

SAMA

INSIDER

OCTOBER 2019

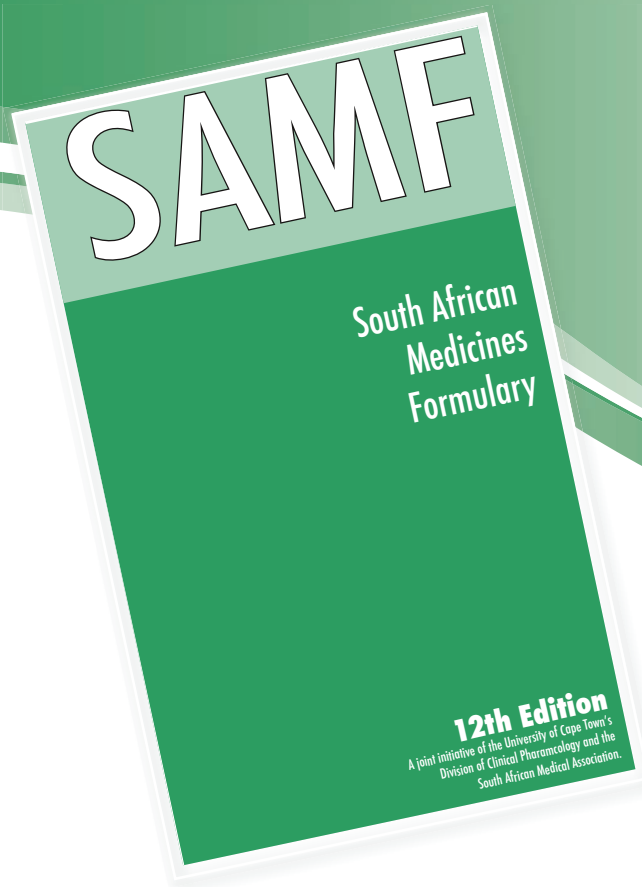
**SAMA conference
tackles healthcare
challenges**

**Unpacking new social
media ethical guidelines**



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CARE COORDINATION - AT THE HEART OF IMPROVING HEALTHCARE DELIVERY

Background

The Government Employees Medical Scheme (GEMS) introduced its Emerald Value Option (EVO) in January 2017 with the aim of improving the quality of healthcare, while simultaneously containing costs by championing care coordination.

Care coordination sees healthcare professionals working together to ensure that patients receive appropriate care. The EVO is premised on this concept. In practice, EVO members nominate a family practitioner (FP), who then handles specialist referrals. Members also use an efficient hospital network.

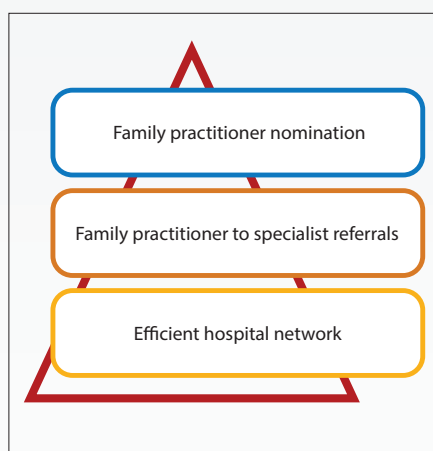


Figure 1. Care coordination on the EVO

If applied across the medical schemes industry, we believe care coordination, as pioneered by the EVO, can reduce healthcare costs by around R20-billion a year.

Family practitioner nomination

FP nomination is a central tenet of the EVO. Beneficiaries on the EVO are required to nominate a FP, who will be responsible for overseeing their care. Beneficiaries have to use their nominated FP for all consultations, or incur a co-payment. The nominated FP must be part of the GEMS FP network, which includes 6 700 FPs countrywide.

The benefit of this approach is that care is coordinated and patients build up relationships with doctors who become familiar with their medical history, enabling more effective treatment and limiting the potential duplication of care. Ultimately, this results in better care and savings for both the member and the medical scheme.

Specialist referrals

Beneficiaries on EVO require an FP referral before consulting a specialist. This limits unnecessary specialist consultations. Beneficiaries who consult specialists and not FPs have risk-adjusted costs per life per month that are 9% higher than average.

Efficient hospital network

Beneficiaries on the EVO access hospital care at network hospitals, or incur co-payments. This network was established through a bidding process. The hospitals selected offer exceptional value in terms of discounted tariffs, hospital-cost efficiencies and quality care management. Geographic coverage and black economic empowerment were also considered when selecting hospitals.

Benefit to GEMS members

The lower costs associated with care coordination are passed on to members in the form of lower contributions. Contributions on the EVO are around 15% lower than on GEMS's Emerald option, despite the EVO offering the same comprehensive benefits.

Relevance to NHI

The concept of care coordination is entrenched in the draft National Health Insurance Bill, which champions primary care. Both FP nomination and specialist referrals prevent unnecessary specialists consultations.

The NHI policy document also refers to the use of contracted providers meeting predetermined criteria. The establishment of the GEMS EVO hospital network is aligned to this principle.

Conclusion

The EVO has grown significantly since its inception in January 2017 and now covers 195 000 beneficiaries. If it was a scheme in its own right, it would be South Africa's fifth-largest closed medical scheme. This growth illustrates the support for care coordination and the need for more affordable options. Care coordination is therefore one of the initiatives necessary for achieving universal healthcare coverage.

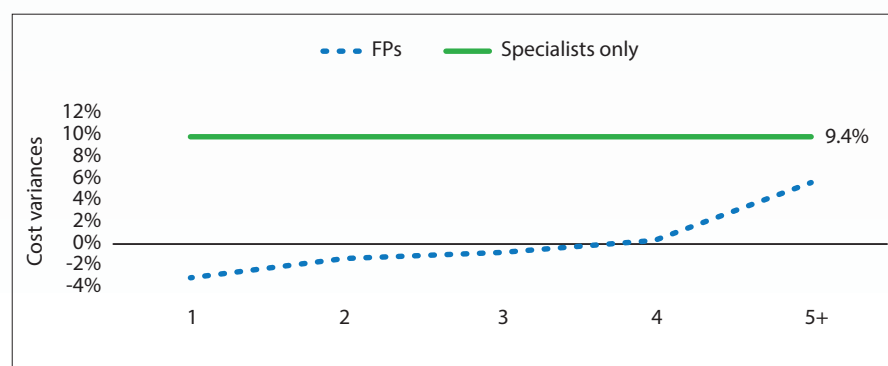


Figure 2. Cost variances for specialist visits without a family practitioner referral



Diane de Kock
Editor: *SAMA INSIDER*

Recognition and the path ahead

This month we acknowledge achievement, and take stock of some of the challenges facing our members, and the role SAMA plays in helping to meet them.

The annual SAMA conference was held in Durban this year. See pages 5 - 12 for reports on the conference itself, the enlightening abstract sessions and the prestigious Merit Awards, which were presented at the gala dinner.

We all use social media, a growing and useful tool in both our professional and personal lives. However, as Brandon Ferlito points out in his article on page 12, "there is a growing concern that [healthcare professionals] may unwittingly expose themselves to ethical dilemmas."

And "if you have been feeling confused about the legal status of *Cannabis sativa* in SA, you are not alone," says Shelley McGee (page 14), who encourages members to contact the Knowledge Management, Research and Ethics Department if they are confronted with questions about its use, efficacy and safety.

On page 16, Prof. Stoffel Grobler looks at reasonable accommodation rather than "light duty" for people with mental illness. We introduce the SAMA legal department (page 17), who offer help to members who need advice on any legal or ethical issues in their practice. Climate change has an impact on healthcare (page 18), says Jolene Hattingh in her article: "the impacts of climate change are felt most severely by vulnerable populations, as the effects are vast, and are all interlinked with health, infrastructure and food security."

Employee relations advisor Modisane Lelaka gives advice on dealing with absenteeism in the workplace (page 19), and the new JUDASA committee outline their vision for 2019/20 (page 20).

Your input and suggestions are always welcome; please contact the editor, Diane de Kock, at Dianed@hmpg.co.za.

Apologies to Gauteng MEC Dr Bandile Masuku for not using his correct first name in the September issue.

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Published by the South African Medical Association
Block F, Castle Walk Corporate Park, Nossob Street
Erasmuskloof Ext. 3, Pretoria

Email: publishing@hmpg.co.za | www.samainsider.org.za | Tel. 012 481 2069
Printed by Tandym Print (Pty) Ltd

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Populism in SA and around the world



Prof. Hoosen Coovadia, SAMA president

I have had difficulty in understanding the term “populism”, imagining it referred to popular currents sweeping through society, such as socialism, capitalism, anarchy or fascism. In recent years, much has been made of the governance transformations occurring globally as being due to populism.

Fukuyama, the internationally renowned scholar, recently clarified some of the key uncertainties and paradoxes within this term, as he observes that it “has been used so broadly that it has become meaningless ... Everything has been called populism.”

It is helpful to distinguish between three broad types of populism, and importantly, to recognise that individual populist leaders may combine these in different ways.

One variant relates to economic policies. An economic populist is a leader who promotes policies that are popular in the short run, but bound to be unsustainable in the long run. A classic example is former Venezuelan leader Hugo Chávez, who launched immensely popular public spending programmes. These, however, relied on government revenues derived from high international oil prices. The moment oil prices collapsed, due to sanctions imposed by the USA on Venezuela, the model collapsed, too.

