

SAMA INSIDER

MAY 2019

**It's time to
eradicate TB**

**Docs, don your socks –
let's save lives**



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

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Diane de Kock
Editor: *SAMA INSIDER*

TB is a serious issue

March 24 was World TB Day, a day that was a stark reminder that TB is an epidemic in most of the world, and in SA the situation is serious. Urgent action is needed, and this was reflected in the theme of the day, "It is time," reinforcing the fact that it is time for the world to act to eradicate TB.

Dr Zolelwa Sifumba, who spoke at last year's SAMA conference and wrote about her experience as a multi-drug resistant TB (MDR-TB) survivor in the December/January 2019 issue of *SAMA Insider*, is one of the doctors featured in the documentary "UnMasked: We all breathe". Released in southern Africa on World TB Day on DSTV, the documentary reminds us that TB does not discriminate based on class, race or social standing, as it focuses on the experiences of three young SA doctors who were diagnosed with MDR-TB (page 5).

The documentary highlights the risks for healthcare workers in SA, who are six times more likely to contract TB than the general population.

"Make no mistake, TB is a serious issue in SA and, unless something drastic is done to deal with it, it will only get worse," says Dr Angelique Coetzee, chairperson of SAMA, who recognises that being responsible for providing healthcare does not make healthcare workers immune from contracting the disease.

The seriousness of the situation is reflected in the fact that ending the TB epidemic by 2030 is among the health targets of the Sustainable Development Goals, a collection of 17 global goals set by the UN General Assembly in 2015 for the year 2030.

"TB is a public health scourge, a health security threat and a development challenge. The World Health Organization's new and holistic strategy approved by the World Health Assembly of 194 member states in 2014 places patients and communities at the heart of the response," says Dr Mario Raviglione, Director of the WHO Global TB Programme.

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Happiness in a globalised world



Prof. Hoosen Coovadia, SAMA president

The UN Sustainable Development Solutions Network released its annual World Happiness Report in March 2019 (<http://worldhappiness.report.ed/2019>). Compiled annually since 2012, the report provides an overview of happiness around the planet. While it might seem a subjective category in our lives, the report indicates that happiness is more complicated and politically consequential than we may realise. Happiness is a difficult category to define. Ask a handful of people what makes them happy, and a slew of answers is likely to emerge. What makes people happy at one point in their lives might not be the case later; happiness for the individual may alter with their changing circumstances. Happiness becomes even more complicated when contemplating what it means on a global scale. Life is complex, and happiness, like other emotions, does not exist in a vacuum.

These ambiguities are precisely why it is important to think seriously about what constitutes happiness, how it can be categorised and measured and how this information might lead to the development and implementation of policy frameworks aimed at not only cultivating, but also sustaining happiness.

Taking this into consideration, the World Happiness Report taps into the field of psychology that is devoted to the science of happiness. Drawing from measures of subjective wellbeing, a field of psychology that attempts to account for mood and life assessments, it grapples with the distinction

between cognitive life evaluations and emotional reports.

Cognitive life evaluations measure how happy an individual might be based on the individual's assessment of his or her life. Using the Cantril ladder, respondents are asked to rank the status of their life on a scale of 1 - 10. As an alternative measurement, emotional reports are engaged with ranges of positive and negative affects. While life evaluations encourage respondents to reflect on whether their life makes them happy, an emotional report is more probing, asking people to consider what in life makes (or doesn't make) them happy.

In the 2019 World Happiness Report, big data and wellbeing, prosocial behaviour and how happiness correlates with voting behaviour are examined. One important conclusion about happiness and voting behaviour is that higher levels of happiness generally correlate with more active voters, who are more likely to vote for incumbent parties, while unhappiness tends to mean people are less active.

In a country such as SA, which ranked 106 out of 156 countries in 2019, the ramifications of this finding are significant. Ahead of the 2019 general elections, parties such as the Democratic Alliance (DA) and the Economic Freedom Fighters (EFF), among other smaller parties, seem likely to capitalise on the feelings of unhappiness throughout the country, which could mark a seismic shift in the development of SA's democracy away from the African National Congress (ANC).

Additionally, the report builds on previous studies of global happiness from the Gallup World Poll between 2005 and 2011, as well as on its own data from 2012 to 2018. In assessing the world rankings of happiness according to country, the study relies on six variables to try to determine the significance of emotional reports and positive and negative affect. These variables are: GDP per capita, social support, healthy life-expectancy at birth, freedom to make life choices, generosity and absence of corruption.

Of the three worldwide samples that were assessed for happiness using Cantril's ladder, the weighted and unweighted samples provide interesting results, in comparison. In the weighted sample, which is made up of each country's share of the total world

population, happiness remains relatively stable, but trends downward. However, in the unweighted sample, which is made up of the average of individual national averages, happiness trends upward. As the study indicates, this contrast demonstrates that recent upward trends have tended to be experienced in smaller countries rather than those with large populations, such as the USA, China and India.

Reports suggest that sub-Saharan Africa is becoming unhappier

Regional data on happiness present a different picture. While there was no discernable trend in happiness, using Cantril's ladder, in sub-Saharan Africa between 2005 and 2018, the Middle East and North Africa have trended downward by nearly 1 full point. Similarly, in the Americas and Australia-New Zealand, happiness has also trended downward during the same period. In Western Europe, there is no discernable trend, whereas in central and eastern Europe, happiness has trended upward by more than 0.5 over the same period.

One point in happiness may not seem like a significant change. However, the difference between ranking one's life as a 5 one year and a 6 the following year may mean moving from living paycheck-to-paycheck towards saving for the future. In reverse, ranking one's life as a 6 one year and a 5 the following year could also mean emerging support for populist parties that self-servingly tap into feelings of unhappiness.

Looking at regional trends of positive and negative affect in Africa, the results are even more interesting. In the Middle East and North Africa, positive affect has decreased, and negative affect has remained stable. Conversely, while positive affect remains stable in sub-Saharan Africa, negative affect has risen about 1 point from 2005 to 2018, suggesting that sub-Saharan Africa is becoming unhappier.

Just as regional data differ from global data, country-by-country data from sub-

Saharan Africa tell another story. Since countries around the world do not gather data on the six variables generally employed in most studies equally, variation among countries is not apparent in the broader sets of global and regional happiness trends. For instance, over the 2005 - 2018 period, the 28 countries that make up sub-Saharan Africa illustrated a wide range of happiness levels.

Nevertheless, the question remains: What does it all mean? Venezuela's happiness score, for instance, has dropped dramatically in recent years. In data gathered between 2010 and 2019, Venezuela dropped nearly 100 places, from the 20th-happiest country in 2013, to 108th in 2019. Although the World Happiness Reports indicate that people tend to rate their happiness consistently, an example such as

Venezuela suggests that happiness is a reactive, rather than proactive, emotion.

Although we all experience happiness, we don't share a common understanding of what it means, especially on a global scale. What the 2019 World Happiness Report foregrounds is that a better grasp of happiness may help us to understand the changing dynamics of societies and political behaviour around the world.

Uplifting documentary reminds us that we can all help fight TB

SAMA Communications Department

World TB Day, 24 March, was the air date of the new documentary "UnMasked: We all breathe" on DSTV channel 104 in southern and west Africa. TB Day aims to raise public awareness that TB remains an epidemic in much of the world, causing devastating health, social and economic consequences. SA is among the countries with the highest TB burdens in the world, with over 89 000 deaths each year.

"We are all the demographic, because we all breathe"

"UnMasked" is a documentary that candidly explores the experience of this illness in three young SA doctors whose daily lives were turned upside down by the devastating diagnosis. These brave, resilient women clawed their way up from the depths of despair, creating new lives for themselves and helping others in the process. Dr Zolelwa Sifumba, Dr Arlette Bekker and Dr Dalene von Delft have moulded this harrowing experience into a widespread and global movement to end TB. They bravely share their stories because they want to change perceptions and, ultimately, save lives.

Directors Ashleigh Hamilton and Emma Watts state: "UnMasked" is a showcase of real grappling that illustrates that a disease we all thought belonged to 'them' actually belongs

to all of us. It is a palpable exploration of understanding that because we all breathe, we are all without masks."

