

SAMA INSIDER

AUGUST 2019

**Good is the enemy of great:
Cultures of leadership**

COHSASA CEO elected to IAQS



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Diane de Kock
Editor: *SAMA INSIDER*

Leadership and quality healthcare

Good-quality leadership is vital in delivering good-quality healthcare. This month we focus on leadership in the workplace, its importance, self-care and striving for excellence.

On page 4 SAMA president Prof. Hoosen Coovadia discusses some lessons for SA, and particularly our leaders. We congratulate Jacqui Stewart (page 5) on her election to the International Academy of Quality and Safety (IAQS), "a recognition of the importance of Africa". Jacqui, CEO of the Council for Health Service Accreditation of SA, is the first board member from an African organisation.

Elaine Jacob from the Leadership Academy of SA (page 7) warns of the perils of settling for good instead of great. "The only way to keep relevant is to strive for greatness." She maintains that leadership is a skill we can all learn: "Leadership is not a gene, and it is not a trait – it's a set of skills, and anyone can learn new skills."

The effects of bad leadership are highlighted in the article (page 14) on the workplace psychopath. Dr Renata Schoeman, psychiatrist and associate professor in leadership, says it is often leaders – who should be at the forefront of reducing the workplace conditions that lead to stress and burnout – who contribute to the problem, rather than the solution.

These articles serve as an introduction to the challenges of leadership in the healthcare sphere. The theme of the SAMA conference, which takes place from 8 to 10 August, is "Leadership & Quality in Healthcare – Let's Close the Gap". We look forward to reporting on the conference in the October issue of *SAMA Insider*.

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Lessons for SA from an unusual source



Prof. Hoosen Coovadia, SAMA president

The most recent elections in our country have given us a mixed bag of some benefits, but also huge disadvantages. It is hard to know the likely outcomes in the medium to long term of the introduction of a new set of legislators and their cronies, under the fixed smile and leadership of Cyril Ramaphosa and the disunited ANC. In addition to all the well-recognised shortcomings of the country in 2019, which include a precarious governance system, a shattered economy, a restless populace and severe basic services disarray, with dysfunctional health, education and welfare institutions, we also have a deplorable unemployment rate – especially among the youth, who will need all the optimism they can muster to see a brighter future under the present setup. We are not alone: even a brief glance around the world will show clearly that the despairing effect is almost global; we see the US under the vacillating and belligerent Trump administration, the travails of a Brexit Europe, an unstable and often impoverished Africa, Latin America (Venezuela) desperate for survival under a welter of US economic sanctions and an array of countries struggling to deal with poverty and its attendant suffering.

But I wish to discuss a lesser-known factor that gives us a promise of hope. This is the rise of younger activists and community-based revolutionaries who are challenging the status quo, though the example given here may be nothing more than a single phenomenon, transient and ephemeral. It concerns the actions of a remarkable young woman in India: this is the story of a female

first-time MP in India's parliament who listed the "signs of early fascism" in what has been hailed on social media as the "speech of the year". I listened to her maiden speech and was bowled over by the eloquence with which she delivered it, and by its devastating content, which reinforces, and maybe even confirms, many widely believed accusations against the new President of India, Narendra Modi: generally held to display fascist beliefs and represent a deviation from India's history of democracy, secularism and inclusiveness.

The main thrust of what Mahua Moitra, of the opposition Trinamool Congress party (TMC), said was that she had seen a list of the early warning signs of fascism on a poster in the Holocaust Memorial Museum in the USA. She pointed out that India's constitution was under threat, and the country was being "torn apart" by the ruling party's "lust to divide". Ms Moitra acknowledged Modi's Bharatiya Janata Party (BJP)'s landslide victory in the recent general elections, but said that "the very nature of the overwhelmingness of this mandate makes it necessary for the voices of dissent to be heard."

A former investment banker with JP Morgan, Ms Moitra quit her well-paying job in London in 2009 to return to Indian politics. She has been the TMC's national spokesperson for several years, and regularly appears in prime-time TV debates. During the recent elections, on the campaign trail in rural Krishnanagar constituency in West Bengal state, where the TMC is in power, Ms Moitra took direct aim at Mr Modi. She talked about the recent deadly suicide attack in Kashmir, and India's subsequent air raid on Pakistan. She accused the BJP of trying to divide Hindus and Muslims. She said elections in the past were to change the government, but this election was to save the constitution of India.

And now, in her maiden parliamentary speech, she listed the seven "danger signs of early fascism" that she saw in Modi's party. It is critical that we in SA, given the right-wing and raucous voices fighting for control in the African National Congress (ANC) and other parties, pay attention to her words.

"There is a powerful and continuing nationalism that is searing into our national fabric," she said. "It is superficial, it is xenophobic and it is narrow." She pointed to a "resounding disdain for human rights", which she said had led to a 10-fold increase in the

number of hate crimes in India between 2014 and 2019.

She also criticised the government for its "unimaginable subjugation and control of mass media", including the fact that India's TV messages channels spend "the majority of airtime broadcasting propaganda for the ruling party".

The government, she said, had an "obsession with national security". An "atmosphere of fear" pervaded the country, with new enemies being created every day. On top of this, "the government and religion are now intertwined. Need I remind you that we have redefined what it means to be a citizen?" she demanded, saying laws had been amended to target Muslims.

She also said that "a complete disdain for intellectuals and the arts" and "the repression of all dissent" was the most dangerous sign of all – and it was "pushing India back to the Dark Ages".

The last early warning sign of fascism evident in India, Ms Moitra said, was the "erosion of independence in our electoral system".

Although MPs from the treasury benches tried to shout her down, she stood firm and called on the parliamentary Speaker to rein in the "professional hecklers".

We in this country can take away many lessons relevant to our situation. Ms Moitra's speech is significant at a time in India when one party – Mr Modi's BJP – dominates parliament, and the opposition is struggling to be heard. Like the BJP, the ANC has a dominant role in SA; indeed, the ANC has an enviable historical status, and can therefore marshal more legitimate policies for the country on some of the key determinants of life. But in fact, the ANC is riddled with fissiparous tendencies, which inhibit its effectiveness. There are, however, many examples of brave persons who have fought for justice and the elimination of corruption, in society and within the ANC. These activities need to be given more cohesion and strength.

Ms Moitra's speech is especially significant because politics in India is still very patriarchal: it is dominated by men, and women make up only 14% of members of the house. From this perspective, we in SA start from higher ground in our fight for justice and freedom, but we should take note of Ms Moitra's intellectual criticisms, messages, courage and passion.

COHSASA CEO elected to IAQS

SAMA Communications Department

Ms Jacqui Stewart, CEO of the Council for Health Service Accreditation of Southern Africa (COHSASA), has been elected to the International Academy of Quality & Safety (IAQS). The academy was established by the International Society for Quality in Health Care (ISQua).

The IAQS recognises distinguished individuals who make a significant contribution in the field of quality and safety in healthcare. Ms Stewart was nominated by an inaugural member of the academy.

"I am extremely honoured and humbled by this appointment. My first reaction was 'Why me?'" explains Ms Stewart.

She says being part of an international body such as the IAQS gives her, and COHSASA, an opportunity to interact with leaders and experts in patient safety and quality in healthcare from around the world.

In 2017 Ms Stewart was appointed as an institutional member to the ISQua board. "I am the first board member from an African organisation, which is important because it means that lower-middle income countries, which previously didn't have an elected voice on this body, now have someone representing their interests. It's a great responsibility, and I am thrilled to be a part of it," she says.

Ms Stewart was a member of the SA Lancet Commission on High Quality Health Systems. An ISQua expert, Ms Stewart also serves on the accreditation council of the ISQua External Evaluation Association.

She holds a Master of Professional Studies (Health) from Middlesex University, London, and was recently chosen as one of the 100 Most Impactful Healthcare Leaders of 2019 by the World Health & Wellness Congress.



Jacqui Stewart

She has worked in the public and private healthcare sectors in SA and England. She qualified as a registered nurse in Cape Town, going on to specialise in cardio-thoracic nursing in London where she ran the heart transplant unit at Harefield Hospital, Middlesex, for 5 years. She has since been involved in a variety of managerial roles in nursing, quality, capital and service planning in the UK National Health Service.

Between 1996 and 2002, Ms Stewart was a director at the Family Health Services Authority in Kent, and then the East Kent Health Authority, responsible for primary healthcare, service development and integration. She moved to a regional role and then became the director of career development and succession planning at the NHS Modernisation Agency Leadership Centre.