The second strand could be described as charismatic populism, and relates more to a style of leadership than to policy. The populist leader claims a particular kind of authority, that of a direct relationship with “the people”, which is used to justify a policy programme. “The problem with this kind of charismatic populism is that it is inherently anti-institutional,” Fukuyama says. “The leader gets up and says, ‘Well, the people voted for me, I embody in my own person the people’s will and there’s a court that is blocking me from doing something ... so I’m going to shut down the court or stock it with my own people and get around it’”

Fukuyama argues that, with the rise of charismatic populism, “the democratic part of liberal democracy is rising up and attacking the

liberal part.” In his view, this form of populism constitutes the greatest threat to democracy around the world. “When Donald Trump accepted the Republican nomination in 2016, he said something truly remarkable: ‘I alone understand your problems, and I alone can fix them.’ He has gone on to attack virtually every institution in the American government that he feels has threatened him.” Democratic government depends on checks and balances between institutions.

The third form of populism could be described as racial or ethnic populism. Here, the populist leader claims a special relationship not with the population as a whole, but with a certain segment of “the people” – frequently, those of a certain race or ethnicity. Victor Orbán of Hungary, for example, has said that Hungarian national identity is based on Hungarian ethnicity. This is a highly problematic claim in a democracy. Not all citizens of Hungary are ethnic Hungarians. Furthermore, there are numerous ethnic Hungarians outside of Hungary. Ethnic populism therefore creates minority race issues in Hungary, and also foreign policy tensions. This type of populism is often accompanied by a conspiratorial worldview in which politics is alleged to be controlled by secretive elites linked to “foreigners” or shadowy global conspiracies.

Fukuyama believes we can use these three types of populism to understand the leaders labelled “populist” around the world. Existing populists may embody one or more of the three strands. Hugo Chávez deployed unsustainable redistributive policies, but he also claimed a direct relationship with his people with which he might justify ignoring any institutional, legal or political check on his power, thus blending the economic and the charismatic types. The new Brazilian president, Jair Bolsonaro, is not an economic populist – indeed, he has hired an orthodox Chicago-educated economist to be his finance minister – but he has cultivated a charismatic persona, and made claims about his “authentic” relationship with the Brazilian people. He is also a racial populist. Although Brazil is a country in which white people represent a minority, he makes use of all manner of racial innuendo.

In Northern Europe, populist parties all rest on some combination of charismatic and ethnic populism, but are much less economically populist. The ethnic dimension is especially critical for them, because the single thing that most unites these different parties is the fear that national identity is going to be “stolen” from them through immigration.

In SA, the Economic Freedom Fighters (EFF) under Julius Malema articulate a variant of economic populism, but Malema himself evidently has aspirations to be a charismatic leader too. Fukuyama is uncertain about the extent to which race and ethnicity constitute central elements of Malema’s appeal, although he found local audiences believed it to be significant. Malema has a distinctly opportunistic and inconstant approach in his public statements. And because there is credible evidence of his dishonesty, he is more than simply an economic populist. Indeed, given his predisposition to various forms of outright thuggery and threats of violence, he is an aggregation of economic, racist and fascist populism.

Distinguishing these different aspects of populism is crucial to understanding its rise globally, and its significance for the future. Economic populism flourishes among the poor in highly unequal countries in Latin America, and perhaps now in SA. The social basis of European and US populism is quite different, though. Rather than resting on the very poor, it feeds in part on a working class threatened by jobs loss and de-industrialisation, and mobilises dangerous forms of ethnic resentment to do so.

The conventional wisdom is that this is a “backlash against globalisation” as a result of lower-skilled people in rich countries losing out to cheaper labour in poor countries. However, this does not explain why right-wing rather than left-wing populism has made gains around the world.

Fukuyama believes that the issue of identity is crucial here. All human beings yearn for our worth to be recognised by other people. Adam Smith, in *The Theory of Moral Sentiments*, observed that there was no mass starvation in the Britain of his day, even among the very poor. The pain of poverty was instead constituted by a feeling of invisibility: a sense that the wealthy and privileged did not recognise a poor person as a fellow human being. Fukuyama believes that this yearning for recognition may well be a common factor linking all three dimensions of populism.

From the older verities of left-wing and right-wing political ideologies we have segued into the populist propositions of today, when failures of globalisation, the loss of jobs, increasing unemployment and worsening social conditions have encouraged increasing attention to the identity of people and individuals, inevitably deepening fractures across previously homogenous societies, bringing greater disorder into the modern world.

SAMA conference tackles healthcare challenges

SAMA Communications Department

Women's Day and the promulgation of the new National Health Insurance (NHI) Bill before Parliament provided the perfect backdrop to the 2019 SAMA conference, held in Durban this year. A sense of excitement prevailed as eager networking took place alongside a stimulating programme, all accompanied by delicious food, from 8 to 10 August in the conference centre at the Southern Sun Elangeni & Maharani Hotel, conveniently located on Durban's picturesque Golden Mile.

The theme "Leadership and quality in healthcare: Let's close the gap" dovetailed with the tabling of the NHI Bill in Parliament, the first step on the journey to equitable healthcare for all South Africans, a scenario that will demand good leadership from all in the healthcare profession. The atmosphere was enthusiastic, engaging and supportive, and there was never enough time for all the questions after each presentation.

The programme encompassed oral presentations at both the plenary and parallel sessions (see article page 7) and discussion panels led by experts in their field. "This year's programme included international speakers from the USA who are actively involved in making a difference in healthcare," said Prof. Mergan Naidoo, chairman of SAMA's Education, Science and Technology (EST) Committee. "The theme resonated well with the future direction of healthcare, and speaks to accreditation of sites by the Office of Health Standards Compliance and various initiatives of the NHI. It also resonates with the discussions emanating from the private sector in SA." The hard work of both the SAMA Marketing Department and the EST Committee was very evident on the day.

SAMA thanks the conference sponsors, some of whom were represented in the exhibition hall, where delegates were treated to welcome tea breaks and delicious lunches – a perfect place to catch up with colleagues both old and new.

The conference provided an important update on common clinical conditions in practice, and focused on using the fourth industrial revolution to improve healthcare in SA. "So many of our healthcare institutions suffer from poor leadership, which often translates into poor quality of care for our patients. We are currently facing increased costs of healthcare



Conference delegates at the Ushaka aquarium

with shrinking budgets, so leadership is key in managing limited resources," said Prof. Naidoo.

The conference themes also engaged with the current discourses in healthcare, namely: leadership and quality (the overall theme); maternal and child health; women's health; doctors' mental health; preventive and promotive health; and mitigating against risk.

Dr Asad Latif, a faculty member in the Department of Anesthesiology and Critical Care Medicine at Johns Hopkins University School of Medicine, and core faculty at the Armstrong Institute for Patient Safety and Quality, gave a presentation on "Leadership: Sustaining change in healthcare" that opened the conference with the question, "Are we doing what we think we are doing?" with regard to quality and safety in healthcare. In the USA, preventable harm causes up to 440 000 deaths per year, which reinforces the fact that we have to view the delivery of healthcare as a science, because "system failure leads to error." Dr Latif's research interests lie in patient safety and quality improvement, with an emphasis on global surgical care, preventing hospital-acquired infections, improving patient outcomes and communication and health system strengthening, particularly in developing countries. He believes that it takes culture change to get the most out of best practices, and that his approach would work well in SA with the right leadership commitment and buy-in.

Dr Vuyo Gqola, Government Employees Medical Scheme (GEMS) executive in healthcare management, followed with a presentation on partnering for better outcomes, and the

importance of creating more access to improve outcomes.

Leadership and management

The first presentation in this section was by Dr Logandran Naidoo, the senior medical manager of medical services at Grey's Hospital in Pietermaritzburg, and a man with a passion for enhancing systems through quality management and lean thinking. He looked at practical considerations for applying lean thinking in hospitals.

Prof. Satish Bhagwanjee's presentation followed, on inverting the pyramid – an approach that puts the patient first. A professor in the Department of Anesthesiology at the University of Washington Medical Center, Prof. Bhagwanjee proposed a model for delivery of critical care in SA. He has established the SA Critical Care Clinical Trials Group, and more recently has formed, and leads, the Acute Care for Africa Research and Training (ACART) group. His clinical experience has been in trauma, surgical and cardiothoracic intensive care, and his research interests have been in outcome prediction in the critically ill and the development of regional mechanisms for critical care delivery. "Good critical care requires good teamwork," says Prof. Bhagwanjee, who believes the operative word is teamwork, not leadership.

The presentation by Deputy CEO of Discovery Bank Dr Ryan Noach on "Leadership in healthcare" emphasised the idea that doctors need to organise and lead, particularly in these challenging times in SA. "Doctors need to work on a vision, they need to be proactive, and take the high road."

Quality in private practice

This session opened with a presentation by Prof. Morgan Chetty, a specialist family physician whose interests are patient-centred care and quality in healthcare. His presentation "How does the accreditation of GPs improve quality?" looked at the structural process required to achieve quality, and provided an overview of the international perspective. "It is here to stay, we have to prepare for accreditation."