While most cases of TB in SA are susceptible to a standard antibiotic treatment and can be cured within a matter of months, the three doctors in this film contracted multidrug-resistant TB (MDR-TB). This is an evolved form of the disease that does not respond to the same classes of antibiotics, and must be treated for much longer with a more gruelling and aggressive drug regimen. The dark truth is that doctors and healthcare workers in SA are six

times more likely to contract TB than the public at large.

In this moving film, the three central characters open their homes and lives to advocate for better treatment and diagnostic care for all TB patients. Their voices join that of health minister, Dr Aaron Motsoaledi, who has been instrumental in the fight to get the world to take the threat of TB seriously. This past June (2018), in a world first, the SA government chose to officially replace the debilitating injectable regime with a new drug for all SA MDR-TB patients.



Dr Arlette Bekker says the person she was "before TB will never be again. That person died." But she is now getting back to work and going on rounds, making good decisions and being the best surgeon she can be.



For Dr Dalene von Delft, a mother, activist and global speaker, it's about impact and supporting lives across the world through her non-profit organisation, TB Proof, in the hope that in 20 years' time she can tell her children that TB is one less thing they have to worry about.



Dr Zolelwa Sifumba says her battle with TB makes her a better doctor, someone who can relate to her patients and say that she too survived TB – that anyone can get TB. On the global stage, she is an energetic voice and force for raising awareness.

Now, as survivors and activists, Zolelwa and Dalene channel their energy into taking off the mask, removing the stigma and debunking stereotypes, to unveil the truth about TB. Zolelwa was alone in her fight through illness, and now wants to use her voice to ensure that others are heard, while

Arlette is simply happy to be back in the operating theatre.

This documentary is a reminder that TB does not discriminate based on class, race or social standing. In Zolelwa's words: "We are all the demographic, because we all breathe."

The documentary can be viewed on DSTV Catch up and Catch up Plus, with additional screenings scheduled for later in the year. Watch the trailer: <https://vimeo.com/315337117>. To join the fight, go to www.takesallofus.com, www.tbproof.org or www.stoptb.org.

SAMA on World TB Day

SAMA says that government must focus on neglected groups such as healthcare and mine workers, as the world commemorated World TB Day. The theme of this year's commemoration is "It's time", a reference to the urgent need for governments around the world to act on commitments to eradicate TB, as set out in the Global 2020 milestones.

Ending the TB epidemic by 2030 is among the health targets of the Sustainable Development Goals. To accelerate countries' TB response in order to reach the targets, heads of state made strong commitments to end TB at the first-ever UN High-Level Meeting in September 2018.

"More urgent action to deal with TB is needed. High-risk groups such as healthcare and mine workers have all but been forgotten in the fight against TB, and we believe there is a need to refocus attention on them as vulnerable groups," says Dr Angelique Coetzee, chairperson of SAMA.

Dr Coetzee says the 2019 World TB Day theme is aimed at, among other things, scaling up access to TB treatment, ensuring sufficient and sustainable financing for TB research, promoting an end to stigma and discrimination associated with TB and promoting an equitable, rights-based and people-centred TB response.

"Make no mistake, TB is a serious issue in SA and, unless something drastic is done to deal with it, it will only get worse," says Dr Coetzee.

She says being responsible for providing healthcare does not make healthcare workers immune from contracting TB. In fact, she points out, healthcare workers are more likely to spread the disease to other uninfected patients within healthcare facilities, which makes intervention in this group particularly important.

"The other high-risk group – mine-workers – work in enclosed environments and are forced to breathe the same air due to the lack of ventilation. It is critical that they, and healthcare workers, are tested at least once a year for TB," states Dr Coetzee.

Are you suffering from occupational-specific dysphoria?

Prof. Christoffel Grobler, *associate professor, Walter Sisulu University*

In a recent article on burnout by, arguably, the world's leading expert, Christina Maslach, she referred to it as "occupational-specific dysphoria". While reading it, I thought back to the first time I gave a presentation on burnout, many years ago, while still in private practice as a psychiatrist.

As I stood there in front of the audience, I thought to myself, "You hypocrite! You're here in front of an audience of doctors, preaching about the prevention of burnout, yet you are suffering from it yourself!" That day, I made a decision to do something about it. Two years later, I left full-time private practice and went to work in Ireland, where I recovered from that sense of permanent emotional exhaustion.

Last year, after I presented on the topic of "Depression in doctors" at a SAMA CPD function, one colleague asked, "Is burnout a real thing?" The question was followed by laughter, and quips such as "We are all probably suffering from burnout." Well, as they say, there's many a true word spoken in jest: the sad fact is that most of them probably were. Doctors seem to have resigned themselves to the fact that they must live out their lives in a constant state of emotional exhaustion and detachment.

What is burnout?

The term "burnout" was coined in the 1970s by American psychologist Herbert Freudenberger. He used it to describe the consequences of severe stress and high ideals in the so-called helping professions.

Those in the helping professions, who sacrifice themselves for others, often end up being "burned out" – exhausted and struggling to cope with life's demands. It is also referred to as "compassion fatigue" or "the dark side of self-sacrifice". Burnout has been recognised for many years as an occupational hazard in professions such as human services, education and healthcare. The relationships that such providers develop with their patients or clients require an intense level of personal and emotional contact, and although this can be rewarding, it can also be emotionally draining. Within such occupations, the predominant habits are to be selfless and put others' needs first, to work

long hours and to do whatever it takes to help a patient.

Defined as a "prolonged response to chronic emotional and interpersonal job stressors", Maslach and others describe burnout as "a point at which important, meaningful and challenging work becomes unpleasant, unfulfilling and meaningless". Energy turns to exhaustion, involvement (or engagement) becomes cynicism, and efficacy is replaced by ineffectiveness. The Maslach Burnout Inventory is one of the most commonly used instruments for assessing this psychological syndrome.

In order to better understand burnout in context, the conceptual models, causes and consequences need some consideration, as does burnout as a clinical diagnosis.

Conceptual models

There have been various conceptual models of the development of burnout, and its subsequent impact. The following are currently receiving attention:

- The transactional model refers to sequential stages and imbalances. Its three stages are: (i) job stressors (an imbalance between work demands and individual resources); (ii) individual strain (an emotional response of exhaustion and anxiety); and (iii) defensive coping (changes in attitudes and behaviour, such as greater cynicism).
- The job demands-resources model focuses on the notion that burnout arises when an individual experiences incessant job demands and has inadequate resources available to address and to reduce those demands.
- The conservation-of-resources model follows a basic motivational theory assuming that burnout arises as a result of persistent threats to available resources. When individuals perceive that the resources they value are threatened, they strive to maintain those resources.
- The areas-of-worklife model frames job stressors in terms of a person-job imbalance, or mismatch, and identifies six key areas in which these imbalances take place: workload, control, reward, community, fairness and values. The greater

the mismatch between the person and the job, the greater the likelihood of burnout.

Causes

Work overload depletes the capacity of a person to meet the demands of the job. When overload is a chronic job condition, there is little opportunity to rest, recover and restore balance.

There is also a clear link between a lack of **control** and burnout. When employees cannot exercise professional autonomy and do not have access to resources necessary to do an effective job, they are more likely to suffer from burnout.

Lack of recognition and **reward** (whether financial, institutional or social) increases people's vulnerability to burnout, because it devalues both the work and the workers, and is closely associated with feelings of inefficacy.

Community refers to the relationships that employees have with other people on the job. When these relationships are characterised by a lack of support and trust, and unresolved conflict, then there is a greater risk of burnout.

Fairness refers to the extent to which decisions at work are perceived as being fair and equitable. Cynicism, anger and hostility are likely to arise when people feel they are not being treated with the appropriate respect.

Finally, **values** are the ideals and motivations that originally attracted people to their job – the motivating connection between the worker and the workplace. When there is a values conflict or a gap between individual and organisational values, employees will find themselves making a trade-off between work they want to do and work they have to do, which can lead to burnout.

As in many other countries in the world, my personal experience is that healthcare resources are limited in SA, and the environment is unforgiving of mistakes. A recent publication by the WMA observed: "Physicians in many countries are experiencing great frustration in practising their profession, whether because of limited resources, government and/or corporate micromanagement of healthcare delivery,

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Consequences

The consequences of burnout in doctors are absenteeism, decreased productivity, job dissatisfaction, lower quality of care, lowered retention of skilled staff and poor patient care, and greater patient dissatisfaction.