In 2005, Ms Stewart returned to SA and joined COHSASA as chief operations

manager. She was appointed interim CEO in January 2015, and CEO in April 2016.

Ms Stewart's election to the academy is not only a personal milestone, she says, it is also a recognition of the importance of Africa in this forum.

"I am obviously delighted to be in this position, but what it means for SA and Africa is far more important. The recognition Africa is getting is also evident in the fact that, for the first time in 36 years, the ISQua annual conference will be held in Africa, in Cape Town in October. This is a signal of the growing importance of Africa's involvement to this body," she notes.

Ms Stewart says COHSASA's bid to co-host the event – which attracts between 1 500 and 1 700 delegates – was supported by other African delegates at the conference in Malaysia last year, an indication of the support and unity within the African healthcare community.

"I made the presentation, but I wasn't alone; the other African delegates all stood with me, which is encouraging and important," she says.

Fellow members of the academy from SA are Prof. Laetitia Rispel, professor of public health at the University of the Witwatersrand, and Prof. Morgan Chetty, chair of the Independent Practitioners Association Foundation in SA.

Other elected members of the academy from Africa are Dr Gilbert Buckle, executive director of the Africa Institute of Healthcare Quality, Safety & Accreditation in Ghana (and also a COHSASA board member), Dr Sodzi Sodzi-Tettey, executive director and head, Institute for Healthcare Improvement, Africa Region, Ghana, and Dr Emmanuel Aiyenigba, improvement advisor for the Institute for Healthcare Improvement in Nigeria.

Advertising professional services and products – legal and ethical requirements

Hanneke Verwey, legal advisor, SAMA Governance and Legal Unit

Until relatively recently, doctors were limited in the manner in which they were permitted to advertise their

professional services or products. These restrictions were lifted by the HPCSA in 2006. Less restrictive guidelines and rules were

subsequently published, in recognition of the fact that marketing may be required in order to run a sustainable practice. Advertising is,

however, still highly regulated, and doctors must comply with the ethical rules, guidelines and legislation.

HPCSA rules and guidelines

In terms of rule 3 of the "Ethical rules of conduct for practitioners registered under the Health Professions Act" (No. 56 of 1974), a doctor may advertise professional services, or permit, sanction or acquiesce to such advertisement, provided that the advertisement is not unprofessional, untruthful, deceptive or misleading, or causes consumers unwarranted anxiety that they may be suffering from any health condition. The HPCSA defines "advertising" as any written, pictorial, visual or other descriptive matter, or verbal statement or reference in respect thereof: (i) appearing in any newspaper, magazine, pamphlet or other publication; or (ii) distributed to members of the public; or (iii) brought to the notice of members of the public in any manner whatsoever, that is intended to promote the sale of orthodox medicine, complementary medicine, medical devices or scheduled substances or health-related products, or to attract patients to any particular health establishment or health-related service. Furthermore, a doctor may not canvass or tout, or allow canvassing or touting to be done on his or her behalf.

"Canvassing" is defined as conduct that involves direct contact with prospective clients, either verbally or by, among other things, distributing letters, pamphlets, circulars or other means of communication, including printed or electronic communication, in which attention is drawn to one's personal qualities, superior knowledge, quality of service, professional guarantees or best practice in order to secure the prospective clients' custom. Doctors should therefore refrain from mentioning anything related to their superior service, personal excellence, special knowledge, best prices and so forth, as this could be construed as canvassing.

"Touting" means, but is not limited to, conduct that draws attention, either verbally or by means of printed or electronic media, to one's offers, guarantees or material benefits that do not fall into the categories of professional services or items, but are linked to the rendering of a professional service, or designed to entice the public to the professional practice. Touting thus entails enticing members of the public on the basis of benefits that fall outside of the boundaries of the doctor's professional service. By way of example, offering a free gift with every

consultation, or advertising the fact that free Wi-Fi is available in the practice waiting room, could be construed as touting.

The HPCSA's "Guidelines on over-servicing, perverse incentives and related matters" (booklet 11) further provide that doctors may not advertise or endorse or encourage the use of any health establishment or orthodox medicine, complementary medicine, medical device or scheduled substance or health-related product or service in a manner that unfairly promotes the practice of a particular doctor or healthcare facility for the purpose of financial gain or other valuable consideration. "Endorse" means any action whereby a person or body attaches approval to or sanctions any health establishment or orthodox medicine, complementary medicine, medical device or scheduled substance, or other health-related product or service, with a view to encouraging or promoting the preferential use or preferential sale thereof for the purpose of financial gain or other valuable consideration.

Doctors must comply with ethical rules, guidelines and legislation

The precise scope of what constitutes "unfair" promotion is not defined in the rules or guidelines. The fairness of the promotion will be determined on a case-by-case basis, and therefore a conservative approach should be adopted for the sake of prudence. The guidelines merely define "promote" as any action taken by a person or body, or allowed to be taken by such person or body, to further or to encourage the preferential use of any health establishment, health-related services or products, or the preferential sale of these, for the purpose of financial gain or other valuable consideration.

The council's 2001 booklet "Guidelines for making professional services known" was discontinued in 2007, and replaced with booklet 11. The requirements and specifications for outside signs and nameplates and the use of graphics (including anatomical structures) and colours in promotional material therefore no longer apply. Outside signs may, however, not be indecent, deceptive or misleading, or bring the profession into disrepute. The rules relating to information on professional stationery were, however, retained following the amendments.

In this regard, rule 4 provides that letterheads may only contain the practitioner's: (i) name; (ii) profession; (iii) registered category; (iv) speciality or subspecialty, or field of practice; (v) registered qualifications or other academic qualifications or honorary degrees, in abbreviated form; (vi) registration number; (vii) address (including email address); (viii) telephone and fax numbers; (ix) practice or consultation hours; (x) practice code number; and (xi) dispensing licence number (if any).

Consumer Protection Act

Advertising of professional services is also regulated in terms of the Consumer Protection Act No. 68 of 2008, as patients and doctors qualify as "consumers" and "suppliers" in terms of the Act. Patients are entitled to fair and responsible marketing, as set out in part E of the Act. Part E contains various provisions relating to fair marketing, but those most relevant to the medical profession are sections 29, 30 and 32. In terms of section 29, goods or services may not be marketed in a manner that is reasonably likely to imply a false or misleading representation, or is misleading, fraudulent or deceptive in any way. In terms of section 30, a supplier may furthermore not advertise goods or services as being available at a specified price in a manner that may result in consumers being misled or deceived in any respect relating to the actual availability of those goods or services from that supplier, at that advertised price. Although patients may agree to the direct marketing of goods and services, section 32 of the Act provides that they should be informed of their right to opt out of that agreement.

Medicines and Related Substances Act

The marketing of medicine is regulated by the Medicines and Related Substances Act No. 101 of 1965, and the regulations published under it. This Act defines advertising as any "written, pictorial, visual or other descriptive matter or verbal statement or reference appearing in any newspaper, magazine, pamphlet, electronic media (including radio and television), or other publication, distributed to the public, or brought to the notice of the public in any manner whatsoever" that is intended to promote the sale of any medicine, scheduled substances, medical devices or *in vitro* diagnostics (IVDs).

In terms of section 18 of the Act, no person may advertise any medicine or scheduled

substance, medical device or IVD for sale unless such advertisement complies with the prescribed requirements. Section 20 furthermore provides that no person may publish any false or misleading advertisement concerning any medicine, medical device or IVD, or make any claim to the therapeutic effect and efficacy of any medicine, device or IVD, other than that stated by the CEO of the South African Health Products Regulatory Authority. Section 20 also prohibits stating or suggesting that any medicine, medical device or IVD should be used for any purpose or under circumstances or manner other

than that stated by the CEO. In terms of the general regulations under the Act, only medicines that do not contain a scheduled substance, and medicines that only contain a substance appearing in schedule 0 or 1, may be advertised to the public – that is, off-the-shelf and over-the-counter medication.

Doctors are encouraged to read the relevant legislation in conjunction with the HPCSA's guidelines, in order to ensure compliance with both the ethical and the legal requirements. Doctors whose conduct falls foul of the HPCSA's rules and guidelines may be subject to disciplinary steps in terms

of the Health Professions Act. In the event of a finding of unprofessional conduct, any of the sanctions listed in this Act may be imposed, including a caution or reprimand, suspension, removal from the register or a prescribed fine. Furthermore, any person convicted of an offence in terms of the Consumer Protection Act or the Medicines Act may be liable to a fine or imprisonment, or both.