Jane Ball, Discovery's head of population health management, unpacked how medical schemes measure doctors' quality, and asked "How have we come to this?" She acknowledged that doctors are under increasing pressure and that we have not achieved the results we would like to have seen. "We need to look to improving value, and place the patient at the centre."

Funding decisions and their alignment with clinical guidelines was the subject of Dr Siphon Kabane's presentation. He is an acting CEO/registrar and senior strategist in the regulation of the medical scheme industry. "We aim to accelerate clinical guidelines, and are working with all stakeholders in an ongoing and transparent process."

Focus on women's health

An inspiring and energetic presentation by Prof. Carol-Ann Benn entitled "Breast cancer: Focusing on quality of care in prevention, detection and treatment – the Flamingo Project", opened this section. Prof. Benn, as head of the breast unit at Helen Joseph Hospital, is committed to clinical excellence and recognised internationally as a leader in breast disease. She emphasised the need for community education, and the fact that diagnosis should be based on symptoms. "Less is more, not one size fits all," she explained. "We need to take out the 'I', and become 'we'."

Dr Kamendran Govender, a gynaecologist, presented on cancer of the cervix in a resource-constrained environment. It is the most prevalent cancer affecting women in the 15 - 44 age group, with a high mortality rate. Challenges include a shortage of oncologists nationally, a non-functioning screening programme, low and non-equivalent resources, density of population and a need for more education. "We need to form a national cervical cancer task team," said Dr Govender.

Lisa Vetten has spent over 25 years in the field of combatting violence against women, working as a counsellor, paralegal, facilitator, researcher and activist. She has also been closely involved in the drafting of a number



of government policies in this area. Her presentation on "Gender-based violence: What role for the health sector?" was a call for involvement. In light of recent developments in SA, this is a vital call!

Quality in healthcare and medical education

Prof. Andrew Parrish, a specialist general physician based at Cecilia Makiwane Hospital in Mdantsane, East London, presented on quality in healthcare, highlighting the need for more controls. "There is a lot we can do that has to do with our own standards ... 'I made a difference' is a very positive tool."

Leadership's impact on quality was the subject of Prof. Norman Faull's presentation. "We learn from the problems," says Prof. Faull, of the Lean Institute Africa; "no system is perfect." After working in two SA hospitals, he found that leadership training resulted in improvements: "If the learner hasn't learnt anything, then the teacher hasn't taught."

Prof. Dianne Manning then addressed the topic of "Medical education in SA: Is the curriculum fit for purpose?" Prof. Manning has been involved in health professions education since 1976 and is currently the co-ordinator

of the curriculum subcommittee of the SA Committee of Medical Deans.

This was followed by a presentation on the revision of the curriculum for a 2-year internship, by Prof. Binu Luke. She looked at the history of internship and the objectives for 2020 and beyond, "so we will be able to achieve the dream of universal healthcare."

Doctors' mental health

Cassey Chambers, who started at the SA Depression and Anxiety Group (SADAG) as a volunteer counsellor in the call centre, helping to man the suicide crisis helpline, over 12 years ago, is now involved in the establishment of the Discovery Medical Student Helpline. This call centre provides free counselling to over 600 callers per day, providing 19 helplines 24 hours a day.

How to reduce stress, recognise depression and prevent suicide was the subject of PPS's Dr Anwar Bulbulia's presentation. He analysed the depth of the challenge, and looked at prevention and management, both subjective and objective.

A panel discussion followed in which invited doctors and members of SAMA management shared their experience and advice. This was

followed by the launch of SAMA's doctors' resilience programme, introduced by Prof. Bernard Janse van Rensburg and SAMA's Dr Vusi Nhlapho.

Dr Brenda Kubheka, co-founder of Health IQ Consulting, specialising in risk management and ethics in healthcare, has a special interest in leadership, patient safety, digital health and ethics. She presented on "Mentorship of junior doctors: Are we setting them up for failure?" She emphasised the need for self-care, endurance and providing valuable coping guidelines: "Healthcare is a team sport – poor teamwork and poor communication have a negative effect on safety."

The Gala dinner

Appropriately, the gala dinner was held on Women's Day, 9 August, in the Durban ICC. Dr Zanele Bikitsha, KZN Coastal branch chairperson, opened the evening by singing the praises of women in healthcare. "We are winning ... take care of a woman, take care of a community." She emphasised the need to create leadership among women in the NHI.

The audience were entertained by MC Anrich Herbst, who had the pleasure of interviewing Caster Semenya on stage. "I will never back down," stated the super-confident and positive icon. She went on to describe her childhood, and how taking control of her life had set her up for success. An inspiration to all, Caster said, "It does not matter how you look and where you come from, go out and achieve your goals ... [as women] we need to support each other in everything we do. Love yourself first, love one another and respect each other."

The Durban Divas had the audience dancing in the aisles.

Prof. Hoosen Coovadia, president of SAMA, welcomed guests with an overview of the history of medical associations in SA,

and the role they have played in progressive primary healthcare. SAMA now has the ear of government during this critical time, and has a duty to speak on behalf of doctors to implement NHI: "We have a job to do ... people must have access to quality treatment, everyone is entitled to that. You cannot sell health or education."

Dr Angelique Coetzee, proudly the first-ever woman chairperson of SAMA, presented the prestigious Merit Awards at the gala dinner (see page 9).

Preventive and promotive health

The last day of the conference was opened by Dr Anban Pillay, deputy director general for NHI at the National Department of Health. He is responsible for medicine policy and regulation as well as the NHI policy. His presentation unpacked updates on NHI and its implementation.

Dr Mohamed Irhuma, a clinical pharmacologist and the secretary-general of the College of Clinical Pharmacologists of SA, provided valuable insight into the challenging topic of cannabis and its health benefits from a clinical pharmacology and evidence-based perspective. He looked at whether cannabis works, how much we should prescribe, what the research says and whether it is addictive. "SA is the third largest producer in the world ... we need to start clinical trials soon," he said.

"Obesity is a chronic disease: Busting the lifestyle myth", a presentation by Dr Hilton Kaplan, a consultant physician and endocrinologist, gave new insight into this disease. His interest in obesity stems from the fact that this condition is one of the main contributory factors for the epidemic of type 2 diabetes worldwide, and a risk factor for many other diseases impacting negatively on quality

of life. "There are more obese than thin people in the world today," says Dr Kaplan.

Managing against risk

This final section of the conference included presentations from the Medical Protection Society's Dr Volker Hitzeroth on "When things go wrong", and "Fraud, waste and abuse" by Dr Katlego Mothudi, managing director of the Board of Healthcare Funders. Dr Hitzeroth emphasised the importance of communication to reduce risk, and of keeping accurate medical records. Dr Mothudi questioned whether we are identifying the correct issues to combat fraud, waste and abuse, and the importance of preparation in running a private practice. Our first duty should always be "do no harm."

In closing

Dr Vusi Nhlapho, head of SAMA's Private Practice Department, and Dr Mvuyisi Mzukwa, vice-chairperson of SAMA, closed the conference by thanking the sponsors, all those who attended and participated with enthusiasm, Prof. Mergan Naidoo and the EST committee, SAMA's marketing department, SAMA staff and the service providers.

"SAMA 2019 was an outstanding, high-level and professionally organised event. The organisation group walked the extra mile, and every single aspect was measured and delivered in a diamond scale. SAMA 2019 was world class, I have attended hundreds of international conferences and this made me believe that SA can do more, even better, if all local conferences can learn from this conference. Well done." Dr Mohamed Irhuma

"It was of good benefit to attend."

SAMA conference abstract presentations highlight key issues in quality and leadership

Shelley McGee, health policy researcher, SAMA Knowledge Management, Research and Ethics Department

The SAMA conference abstract presentations ran parallel to the main programme on Friday 9 August. The presentations covered multiple topics, from quality clinical care through to the development of formalised leadership programmes for medical doctors.

The abstract programme adjudicators would like to commend all the participants on the high standard of their presentations, and for being well-prepared.

Ultimately, the best presentation award went to **Dr Nisha Naka**, third-year paediatric registrar on the University of the

Witwatersrand (Wits) academic circuit, for her submission and presentation of an improved routine pain assessment and management method using a validated assessment tool in the neonatal ICU at Chris Hani Baragwanath Academic Hospital (CHBAH). Dr Naka took us through the multiple challenges in treating



Dr Nisha Naka delivered the winning abstract presentation



Prof. Deb Basu



Dr Steve Selepe

pain in neonates. Previously, there was no standardised pain assessment tool, nor any standardised protocol. In the project that she presented, a quality-improvement tool, the Neonatal Pain, Agitation and Sedation Scale (N-PASS), was introduced, and a step-wise pain management protocol was devised. Several successes were observed, including improved recognition of pain in neonates, lower use of inappropriate sedation and rationalisation of analgesic choices.

Dr Mantwa Chisale Mabotja, public health medicine registrar at Wits, presented research that examined the associations between women's beliefs about cervical cancer and screening and the uptake of Pap smears in a cross-sectional study in women aged 30 years and older attending primary healthcare facilities in 2017. The team applied a validated measurement scale based on the health belief model to describe health beliefs regarding cervical cancer and screening. Older women, those with better disease knowledge

and those who perceived cervical cancer as severe were more likely to have smears. Dr Mabotja concluded that interventions should focus on younger women, and on improving women's knowledge about the disease and procedure.