Interestingly, a Canadian study found that burnout may cause people to relocate, as more than half of the respondents in the study had considered relocating due to burnout. Moving to Ireland after private practice makes sense to me, in retrospect.

Burnout as a clinical diagnosis

There has been a drive to “medicalise” burnout by the medical profession, seemingly with the goal of establishing a clinical diagnosis, so that health professionals can receive reimbursement for treating individuals suffering from burnout.

This shift to diagnosing burnout as an individual disorder has mostly taken place in Northern Europe, primarily Sweden and the Netherlands. Sweden began using “work-related neurasthenia” as a burnout diagnosis in 1997, which soon became one of the five most common diagnoses. In 2005, the country revised the ICD-10 burnout diagnosis (Z73.0) to a difficulty in life management characterised by “vital exhaustion”. The signs of vital exhaustion include 2 weeks of daily experiences of low energy, with difficulties in concentration, irritability, emotional instability, dizziness and sleep difficulties. Additionally, these symptoms must interfere with the patient’s capacity to perform his or her work responsibilities.

In the Netherlands, the term *overspanning*, or “overstrain”, is used to indicate burnout. This diagnostic approach estimates burnout prevalence at 3 - 7% across various occupations, with psychotherapists at 4%.

It is interesting that the USA has been reluctant to recognise burnout as a clinical diagnosis, partly due to concerns about a flood of requests for disability coverage. This absence of an official diagnosis of burnout limits access to treatment, disability coverage and workplace accommodations. An unfortunate consequence is that inaccurate diagnoses may reduce possibilities for successful recovery and return to work.

However, in the end, the medicalisation of burnout in this manner constitutes a one-dimensional approach. Current research has now begun focusing on all three dimensions of burnout, which allows for identification of multiple distinct patterns on the burnout-engagement continuum, having realised that exhaustion alone is not a proxy for burnout.

Treatment and prevention

Intervention strategies for burnout have to consider the high costs involved, both personal and organisational. Some attempt to treat burnout after it has occurred, while others focus on how to prevent it, by promoting engagement.

A Canadian study of physicians identified resilience as a dynamic, evolving process of positive attitudes and effective strategies that can prevent burnout. The study found four main aspects of physician resilience:

- attitudes and perspectives, which include valuing the physician role, maintaining interest, developing self-awareness and accepting personal limitations
- balance and prioritisation, which include setting limits, taking effective approaches to continuing professional development and honouring the self
- practice management style, which includes sound business management, having good staff and using effective practice arrangements
- supportive relations, which include positive personal relationships, effective professional relationships and good communication.

No measures to prevent burnout will be effective unless attention is paid to enhancing a positive work environment. Isolated strategies directed at individual doctors may prove of limited benefit. A positive work environment is defined as one that “attracts individuals into the health profession, encourages them to remain in the health workforce and enables them to perform effectively, to facilitate better adaptation to the work environment”.

Key features of a positive work environment include achieving work-life balance by providing a family-friendly work environment and flexible working hours. Protection from exposure to occupational risks, enhancing job security, provision of childcare opportunities, compensation for reduced employment and maternity/parental leave were identified as attributes of the work environment that prevent burnout.

In as much as a positive work environment lowers the risk of burnout, the opposite is also true – the risk for burnout increases for doctors working in poorly functioning organisations.

Conclusion

In conclusion, if any of the following statements ring true for you, there is a chance that you might be suffering from burnout, or occupational-specific dysphoria:

- “I feel demoralised and emotionally exhausted all the time.”
- “I have become cynical about my work environment, and I protect myself by being disengaged from patients, colleagues and my work.”
- “My work has become meaningless and I don’t enjoy what I’m doing anymore; I do not feel I’m making a difference anymore.”

And if you just can’t face another day of work, don’t quit – at least not yet. Here are some practical suggestions:

- Talk to colleagues about it. This can be in the setting of a regularly scheduled group, or simply informal conversations about the stresses of work.
- Minimise administrative work. This may involve a financial investment in an assistant, but the cost can be minimal, especially if you hire a virtual assistant who can work a few hours a week from a remote location.
- Develop new professional skills, such as teaching, consultation or business management.
- Make a conscious effort to get re-engaged with your clinical work. Rediscover the idealism and intellectual curiosity that got you into medicine in the first place.
- Learn how to meditate, and schedule at least 5 - 10 minutes of meditation into your day.

At present, I can honestly say that I do not suffer from burnout. I ascribe it to the fact that I work in a hospital where the collegial support, ranging from medical colleagues to the other allied health professionals, and including management, is tangible. I feel privileged to work with such people, and it fills me with humility and thankfulness.

If you, the reader of this article, realise that you may be suffering from burnout, you have my fullest sympathy, and I implore you to do some introspection and make the necessary changes. For yourself, your family and, most importantly, your patients.

ADASA aims to serve the best interests of doctors in academia



SAMA Communications Department

ADASA, the Academic Doctors Association of SA, is a special interest group of the SAMA Trade Union (TU), as well as a division of the SAMA non-profit company. To become a member, you must be a medical specialist registered with the HPCSA, a member of SAMA and employed in the academic sector.

SAMA aims to serve the best interests and needs of its members in any and all healthcare-related matters, while ADASA aims to serve the best interests of doctors in the academic sector, including specialists employed in the joint establishment of a university and department of health, and ADASA affiliates, including academic societies and specialty groups who are members of ADASA.

Objectives

The association's objectives are to promote and maintain the professional, academic and legitimate interests of doctors employed in the academic sector (including those employed according to joint agreements between the universities and other parties, or those accredited for undergraduate and/or postgraduate training), and to define and establish relationships among members of the association, between members and other medical associated groups, hospitals and public and private institutions, and between the profession and the public.

It also aims to promote the SAMA mission of uniting doctors for the health of the nation, to promote health for all by striving for an affordable, accessible, comprehensive, effective and unitary health system and to support and promote the aims and objectives of the SAMA TU.

Member benefits

ADASA provides updates on legislation, medical ethics, labour relations, CPD and coding products and practice tools, as well as representation for individuals and groups in all matters affecting the profession, including industrial relations assistance, support and representation and private practice assistance and medical coding support services. CPD services are also provided.

Members receive a monthly hard copy of the *SA Medical Journal*, and electronic access

to the biannual *SA Journal of Bioethics and Law*. Membership benefits include offers exclusive to SAMA members, such as preferential and discounted rates.

Being a member of ADASA means that:

- academic doctors and what they do are respected;
- academic doctors and their rights are promoted;
- academic doctors are fairly compensated for what they do; and
- what academic doctors do, how they do it and how they are seen remains sustainable and enduring.

Structure

The committee for 2018 - 2021 will consist of: Prof. Bernard Janse van Rensburg, chairperson; Prof. Mark Sonderup, vice chairperson; Prof. Kebashni Thandrayen, treasurer; Prof. Deb Basu, secretary; and Dr Dirk Hagemester and Dr Ogbo Harbor as additional members. The schools of clinical medicine (ScOCMs) and pathology at the following institutions are represented: University of Pretoria, Sefako Makgatho Health Sciences University, University of the Witwatersrand, University of KwaZulu-Natal, University of the Free State, Walter Sisulu University, Stellenbosch University and the University of Cape Town.

Vision and mission

Vision: to promote, maintain and protect the honour and interests of ADASA members and their different specialist disciplines, and to serve the community.

Mission: to support all matters academic for joint-appointed and private specialists and their disciplines who are not adequately represented in their organisation, interest group, and place of employment.

Agenda

During this term of office, ADASA intends to focus on professional/advocacy matters in consultation with the SAMA NPC board, including: the academic doctors' constituency; proposed models of healthcare; academic medical governance; medical teaching and learning, both under- and postgraduate; academic medical employee

health and wellness (consultants, registrars, undergraduate students); and stakeholders and sources of funding (e.g. the National Departments of Health, Higher Education and Science and Technology).

The agenda also includes a focus on labour matters, academic/joint-appointed medical staff and the SAMA TU and the trade union task team including: remuneration of academic medical staff (SAMA cost studies; establishing a separate bargaining chamber); university MOAs with provincial departments of health – existing contracts, gaps; uniform structure and content of an academic/joint-appointee employment contract; uniform conditions of employment and performance assessment in teaching and research; and the availability of funded posts for trained staff.