Should members be unsure as to whether or not their marketing material complies with the ethical and legislative provisions, they are encouraged to approach SAMA's legal department for it to be reviewed.

Good is the enemy of great: Cultures of leadership greatness improve employee engagement

Elaine Jacob, *Leadership Academy of SA*

Jim Collins opened his book *Good to Great* with the statement "Good is the enemy of great." He explained that when we have good schools, good businesses and good government, we are prone to accept that level of quality as sufficient. Collins observed: "Few people attain great lives, in large part because it is so easy to settle for a good life."

Many people have bold aspirations and dreams, but unfortunately, they end up settling for good instead of great. Good gives us a false sense of security. We feel okay because, while we may not have reached our potential, at least we're not bad.

We can do good work on autopilot, but great work takes initiative, creativity, passion and courage. That sounds like a lot of effort when there's no burning need to change.

That is why good is the enemy of great. It's because it lulls us, deadens us and seduces us into thinking that we don't really need to try. You're not that bad, so why bother?

Too many times, we think that as long as we aren't the worst, as long as we're competent, if the person in the next cubicle isn't performing as well as we are, then that's good enough. It's not, anymore. The world, as we know, has changed, and continues to change: we are living in VUCA (volatile, uncertain, complex and ambiguous) times. There are many external pressures, and besides these, we have internal pressures that tell us that business as usual is not going to cut it any longer.

The only way to keep relevant is to strive for greatness. We need every person within our organisation to strive for greatness. We need our performance to match our potential. We need to step up and go to the next level. We need to aspire to greatness!

State of the global workforce

Globally, according to Gallup's *State of the Global Workplace* 2017 report, only 13% of adults who work full time for an employer across 142 countries worldwide are engaged in their jobs: 63% are disengaged, and 24% are actively disengaged. The low percentages of engaged employees represent a barrier to creating high-performing work cultures around the world.

What is the correlation between employee engagement and business outcomes? According to Gallup's employee engagement survey, engaged employees produce better business outcomes (based on a composite of financial, customer, retention, safety, quality, shrinkage and absenteeism metrics) than other employees, across industries, company sizes and nationalities, and in good economic times and bad.

Improve employee engagement

We believe leadership is the answer. "Everything rises and falls on leadership," states Dr John C Maxwell. "Most people like being leaders by title and position, but being

called a leader is only half the battle; learning to lead is the other half." Dr. Maxwell explains that transforming yourself and those around you into leaders who successfully lead in the real world is the key to success or failure for any organisation.

People working with leaders who understand and live out their leadership ability are significantly more satisfied with those leaders' actions and strategies. They also feel more committed, excited, energised, influential and powerful. There is no hard evidence to support the assertion that leadership is imprinted in the DNA of only some individuals. Leadership is not a gene, and it is not a trait – it's a set of skills, and anyone can learn new skills.

Create a leadership culture

By creating a leadership culture at every level of the organisation, you're also creating a culture of accountability, boosting overall productivity and raising organisational outcomes. How can you get started? Here are four methods.

Provide the right foundation:

- Clarify: Leadership development is a highly misunderstood factor. Often people and organisations use the words "management" and "leadership" interchangeably. Understand the difference between the two.
- Gain buy-in: Buy-in from all levels of the organisation is key to instilling a leadership

culture. Peter Drucker stated: "Culture eats strategy for breakfast." A culture of apathy and disengagement is sometimes evident from board level, and runs rife into the lower levels of organisations. Therefore a culture of leadership demonstrated at board level improves the culture of the entire organisation.

- **Develop:** Develop a recruitment strategy to attract leaders, and develop new and junior-level staff by giving them skills to increase focus, improve efficiency, and maximise their individual impact within a team.

Leadership is not a gene, and it's not a trait – it's a set of skills

Develop strengths: All employees have strengths – the unique combination of talents, knowledge, skills and practice that help them do what they do best every day. These strengths provide employees and employers with their greatest opportunities for success. What leaders do, or fail to do, with this workforce potential has enormous implications for a company's future. Gallup's data show that simply learning their strengths makes employees 7.8% more productive, and teams that focus on strengths every day have 12.5% greater productivity. Investing in and focusing on employees' talents boosts employee and customer engagement, according to Gallup's research, leading to higher levels of performance, profitability and productivity,

and greater earnings per share for businesses. Helping people play to their strengths is the most time-effective way to improve their performance and engagement at work.

Promote great leadership practices: Culture wins. Culture is made up of the behaviours and practices of the leaders of the organisation.

Most leaders want leadership culture, but the problem is that in many companies, they merely talk the talk and don't walk the walk. Often the leadership culture becomes just a reflection of the leader, which may be created subconsciously rather than consciously.

Our leadership practices fall into five broad categories: (i) challenging the process; (ii) inspiring a shared vision; (iii) enabling others to act; (iv) modelling the way; and (v) encouraging the heart.

Develop growth plans with leadership strengths and practices in mind: Leading companies such as Google, Microsoft, Accenture and Deloitte understand that the people-development continuum needs to be revolutionised to help people be their best at work and in life. We suggest that performance appraisals include a leadership growth plan. The approach includes real-time, frequent, forward-looking coaching discussions that help people:

- understand expectations
- build on their strengths
- understand areas for growth
- achieve their career aspirations.

Conclusion

The Google CEO explains that "with two-thirds of the workforce being millennials and Generation Z just around the corner,

we need to be extremely relevant to our people. When we look at our return on investment, we not only focus on our return to shareholders or return to reinvest back into our business – but also on the return to our people. Putting our people at the centre and helping them to achieve their best is part of our talent-led DNA." Business and political leaders must recognise when traditional patterns in management practices, education or gender roles, for example, become roadblocks to workers' motivation and productivity, and when selectively disrupting tradition will help clear a path to greater prosperity and transformed company cultures. Employers who focus on replacing outdated management processes with ones that enhance workplace cultures and support engagement can drive their percentage of engaged workers high above average. This is the journey from good to great!

The Leadership Academy SA

The Leadership Academy SA is an organisation of leadership and performance coaches that aims at optimising workplaces for economic and human development, by providing tools that create cultures of leadership greatness.

They are a partnership with international leadership author and authority on leadership Dr John C Maxwell, and the coaching authorities: the International Coach Federation (ICF) and Harvard Institute of Coaching.

New essential medicines and diagnostics lists published

World Health Organization

The WHO recently updated their global guidance on medicines and diagnostic tests to address health challenges, prioritise highly effective therapeutics and improve affordable access. The Essential Medicines List (EML) and List of Essential (in vitro) Diagnostics are core guidance documents that help countries prioritise critical health products that should be widely available and affordable throughout health systems.

Published on 9 July 2019, the two updated lists focus on cancer and other global health challenges, with an emphasis on effective solutions, smart prioritisation and optimal access for patients.

"Around the world, more than 150 countries use the WHO's EML to guide decisions about which medicines represent the best value for money, based on evidence and health impact," said WHO director-general Dr Tedros Adhanom Ghebreyesus. "The

inclusion in this list of some of the newest and most advanced cancer drugs is a strong statement that everyone deserves access to these life-saving medicines, not just those who can afford them."

Essential Medicines List 2019

Cancer treatments: While several new cancer treatments have been marketed in recent years, only a few deliver sufficient therapeutic benefits to be considered essential. The 12

medicines that the WHO has added to the new EML for 5 cancer therapies are regarded as the best in terms of survival rates to treat melanoma, lung, prostate, multiple myeloma and leukaemia cancers.

For example, two recently developed immunotherapies (nivolumab and pembrolizumab) have delivered up to 50% survival rates for advanced melanoma, a cancer that until recently was incurable.

Antibiotics: The Essential Medicines Committee strengthened advice on antibiotic use by updating the Access, Watch, and Reserve (AWaRE) categories, which indicate which antibiotics to use for the most common and serious infections to achieve better treatment outcomes and reduce the risk of antimicrobial resistance. The committee recommended that three new antibiotics for the treatment of multidrug resistant infections be added as essential.

Other updates to the medicines list include:

- new oral anticoagulants to prevent stroke as an alternative to warfarin for atrial fibrillation and treatment of deep vein thrombosis. These are particularly advantageous for low-income countries as, unlike warfarin, they do not require regular monitoring.
- biologics and their respective biosimilars for chronic inflammatory conditions such as rheumatoid arthritis and inflammatory bowel diseases.
- heat-stable carbetocin for the prevention of postpartum haemorrhage. This new formulation has similar effects to oxytocin,

the current standard therapy, but offers advantages for tropical countries, as it does not require refrigeration.

