing systems, there is little excuse not to look at previous X-rays. Both clinician and radiologist would have been alerted to the fact that the changes in the chest X-ray were chronic, and would therefore have been suspicious that a foreign body was present.

## Contributing to the iThemba Christmas party

The SAMA Western Cape councillors donated funds towards the iThemba Christmas Party, which was held on 7 December. A non-profit organisation, iThemba runs a preschool in Capricorn for 86 underprivileged children between the ages of 3 and 6. The children are educated and fed 3 times a day, 5 days a week.

At the Christmas party, each child was given either a pair of Crocs or school shoes, if they were starting Grade 1 this year.



*At the iThemba Christmas party*



## Intern orientation a success

Border Coastal branch recently held an intern orientation event, which was attended by some of the 53 new interns who started at the East London Hospital Complex last year.

Branch secretary Stella Kaschula attended the event, and handed out goody bags, which included a SAMA and Border Coastal branch welcome letter, membership application forms, tourism information, a street map,

*What's On* booklet, SAMA gift and chocolate. Eight interns completed membership application forms at the intern orientation, and persal numbers are still awaited. Follow-up will be carried out with all of the new interns for recruitment.

An intern social was arranged by the Frere Hospital Doctors' Committee, where interns could share a welcome drink, and socialise.



*Dr Ludo van Hillegondsberg delivering the SAMA presentation*

## KZN Midlands welcome interns

The Pietermaritzburg Hospital Complex intern orientation took place on 28 December 2018 in Pietermaritzburg. The programme was opened by Dr Eben Marais, intern curator.

Chairperson of the KZN Midlands branch, Dr G T T Buthelezi, welcomed the interns, and a presentation followed. The interns were left with food for thought: "Don't delay, join SAMA, be actively involved, and you are the future."



*Dr Buthelezi with branch secretary Mandy Hattingh*



*Dr Eben Marais, intern curator, opened the event*

## Griqualand West year-end function

At the end of 2018, the Griqualand West branch hosted an annual branch dinner at the Sun International Flamingo Casino, in Kimberley.

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

Dr M J Ngundu, chairperson of the branch, presented the 2018 overview of the branch's activities, which comprised the hosting of several successful CPD events, intern support, recruitment programmes and others.

The dinner was a good social encounter for members to meet and indulge in sharing their memories.



*Griqualand West Branch Council, from left: Dr C S Moses (treasurer), Dr T F Konso (branch councillor), S Hartzenberg (secretary), Dr M J Ngundu (chairman), Dr I N Blanche (vice-chairperson)*

## Making contact



*June du Toit (Free State Branch) recently visited Sandra Ferrone (left) at the SAMA Tygerberg Boland branch. June was on holiday in the area and popped in to share ideas, as all branches operate differently*

## KZN Midlands hold CME conference

The KZN Midlands branch held the 47th annual CME conference on 21 October 2018 in Pietermaritzburg. Delegates from the public and private sectors came from near and far to attend. Excellent topics and speakers were arranged for the day: Cardiac intervention in the 21st century (Dr S Maharaj); The dizzy patient (Prof. M H Cassimjee); Update on COPD (Dr M Suleman); Ethics in consent of blood transfusion (Dr S Ngcobo); Current perspectives in peripheral arterial disease (Dr M Saley); Challenges in the management of childhood asthma (Prof. P M Jeena); Doctors and social media, and ethical, commercial and reputational aspects (Ms S McGee).



*Dr Nyembezi and Dr W Fritsche (past chairperson 2003)*



*Dr S Maharaj (right), a Midlands Hospital Heart Centre cardiologist, with the Mediclinic marketing team*



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### Call For Abstract

- Please submit your abstract online: [www.challengingbeliefs.co.za](http://www.challengingbeliefs.co.za).  
For further information or assistance, kindly contact me at any of the numbers listed below.
- The deadline for the submission of abstracts is 30 April 2019. Registrars are specifically invited to present
- The committee invites the submission of abstracts to be considered for oral and e-poster presentations
- Faxed abstracts will unfortunately not be accepted
- All appropriate abstracts will be reviewed by the Scientific Committee. All abstracts received will be acknowledged, and authors will be sent acceptance or rejection letters by the 1st of May 2019. Please note that authors of accepted abstracts must be registered delegates

### Instructions to Authors

**1. Each abstract must clearly state the following:**

- a. Abstract title (the title of the abstract must not exceed 25 words)
- b. Name of list of author(s). The name of the presenting author must appear first in the list of authors
- c. Affiliation of author(s)
- d. Contact details of first author (telephone numbers, e-mail address etc)

**2. Abstracts must be typed in English, single line spacing, Arial font size 12**

**3. The body of the text must not exceed 350 words (this excludes the information listed in point 1)**

**4. Please adhere to the following format:**

- a. Introduction: should be brief and informative and state the aim of the study
- b. Methods: include a description of subjects and research methodology
- c. Results: outline the findings of the study supported by statistics as appropriate. Do not use figures, graphs or tables in the abstract. The data provided must be sufficient to permit peer review of the abstract
- d. Conclusion: provide summary and relevance of the main findings



**CWIG** | Chest Wall  
International  
Group

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### CPD:

Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association is one of the institutions that have been appointed by the Medical and Dental Professions Board of the Health Professions Council of SA to review and approve CPD applications.

**For further information please contact the SAMAREC/CPD Secretariat on 012 481 2000 OR email us on [samarec@samedical.org](mailto:samarec@samedical.org) or [cpd@samedical.org](mailto:cpd@samedical.org)**