Priorities for the current term of office:

- active engagement and building of structures
- effective representation of all disciplines
- remunerative work outside the public service, and commuted overtime
- structured contract with both employers
- memoranda of association with universities and provinces
- alignment with stakeholders
- effective subcommittees at each of the ScOCMs
- representation from all specialist associations
- council representation in all SAMA branches with schools of clinical medicine and pathology.

Year 1 (2019) operational plan

- membership
- ADASA labour matters
- ADASA advocacy matters
- stakeholder liaison
- SAMA tender proposals
- SAMA/ADASA workshop(s)
- ADASA constitution.

For more information, please contact Mrs Girly Moseki: GirlyM@samedical.org or +27 (0)12 481 2091.

Addiction in the medical profession: When habits become destructive

Prof. Zuki Zingela, HOD, Department of Psychiatry and Behavioural Sciences, Walter Sisulu University

From use by priests in ancient times for religious ceremonies, to use by traditional and other types of healers across the ages, our ancestors across the world have devised ever-more potent compounds and faster ways to deliver psychoactive substances to our brains, in order to influence or change our perception of reality and our emotions.

One outcome of this gives rise to questions that we grapple with today, including: what makes some people more vulnerable to drug addiction than others? If a substance is potentially harmful, is it a perverse contradiction to talk about socially acceptable use, as seen with, for example, caffeine, nicotine and alcohol? What of addiction when it afflicts those in our profession, who are meant to help others?

The scale of the problem

In the March 2019 SAMA Insider article “Coping strategies for the distressed doctor”, I referred to the HPCSA 2018 statistics on impaired physicians. Up to 40% of medical practitioner impairment recorded in the HPCSA database is reported to be due to substance abuse or dependence. The stark reality of these figures means that in 4 out of every 10 doctors declared impaired by the HPCSA, the impairment is due to substance use.

The reasons for these sobering stats are likely similar to those leading to doctors struggling with their mental health, such as overwork, short staffing and being sandwiched between unrealistic demands and expectations from patients and managers, and being provided with very few resources to deliver quality services. Add to this financial pressures, societal and personal expectations of excellence, little room for failure, alongside perfectionistic traits, and the recipe is set for the catch-22 situation that doctors often find themselves trapped in: “Yes, I realise my job is destroying me, but I have invested too much in it to just walk away” – so, we stay. And if need be, we reach for whatever crutch we can find to keep us going. When the crutch turns into a destructive habit, however, this can make us vulnerable to mental distress and ill health.

Addiction is a challenge precisely because the fine line between socially acceptable use

and pathological use can become blurred. It may be easier to demarcate the boundaries when the substance of abuse is illicit, but it poses a dilemma when the substance is seen as socially acceptable, for example, caffeine, alcohol, prescription drugs or specific types of addictive behaviours, such as gambling. An occasional drinker or gambler, for example, does not suffer from any disorder. Yet the same behaviours can become so entrenched as to become disabling and pathological.

Addiction in the medical profession

Without getting into technical detail about the effect of substances on the brain, and how a potentially addictive substance can fuel an escalation into the taking of larger amounts of that substance, it is worthwhile mentioning novelty-seeking as a factor that has been identified numerous times as associated with a vulnerability for addiction. This refers to the tendency to seek new stimuli and environments. It is influenced by both genetic and environmental factors, and may manifest as a personality trait. It has also been identified as a strong contributory factor – though not the only one – to the development of addiction.

In general, we all have coping strategies, developed over time, which allow us to face stressors head on and continue to function. Such coping strategies play an important function, and enable us to keep going in the face of potentially overwhelming adversity. Balanced approaches or habits to destress allow us to regroup, and may buy us time and resilience while we try and figure out how to get ourselves out of troubling situations. The dilemma we face, however, is as described above. The idealist in us wants to deliver the best care possible to the patients we serve, but the realist in us recognises the near impossibility of this, whether due to limitations in the public sector or limitations to what medical aids will and will not pay for in the private sector.

Many of us may find something positive to keep us hanging on, whether it be the colleague who lightens the mood through effective use of humour as a defence, or the patient who bears their pain with a smile.

Others find comfort and motivation in academic pursuits and/or research, volunteer work and similar activities. This is over and above the things we do in our spare time to try and cope.

The ease of access to substances of abuse is a realistic, easily accessible temptation to the average doctor

The ease of access to substances (or behaviours) of abuse, however, is a realistic, easily accessible temptation to the average doctor. Your earning power means that you can get whatever your hard-earned salary can buy, be it expensive alcohol or more illicit substances of abuse. You can also raise enough capital to go toe-to-toe with serious gamblers. For a few hours, while in the grip of acute intoxication, your mind can escape the misfortune of your situation, and you feel good. The powerful illusion of being in control, though, lasts only as long as the high.

Practicalities

Am I addicted? This is often a hard question to ask, and an even harder one to answer honestly to oneself. The four-item CAGE questionnaire (<https://psychology-tools.com/test/cage-alcohol-questionnaire>) is good for assessing alcohol use, and it may assist in giving you insight into other addictive behaviours. If you answer yes to two or more of the four items, then, realistically, you have a problem.

What do I do about it?

- Tell a trusted friend, relative or colleague, so you can have someone in your corner who supports you.
- Examine what you gain from the substance use v. what you lose or stand to lose by continuing.
- Examine what (or who) supports you and makes you stronger in your attempts

to quit. What (who) detracts you from progress? Change your social circle if need be to minimise chances of relapsing into addictive behaviours.

- Reach out to a clinical psychologist to help you re-look at triggers for substance-taking behaviours and alternative coping strategies.

- You may be in a position to take your supervisor at work into your confidence. It is likely that they have observed a drop in your work performance already, so coming clean may assist in clearing the air, while providing space for you to address the issue.

- Consider self-reporting to the HPCSA as a means of assisting you to structure your path back to recovery.
- Consider checking into rehab if you have tried time and time again to come off the substance(s) without success. It may save your life.

Tshemba Foundation makes a difference

SAMA Communications Department

The idea behind Tshemba Foundation was simple: to bring world-class medical practitioners to the most underserved areas in South Africa. Founded in 2014 by Neil Tabatznik, this unique volunteering programme provides the opportunity for medical professionals to treat, teach and learn, while also being accommodated at a 5-star lodge on a private game reserve.

"I probably got back more than I gave to the community"

Tshemba is privately funded, but has an MOU with the Mpumalanga Department of Health that allows it to place doctors in their hospitals and clinics. In the past two years, about 50 local and international medical professionals from various fields have volunteered their time, from a couple of weeks to over a year. Volunteers assist many patients during their stay, while a programme such as our five-day dental outreach, resulted in more than 1 700 children being educated about dental care.

The foundation was started as a way for medical professionals to give back to the most vulnerable communities, but it is also a place where like-minded volunteers can exchange ideas, connect with peers from around the world and create healthcare solutions for the challenges they experience.

"I loved every moment of my time in Hoedspruit, Tintswalo and Tshemba. I probably got back more than I gave to the community, where the need is so great, but I really did feel like I was making a difference. One of the values of Tshemba that I love the most is "skills transfer" – that although we volunteer for a short time, our legacy lasts longer, reaching beyond



Relaxing in the beautiful surroundings



Dr Kate Meyer, a Tshemba volunteer

the small areas that we work in. Hoedspruit is a fantastic area to explore and Tshemba provides wonderful relief at the end of the day," says Dr Kate Meyer, a Tshemba volunteer.

To volunteer, or for more information, visit www.tshembafoundation.org or email lexi@tshembafoundation.org.

About Tshemba Foundation

The foundation offers a unique volunteering programme, aiming to improve access to healthcare in low-income communities in Limpopo and Mpumalanga, while enriching the lives of qualified medical professionals.

Volunteers (local and international) reside in a 5-star lodge, while providing essential medical care at the surrounding hospitals and clinics, as well as upskilling local healthcare providers.

Phone +27 (64) 507 5527 or visit www.tshembafoundation.org for more information.

Docs, don your socks – let's save lives

Prof. Lizette Rabe, Stellenbosch University, Ithemba Foundation



According to research in the USA, one doctor dies of suicide every day. This is the highest suicide rate of any profession. Indeed, the number of doctor suicides in the USA – 28 to 40 per 100 000 – is more than twice that of the general population, where the rate is 12.3 per 100 000.