Dr Jayati Basu, associate lecturer at Wits, and Ekurhuleni district obstetrician, examined trends in maternal deaths in Ekurhuleni since the district clinical specialist team was introduced in 2012. At that time, Ekurhuleni was one of the country's worst-performing districts in terms of maternal deaths. Over 7 years, the number of births in the district has increased, but maternal deaths have decreased, resulting in a gradual reduction in Institutional maternal mortality rate (iMMR). Most maternal deaths were postpartum, and there were very few deaths during labour. Most haemorrhagic deaths were post caesarean section, in keeping with national trends. There was still a notable death burden from HIV-related illness – patients presenting for labour were often not on treatment, and viral loads were high.

Dr Steve Selepe, medical officer at Dr George Mukhari Academic Hospital, presented an interesting case record of torrential otorrhagia. A patient who had been involved in a car accident and suffered a traumatic injury a few years before, presented with intermittent bleeding from his left ear and conductive hearing loss. He also had swelling of the left peritonsillar area, with the tonsil pushed to the midline. CT angiography revealed an aneurysm of the left petrous portion of the internal carotid artery. An external surgical approach is associated with high mortality in these cases, so is no longer advocated. The aneurysm was coiled and stented by the interventional radiologist. Bleeding was minimal, and after the 3-month follow-up, the ear did not bleed again.

Prof. Debashis Basu, academic head of public health medicine, Steve Biko Academic Hospital and University of Pretoria, described a multidisciplinary training programme in preventive and promotive healthcare that is currently being implemented in Tshwane District. Training is provided through sub-district masterclasses comprised of managers and health professionals working in the subdistricts. Monthly training sessions that use a participatory approach are organised, focusing on prevention of diseases of public health importance (HIV/TB, non-communicable diseases (NCDs) and maternal, child and women's health). The success of this project was measured through key preventive

medicine indicators such as HIV counselling and testing (HCT) and screening for cervical cancer. The project provided an opportunity to explore the challenges of implementing prevention/promotive services, and enabling health professionals/managers working in subdistricts to manage them within the available resources.

Prof. Basu also presented on behalf of one of his students, **Dr Mutshekwane**, on professionalising medical management in SA. The aim of the research was to evaluate the scope of practice of medical managers and medical management programmes in SA. The research was based on document review and analysis of a questionnaire sent to a group of medical managers. Medical managers' scope of practice, setting and academic and experiential learning varies substantially. Most medical schools do not emphasise management in their curricula, and doctors become leaders coincidentally rather than as a deliberate career choice. The research proposed, as a way forward, setting up a task team within the SA Society of Medical Managers to promote and develop the necessary courses to make medical management a recognised speciality.

Dr Svitlana Avramenko, medical officer at Helen Joseph Hospital in Johannesburg, presented two analyses on stress and burnout in doctors and nurses, respectively, in a regional hospital in Gauteng. A cross-sectional study was conducted in which participants (doctors and nurses) were given the Maslach Burnout Inventory, Sources of Work Stress Inventory and a sociodemographic questionnaire. Among the 65 doctor-respondents, high levels of emotional exhaustion were noticeable in 52%, 30% had high levels on the depersonalisation subscale and 27% experienced low levels of personal accomplishment. In the nursing group, the corresponding scores were 52%, 30% and 49%. The authors hope that these findings will help to develop better organisation of the working environment and of specific programmes, in order to improve relationships and stress levels at work.

Dr Jean Musas of the general surgery department at Wits presented a case study of an investigation into gastrointestinal bleeding at CHBAH. A 54-year-old female patient presented with lower gastrointestinal bleeding. Several investigations were performed, including an upper and lower scope, a CT angiogram of the abdomen and a red cell scan. These were all negative. Wireless video capsule endoscopy was finally used, and

telangiectasia in the small bowel was found to be the source of the bleeding. Given the challenges of the other modalities, Dr Musas posed the question as to whether there is a case to be made for capsule endoscopy at first presentation.

Dr Abel Lekoloana, public health medicine registrar at the University of Limpopo, presented on his research looking at whether medical doctors know the rules about medical certification of cause of death. Studies evaluating death notification forms have consistently found a high proportion of errors. A cross-sectional descriptive study was conducted in 12 hospitals across all levels of care in Limpopo Province. Doctors were asked to complete a validated self-administered questionnaire, adapted from various sources, to test their knowledge of the ICD rules of death certification. A total of 300 doctors were recruited. Only 18% had attended a CPD meeting on this issue, and 86% said they needed training in death certification. Only 26% knew about the unnatural death rules. Rank, years of experience, previous training and awareness of guidelines were significantly associated with adequate knowledge. The study highlighted the scarcity of workshops on medical certification of cause of death, and other areas of concern. Junior doctors must be prioritised for training in order to improve the quality of mortality data.

Dr Lehlohonolo Makhakhe, dermatology registrar at the University of the Free State, took the audience through a case series involving cryotherapy for pedunculated keloids. There are many treatment modalities for keloids. Excision is generally problematic as it is followed by regrowth. Cryotherapy can be delivered intralesionally to freeze the core

of the keloid, but patients must be carefully selected. The series involved 12 patients who met the entry criteria for keloids – small, symmetrical and non-hypertrophic scarring. A significant reduction in the exophytic keloidal mass post deep freezing, irrespective of the keloid area, duration, gender or cause, was observed in 8 patients. Two-thirds of the patients were either satisfied or very satisfied with the clinical outcome of the scar at 6 months. The use of intralesional cryotherapy was shown to have a significant effect on the treatment and size reduction of exophytic keloids, with minimal side-effects and great patient tolerability.

Dr Kgomotso Mogapi, medical doctor at the Kwamqemane Lifestyle and Wellness Centre, took the audience through an interesting exploration of the principles of health restoration. Despite all the developments in biomedical medicine, the prevalence and incidence of NCDs has not decreased. Medical doctors do not necessarily recognise the importance of homeostasis in the body. Dr Mogapi presented 11 principles that she believes are key to the restorative processes in the body, namely rest, exercise, sunshine, temperance, oxytocin, imagination, rehydration, air and nutrition. Dr Mogapi advocated for increased attention to these issues in medical curricula. She finished off with a discussion of the concept of truth.

Finally, **Dr Zola Ncube**, fourth-year paediatric registrar at Rahima Moosa Mother and Child Hospital, presented her research on supporting mothers to bring expressed breast milk (EBM) from home for their infants in the neonatal unit. This quality-improvement project aimed to improve the availability of EBM in the neonatal units at CHBAH. As part of



Dr Abel Lekoloana



Dr Kgomotso Mogapi

the project, low-cost glass collection bottles were purchased. Issues of adequate bottle sterilisation and the refrigeration, labelling and distribution of EBM were addressed. Increased individual and group support for breastfeeding was also offered to mothers. The number of mothers bringing EBM from home increased exponentially. Exclusive breastfeeding rates in the unit increased from 45/162 infants (28%) to 88/159 (55%), as infants were offered the home-collected EBM at night. Mothers reported feeling supported in initiating as well as maintaining breastfeeding. Overall, the researchers considered that a low-cost, safe home-collected EBM system was successfully established.

Merit Awards recognise significant contributions to medical profession

Prof. Mergan Naidoo, *chairman, SAMA Education, Science and Technology Committee*

The SAMA 2019 Merit Awards ceremony was held at the Durban ICC on 9 August. Those doctors who have made significant contributions to the profession, their communities or SAMA were nominated by colleagues for the awards, and the Education, Science and Technology (EST) committee had the difficult task of selecting from among

these highly esteemed nominees. The winners were chosen after much consideration and thought, and Dr Angelique Coetzee, SAMA chairperson, presented the awards as follows to the deserving recipients.

Fellowship in Art and Science of Medicine Award: This is given to an individual who has won international acclaim for excellence in

the practice of medicine as both an art and a science, achieving an iconic international footprint. The awardees constitute an exclusive group who have been awarded the Fellowship for breakthrough contributions to medicine, moving the frontiers of medicine forward or widening the horizon for its greater understanding, while fully acknowledging



Prof. John Pettifor



Prof. Bob Mash

the philosophical and ethical constraints of the profession. The selected individual also champions the cause of healthcare despite obstacles; a previous awardee was the late Prof. Bongani Mayosi. This award is equal in prestige and status to the Heroes in Medicine Award (Canada), or becoming a Member of the Institute of Medicine (USA). For his impact on art and science in medicine, this year's recipient was **Prof. John Pettifor**.

An internationally renowned paediatric bone health specialist and clinician, Prof. Pettifor graduated from Wits in 1968 and in 1972, completed his FC Paeds through the Colleges of Medicine SA and was awarded the Robert McDonald Medal. As a researcher in the Metabolic and Nutrition Research Unit at Baragwanath Hospital, he developed an interest in rickets, a disease prevalent among infants and toddlers in Johannesburg at the time. Studies conducted in the community led him to propose that dietary calcium, rather than vitamin D, deficiency was the major factor responsible for the bone disease in these children, a concept which was not considered appropriate in otherwise healthy ambulatory children.