Not all submissions to the EML committee are included in the list. For example, medicines for multiple sclerosis that were submitted for inclusion were not listed. The committee noted that some relevant therapeutic options currently marketed in many countries were not included in the submissions; it will welcome a revised application with all relevant available options. The committee also did not recommend including methylphenidate, a medicine for attention deficit hyperactivity disorder (ADHD), as the committee found uncertainties in the estimates of benefit.

List of Essential (*in vitro*) Diagnostics

The first List of Essential Diagnostics was published in 2018, concentrating on a limited number of priority diseases – HIV, malaria, tuberculosis and hepatitis. This year's list has expanded to include more non-communicable and communicable diseases.

Cancers: Given how critical it is to secure an early cancer diagnosis (70% of cancer deaths occur in low- and middle-income countries largely because most patients are diagnosed too late), the WHO added 12 tests to the diagnostics list to detect a wide range of solid tumours, such as colorectal, liver, cervical, prostate, breast and germ cell cancers, as well as leukaemia and lymphomas. To support appropriate cancer diagnosis, a new section covering anatomical pathology

testing was added – this service must be made available in specialised laboratories.

Infectious diseases: The list focuses on additional infectious diseases prevalent in low- and middle-income countries, such as cholera, and neglected diseases such as leishmaniasis, schistosomiasis, dengue and Zika.

In addition, a new section for influenza testing was added for community health settings where no laboratories are available.

General tests: The list was also expanded to include additional general tests that address a range of different diseases and conditions, such as iron tests (for anaemia), and tests to diagnose thyroid malfunction and sickle cell anaemia (an inherited form of anaemia very widely present in sub-Saharan Africa).

Another notable update is a new section specific to tests intended for screening of blood donations. This is part of a WHO-wide strategy to make blood transfusions safer.

"The List of Essential Diagnostics was introduced in 2018 to guide the supply of tests and improve treatment outcomes," said Mariângela Simão, WHO assistant director-general for medicines and health products. "As countries move towards universal health coverage and medicines become more available, it will be crucial to have the right diagnostic tools to ensure appropriate treatment."

The lists are available at: <https://apps.who.int/iris/handle/10665/325771> and https://www.who.int/medical_devices/publications/Second_WHO_Model_List_of_Essential_In_Vitro_Diagnostics/en/.

One in three people globally do not have access to safe drinking water

World Health Organization

Billions of people around the world continue to suffer from poor access to water, sanitation and hygiene, according to a new report by UNICEF and the WHO. Some 2.2 billion people around the world do not have safely managed drinking water services, 4.2 billion people do not have safely managed sanitation services and 3 billion lack basic handwashing facilities.

The Joint Monitoring Programme report, "Progress on drinking water, sanitation

and hygiene: 2000 - 2017: Special focus on inequalities", finds that while significant progress has been made toward achieving universal access to basic water, sanitation and hygiene, there are huge gaps in the quality of services provided.

"Mere access is not enough. If the water isn't clean, isn't safe to drink or is far away, and if toilet access is unsafe or limited, then we're not delivering for the world's children," said Kelly Ann Naylor, associate director

of water, sanitation and hygiene, UNICEF. "Children and their families in poor and rural communities are most at risk of being left behind. Governments must invest in their communities if we are going to bridge these economic and geographic divides and deliver this essential human right."

The report reveals that 1.8 billion people have gained access to basic drinking water services since 2000, but there are vast inequalities in the accessibility, availability

FEATURES

and quality of these services. It is estimated that 1 in 10 people (785 million) still lack basic services, including the 144 million who drink untreated surface water. The data shows that 8 in 10 people living in rural areas lack access to these services and in 1 in 4 countries with estimates for different wealth groups, coverage of basic services among the richest was at least twice as high as among the poorest.

"Countries must double their efforts on sanitation or we will not reach universal access by 2030," said Dr Maria Neira, WHO director of the Department of Public Health, Environment and Social Determinants of Health. "If countries fail to step up efforts on sanitation, safe water and hygiene, we will continue to live with diseases that should have been long ago consigned to the history books: diarrhoea, cholera, typhoid, hepatitis A and neglected tropical diseases including trachoma, intestinal worms and schistosomiasis. Investing in water, sanitation and hygiene is cost-effective and good for society in so many ways. It is an essential foundation for good health."

The report also says that 2.1 billion people have gained access to basic sanitation services

since 2000, but in many parts of the world the wastes produced are not safely managed. It also reveals that 2 billion people still lack basic sanitation, of whom 7 out of 10 live in rural areas and one-third live in the least developed countries (LDCs).

Since 2000, the proportion of the population practising open defecation has been halved, from 21% to 9%, and 23 countries have achieved near-elimination, meaning that less than 1% of the population practises open defecation. Yet 673 million people still practise open defecation, and they are increasingly concentrated in 'high burden' countries. Worse, in 39 countries, the number of people practising open defecation has actually increased, the majority of whom are in sub-Saharan Africa, where many countries have experienced strong population growth over this period.

Finally, the report highlights new data showing that 3 billion people lack basic handwashing facilities with soap and water at home in 2017. It also showed that nearly three-quarters of the population of the LDCs did not have basic handwashing facilities. Every year, 297 000 children under 5 years old die due to diarrhoea linked to inadequate

water, sanitation and hygiene. Poor sanitation and contaminated water are also linked to transmission of diseases such as cholera, dysentery, hepatitis A and typhoid.

"Closing inequality gaps in the accessibility, quality and availability of water, sanitation and hygiene should be at the heart of government funding and planning strategies. To relent on investment plans for universal coverage is to undermine decades of progress at the expense of coming generations," said Kelly Ann Naylor.

About the JMP

The WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply, Sanitation and Hygiene is the official UN mechanism tasked with monitoring country, regional and global progress, especially toward the Sustainable Development Goal targets relating to universal and equitable access to safe drinking water, sanitation and hygiene. The JMP is an authoritative source of internationally comparable estimates to inform policy decisions and resource allocation, especially at the international level.



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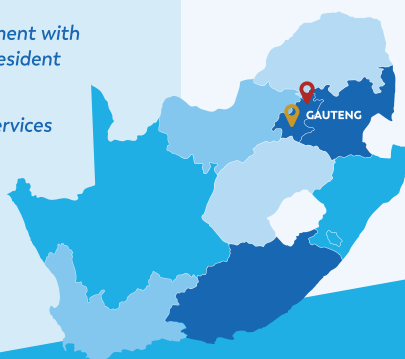
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Introducing the KMRED

Dr Selaelo Mametja, head of department, KMRED

This article is long overdue, but as they say, better late than never. I am happy to introduce to our SAMA family and members the Knowledge Management, Research and Ethics Department (KMRED), fondly called KIMRED. We take pride in serving the members, and can only hope that our work and efforts continue to have impact.

Our department consists of eight people:

- HOD: Dr Selaelo Mametja (SelaeloM@Samedical.org)
- Two health policy analysts: Shelley McGee (ShelleyM@Samedical.org) and Katlego Mothlaoleng (KatlegoM@Samedical.org)
- Bioethics researcher: Brandon Ferlito (BrandonF@Samedical.org)
- Research assistant and administrator: Jolene Hattingh (JoleneH@Samedical.org)
- Intern: Thabiso Nchabeleng (ThabisoN@Samedical.org)
- CPD officer: Lisa Reid (LisaR@Samedical.org)
- SAMAREC officer: Adri van der Walt (AdriV@Samedical.org).

The overall function of the department includes health policy, ethics, research and CPD accreditation and offering.

Health policy research, monitoring and evaluation

This responsibility includes scanning for health policy discussions, making submissions regarding relevant health policy and legal documents, and advocacy for health policy matters relevant to the department. The motive behind this is that health policy influences the environment within which medical doctors work, and as a member organisation it is imperative that we engage with policy development, implementation and review. Over the last 4 years, our submissions on health policy included healthcare financing policies, mainly responding to the NHI White Paper and Bill, Medical Schemes Amendment Bill, low-cost benefit options (LCBOs) and the consolidation of medical schemes, among others.