Mood disorders in the health professions are not, of course, restricted to North America. Studies from various countries have shown an increase in anxiety and depression, as well as suicidal thoughts, among health professionals – and also medical students.

We can safely surmise that SA statistics would not be far off. Indeed, the conditions under which our medical professionals work are far from ideal. When in June last year I sent an article on mental health among doctors to a number of SA doctors, the response was unanimous: here, it is far worse. Plus: "In SA we do not even have a practitioner health programme, as in the UK." The following month, *SAMA Insider* focused on mental health. In particular, the article by Dr Christoffel Grobler was spot on: "Don't wait until it's too late."

And then, at the end of July, it was too late for one leader within the profession. Prof. Bongani Mayosi, dean of health sciences at UCT, died of suicide. Prof. Mayosi became part of SA's statistics of about 23 people per day who would die of suicide, with many more attempts – one estimate indicates up to 460 attempts every 24 hours.

As found in many studies, a fatal depression episode is the cause of suicide in more

than 90% of cases. The US study also indicated that doctors who die of suicide often have untreated or undertreated depression or other mental illnesses. And as Prof. Beth Brodsky, associate clinical professor of medical psychology in psychiatry at Columbia University, stressed: People do not "commit" suicide. They die by suicide. Also: "Suicide is an illness, and not a crime."

The question is: How can we break the silence and the stigma in the medical fraternity?

Well, one way is by wearing your "crazy socks" on this year's CrazySocks4Docs Day (CS4D), on 7 June. It all began with an Australian cardiologist, Dr Geoff Toogood, who on a day in 2016 wore mismatched socks to work, and heard sniggering remarks behind his back.

So, in 2017, he officially started the CS4D initiative: "The message needs to get out there that doctors need to look after each other, so that we can look after everyone else."

And the reason why he chose to reclaim the word "crazy"? Because "we often call people with mental health issues 'crazy' and I wanted to make crazy fun – instead of the mental health connotation."

The Ithemba Foundation caught on to CS4D, promoted it on our Facebook site in 2018, made contact with Dr Toogood and after such a positive response locally, decided

to plan an all-out CS4D-campaign as one of our 2019 projects, as the wellbeing of our medical practitioners should be a priority. That is also the reason why we decided on the slogan "Caring for the carers".

Studies indicate that the situation on medical campuses is not healthy either. The stress starts to add up in medical school, then continues in residency. Mental ill-health, in fact, is debilitating our medical students, as they cannot say "Help me," fearing that they will be discriminated against.

Asked to speak at my university's medical campus during our Mental Health Awareness Week last year, the students agreed about their stressors, and how they cannot ask for help because of stigma and discrimination. An article by a US medical student that I used as my point of departure was something they could all identify with. That is also the reason why Ithemba decided to include medical schools in our campaign, with sock manufacturer Falke sponsoring 10 000 pairs of mismatched "crazy socks" for medical students with the clear message: empower yourself, look after your own health. Break that debilitating stigma. One study in 2016 found that 50% of female doctors who completed a questionnaire met the criteria for a mental disorder, but were reluctant to seek help because of the fear of stigma.

But we can each make a difference, and together, we can make an even bigger difference, especially by "Caring for the carers". So wear your crazy socks on 7 June. Show you care.



Lizette Rabe, professor at Stellenbosch University, founded the Ithemba Foundation (www.ithembafoundation.org.za) when her bright, brilliant medical student son died of depression in his fourth year. Ithemba, meaning hope in isiXhosa, is a non-profit organisation that raises awareness of depression and related diseases as biological diseases, and raises funds for research. The Hope Hike and Hope Bike are held annually in October, around the World Health Organization's Mental Health Awareness Day. Ithemba's registration number is 2012/171250/08, and its SARS PBO (public benefit organisation) number 930/048/019.

A dispensing licence – is it really necessary?

Laetitia Crause, CEO, Health Science Academy

Doctor A is considering a locum position in a practice that dispenses medicines to patients. She knows very little about good pharmacy practice (GPP) or the rules involved in dispensing. Are there any legal obligations or risks when accepting this position?

The Medicines and Related Substances Act No. 101 of 1965 gives the answers. In short:

- A doctor can only dispense or compound medicines when holding a licence issued by the Director-General: Health.
- This licence is issued to a specific applicant who has successfully completed a dispensing course approved by the SA Pharmacy Council (SAPC). Locums should note that the licence is linked to the applicant, and not to the practice.
- Once the licence has been issued, the applicant has definite obligations in terms of GPP and good dispensing practice.

The relevant clauses of the Act read as follows:
Section 22C(5):

“No person shall compound or dispense a medicine unless he or she is authorised thereto in terms of the Pharmacy Act [No. 53 of] 1974, is a veterinarian or is the holder of a licence as contemplated in subsection (1) (a).”

Section 22C(1)(a):

“The Director-General may, on application in the prescribed manner and on payment of the prescribed fee, issue to a medical practitioner, dentist, practitioner, nurse or other person registered under the Health Professions Act [No. 56 of] 1974 a licence to compound and dispense medicines, on the prescribed conditions.”

Section 22C(2):

“A licence referred to in subsection shall (1)(a) shall not be issued unless the applicant has successfully completed a supplementary course determined by the South African

Pharmacy Council after consultation with the Health Professions Council of South Africa, the Allied Health Professions Council of South Africa and the South African Nursing Council.”

The regulations to the Medicines and Related Substances Act clarify the obligations of the licensed dispenser to:

- keep a prescription book or permanent record relating to medicines dispensed/ compounded for a period of 5 years from the date of sale
- ensure that the dispensary and any premises where medicines are kept are suitable for dispensing, in accordance with GPP
- keep the medicines under storage conditions as specified
- not repackage medicines at the premises unless authorised to do so
- label medicines with a reference number that links to a patient record
- dispense medicines in accordance with a prescription based on a diagnosis for a particular patient
- keep expired medicines in a demarcated area in a sealed container clearly marked “expired medicines”
- secure the premises where the dispensing/ compounding is carried out
- comply with the terms of the recall of a medicine
- clearly display and comply with the conditions of the licence.

What is good pharmacy practice?

GPP regulations are compiled by the SAPC. The council strives continuously to ensure that the highest standards of pharmaceuticals services are maintained.

There are minimum standards for the medicine room of a person licensed to dispense medicines, relating to the:

- premises, access control and condition of the medicine room

- equipment required for dispensing
- storage area
- reference resource available.

Dispensing course for healthcare professionals

The Dispensing for Healthcare Professionals course at the Health Science Academy is based on the recommended standards for the dispensing course for prescribers in terms of the Medicines and Related Substances Act as amended, which was developed by the SAPC in consultation with the HPCSA, the Allied Health Professions Council of SA and the SA Nursing Council.

The course is targeted at healthcare professionals who are authorised prescribers, and who must be licensed to dispense medicines in terms of regulation 22 of the Medicines and Related Substances Act as amended. The successfully completed dispensing course (NQF 6) is accredited through SAMA for a total of 30 CPD points, of which 5 are ethical points.

The course can be completed in distance format over 6 months, with a face-to-face practical examination after completion of the portfolio and questionnaire.

Obtaining a licence from the Department of Health

After successful completion of the course, an application for a licence to compound and dispense medicines must be submitted to the Department of Health, Directorate: Affordable Medicines.

It is recommended that a refresher course is done every 3 - 4 years to ensure that dispensers stay up to date with legislation and GPP.

Contact hsaenquiries@healthscience.co.za for more information.

References available on request.



Based on the recommended standards for the dispensing course for prescribers in terms of Act 101 of 1965 as amended

MODE: Distance Tuition with practical examination
CEUs: 25 Clinical & 5 Ethics CEUs
PRICE: R 2 320.18 (incl VAT)

Living wills – current status and recent legal developments

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

A living will is an advance directive given by a competent patient to express his or her preferences and give instructions regarding future medical treatment in the event that (s)he becomes unable to make or communicate healthcare decisions. This might, among other situations, occur if the patient suffers from a terminal and incurable condition that renders him or her incompetent to make or communicate decisions concerning medical treatment, is in a permanent vegetative state or is completely and irreversibly unconscious.