Aspects of this work resulted in him being awarded a PhD in 1981. In 1985, The SA Medical Research Council and Wits

appointed him Director of the Mineral Metabolism Research Unit at the now Chris Hani Baragwanath Academic Hospital. In 1983 he was appointed reader in paediatric bone and mineral metabolism in the Department of Paediatrics, and in 1988 he was appointed to the professoriate. In 1990 he became chief specialist of the Department of Paediatrics at Chris Hani Baragwanath Hospital, a position he held until his retirement in 2010.

He has mentored many clinician scientists during their PhDs, and continues to participate in paediatric bone clinics. He was recognised as a member of the Academy of Science of South Africa in 2008, and received an honorary fellowship of the College of Paediatricians of SA in 2016. Between 2005 and 2015, he was an NRF A2-rated scientist. He has published over 260 peer-reviewed and accredited research articles and 50 book chapters. He is a reviewer for numerous journals, is on the editorial boards of a number of international journals and is editor of the *SA Journal of Child Health*. Last year he was awarded a DSc (Med) (*honoris causa*) from his alma mater. As part of his social responsibility, he has been a member of the Board of Joburg Child Welfare since 2000, and is currently the chairman.

Extra-Ordinary Service to Medicine: This awardee must have made an outstanding contribution to medicine in a dedicated field, having pursued with single-minded purpose the chosen area of interest and made a substantial contribution in the research, promotion and advancement of that field. The work must extend beyond the ordinary terrain of medicine into the wider community and nation. Publication of work in internationally recognised medical journals is a prerequisite. For his extraordinary service to medicine, the award this year went to **Prof. Bob Mash**.

Prof. Mash is professor of family medicine and primary care at Stellenbosch University, and currently also the president of the SA Academy of Family Physicians. His former clinical practice was in Khayelitsha in Cape Town, where he was the first family physician to be appointed in 1997. He is currently the executive head of the Department of Family and Emergency Medicine at Stellenbosch University, where he has developed new training programmes for both under- and postgraduate students in family medicine.

He is the editor of the *Handbook of Family Medicine*, the *SA Family Practice Manual* and the *SA Clinical Nurse Practitioner's Manual*. These standard texts are used extensively in sub-Saharan Africa.

More recently he has focused on primary care research, and has become the editor-in-chief of the *African Journal of Primary Health Care and Family Medicine*. He has published more than 160 original research and scientific articles, and has recently co-edited books for the World Organization of Family Doctors on primary care research methods, and international perspectives on primary care research. His research interests have focused on the contribution of family medicine to African health systems, and the development of the discipline. This research formed the basis of the "Statement of consensus on family medicine in Africa". He is also a founding member of the Chronic Disease Initiative for Africa, and has focused on research to improve patient education and counselling for non-communicable diseases. Currently he is busy implementing group empowerment and training (GREAT) for diabetes mellitus nationally, and scaling up training for primary care providers in brief behaviour change counselling.

In sub-Saharan Africa, he has helped to develop the Primary Care and Family Medicine network (Primafamed), which is a network of departments of family medicine and primary care across 25 African countries. The network enables south-south-north collaboration to strengthen family medicine and primary care. Through this network he has helped to develop family medicine in countries such as Botswana, Zimbabwe, Kenya and Namibia. Currently the network is organised from the family medicine department at Stellenbosch University, and is engaging in a global research consortium to address key research questions in primary healthcare.

The **Lifetime Achievement Award** is presented to an individual who has dedicated his or her life to the single-minded pursuit of medicine as a career, and served it with distinction, making the profession proud. His or her loyalty, dedication and professional conduct is worthy of emulation. This year's lifetime achievement award went to **Prof. Greg Lebona**.

He is presently the acting head of department at Sefako Makgatho Health Sciences University (SMU). He has an MMedSc in anatomy, and started his career practising as a doctor at Edendale Hospital, Pietermaritzburg, in 1977. He moved to King Edward VIII Hospital in Durban in 1981, and then relocated to the Medical University of SA (MEDUNSA; now SMU) in Pretoria in 1983, and was appointed as senior lecturer in the Department of Anatomy. He was then appointed associate professor and chief medical officer in the department in 1996.



Prof. Greg Lebona and Dr Angelique Coetzee



Dr Carol Thomas's partner Alison Grey accepted the award from Prof. Mergan Naidoo and Dr Malikah van der Schyff

He has extensive teaching experience in both undergraduate and postgraduate programmes, and has served as an external examiner throughout his career, participating in many international and national seminars in his field. He has presented at numerous symposia and conferences locally and internationally and has many publications, and contributed extensively in his areas of research interest. He introduced and developed curricula for radiography, nursing and dentistry. Prof. Lebona has many merit awards, honours and prizes gained throughout his 40 years of practice, and has mentored students across a range of disciplines.

The **Spirit of Medicine Award** is awarded to an individual who has provided extraordinary service to his or her community or to the nation extending beyond the field of medicine. This award is made to doctors who have created an enabling environment and/or living habitat, working in the wider interests of mankind. This includes championing the cause of the poor, indigent and dispossessed within a given ecosystem. The award is given for selfless service to medicine without a view to material gain or personal aggrandisement and pretension, or for illustrating by precept and example that medicine is a "calling" and service in the name of the profession, a special privilege. The 2018 Spirit of Medicine Award was presented to **Dr Carol Thomas**.

Dr Thomas was an excellent and beloved obstetrician and gynaecologist, based in Cape Town, who mentored many young specialists and assisted them through difficult times. Her manner and spirit inspired and healed many. As a pioneer and leader in women's health, she was a kind, inspiring soul who cared about every woman she treated, displaying excellent communication skills. She was the first female president of the SA Menopause Society, and awarded honours

for "selfless dedication and commitment to reproductive and sexual health and rights" by the Planned Parenthood Association of SA.

An award-winning health innovator with her development of iMobiMaMa, her mobile design for improving antenatal care in poorly resourced areas, she was a solutions-based health innovator, involved in collaborative work on endoscopic medical equipment. She was a women's health social entrepreneur and a founder of the WomenSpace, about which she said "I have always had the vision of having a comprehensive women's health service for my patients where women would find the level of expertise they deserve, with the quality of care we should all have." She died at the height of her professional career on Friday 12 April 2019, following complications of a double lung transplant, and tributes poured in from devastated friends, colleagues and patients worldwide.

Her legacy will continue through her healthcare contributions, scientific innovation and mentorship.

The **Community Service Award** is awarded to someone who has rendered yeoman service over a sustained period of at least 20 years. This person has taken a leadership role in managing a specialised field of medicine and healthcare, and rendered humane, innovative care under extreme trying conditions, be they in the face of poor or unavailable facilities or conditions calling for personal sacrifice in a rural setting, for at least 10 years. They may have also demonstrated educative and mentorship roles in adding value to the health knowledge of a community. This year's awardee was **Dr Bongile Baloi**.

Dr Baloi has rendered outstanding service and taken a leadership role in the field of medicine and healthcare by caring for the physically and mentally challenged and the elderly. She has rendered free health services and provided food parcels to the elderly

community in KaNyamazane since 1998. She chose to remain in the primary healthcare sector due to an overwhelming need to help the disadvantaged, even while her colleagues were specialising.

She has shown compassion and empathy to the community at large, dedicating many hours to providing free classes on diabetes. She is a strong advocate for health promotion and disease prevention, and has run Papsmear screening and breast self-examination campaigns. She has also provided care to indigent patients who are unable to afford private healthcare through her corporate and social responsibility work. She continues to provide an after-hours service, and makes home visits especially for the elderly without any view to material gain.

She has taken an educative and mentorship role in adding value to the community through talk shows for the past 15 years, and is an organiser of CPD for doctors. She co-ordinates a primary healthcare clinic for 5 000 patients at a local church, served patients in rural areas by arranging school uniforms, advocated for healthy lifestyles through regular talks, encouraged participation in sporting events and worked in community development by promoting vegetable gardens.

Service Excellence in the Private Sector rewards doctors in the private sector who have been practising medicine for at least 10 years and made a difference in their community, and who show compassion and empathy towards their patients. It is incumbent on the person submitting the nomination to show this "making a difference" element in the application. This year's award went to **Dr Andre van Greunen**.

Dr van Greunen has been an integral part of the Langkloof community for the past 36 years, serving the community as a general practitioner and providing a service



Dr Bongile Baloi



Dr Andre and Mrs van Greunen



Prof. Edward John Coetzee

to public healthcare clinics throughout the area, and at the local hospital. He has opened farm clinics to accommodate farm workers who did not have the means to travel to Joubertina. In recent years he has expanded his services to Uniondale and Willowmore, after the local doctors left.

He has a passion to serve his community, and this has resulted in him providing a sterling service. He is available 24 hours a day, and his willingness to always help everyone, including farmers, farm workers, young children and the residents at the old age home, has made him a popular and well-respected resident in Langkloof. He started an ambulance service many years ago that still provides functional medically equipped transport from Joubertina

to Port Elizabeth and George daily. He also supports local sports days by supplying an ambulance if needed, often free of charge. He served on the municipal board for many years, as well as the Chamber of Commerce and the governing body of the local high school.

The **SAMA Award of the Year** is an award given to a doctor who has contributed distinguished service to SAMA of an extraordinary nature. This year, it was awarded to **Prof. Edward John Coetzee**.