SAMA's view is that everybody deserves universal access to healthcare. Pooling must occur at a population level, with sufficient health and wealth cross-subsidies. Users must access healthcare based on need, not only on the ability to pay, in order to reduce



Dr Selaelo Mametja



Shelley McGee



Katlego Mothlaoleng



Brandon Ferlito



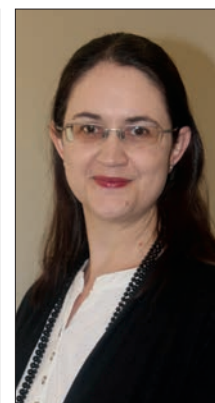
Jolene Hattingh



Thabiso Nchabeleng



Lisa Reid



Adri van der Walt

existing inequities in health and improve efficiencies.

We found that if the pooling of finances, and cross-subsidies, does not occur at a fund level, doctors find themselves in a moral dilemma, between patients with fewer needs but excessive benefits, and those with serious health needs, but no access to health benefits. LCBOs were retracted in 2015, subsequent to SAMA's intervention, as the package did not provide any guaranteed and meaningful health benefits to address the burden of disease. The Council for Medical Schemes (CMS) has published a call for comments regarding LCBOs, and we are again concerned that these packages will not adequately provide for the needs of the covered population unless there are meaningful cross-subsidies. One of our doctors nailed it on the head when she said: "Doctors are essentially being asked to treat their patients with their hands tied behind their backs."

Our department has been key in making submissions to the health market inquiry (HMI). The HMI panel has heard our concerns,

and some of our issues were addressed in the draft report, for example: the fact that doctors are often the price-takers; the need to protect and promote evidence-based medicine; the need to regulate the employment of doctors in profit-making institutes, to promote and protect doctors' autonomy; and the need to monitor outcomes to ensure that doctors and schemes are able to provide an account of quality healthcare. We have made a submission regarding the manner in which HMI has concluded that there is supplier-induced demand, as we believe the methodology was flawed (reports are available for our members on request). One of the craziest examples of this is the fact that admissions in paediatrics and psychiatry are all called discretionary, and the statement that there is an oversupply of circumcision in KZN. It makes perfect sense that KZN doctors' circumcision levels are higher than those in other provinces, since due to a lack of traditional circumcision, men are more likely to take up medical circumcision.

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We also continue to engage the CMS on benefit definitions, and one of our key successes has been the inclusion of laparoscopic appendicectomy as a prescribed minimum benefit (PMB). We support and advocate for PMB review to include primary, secondary and tertiary healthcare. We have made numerous requests for the National Department of Health (NDoH) to revise the pharmacy-based diagnosis and treatment (PCDT) guidelines, as although they claim to have reviewed the document, the latest list remains scary, as we believe some of the diagnoses require on- and offsite investigations, and pharmacists do not have the ability to do these. We are continuously engaging the NDoH on the matter.

Bioethics and research ethics committee

Bioethics research includes research on professional and medical ethics. Our research on the ethics of electronic health records and telemedicine is currently being disseminated via CPD events. Our recent medical ethics work includes our support for Caster Semenya. SAMA issued a media statement, and urged the WMA to speak out

on the ethical concerns of the International Association of Athletics Federations (IAAF) guidelines. While our own effort did not get much media attention, the WMA statement was influential to the extent that it elicited an IAAF response, which shows that to deal with international matters, it is imperative for SAMA to affiliate with international organisation. We identified the key ethical issues around the case in the July issue of *SAMA Insider*.

Our work also includes promoting awareness of medical ethics, especially to our stakeholders who may want to partner with doctors in a manner that violates medical ethics. Our recent stakeholder engagements included schemes and some telephone marketing companies. We found that engaging with businesses protects our members from dealing with these issues at the implementation level.

Part of our work also includes providing administrative support to the SAMA Research Ethics Committee (SAMAREC). SAMAREC is an independent committee specifically appointed for the purpose of research ethics approval. Should you need ethics approval for research in the private sector, this service is

available. We offer value for money compared with other research committees.

CPD accreditation, knowledge management and research

Our research includes providing forecasts on issues that may affect doctors in the future, and addressing them in order to maximise opportunities and mitigate risk. In the last 4 years, we have done research on electronic health records, telemedicine and cannabis. This year and next year, we will focus on the fourth industrial revolution and the profession.

Our knowledge management function includes management of knowledge that is generated within SAMA.

We also offer CPD accreditation. We will help you with all your CPD accreditation; our service is speedy and efficient.

At KMRED our work comes directly from members, delegation from the boards and committees and from scanning the policy and ethics debates. Should you need us to address or advise on a policy or ethical issue, you can contact the department: queries can be sent to Jolene Hattingh at JoleneH@samedical.org or Thabiso Nchabeleng at ThabisoN@samedical.org.



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A South African doctor in South Sudan

Dr Carissa Saunderson

Dr Carissa Saunderson, an emergency doctor from Cape Town, shares her experiences while working with Doctors Without Borders (Médecins Sans Frontières; MSF) in a primary health centre in rural Mayom, South Sudan.



If you had asked me in the first weeks after landing in Mayom, South Sudan, if I would return for another MSF assignment, I would have replied with an eye-roll and a “hell, no.” I would have selfishly pointed out how I missed simple things like hot showers and flushing toilets. There’s an English proverb that goes: “A smooth sea never made a skilled sailor.” In this story, I’m not the sailor. I’m the person who got to work and live next to the sailor. And watch the resilience of the sailor blossom daily in a very muddy clay-like environment. I learnt about resilience and the strength of humanity. I’m immensely grateful to the souls I worked with for allowing me to do so. The longer I stayed, the more the reason I initially joined MSF rang true: that it’s only ever about the patient.

In Mayom, I worked in MSF’s primary healthcare centre. The next medical facility was in Agok, a town a 120 km away where we would refer acutely unwell patients or surgical cases. Unfortunately, due to the difficult road conditions, the trip could take anything from eight to 10 hours.

Working in a primary clinic was different to what I was used to doing back home in an emergency room in Cape Town where, for example, you could request a chest X-ray, do some simple bloodwork – or refer a patient to an appropriate department or different facility altogether. Not in Mayom. There we had to think more, to use clinical judgement, our stethoscopes and our hands.

How to become part of MSF

Doctors work in MSF projects around the world where they are responsible for patient consultations, examinations, diagnosis and treatment. They are required to be able to use ultrasound equipment and perform minor surgeries. In MSF projects, they will be responsible for some management and administration, as well as health education and supporting and liaising with other healthcare professionals and hospitals.

What are the requirements? A Bachelor’s medical degree and at least 2 years’ professional experience. Commitment to MSF’s humanitarian work and principles, and willingness to work in different contexts worldwide, including unstable areas. Being a strong team player able to work well in a multicultural team. Flexibility and adaptability. Capacity to manage stress. Being self-driven with a solution-oriented approach. Abilities to train staff and colleagues. Fluency in English and/or French – other languages are an asset, especially Spanish, Portuguese, Arabic or Russian.

Benefits:

- Volunteer stipend
- All expenses covered (accommodation, daily expenses, travel, etc.)
- Professional liability cover, medical insurance and repatriation cover.

Applicants must be able to work with MSF for a minimum of 6 months.

To apply, visit the MSF stand (stand 23) at the SAMA conference from 8 to 10 August 2019, or go to www.msf.org.za/work-with-us.

At the beginning, it was stressful. But not instantly resorting to special investigation taught me to be more critical from a clinical point of view. By making us think a bit more, and really weigh our options and discuss a case, in the end this makes us better clinicians.

I remember one particular patient – a feverish, malnourished baby who had severe diarrhoea, was very dehydrated and nearly in shock. His mother had been struggling, alone and in vain, for a week before bringing him to the facility.

The team was able to help by giving him IV fluids and medicine, and monitoring his progress, doing sponging and providing supportive care. Eventually this tiny person improved. The gratitude on this mother’s face spoke volumes. It was unlike anything I had ever seen.

Without me being able to speak her language nor her to speak mine, she called me over. She reached behind her neck and took off her necklace, and insisted I have it.

I realised that it was her most prized possession and she wanted to show her gratitude. Refusing it would have been an insult. With much protest, I accepted. I wore it immediately and for days after.



Dr Carissa Saunderson at work in Mayom

If you asked me today whether I would return for another MSF assignment in South Sudan, I would smile and tell you that an army of elephants couldn’t keep me away! Although I went there to help, I feel like I received so much more out of it.

2020 CCSA products launched

Rendani Tendane, medical coding consultant, SAMA Private Practice Department

The Complete CPT for South Africa 2020 (CCSA) book set and electronic browser (eCCSA) will be available by mid-July 2019. This 2020 CCSA will be valid or in use from 1 January 2020 to 31 December 2021.