The High Court has in the past sanctioned the removal of life-sustaining treatment with reference to prevailing societal convictions, as interpreted by the court. In 1992, the High Court permitted the removal of a patient's nasogastric tube to allow him to die. The patient had suffered serious and irreversible brain damage due to cerebral anoxia and had become deeply comatose, and remained in that condition. The patient's wife applied to the High Court for an order allowing the discontinuance of any life-sustaining treatment. The patient was a life member of the SA Voluntary Euthanasia Society. He had signed a document titled "A living will" that was directed to his family, his doctor and to any hospital. It read that if there were to be no reasonable expectation of his recovery from extreme physical or mental disability, he directed that he be allowed to die, and not be kept alive by artificial means and heroic measures. Although the judgement referred to the patient's living will, the lawfulness of the withdrawal of treatment was ultimately determined on the basis of societal convictions rather than the existence of the living will itself. The High Court thus chose not to address the legal status of a living will, despite the opportunity to do so.

Notwithstanding the above, living wills should be respected in terms of SA common law. In principle, every person of sound mind has a right to refuse medical treatment, even if this refusal has the effect of hastening death. Doctors should, however, be satisfied that convincing evidence exists that the document in fact reflects the wishes of the patient (for example, ascertaining whether it was drafted recently, and was submitted to

the patient's doctor or lawyer, or found on the patient's person). Doctors should furthermore be satisfied that the patient's condition and prognosis in fact trigger the living will: in other words, if the living will is specific to a particular set of circumstances, it will have no force if these circumstances do not exist. Similarly, if a living will is so broad that it applies to all possible events that could arise, it would likely be too vague to give any definitive direction to the doctor. Doctors should therefore carefully review the living will and, if needed, obtain legal advice regarding its interpretation and validity. If there is any uncertainty regarding the authenticity, validity or applicability of the living will in the circumstances, the senior doctor in charge of the patient's care should make a decision regarding withdrawal of treatment on the basis of professional opinion and clinical indication, rather than the questionable living will. The decision about withdrawal should be made in consultation with the patient's family. Advice should also be sought from other doctors and a person with a background in ethics.

From a regulatory perspective, the HPCSA recognises living wills in its Guidelines for the Withholding and Withdrawing of Treatment. The guidelines state that patients should be given the opportunity and encouraged to indicate their wishes regarding further treatment, and to place in writing their directives for future care in possible critical circumstances (e.g. permanent coma or terminal illness). Furthermore, the guidelines state that where a patient lacks the capacity to decide, doctors must respect any valid advance refusal of treatment. The guidelines indicate that an appropriately drafted living will may be used for this purpose.

Living wills are not recognised by statute in SA. The National Health Act No. 61 of 2003 does, however, make provision for the appointment of a proxy healthcare decision-maker. The Act, furthermore, provides that health services may not be provided to a patient without informed consent, and that a patient may refuse treatment. Nevertheless, the Act does not expressly recognise living wills. Furthermore, the Act does not contain any detail regarding the purpose, scope

and format of advance directives. Similarly, the Act does not set out the manner in which certain potential problems with the enforcement of advance directives should be approached. For example, the Act does not address whether or not a directive may be overridden by the patient's family or treating doctor, whether the treating doctor will be immune from civil and criminal prosecution or how to resolve conflicts where there are several substitute decision-makers who disagree about treatment.

The SA Law Commission investigated issues pertaining to end-of-life decisions, and prepared a report in this regard that was put before parliament for consideration two decades ago. The report was submitted to the then minister of health, but did not receive much attention at the time, reportedly due to the fact that there were other urgent issues that required attention, such as the AIDS epidemic. The report, among other proposals, recommended that advance directives should be afforded statutory recognition.

A bill was recently introduced to parliament in an attempt to implement some of the recommendations of the commission's report. In this regard, the National Health Amendment Bill was introduced by Congress of the People (COPE) MP Deidre Carter to explicitly recognise living wills and a durable power of attorney, and to ensure that these directives are enforced.

The most significant amendments envisioned in the bill are the following:

- Like the current National Health Act, the bill recognises a durable power of attorney with respect to future medical treatment. However, unlike the current Act, the bill specifically states that a proxy decision-maker may make any and all medical decisions, including decisions about withholding or withdrawal of any treatment, on behalf of a patient who is no longer competent to make or communicate such medical decisions.
- The maker of the durable power of attorney for healthcare may also mandate the proxy to take medical decisions relating to the refusal of treatment on his or her behalf for religious or other reasons, and on

- donating any or all of the transplantable organs or tissues of the maker.
- Any decision taken by the proxy in terms of a durable power of attorney for healthcare: (i) must be informed by any medical advice from the treating doctor; (ii) must be informed by the values, principles and beliefs of the patient in so far as these are known to the proxy, and where not known, such decisions must be taken in the best interests of the patient; (iii) must be taken while the proxy is competent to make such decisions; and (iv) is final, and may not be overridden by any other person.
- A person may express his or her refusal for any future potentially life-sustaining medical treatment or procedure in a living will, in preparation for when such person may no longer be competent to express such refusal.
- The potentially life-sustaining medical treatment or procedures contemplated in a living will may include: (i) artificial

- nutrition; (ii) artificial hydration; (iii) dialysis; (iv) any medication or drug, including antibiotics, administered through any method, including an intravenous tube; or (v) life support of any kind.
- The treating medical doctor, before giving effect to the living will, must: (i) satisfy him- or herself that on the face of the facts: the medical condition is terminal and incurable, and the patient is no longer competent to make or communicate decisions concerning medical treatment or refusal thereof; the patient is in a permanent vegetative state; or the patient is completely and irreversibly unconscious; (ii) satisfy him- or herself, in so far as is reasonably possible, of the authenticity of the living will; and (iii) inform, where practicably possible, the patient's spouse or partner, or in the absence of a spouse or partner, the patient's parent, grandparent, an adult child, or a brother or sister, in the specific order as listed, of the existence and content of the living will.

- The treating medical doctor who withholds or withdraws any medical treatment in accordance with a valid living will shall not be criminally or civilly liable, even though such withholding or withdrawal might hasten or has hastened the natural death of the maker of the living will.
- A living will may not be overridden by any other person.
- A living will does not preclude emergency care until a person's condition can be established and the applicability of a living will can be determined.

There is still considerable uncertainty among doctors regarding the legal enforceability of advance directives. This leads to much anxiety regarding possible civil or criminal liability. In light thereof, the statutory regulation of advance directives deserves consideration. SAMA will keep members updated regarding any significant developments relating to the amendment bill.

SAMA discusses proposed 1-year internship

SAMA Communications Department

SAMA convened a stakeholder meeting on 26 February 2019 to discuss issues around internship training from 2020 and beyond. Various stakeholders raised significant concerns after the SA Committee of Medical Deans (SACOMD) recommended a reduction in the internship programme from 2 years to 1 from 2020.

SACOMD also suggested that the 1-year internship and 1-year community service should be part of a vocational training programme co-ordinated by universities. The committee went further, saying it is not the purpose of the internship programme to allow medical interns to gain competencies in surgical procedures such as caesarean sections and the administration of anaesthesia.

Many stakeholders, such as the National Committee on Confidential Enquiries into Maternal Deaths, Committee on Morbidity and Mortality in Children, Rural Doctors Association of SA and National Perinatal Mortality Committee have voiced concerns about the proposed change. SAMA rejected the suggestion in its entirety. This problem was created by the introduction of the Nelson Mandela Fidel Castro Medical Programme,

which has left many new doctors – who are due to enter the healthcare system in January 2020 – without proper logistical and budgetary provisions from the National Department of Health (NDoH).

Two problems currently exist: the lack of accredited posts, and the lack of funds to pay the larger number of interns.

At the stakeholder meeting, the HPCSA confirmed that the internship programme would remain as a 2-year programme in 2020. SAMA has agreed to chart all currently accredited internship facilities. However, all training platforms for internship training at regional hospitals are currently saturated, and the SAMA Education, Science and Technology Committee (EST) has requested that specialty societies involved in internship training apply their minds as to how they could expand existing platforms without compromising training.

There are various models being proposed, which include an 18-month regional/tertiary hospital rotation and a 6-month district hospital rotation. The expansion of the platforms may also include the accreditation of new sites. SAMA would also urge societies

to be mindful of less well-resourced provinces, to ensure that there is equity when new sites are proposed, or when existing sites are expanded.