Dr Coetzee is an obstetrician and gynaecologist who has dedicated his life to women's health, specifically within the sphere of foeto-maternal medicine. He was the long-time head of the Groote Schuur Hospital foeto-maternal unit, until his retirement. He is a fellow of the

Royal College of Obstetrics and Gynaecology (RCOG), and represents RCOG at our local SA Society of Obstetrics and Gynaecology (SASOG).

He has dedicated many tireless hours to SAMA at all levels from local to national, and also represented SAMA on the SASOG council until 2013. He was forced out of retirement when the 2014 SAMA EST committee had a crisis with the resignation of a large number of experienced members. His institutional memory was invaluable in getting the committee functional again within a short period of time. He is still an active member of the SAMA bursary subcommittee. This recognition of loyalty is well deserved and long overdue.

New ethical guidelines on social media for healthcare professionals

Brandon Ferlito, bioethics researcher, SAMA Knowledge Management, Research and Ethics Department



The use and popularity of social media have grown exponentially over the last few years as we embrace user-generated content on social networks, internet forums and personal blogs. This growth continues to increase with the rise of the fourth industrial revolution. Healthcare professionals (HCPs) are increasingly taking advantage of the many benefits that social media brings to conduct their respective professions, by finding new, effective ways to use it. They may find social media useful for staying up to date on the recent trends in healthcare through reputable user-generated

content, creating a network of professional assistance and support and interacting and sharing health-related data with the public and other HCPs. Although many HCPs find social media a pro rather than a con in their daily practice, there is a growing concern that they may unwittingly expose themselves to ethical dilemmas. Even though HCPs should not be discouraged from making use of the benefits of social media, they need to be aware of the potential ethical pitfalls, even if the consequences are unintended. As a result, the HPCSA, at its first annual conference, launched booklet 17 of the *Guidelines for Good*

Practice in the Healthcare Professions, “Ethical guidelines on social media”.

According to the HPCSA, “the guideline was developed to help [HCPs] understand their [ethical] obligations when using social media. It applies to all health practitioners registered with the HPCSA.”

About the guidelines

One of the HPCSA’s key objectives is to “guide the profession and protect the public”. According to the HPCSA, these guidelines must be read together with other HPCSA ethical guidelines booklets (booklet 1, “General ethical guidelines for healthcare professionals”, booklet 5, “Confidentiality: Protecting and providing information” and booklet 10, “General ethical guidelines for good practice in telemedicine”), and any other applicable publications, including the Promotion of Administrative Justice Act No. 3 of 2000, the Protection of Personal Information Act No. 4 of 2013 (POPIA) and the common law.

Patient confidentiality and privacy

Privacy is a human right, and all patients have the right to privacy and confidentiality, as enshrined in the SA Constitution and the National Health Act No. 61 of 2003. Therefore a HCP may only disclose a patient’s information with that patient’s consent, or if instructed by a court order and in accordance with any other relevant law. HCPs may also disclose a patient’s information if non-disclosure will result in harm to the public or to the patient themselves. With regard to a patient under the age of 12 years, the HCP must obtain the assent of the minor and written consent from the parent or guardian. With specific relation to social media, the guidelines state the following:

- HCPs must obtain the written consent of a patient before publishing any information (such as photographs, case histories, etc.) in the media or on platforms that the public has access to, even if such information does not contain any identifiable data.
- HCPs who share patient information or data for educational, training, research or academic purposes must anonymise such information or data.
- HCPs must understand that patient information received via social media must be treated as confidential.
- The disclosure of patient information on social media must be kept to the bare minimum in order to protect the patient’s identity and human rights.

- HCPs ought to be aware that there is always a risk that information can be shared, even in so-called “closed” or “invisible” groups or platforms.
- The obligation to keep patient information confidential remains even after the death of the patient.

HCPs must apply the same the ethical principle of confidentiality on social media as they would in face-to-face situations.

The practitioner-patient relationship

Social media can at times blur professional boundaries in the HCP-patient relationship. Patients may feel that HCPs are available 24 hours a day, due to the 24/7 nature of social media. Therefore, the guidelines advise HCPs not to interact with patients via social media or on social media platforms, “as a failure to maintain strictly professional relationships with patients could result in other ethical dilemmas”. Although POPIA has not been signed into law, it would be wise for HCPs to start implementing it. The guidelines explain that POPIA outlaws the acquisition of data or information pertaining to a patient’s health or sex life outside the healthcare or clinical setting, and “by having access to patients’ social media profiles, HCPs may find themselves privy to personal patient information that has not been shared in the healthcare setting.”

Although HCPs and, similarly, patients, may share personal information about themselves during face-to-face consultations, doing so via social media does not guarantee the same level of control over the extent and type of content that is shared.

HCPs may find it difficult to maintain professional boundaries if they also perform non-medical roles in their communities. An example of such a difficulty would be receiving a friend request on social media from patients who one knows in a non-medical or professional capacity. The guidelines state that in such instances, HCPs ought to apply their minds and weigh the pros and cons of accepting such a request.

Additionally, the guidelines also state that if a HCP receives inappropriate messages from a patient(s) via social media, the HCP should civilly re-establish the professional boundaries, and give reasons for doing so.

In the case of a patient seeking healthcare advice over social media in an emergency or life-threatening situation, the guidelines state that the HCP should politely ask the patient to

set up an appointment in person. However, it would be more correct to state that the HCP should advise the patient to go to their nearest hospital or clinic casualty department in such a situation.

The guidelines also discourage providing health or medical advice via social media to patients with whom the HCP does not have a HCP-patient relationship, and warn that this should only be done with extreme discretion. Also, if health or medical advice is shared via social media, it ought to be evidence-based, scientifically sound and generic. The recipient of such advice must be directed to consult with a HCP in person before acting on it.

If all else fails and the patient still persists in communicating via social media, the HCP should keep records of all communication and seek advice from the HPCSA. HCPs should separate their professional and personal social media accounts so that professional boundaries can be maintained.

The health profession’s image

A HCP who uses social media in their personal capacity should remember that their personal online activity may still bring the profession into disrepute. The traditional media monitors online activities on a regular basis, to research any potential story. HCPs need to remember that any information posted online might be shared with a larger audience, and may be taken out of context, whether intentionally or otherwise.

Once more, HCPs need to be aware that content posted online may have unintentional negative consequences that may harm their employment and recruitment prospects and limit their professional development and advancement. It is a known fact that some employers screen the social media accounts of prospective employees, and may turn down an application for employment based on questionable digital behaviour.

The guidelines further provide examples of social media activities HCPs should stay clear of:

- “taking photographs during surgery and other forms of care or treatment;
- making unsubstantiated negative comments about individuals or organisations;
- making informal and derogatory comments about patients;
- making comments that can be perceived as racist, sexist, homophobic or otherwise prejudiced, even if meant in jest or as satire.”

Conflicts of interest

HCPs using social media, even in a personal or anonymous capacity, must comply with

the HPCSA rules on advertising practice, and this “includes not engaging in active or passive touting and canvassing, or allowing others to do so on their behalf, and [HCPs] must make sure that they declare their financial interests in hospitals”. Information regarding this can be found in booklet 2, “Ethical and professional rules of the HPCSA”, and booklet 11, “Guidelines on overservicing, perverse incentives and related matters”.

Failure to follow these guidelines when using social media may undermine the public’s trust in the healthcare profession.

Precautionary measures

The ethical guidelines on social media go on to further state the following precautions for HCPs to be aware of when using social media:

- Even if using a pseudonym, there is no guarantee of anonymity on social media. The location and the identity of the user can be traced by means of an IP address.
- HCPs who make use of social media in their personal capacity should ensure that their privacy settings are adjusted to restrict public access and viewing. Nevertheless, even with modern security advancements such as end-to-end encryption, complete security on social media is not guaranteed.
- HCPs should be aware that once content is posted and/or shared on social media, it becomes difficult to delete, and even when it has been removed, there is no guarantee that this is permanent.
- HCPs “should avoid using social media when stressed, tired, upset or under the influence of alcohol.”
- HCPs “are advised to err on the side of caution when using social media. If uncertain about whether it is ethically and legally permissible to share particular content via social media, it is best not to do so until advice has been obtained.”

These guidelines are not intended to discourage HCPs from using social media, but rather to inform and guide them on the potential unintended negative ethical consequences that they may expose themselves to when doing so. The “Guidelines for good practice in the healthcare profession: Ethical guidelines on social media” will soon be available on the HPCSA’s website.

References available on request.

The legal complexities of cannabis for medicinal use

Shelley McGee, health policy researcher, SAMA Knowledge Management, Research and Ethics Department

If you have been feeling confused about the legal status of *Cannabis sativa* (marijuana, dagga) in SA, you are not alone.

While calls for the decriminalisation and legalisation of cannabis have been ongoing for decades, some significant steps have been taken towards achieving this in the last 2 years. However, not all aspects of policy and legislation have caught up with the changes, and there is still a blurring between the use of cannabis for medicinal purposes and recreational purposes, and lack of clarity around the legal conditions of use, which makes for a very confusing environment.

SAMA’s stance remains that issues of cannabis for medicinal use and cannabis for recreational use need to be separated – and that the intentions and regulatory frameworks behind these need to be differentiated. For medical doctors, it is important to be aware of the clinical evidence, legal situation and potential caveats around cannabis, in order to advise patients regarding the multiple claimed indications for cannabis and its derivatives.