Please note the following changes: 350 new codes have been added, 155 discontinued and 215 revised. Most changes that have been made are in the cardiovascular and integumentary systems.

To make a purchase or request an invoice, please go to the SAMA website, www.samedical.org. To be eligible for a discount, SAMA members need to log in first, using your username and password. Once logged in, select SAMA products, then CCSA book set or electronic CCSA browser. Non-SAMA members must select SAMA products, then CCSA book set or electronic CCSA browser.

The prices and delivery costs are shown in the tables below. If opting to collect the books from one of our offices, there will be no delivery fee charged. They can be collected from SAMA head office, Block F, Castlewalk Corporate Park, Nossob Street, Erasmuskloof Ext. 3, Pretoria (entrance in Kuiseb Street), or the HMPG office, Lonsdale Building, Lonsdale Road, Pinelands, Cape Town.

Electronic licence period

The eCCSA has a 2-year licence period valid from 1 January 2020 to 31 December 2021. Should you purchase the product within this allocated period, the licence will only remain valid for the remainder of this 2-year period.

2020 CCSA book set prices (vol. 1 and 2; VAT incl.)

Number of copies	Price per unit, ZAR
1st book set for SAMA members	807.27
1st book set for non-SAMA members	1 614.54
2nd - unlimited no. of book sets	1 614.54

Book set delivery costs

Price, ZAR

Postage (as quoted by the SA Postal Services; mailed with tracking number; client must collect at the Post Office)

Single copy	146.20
2 - 7 copies	694.15
Courier (door-to-door)	
Main centres, ≤5 kg	71.73
Regional areas, ≤5 kg	136.62
>5 kg	Quote on request
Neighbouring countries and overseas	Quote on request

Please note: We are experiencing delays with using the postal services – we suggest that you rather use the door-to-door courier services to ensure speedy delivery.

2020 eCCSA browser prices

Number of licences	Price per unit, ZAR
1st licence for SAMA members	322.91
1st licence for non-SAMA members	645.81
2nd - unlimited no. of licences	484.36

2020 CCSA flat file

We have two types of contracts, the multi-user and the value-added reseller (VAR) agreement. You will need to sign one of these agreements to obtain the 2020 CCSA flat file in Excel format. Pricing depends on the number of users and also on the type of licence required:

- multi-user agreement: for internal use only, such as for medical schemes

- VAR agreement: for entities wishing to integrate the eCCSA into their own software product, and then sell that integrated product to their customers.

Please direct any coding queries to our Coding Division on 012 481 2073 or email coding@samedical.org and we will gladly assist you.

They walk among us – the workplace psychopath

SAMA Communications Department

Psychopaths are not just found in serial killer movies and crime novels – they stalk corporate corridors too, where their trail of destruction might not include murder, but can mean the death of productivity, motivation and profits.

The manipulation, deception, inflated self-opinion and back-stabbing of the corporate

psychopath or narcissist often causes work-related depression, anxiety disorders, burnout and physical illnesses in those around them: conditions that cost the SA economy more than ZAR40 billion annually.

Corporate Mental Health Week (1 - 5 July 2019) turned the spotlight on work-related stress, which accounts for more than 40% of

all workplace-related illness in SA – with at least one in four employees diagnosed with depression.

Dr Renata Schoeman, psychiatrist and associate professor in leadership at the University of Stellenbosch Business School (USB), says it is often leaders – who should be at the forefront of reducing the workplace conditions that lead

to stress and burnout – who contribute to the problem, rather than the solution.

“We are not talking about the ‘difficult’ boss here, but the boss who is a bully – and many of these could be defined as corporate psychopaths.

“The bullying tactics of corporate psychopaths increase conflict, stress, staff turnover and absenteeism, reduce productivity and collective social responsibility and erode corporate culture and ethical standards – diminishing shareholder value and returns on investment,” Dr Schoeman said.

Workplace bullying is a major cause of work-related stress, Dr Schoeman said, pointing to a 2017 survey in the USA that found that adults were being bullied at levels similar to teenagers – 31% of adults had been bullied at work, and almost half believed that bullying behaviour was becoming more acceptable in the workplace.

“Bullying can make you ill,” she said. “In the same survey, 70% or more of bullying victims had experienced stress, anxiety or depression, 55% reported loss of confidence, 39% suffered from lack of sleep, 17% called in sick frequently and 19% had suffered mental breakdown. Emotional stress can also cause or aggravate physical illnesses such as gastrointestinal problems (e.g. irritable bowel syndrome) and cardiovascular problems (e.g. hypertension), while victims of workplace bullying had double the risk of considering suicide in the 5 years following.”

Chief executives have the highest prevalence of psychopathic traits of all jobs, at a rate second only to prison inmates, and while it is estimated that 1 in 100 of the general population have psychopathic traits, this rises to 1 in 25 in business leaders.

In what she calls “the curse of confidence”, Dr Schoeman said that many of the traits characteristic of psychopaths – such as charm, fearless dominance, boldness and a “grandiose sense of self” – are also what help people get ahead in business.

She emphasised, however, that “not everyone with loads of confidence, and who is successful, even if they have a brash approach to people, has a personality disorder.”

The workplace bullies we need to be most concerned about, she said, are those with narcissistic personality disorder or antisocial personality disorder.

Dr Schoeman says narcissists can be brilliant strategists, have the courage to take risks and push through massive change and transition, and use their charisma and compelling visions to inspire others – all characteristics that fit into conventional ideas of leadership.

“These masters of self-image, who take credit but deflect blame, tend to gather a group of co-dependent people around them to support and reinforce their behaviour. They profess loyalty to the organisation, but are really only committed to their own agenda, and people may experience them as distant and cold.

“Narcissists tend to be oversensitive to criticism and over-competitive, and often engage in counter-productive work behaviour when their self-esteem is threatened. They expect great dedication, and may overwork others without any regard for the impact on their lives,” she said.

It is often the leaders ... who contribute to the problem, rather than the solution

She said narcissists favoured “indirect bullying tactics” such as withholding information, ignoring people or giving them the “silent treatment”, spreading rumours to discredit others, and inflating their own contribution or taking credit for achievements they had little to do with.

Narcissists are also more likely to engage in sexual harassment, due to their inflated sense of importance and tendency to exploit others.

The “darker personality”, she said, is the psychopathic character, the boss or colleague with antisocial personality disorder – who replaces the narcissist’s exploitative tactics with a predatory drive for strategic conquests, domination and cruelty.

She said that “successful psychopaths” share the same core characteristics as those who become criminals: deceit, manipulateness, indifference to the consequences of their actions, superficial charm, lack of empathy and lack of remorse – but they tend to come from more privileged backgrounds, and have higher IQs.

“Successful psychopaths tend to be more conscientious than those with a criminal record. They are less impulsive, negligent and irresponsible, but this does not mean they are always law-abiding citizens – they may just be better at avoiding being caught,” she said.

Dr Schoeman said the bullying tactics of the “successful psychopath” were based on assessing the usefulness and weaknesses of those around them, manipulating others to bond with them, using their victims’ feed-

back to build and maintain control, and then abandoning them when they were no longer useful.

“They are extremely efficient at using and manipulating communication networks to enhance their own reputation while discrediting others, and creating and maintaining conflicts and rivalries among colleagues. They are excellent at spreading disinformation, while covering up their own association with this false information,” she said.

Dr Schoeman said both narcissists and psychopaths have traits that can be positive, and they can be highly successful in business – “but they can also create highly toxic environments, with just as significant an emotional and financial toll on employees and organisations as other more obvious workplace stress factors.

“It is important to be equipped to recognise and safeguard oneself against these workplace bullies,” she said.

So how to deal with the office narcissist or psychopath? Dr Schoeman shares the following tactics.

Dealing with a narcissist boss or colleague:

- Avoid contact.
- Ignore their actions.

Stay neutral, calm and professional:

- Resist the urge to challenge or confront them.
- Don’t offer or give any personal information or opinions.

Ground yourself:

- Realise it is not personal.
- Realise their insecurity.
- Accept that change likely won’t happen.
- Build a supportive network.
- Reach out for help.
- Know your legal rights.

Protect yourself:

- Set clear boundaries (be assertive but not aggressive).
- Have a witness.
- Get everything in writing.
- Be alert: when a narcissist can no longer control you, they will try instead to control how others see you.

Disarm the narcissist (this is perhaps the most difficult strategy, as you might feel dishonest):

- Always empathise with your boss’s feelings, but don’t expect any empathy back.
- Give your boss ideas, but always let him or her take the credit for it.