It is not SAMA's intention to advantage better-resourced provinces that are able to support an internship programme, at the expense of less-resourced provinces. SAMA will be engaging with the NDoH on an ongoing basis to motivate for funding for the additional internship posts.

Another option that the SAMA EST supports is a distributed platform of training from the regional hospitals to district hospitals/primary healthcare clinics (PHCs). This option may facilitate better support for district hospitals and PHCs from regional and district hospitals, respectively. Other options include integrated longitudinal 8-month rotations for three blocks. None of these options has been formally adopted by the HPCSA.

We will keep you updated on progress, and look forward to any of your suggestions or comments, especially with regard to potential hospitals that could be accredited, and ways to improve the system. Your comments can be forwarded to Karlienp@samedical.org.

Gross negligence in the workplace

Simon Buthelezi, industrial relations advisor, SAMA Trade Union Department

Dealing with discipline in the workplace is as inevitable as breathing – it is an integral part of management, and is meant to promote fairness, harmony and certainty within the organisation. An organisation is a complex system that intentionally co-ordinates the actions of its members to accomplish specific goals, and therefore, guiding one's actions requires a mix of both dangling a carrot and wielding a stick.

In order to prevent detrimental deviation from organisational goals, policies and procedures, there is a need to act promptly and decisively in a fair and transparent manner. At the same time, one should also be cognisant of one's own emotions, and meticulously guard against the abuse of authority, and victimisation.

To counter such potential abuse, any individual in an employment relationship has recourse to certain procedures for protection against unnecessary and arbitrary disciplinary action. In this way, the employee may, in a case of unfair treatment by the employer, resort to grievance and appeal procedures. This article investigates gross negligence, and distinguishes it from the maze of other possible forms of misconduct prevalent in the workplace.

Defining gross negligence

Online legal dictionaries define gross negligence as a conscious and voluntary disregard of the need to use reasonable care, which is likely to cause foreseeable grave harm to persons, property or both. This therefore means that gross negligence is an extreme variant of ordinary negligence. It is

also evident that such serious misconduct deserves serious disciplinary action – hence a finding of guilt of gross negligence may warrant dismissal, even if it is a first offence.

One can therefore conclude that gross negligence is more than simple carelessness or failure to act. It is wilful behaviour, with extreme disregard for the health and safety of others, or potential serious loss. Our courts have tackled this issue on several occasions.

Dealing with gross negligence

Our case law has described gross negligence quite extensively, and included an attitude or state of mind characterised by an entire failure to give consideration to the consequences of one's actions; in other words, it involves an attitude of reckless disregard for such consequences. It is thus a conscious and voluntary disregard for the need to use reasonable care.

In the case of *Moema and Zanzu* (2011) 32ILJ 484 (CCMA), a very important principle was established: a causal connection must be established between the employee's act or omission and the occurrence, or potential occurrence, of the loss or damage. The negligence must also be "gross" to warrant dismissal.

Gross negligence may be said to have occurred where the employee has been persistently negligent, or when an act or omission is particularly serious in itself. This is a very important insight, as may be seen in *Nampak Corrugated Wadeville v Khoza* (1999) 20 ILJ 578 (LAC), where a manager

was dismissed for failing to take proper care of equipment.

The norm is that employees should be warned for a single negligent act, unless it is of a serious nature. Where the consequences of a single act or omission are particularly serious, or when the employee holds a position in which negligence on a single occasion can have disastrous consequences, dismissal can be justifiable on a first occasion. The courts are also less tolerant of employees who possess or claim to possess special skills, and who, because of their position and experience, can be expected to be aware of the performance standard set by the employer.

A ground-breaking case that left many tongues wagging in this area is that of *Somyo v Ross Poultry Breeders (Pty) Ltd* (1997) 7 BLLR 862 (LAC). In the case in point, Mr Somyo, who had managed Rainchick Farm for some years, knew how important it was to adhere to the vaccination programme. The vaccination programme at houses 23/24 and 25/26, which he managed, was between 5 and 12 weeks late, and not just a week or two. What made things worse was that the respondent did not inform his superiors that he was behind in the vaccination programme and ask for assistance, despite the opportunities he had to do so at meetings that were held twice a week. And as has already been stressed as central to gross negligence cases, the potential consequences for the employer and its customers were very serious. Therefore Mr Somyo's dismissal was found to be fair.

References available on request.

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.



Your financial health

Gert Viljoen, *managing director, VPROF*

VProfessional Services (VPROF) is a medical practice administrator, medical bureau and professional accounting firm dedicated to supporting the business activities and patient care of independent medical practices around SA. Gert Viljoen discusses inadvertently encouraging unethical behaviour, and the impact of the sugar tax.

Don't inadvertently encourage unethical behaviour

What causes dishonesty in businesses? This is an important question, with one survey showing that a whopping 41% of employees in a particular company had observed unethical behaviour over a 12-month period. This, despite the common perception that most people are inherently honest. Yet a recent interview with a prosecutor surprisingly revealed that most of the people charged with commercial crime were ordinary and honest. What causes this dichotomy?

Of course, unethical or unlawful conduct is the last thing you want in your own business, but in reality you may – however innocently and inadvertently – actually be encouraging it.

We identify and discuss four ways in which management could be doing this, and we share some suggestions on how to remedy a dangerous situation.

Leadership giving a bad example: It is human nature for staff to hold management to a higher standard than they do themselves. This places an obligation on management to assess the effect of their actions on staff. Take, for example, a manager who is vying for a promotion and is aware that one of the selling activities he is responsible for is potentially resulting in product returns from customers. One of his staff has to write a monthly report on selling strategies, and the report received by the manager indicates the need to investigate the selling strategy to establish if it is causing product returns. The sales manager faces two choices:

- forward the report up the line knowing it may weaken his or her chances of promotion; or
- say to the employee that as the reason for the product returns is not clear, we should carry out our own investigation to

verify whether the strategy is the cause of product returns. Only then should we inform senior management.

If the manager chooses the second option, it tells the employee that the manager is prepared to compromise on transparency and ethical behaviour. If the employee or other members of the manager's staff then act dishonestly, it will be impossible for the manager to act since (s)he is now effectively compromised.

Always act in a fair and transparent manner

Discouraging whistle-blowers and employees who speak up: If employees are aware of a culture where speaking out about unethical behaviour is either ignored by management or, worse, the staff member speaking up is victimised, then accountability essentially goes out of the window.

Speak to your staff often about the importance of ethical behaviour – not just when staff or management are caught out. It is important that employees are made aware that ethical conduct is not a relative matter, and often involves painful choices.

Setting unrealistic goals: If employees are measured on goals that are virtually impossible to achieve, then there is a likelihood that they will cut corners or “fudge” the results. No-one wants to be seen as a failure or an underachiever, so set realistic goals.

Setting conflicting goals: Some goals can encourage staff to act dysfunctionally – if, say, management wants to see a growth in sales but also needs to cut marketing costs, then sales staff could decide to oversell to customers. In the short term this will mean achieving sales targets, but it will also lead to customers returning the excess stock, increasing administration costs and risking the potential for stock write-offs.

Employees would see this situation as unfair, and so might think that they are entitled to act in a way that is clearly against the interests of the business.

Think through the objectives you set for your staff and always act in a fair and transparent manner – in the long term, it will be worthwhile. The last thing you want to do is to inadvertently encourage your employees to act in an illegal or unethical manner.

Good for the taxman, bad for the sugar industry

SA's “sugar tax” has been around for a year now, and although it was, on its introduction, widely welcomed by the health lobby, there were rumblings about its possible negative effects on our economy and employment levels.

While it is still too early to gauge the tax's impact on our healthcare costs and on the health and lifespan of our citizens, several clear trends have emerged as to its effect on the sugar industry and on revenue collections by SARS.

The sugar industry has been struggling with drought and cheap imports in recent years. The sugar tax has worsened this situation, with losses in revenue of ZAR1.3 billion since the tax came into effect. The industry warns of 10 000 potential job losses.

The soft drink market was also predicted to suffer losses. While sales are down, companies such as Coca-Cola have reduced their losses by increasing the production and marketing of sugarless drinks such as Coke Zero and Diet Coke. They have also reformulated their products using less sugar. In the UK, where a sugar tax was also introduced last year, 60% of Coca-Cola's products are not subject to sugar taxes, due to the company adopting similar measures to SA.