SAMA has been running a series of CPD events throughout the country to bring these issues to the fore and ensure that

our doctors are prepared to navigate the legal and clinical complexities inherent in cannabis discussions.

Private use of cannabis

Private use of cannabis was effectively decriminalised by a Constitutional Court ruling in September 2018. The court delivered a unanimous judgement that certain parts of SA’s drug laws are inconsistent with the right to privacy, as enshrined in the Constitution.

Specifically, the ruling declared that the provisions of sections 4(b) and 5(b) of the Drugs and Drug Trafficking Act No. 140 of 1992, and the provisions of section 22A(9)(a)(i) of the Medicines and Related Substances Control Act No. 101 of 1965 are inconsistent with right to privacy entrenched in section 14 of the Constitution.

Therefore, the court declared them invalid to the extent that they make the use or possession, and the cultivation (section 5(b)), of cannabis in private by an adult person for his or her own consumption a criminal offence.

The court suspended the operation of these orders for a period of 24 months to enable Parliament to rectify the constitutional defects in the laws.

Adults are now allowed to use, possess or cultivate cannabis in private, for their own personal consumption and for any purpose, be this medicinal or recreational.

The court gave some broad guidelines about what this would mean in practice, but it has left most of the legal details to Parliament. To date, as far as we are aware, Parliament has not yet moved to make the necessary changes to the legislation, which has left many crucial questions unanswered.

For example, it is not clear how much cannabis an individual may be in possession of, for this to be considered reasonable for “private use” – for the moment, this decision is left to police, with little guidance available to them.

In addition, there are no clear guidelines for cannabis users in the workplace. Drug and alcohol testing is fairly common in many workplace environments, and serves to ensure the safety of employees and those around them. The Occupational Health and Safety Act No. 85 of 1993 includes general regulations for safety, and regulation 2A specifically deals with intoxication of employees at the workplace.

Essentially, an employer may not permit any person who is or who appears to be under

the influence of intoxicating liquor or drugs to enter or remain at a workplace, and no person at a workplace may be under the influence of or have in his or her possession, or partake of or offer any other person intoxicating liquor or drugs. Where an employee is taking a medicine, employers may only allow this if the side-effects of such medicine do not constitute a threat to the health or safety of that employee or to other persons at the workplace.

Whereas the implications of being under the influence of alcohol in the workplace are relatively clear, this is not the case for cannabis or its constituents, and physiological tests and blood and urine levels that could classify an employee as impaired are far less well developed.

Cannabis can be detected in the urine of habitual users for weeks after their last use, and it is not clear at what levels of different cannabinoid constituents employees would be considered impaired.

The aspects of private use are also important for medical doctors who may be advocating for the medicinal use of cannabis. While individuals are permitted to cultivate, produce and use cannabis for their own personal purposes, anyone cultivating, manufacturing and selling cannabis or its derivatives for commercial purposes (i.e. dealing cannabis) would still be guilty of a criminal offence, in terms of the existing laws and the extent of the Constitutional Court's ruling, unless this is in line with the medicinal use regulations.

Medicinal cannabis in SA – current status

Parallel to the debates on personal and recreational use has been the process of down-scheduling cannabidiol (CBD) within the medicines schedules of SA and the SA Health Products Regulatory Authority (SAHPRA)'s framework for the cultivation and manufacture of cannabis products for medicinal use.

This framework is largely separate from the Constitutional Court ruling, and has aimed to make CBD available as a prescription medicine to patients in the country.

In August 2017, CBD was made Schedule 4 in terms of the Medicines and Related Substances Act, although cannabis as a whole remains in Schedule 7. This means that CBD products, once approved and registered by SAHPRA, could be prescribed by medical practitioners, and dispensed by those with dispensing licences or through pharmacies.

CBD is one of the approximately 100 cannabinoids identified in the *Cannabis sativa* species. In contrast to its cousin, delta-9-tetrahydrocannabinol (THC), CBD is associated with fewer psychoactive properties and negative adverse effects. CBD is generally well tolerated, with a good safety profile. Reported adverse effects may be as a result of drug-drug interactions between CBD and patients' existing medications.

It is important to note that no local CBD products have yet been approved by SAHPRA for prescription and use. Any products currently on the market have not been through a registration and approvals process, which actually means that their content may not be what is claimed. Production quality, shelf life, adulterants and other additives all remain largely uncertified at this stage.

In May, SAHPRA issued an exemption from registration to CBD-containing products, which will apply for the next year. This led to the headline "Medicinal cannabis is now legal."

While this is true to a certain extent, the conditions of the exemption criteria are also quite confusing to navigate.

The exemption from the need for regulatory approval applies only to products that:

- contain a maximum daily dose of 20 mg CBD with an accepted low-risk claim or health claim that only refers to:
- general health enhancement without any reference to specific diseases; or
- health maintenance; or
- relief of minor symptoms (not related to a disease or disorder); or
- consist of processed products made from cannabis raw plant material and processed products in which only the naturally occurring quantity of cannabinoids found in the source material is contained, and which contain no more than 0.001% THC and no more than 0.0075% total CBD.

In other words, any products that are currently making claims to be able to treat specific diseases or disorders are not included in this exemption, and would have to be registered by SAHPRA first to be commercially available for medicinal use.

Given the concentration and daily dose limits, it is also clear that the exemption is meant to apply to products being marketed as health or food supplements, and actually containing little of the active ingredients, so that specific claims of therapeutic value cannot be made.

A product containing less than 0.0075% CBD, as per the exemption, would contain

less than 7.5 mg/mL of the active ingredient – well below what most of the existing CBD medicinal products being marketed in SA currently claim.

To provide an idea of the limitations imposed by the exemption, Epidiolex (not currently registered in SA), which is CBD oil, and which achieved Food and Drug Administration (FDA) approval in the USA in 2018 for the treatment of certain very rare and serious seizure disorders, contains 100 mg/mL of CBD. In the clinical registration trials, subjects were dosed with 10 - 20 mg CBD per kg per day. Given that the median age of subjects in these trials was 14 years old, it is clear that daily doses were far in excess of the total daily dose that is allowed for in terms of the SAHPRA exemption.

The WHO reviewed CBD in 2018 and found preliminary evidence that CBD may be a useful treatment for a number of medical conditions, highlighting its role in the rare epilepsy syndromes. However, the WHO report also conceded that the evidence for most of the proposed clinical indications is still very weak, and that CBD and other cannabis constituents cannot be recommended over existing approved and evidence-based treatment. This finding is in line with multiple international reviews of the evidence base for CBD and cannabis, and the current WMA stance on the matter.

The clinical evidence is simply too weak in general to be able to advocate for the use of medical cannabis products at this stage. Now that international legislation is changing, it is expected that better quality clinical trials will shed some light on where CBD and other cannabinoids are clinically useful and safe.

The cannabis medicinal and recreational use lobbies are strong, advocating for further legalisation and decriminalisation through a variety of policy and legislative initiatives.

Given that the regulations around medicinal CBD have actually limited the legal availability of processed products, while cannabis and derivatives are legal for private use, it is safe to assume that patients may grow their own "medicinal" cannabis, or obtain it through other unregulated sources, perhaps unwittingly exposing themselves to products and substances without recognised clinical indications, and additional adverse effects.

SAMA encourages our doctors to contact us for relevant literature and evidence on cannabis and cannabinoids if confronted by questions about their use, efficacy and safety.

References available on request.

Reasonable accommodation rather than “light duty” for people with mental illness

Prof. Stoffel Grobler, head of clinical unit, Elizabeth Donkin Hospital; associate professor, Walter Sisulu University



Doctors are frequently faced with patients who are suffering from either a mental or physical illness that warrants some adjustment to their work responsibilities. They might be booked off for a short period, or are able to work but in need of some work adjustment while recovering from the illness.

In such circumstances, doctors tend to use the term “light duty” on the sick note, but what does it mean, exactly? Is there another term that could be used that is more appropriate and in line with current legislation in SA?

The term “light duty” generally refers to work that is physically or mentally less demanding than normal job duties, created for the purpose of providing alternative work for employees who are unable to perform some or all of their routine duties, until the person is healed or ready to resume all of their responsibilities.

In a 1996 article, “The light duty dilemma”, it is argued that “when an employee sues for disability discrimination, the employer may discover that the light duty assignment was in fact a ‘reasonable accommodation.’”

It stands to reason, then, that light duty is a vague term that can be widely interpreted, leading to confusion for both employer and employee, hence the need for a more appropriate term with a smaller likelihood of misinterpretation.

In order to understand reasonable accommodation in the SA context, with

particular reference to mental illness, some understanding of the relevant legislation is needed. “Reasonable accommodation” is referred to in our legislation in the context of disability. However, not all patients to whom light duty is prescribed will necessarily be considered disabled according to the definition of disability in terms of the legislation. But that does not mean that the doctor cannot use the term, and be very specific as to what (s)he deems to be reasonable adjustments to the patient’s working environment in order for them to recover fully.

Legislation

Our Bill of Rights (in the Constitution) is the principal source of legal rights for persons with disabilities, and supports the right to equality, dignity and freedom for all. This means that any discrimination, including discrimination based on a person’s disability status, is a human rights issue.