Dealing with an antisocial boss or colleague:

- Keep your emotions in check.
- Don’t show that you are intimidated.

- Stick to the facts – do not get drawn into their victimhood stories.

Ground yourself:

- Accept that some people are bad news.
- Know your weaknesses – which the psychopath will exploit.
- Take care of yourself, manage your stress and build your resilience.
- Build your reputation and relationships.

Protect yourself:

- Report incidents of bullying and harassment to human resources.

- Opt for online communication (where negotiation and manipulation are more difficult).

Disarm the psychopath:

- Turn the conversation back to them when they are blaming someone else.
- Point out their flaws (e.g. their reaction in a meeting) and ask them if they are feeling stressed.

Safeguard the organisation:

- Have an ombudsman or anonymous tip line at work – regular workers often pick

up on the psychopath's game before management does.

- Cross-check your impressions of your high-potentials with colleagues who know them well.
- Expect responsibility.
- Guarantee consequences.
- Provide predictable punishment – without delay.
- Know the law.

References available on request.

Worker burnout: Too much work and unclear goals

Gert Viljoen, *VPROF*

Employee burnout is a major problem worldwide. In the USA, for example, it is estimated to cause 120 000 deaths and to cost USD120 billion in healthcare annually. No doubt, in the local context individual businesses also suffer substantial direct and indirect costs. The good news is that research has shown that we can all do something about it.

So let's have a look at the two factors that have been particularly highlighted as causes of burnout, and at the reasons behind them. Most importantly, on the principle that prevention is always better than cure, we'll also discuss three key recommendations from researchers on how to address the problem.

Two issues have come to the fore in terms of staff experiencing burnout: bosses who work too many hours, and conflicts in terms of duties performed.

These can result in burnout and high healthcare costs (as in the example of the USA).

Bosses working excessive hours

Generally, managers who work long hours encourage their staff to work similar hours. This encouragement springs either from employees' following the manager's example, or from the manager's exhortations to also work long periods.

Experts say that a balanced lifestyle between work and leisure is necessary to keep the workforce mentally sharp, and they question the benefit of excessive work

hours. As one has put it, "Darwin only worked 4 hours a day, and he radically changed human thinking."

It is important that you satisfy yourself that your executives are not pushing their staff into an unnecessary workload.

Managers who work long hours encourage their staff to work similar hours

Work-work conflicts

Surveys show that another area of unhappiness is that staff face conflicting duties when performing their work. It is natural that people want to be as proficient as possible in their jobs, but they often find this almost impossible to achieve.

As an example, take the roles that a physician is expected to fulfil:

- diagnosing and treating patients
- researching in his/her chosen field
- mentoring learner physicians
- travelling to and attending conferences
- attending to all the administration required, including staff appraisals, budgets, committee meetings – the list goes on.

Yet when one looks at how the physician is evaluated, it is usually in terms of their most

prestigious function, that is, the research undertaken. Thus the physician ends up in the position of failing to meet some of the requirements, which leads to frustration.

It can also potentially lead to lower productivity, as it may encourage staff, such as the physician, to get political in pleasing their superiors.

What can you do about these conflicts?

Researchers have made some key recommendations to address these work-work conflicts, beginning with defining what outcomes the business requires. This will have the effect of:

- ensuring that staff have an appropriate job description based on fulfilling the key aspects of their job requirements
- making sure that there is clarity and transparency as to what is expected of staff, and what goals they are expected to reach
- aligning staff salaries and bonuses with these defined outcomes.

Work-work conflicts can easily arise in the workplace, so take action to minimise these conflicts.

V Professional 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.

TB infection prevention and control in healthcare

Annatjie Peters, head: Nursing School, FPD

Tuberculosis (TB) remains one of the leading causes of morbidity and mortality in SA, despite the fact that it can be cured with adequate treatment. The rising incidence of multidrug-resistant (MDR-) and extensively drug-resistant (XDR-) TB with associated high mortality has led to a stronger focus on TB infection control.

Most infection prevention and control guidelines on addressing the prevention of nosocomial transmission of *Mycobacterium tuberculosis* have been produced in the developed world, where the incidence of TB is low. The measures are prohibitively expensive, and inappropriate to the SA setting. A review of the most common factors contributing to transmission of infection in the developing world shows that many may be remedied by simple, and often inexpensive, control measures. Of the TB control measures that are likely to have the greatest impact on reducing transmission (e.g. rapid diagnosis and triage of infectious TB patients), many can be implemented with minimal additional financial resources. These represent overall “best practice” in TB control, protecting healthcare workers (HCWs) – a scarce resource – from infection, and serving to ensure that infectious patients are rapidly identified and started on treatment, thereby reducing the infectious pool in the community.

The first and most important level of control is the use of administrative measures to prevent infectious particles from being generated, thereby reducing the exposure of HCWs to TB. Ideally, if the risk of exposure can be eliminated, no further controls are needed. Unfortunately, however, it usually cannot

be eliminated – but it can be significantly reduced. Important administrative measures to reduce the risk of transmission include early diagnosis of potentially infectious TB patients, prompt separation or isolation of these patients and the prompt initiation of appropriate treatment. Other important measures include an assessment of the risk of transmission in the facility, the development of an infection control plan that details in writing the measures that should be taken in a given facility, and adequate training of HCWs to implement the plan.

Measures are prohibitively expensive, and inappropriate to the SA setting

Various environmental control methods can be used in high-risk areas to reduce the concentration of infectious particles in the air. Measures include maximising natural ventilation, and controlling the direction of airflow. In settings such as hospitals, including TB hospitals, a measure such as exhaust ventilation may be warranted. However, in the absence of administrative controls, such environmental control measures will be of limited value.

At all levels, efforts should be made to limit HCWs’ exposure to infectious particles. In certain settings, however, administrative and environmental controls

cannot adequately reduce this exposure. For example, HCWs may be exposed to high concentrations of infectious particles during sputum induction procedures, while providing bedside patient care to infectious TB patients, examining suspect TB patients in poorly ventilated clinic rooms, or performing autopsies, bronchoscopes or other cough-inducing or aerosol-generating procedures. In these circumstances, the recommended control measure is the protection of the HCW from inhaling infectious droplets using personal respiratory protective devices. The type of available surgical masks that are commonly used by HCWs do not filter out infectious TB particles. Instead, devices are needed that fit tightly over the mouth and nose, and filter out infectious TB particles. Personal respiratory protective devices that are capable of adequately filtering out infectious particles may be expensive, however, and for practical reasons cannot always be worn. If administrative and environmental controls are not effectively implemented, the value of these masks is very limited. Therefore, they should only be used in specialised settings (usually in general hospitals’ TB wards, or TB hospitals) when all other administrative and environmental measures have been fully implemented.

The development of administrative TB-control measures should take precedence over all other interventions to reduce nosocomial TB transmission. Without effective administrative controls, environmental measures and personal respiratory protection are of limited value.



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Concealed sepsis

The Medical Protection Society shares a case report from their files

Mr D, 53, had suffered with osteoarthritis (OA) in his right knee since turning 50. This had been confirmed with arthroscopy. It rarely bothered him and he continued to work as a PE teacher. He had experienced a flare-up of knee pain at the start of the autumn term, but this had settled quickly with analgesia.

He contacted his GP on the first weekend of the Christmas holidays, complaining of 2 days of bilateral knee pain, which was unrelieved by his usual co-dydramol. He was seen by Dr C, who documented a normal right knee on examination, but limited movement in the left knee, with positive meniscal signs and no effusion.

Dr C also noticed that Mr D had a painful swollen left little finger, which he had jammed in a door 2 weeks earlier. Since he was afebrile, Dr C attributed the symptoms to OA, and advised Mr D that he should also arrange to get an X-ray of his finger to exclude a fracture. She provided him with naproxen analgesia.

The pain continued after the weekend, and Mr D was unable to leave the house to arrange the X-ray. He spoke to Dr V at his surgery, and an appointment was arranged for the next morning. The following day, Mr D was still unable to get to his car, and called the surgery again, this time speaking to Dr A, who agreed to a home visit.

Dr A recorded an effusion and worsening right knee pain now radiating to the calf and hip. He also noted that Mr D now had swelling over the dorsum of his injured hand, and he also spotted two erythematous patches on the right elbow and left foot. Mr D did not report feeling feverish, and so vital signs were not recorded.