When the tax was introduced, it was expected that it would bring in ZAR1.7 billion in revenue in its first year. After 11 months, SARS had revenues of ZAR3.4 billion from the sugar tax.

In fact, the tax was increased further in the recent Budget, from 2.1 cents per gramme to 2.21 cents per gramme.

The sugar industry is looking for relief, as it is clearly suffering. However, SARS has found a winner with the sugar tax and is highly unlikely to reduce it, especially considering the pressure the service is under to collect taxes.

Wrongly reassured over benign cyst

The Medical Protection Society shares a case report from their files

Mrs D was a 59-year-old clerical worker who presented to her GP with a longstanding lesion on her scalp. She had “had it for years”, but felt that it was starting to get bigger, and was catching on her comb. GP Dr N diagnosed it as a small 7 - 8-mm-sized sebaceous cyst.

Dr N removed the lesion successfully in his consultation rooms shortly thereafter. He did not send the excised material to histology for further analysis.

All samples excised should be send for histological examination

Almost 1 year later, Mrs D re-presented to the practice with another cyst on her scalp, about the size of a marble. GP Dr C prescribed antibiotics for an infected sebaceous cyst, but the swelling persisted, and 2 months later, Mrs D again requested removal of the cyst, and this time Dr C removed it, again in the consultation rooms. He also did not send the tissue to histology.

Mrs D noticed ongoing discomfort around the scar on her scalp, and came back to the practice 3 months later to see GP Dr H. He noticed an unusual appearance to the scar, describing an inverted pit with surrounding induration and tenderness. He also discovered a solitary gland in the posterior triangle of the neck. A referral was made to a plastic surgeon.

The plastic surgeon reviewed Mrs D 2 months later, noting a tethered hypertrophic scar, for which conservative scar management was advised. An ultrasound scan was performed on the neck nodes, which showed that these were likely to be reactive nodes due to the recent surgery. The histopathology results for the two prior excisions were requested from the GP practice.

The practice replied, stating that samples had not been sent to histology. Mrs D

returned for her 3-month review with the plastic surgeon, and the neck nodes had enlarged, prompting a referral for further investigations.

Mrs D was diagnosed with an aggressive, poorly differentiated apocrine adenocarcinoma, with widespread metastases. Despite surgery and adjuvant radiotherapy, she was found to have multiple lung nodules, and she died in a hospice a year later.

The GPs at Mrs D’s practice were criticised for failing to send the samples they had excised for histological examination. Experts agreed that, had they done so, Mrs D would have had an earlier diagnosis and received curative treatment, and her life expectancy would not have been negatively affected.

Mrs D’s husband lodged a claim against both GPs involved. As Mrs D had been a higher earner than her husband, there was a notable financial dependency claim. There was also a significant future-services dependency claim, including childcare that Mrs D would allegedly have provided to her grandchildren.

Although the claim was deemed indefensible, the Medical Protection Society legal team viewed the claim for future services in particular as being overstated, and was able to negotiate a 50% reduction in the amount being claimed. As with any indefensible claim, we aimed to resolve matters as quickly as possible, and it was eventually settled for a substantial sum.



Learning points

Apocrine adenocarcinoma is a rare diagnosis, with few cases reported in the literature. The tumour is typically indolent, presenting as an asymptomatic, slow-growing mass. Most patients report the presence of a longstanding lesion before the diagnosis is made. More than half of all patients have lymph node metastases at the time of diagnosis.

When performing minor surgery, all samples excised should be sent for histological examination. Following this, practices should have robust systems for handling the histology results and ensuring that they are actioned, if necessary, and patients informed of the results.

Requesting clinical information: A practical approach



Drs Aziza and Malikah van der Schyff, Emily Nel and Chenienne Gericke

The Cape Western branch and the Medical Protection Society held a CPD meeting in Worcester on 19 March 2019. Branch chairperson Dr Malikah van der Schyff introduced the speaker, Dr Volker Hitzeroth, who spoke about "A practical approach to a request for your clinical information – pause, peruse, protect and don't panic".

Dr Hitzeroth emphasised how important it is for all healthcare professionals to appreciate the value of keeping accurate and

detailed medical records for each patient. However, many doctors are unaware of how to manage medical records and do not know when it is permissible to dispose of them, or when to disclose them.

The lecture explored the medicolegal issues concerning medical records, including:

- What are medical records?
- Who owns the medical records?
- Documenting patient consent to the disclosure of records
- Who can access medical records?



Dr Volker Hitzeroth

- Child protection issues and disclosure relating to patients unable to consent.

Doctors owe a duty of confidentiality to all patients, past or present, even if they are adults who lack capacity. You may be asked to provide information from the medical records of patients who are incapable of giving consent, are aged under 16, or have died.

Good record management is essential for the continuity of care of patients, and can reduce the risk of adverse incidents through misplaced or untraceable records. Problems with medical records – lack of accessibility, poor-quality information, misinformation, poorly organised notes, misfiling and many others – are known to lie at the root of a high proportion of adverse incidents.

Dr Hoek presents hearing loss CPD

The Griqualand West branch hosted a CPD meeting on Tuesday 26 February 2019 at the Horseshoe Inn in Kimberley. The topic discussed at the meeting, which was presented by Dr Werner Hoek, was "Demystifying hearing loss for the general practitioner".

Dr Hoek is an ear, nose and throat (ENT) specialist from Kimberley who has a wide range of interests and experience in his field.

Born and bred in Bloemfontein, he matriculated from Hoërskool Sand du Plessis in 1996, and completed his degree with honours from the University of the Free State in 2002.

After gaining experience as an ENT during his internship in 2005, he completed his postgraduate studies at the University of the Free State in July 2010.

He started his career as a specialist in Kimberley Hospital complex under the guidance of Dr Gawie de Villiers. From 2011, he acted as head of the unit, and performed outreaches to Mediclinic Kathu and Mediclinic Upington on a monthly basis. In 2013 he started his full-time private practice at the Mediclinic in Gariep.

He attended several courses in SA and abroad in head and neck cancer surgery, microvascular reconstruction techniques, temporal bone and lateral skull-base surgery, and endoscopic sinus surgery.

He is currently busy with two studies on head and neck cancers in the Northern Cape Province, and is a member of Operation Face to Face, the world directive, with a maxillofacial



Dr Werner Hoek receiving a gift from SAMA Griqualand West chairman, Dr M J Ngundu

surgeon and prosthodontist, to reconstruct major facial defects after cancer surgery.



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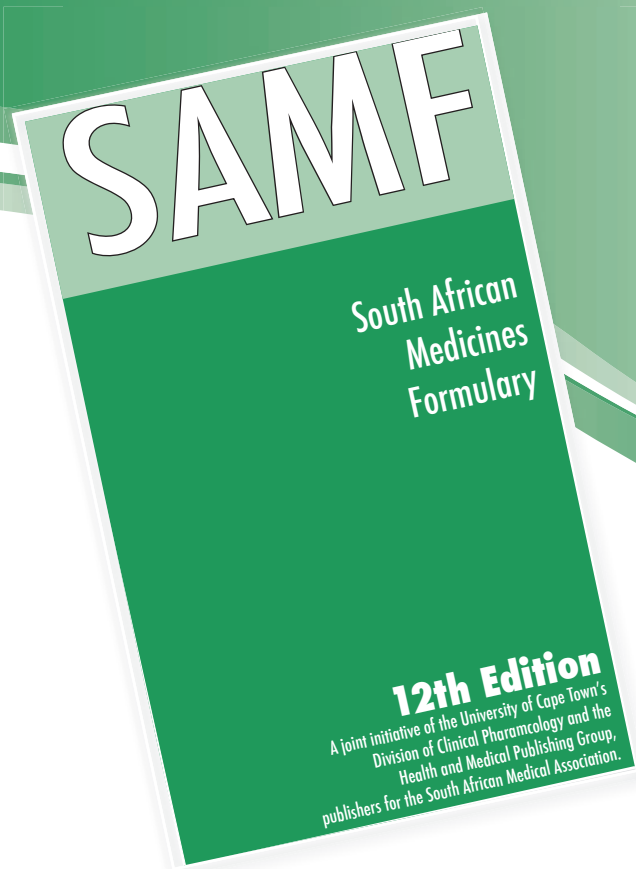
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Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association 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 or cpd@samedical.org



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