Dr A prescribed a course of antibiotics to cover for possible infection in the right hand, and documented that she believed the knee pain was likely to be a strain. She queried gout as a possible cause, and recorded that she was uncertain what the satellite lesions represented. She advised Mr D to contact the surgery again the next day.

The next day was Christmas Eve, and Dr B was on duty for the day. He visited Mr D at home, as requested by Dr A. By now Mr D was feeling better, and the swelling in his hand had reduced, but he was feeling "spaced out" on the codeine analgesia he was now taking. Dr B asked the patient to get out of bed for a full examination, which he was able to do.



Mr D's wife later recalled the doctor taking her husband's blood pressure and advising he omit his antihypertensive medication. Dr B made no record of this examination. He later recalled that he examined the patient fully, including his temperature, and as he found nothing of concern he did not make a note of this. His advice was for Mr D to complete the course of antibiotics and increase his fluid intake.

Mrs D recalled that her husband's condition became worse towards the end of the day, with slurred speech and generalised weakness. He made an attempt to go to the toilet with the assistance of his son, and it took him 40 minutes. Mrs D awoke the next morning to find that her husband was dead.

The pathologist who carried out the postmortem concluded that Mr D had died from complications of septicaemia, but the focus of the infection remained uncertain. He noted splenomegaly, but no

lymphadenopathy. Experts agreed that the cause of death was perplexing but that the knee was the least likely site, with either the hand or an upper respiratory tract infection being the most likely causes.

Crucially, expert opinion agreed that if intravenous antibiotics and volume replacement had been commenced on 23 or 24 December, then arguably the fatal episode of sepsis could have been avoided.

Expert opinion also found that neither Dr A nor Dr B had recorded anything like enough information to suggest that their assessments were adequate. In Dr B's case, with no clinical details recorded and no plausible diagnosis, there would be no possible chance that a court would accept that his assessment was reasonable. Similarly, Dr A had not recorded enough to show that her assessment was reasonable on 23 December.

The case was settled for a substantial sum.

Learning points

Good note-keeping is essential. In this case, recording the patient's vital signs and mobility would have demonstrated that an adequate assessment had been carried out, and made the actions of the doctors involved easier to defend.

Clinical presentation can change quickly. Expert opinion was critical of the lack of a plausible diagnosis. It is not clear from the note-keeping how unwell Mr D was when assessed by Dr A. It may have been the case that Mr D appeared so well that Dr A felt it unnecessary to document normality. However, without adequate information or a clear diagnosis to prove that a reasonable assessment was carried out, it is difficult to defend her action, given the symptoms of polyarthritis with patches of erythema suggestive of infection.

Patients should be advised on the signs to look out for and when to seek further help if they continue to feel unwell.

Identifying sepsis early can save lives. The diagnosis may not always be immediately obvious, and a high index of suspicion is required to make the diagnosis and prevent fatalities.

Local hero award for Dr Kim Harper

Past Border Coastal branch president Dr Kim Harper was honoured with a local hero award at the branch AGM held at the East London golf club on 8 June. The paediatrician, who heads the paediatric unit at Frere Hospital and who has a passion for medicine and children, said, "I am extremely honoured and grateful to be nominated by the branch I have been part of for 14 years."

"We are a small band of brother and sisters and we provide an incredible service under difficult circumstances, and do an awesome job in healing patients in our town."

He attributes his success to his colleagues: "We are all working towards the same goal, and that makes it a lot easier. The colleagues I work with are extremely supportive; everyone works hard and we pull our weight. Without that we would not be able to cope with the number of patients and the severity of the illnesses we have to face."

Dr Harper's passion for medicine grew during his childhood as the son of a nurse. "My mother was a nurse and I think she inspired me, and I had the opportunity at school to visit hospitals and see what was needed and what medicine offered."

The EP branch chairperson said that SAMA is extremely proud of Harper. "Dr Harper deserves the award. His sterling work both in SAMA and at Frere Hospital is unparalleled."



Dr Kim Harper, local hero



The award

Prof. Milind Chitnis, a paediatric surgeon in East London, said, "Over the last 20 years, the name 'Dr Harper' has become almost synonymous with neonatal care and the neurodevelopmental clinic, two exceptionally busy and demanding areas of paediatric care at Frere hospital."

"He has learnt to make the best use of perpetually scarce resources and give the best possible care. It is a difficult juggling act that needs skill and patience. He sets a good example in front of the juniors by working

hard and sincerely. He gets along well with colleagues from various departments, and his advice is sought even by senior leadership at the hospital. His dedication to the work of the Border Coastal branch of SAMA has been exceptional. He has always been available for advice and/or help for any SAMA member who asked for it. His work with SAMA has enabled him to understand government procedures and processes inside out, and subsequently to help colleagues working in the state sector to protect their interests."

KZN Midlands keep members out of trouble

Over 60 delegates joined the SAMA KZN Midlands branch and the Medical Protection Society (MPS)'s medicolegal CPD meeting on 20 June 2019.

Dr Graham Howarth, head of medical services at MPS, spoke on "Keeping out of Trouble: The 10 Cs".

Delegates left the meeting with top medicolegal and ethical tips for keeping out of trouble.



From left to right: Mr Barry Naude (member engagement executive), Ms Margi van Gogh (regional director), Dr Graham Howarth (head of medical services at MPS), Dr Thami Buthelezi (chairperson of the SAMA KZN Midlands branch)



Interacting with delegates after the meeting

EP branch AGM honours six life members

The SAMA Eastern Province (EP) branch held its AGM on 6 June at the Pine Lodge Conference Centre in Port Elizabeth.

Despite it being the coldest night of the year thus far, with a temperature of 2°C, SAMA members braved the cold to ensure a well-attended event.

The branch thanked outgoing branch president Dr G Parker for his year of service, and

welcomed Dr E Adudua as branch president for 2019/20.

Drs A J G Black, D P Doubell, B G Duncan, G P Greeff, J Olivier and C J Pistorius were awarded life membership certificates.

SAMA EP branch chair, Dr Farhaad Khan, informed the members of the progress made by the branch in the past year. Specific mention was made of the successful first annual trail run, which

enabled the EP branch to make a donation of ZAR10 000 to the Association for Babies in Crisis.

Guest speaker Shelley-Ann McGee delivered two excellent talks that were well received. The first talk covered "Cannabis for medical purposes" and the second "Telemedicine".

Members were informed of future events and encouraged to submit topics for future CPD events.



Dr R P Benson, 90 years old and still an active member and co-opted branch councillor, presents a life membership certificate to Dr D P Doubell



Dr O Olubiye (EP branch vice chairperson) hands over a lucky draw gift to Dr Saajida Khan



Dr E E Ajudua (EP branch president), Shelley McGee (SAMA head office) and Dr Farhaad Khan (EP branch chairperson)

Cape Town branch visit Eerste River

Branch secretaries Chenienne Gericke and Emily Nel, together with Ruan Vlok, the new industrial relations advisor, visited Eerste River Hospital on 7 June to promote SAMA and to nominate SAMA hospital representatives.

Approximately 30 public sector doctors attended a successful meeting.



Ruan Vlok addresses doctors at the Eerste River Hospital

Griqualand West thank Dr Konso

On 12 June, Griqualand West branch had a get-together to honour Dr T F Konso for his dedicated service and support on the branch council.

Dr Konso has served in the role of branch councillor, state doctors' representative and SEDASA provincial councillor. During this time he was always available and willing to

assist members with issues they raised, and was involved in the day-to-day running of the branch. He emphasised the continued commitment of the branch council members to the goals and ambitions of the branch, and to SAMA as a whole.

Chairperson Dr M J Ngundu presented a gift of appreciation to Dr Konso at the event.



SAMA Griqualand West branch chairman, Dr M J Ngundu, hands over a gift of appreciation to branch councillor Dr T F Konso



CPD

For further information
please contact the
CPD Officer on

012 481 2000 

cpd@samedical.org 

WHAT ARE WE ABOUT

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.

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 - Empowering Doctors to bring health to the nation
 - Excellent Service
 - Quick Turnaround
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SAMA RESEARCH ETHICS COMMITTEE

WHAT ARE WE ABOUT

Evaluating the ethics of research protocols developed for clinical trials conducted in the private healthcare sector. Ensuring the protection and respect of rights, safety and well-being of participants involved in clinical trials and to provide public assurance of the protection by reviewing, approving and providing comment on clinical trial protocols, the suitability of investigators, facilities, methods and procedures used to obtain informed consent.

SERVICES AVAILABLE

- South African Medical Association Research Ethics Committee - SAMAREC
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