Unfortunately, the law, in particular the Employment Equity Act (EEA) No. 55 of 1998, only gives general guidelines, and is not explicit enough when it comes to the definition of what constitutes disability, thereby failing to provide adequate protection for both employers and employees with disabilities.

The EEA is supported by two documents, the *Code of Good Practice* and the *Technical*

Assistance Guidelines on the Employment of Persons with Disabilities, to further define the requirements of being declared disabled, be it temporarily or permanently. These two documents require employers to design and implement a workplace that eliminates unfair discrimination, and include guidelines on how to effect this purpose.

In order to qualify for reasonable accommodation, the employee will have to disclose their mental illness to the employer. Unfortunately, many employees are reluctant to disclose their disability status, especially when it is not “visible” – for example, mental illness. However, once an employee does disclose the disability, the employer has three duties placed upon them: (i) to investigate; (ii) to consult with the employee; and (iii) to implement reasonable accommodation.

Unfortunately, employees usually only disclose such a disability once a crisis has been reached, as for example when they are subjected to disciplinary action due to a drop in productivity. At this point, employers would typically start incapacity proceedings. Should an employer dismiss an employee on the grounds of their disability (if they have disclosed it), the dismissal is automatically unfair.

Important terminology

There are three terms that are not synonymous, and that lead to great confusion among doctors, employers and employees alike. These terms are impairment, incapacity and disability.

Impairment refers to “a significant deviation, loss or loss of use of any body structure or body function in an individual with a health condition, disorder or disease”. In layman’s terms, there has been a loss or decline in a person’s ability to perform certain functions, either physically, mentally or both.

Disability, according to the EEA, is defined as (i) a long-term or recurring (ii) physical or mental impairment that (iii) substantially limits a person’s prospect of entry into or advancement in employment. The EEA states that a person has to meet the third criterion (substantially limiting) in order to be classified as disabled. It is only within the scope of practice of occupational therapists to decide

whether a condition is substantially limiting after a job analysis and a functional capacity assessment has been done.

Incapacity refers to a case in which an employee is unable to carry out or perform his/her contracted obligations due to inherent inability on the part of the employee. Incapacity is distinguished from misconduct and discipline in that fault or blame are not alleged.

Reasonable accommodation

The EEA states that employers should reasonably accommodate the needs of persons with disabilities. The aim of reasonable

accommodation is to remove barriers affecting the person's ability to perform the essential functions of the job. It can also be described as making modifications or alterations to the way a job is normally performed.

For persons with mental illness, reasonable accommodations may be as straightforward as allowing the employee to take breaks in a private space, such as a small conference room or meeting room, or to work from home some days, to wear headphones to block out noise, to be seated in a space that is quiet, with little traffic, to not attend non-essential meetings or to indicate when they feel overwhelmed and need a break.

Conclusion

Equipped with this knowledge, I would like to encourage doctors to prescribe reasonable accommodation instead of light duty in cases with mental illness. And even though your patient may not fulfil the criteria for being considered temporarily disabled, using the term "reasonable accommodation", in conjunction with very specific recommendations, would go a long way towards protecting him or her, and avoiding confusion.

For some guidance regarding reasonable accommodative measures, the website <https://askjan.org/a-to-z.cfm> may be useful.

Introducing the SAMA Legal Department

SAMA Communications Department

This month we introduce readers to SAMA's Legal Department. The department serves a critical function within SAMA. As part of their membership benefits, SAMA members enjoy access to legal advisory services relating to the fields of health, medical and general law. Offering members access to a wealth of information in health-related legislation, regulation, guidelines and policy documents, the department strives to provide excellent services to SAMA members and to assist them in navigating and overcoming the wide range of legal and ethical issues that they are confronted with in both private and public practice on a daily basis. In this regard, the department's staff is well versed in law, regulation and policy in the healthcare and medical scheme environment.

The department also provides legal advice, direction and support to SAMA's internal

departments, committees and management concerning any legal matters, obligations and operations, and enjoys a collaborative relationship with the both the Private Practice and the Knowledge Management, Research and Ethics departments. Joint projects are aimed at influencing medical and health legislation, regulation and policies. This work includes research into and drafting of submissions to government and other relevant stakeholders regarding health policy and law, and the investigation and management of strategic litigation to further the interests of SAMA members and the healthcare profession as a whole.

The department is headed by Dr William Oosthuizen, senior legal advisor. Dr Oosthuizen joined SAMA in June 2019. He holds an LLB, LLM and LLD from the University of Pretoria, and is an Advocate of the High Court of SA. Prior to joining SAMA, Dr Oosthuizen was

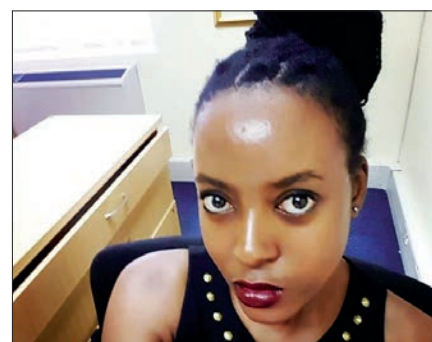
employed as a postdoctoral research fellow at the University of Pretoria, where he was involved in the establishment and running of the Centre for Law and Medicine. During his time at the centre, he conducted research into legal problems concerning medical law and ethics, medical jurisprudence, healthcare law and a multitude of related fields. He was also involved in the presentation of symposia, conferences, seminars and workshops to further the mission of the centre and contribute to the development of law and medicine in Africa, and has presented lectures on a range of topics (NHI, the HPCSA, confidentiality and privacy, medical malpractice, the Office of Health Standards Compliance, patient safety, etc.). Dr Oosthuizen has a special interest in healthcare and malpractice liability reform. One of the many reasons he decided to join the SAMA team was the opportunity to put these principles into practice, and engage



Karlien Pienaar



Dr William Oosthuizen



Wendy Massangaie

with relevant stakeholders regarding the improvement of quality of care and patient safety through legal reform.

The department also consists of Wendy Massangaie, legal advisor, who joined SAMA in 2015. Ms Massangaie holds an LLB degree from the University of the Witwatersrand, and is an admitted attorney of the High Court of SA. She has practical experience in civil, criminal, family and general law, as well as medicolegal law. She has, during her time at SAMA, served the organisation and its members steadfastly, along with lending legal support to various SAMA committees. Ms

Massangaie is well versed in all health-related legislation, rules, guidelines, policies and regulations, along with the Companies Act No. 71 of 2008 and King III and IV reports, and is passionate about ensuring that healthcare providers are empowered in rendering their services in accordance with the guiding legislations and ethical rules governing the profession. She has written articles for *SAMA Insider* and has given presentations on issues affecting members in both the private and public sector.

The Legal Department is ably supported by Karlien Pienaar, who joined SAMA in 1999.

Most members are likely already familiar with the wonderful work and dedicated service of Ms Pienaar. Along with her committed support to the department, she is involved in the Bursary Committee, the Education, Science and Technology Committee and the Human Rights, Law and Ethics Committee.

Members are encouraged to approach the Legal Department directly with queries should they require advice on any legal or ethical issues in their practice. Such queries may be sent to karlienp@samedical.org or wendym@samedical.org.

Climate change and its impact on healthcare

Jolene Hattingh, *SAMA Knowledge Management, Research and Ethics Department*



Climate change refers to a change in climate conditions that is largely caused and aggravated by greenhouse gases such as carbon dioxide (produced by combustion of fossil fuels, biological materials and solid waste), methane (produced by production and transport of coal, natural gas and oil, and agricultural practices involving livestock and decay of organic waste), nitrous oxide (produced during agricultural and industrial activities, fuel combustion and treatment of solid waste and wastewater) and other fluorinated gases (emanating from a variety of industrial processes), along with other anthropogenic activities causing changes to biophysical environments and ecosystems.

Environmental degradation occurs over a long period, and it takes a very long time to reverse the effects. Sufficient evidence is available to link these environmental impacts directly to health-related matters. However,

the concept of climate change remains foreign to many people.

Southern Africa has experienced some extreme flooding and heavy rainfall over the past year. Mozambique has had not one but two cyclones, Idai and Kenneth, and areas in both the Western Cape and KwaZulu-Natal experienced flooding devastation earlier this year, all of which brought death and destruction in their wake.

SA has also experienced its fair share of droughts and water shortages in recent years, the most prominent of which in our memories was the countdown to Day Zero in the Western Cape.

Internationally, the effects of extreme rises in temperature have also been felt in countries such as France, where temperatures reached record highs of over 45°C during June this year. Extreme flooding and heavy rainfall events internationally include Hurricane Dorian, which caused devastation in the Bahamas during September.

NASA's Goddard Institute for Space Studies has produced a chart that illustrates the steady increase in global temperatures, particularly over the past two decades (<https://climate.nasa.gov/vital-signs/global-temperature/>).

The most prominent of the extreme wildfires occurring internationally are those currently raging in the Amazon rainforest, a cause of great concern. There has been an increase in the number of these Amazon fires of over 84% since last year, and over 80 000 wildfires have broken out within Brazil, 50% of which are in the Amazon region.

Health impacts

An increase in temperatures can lead to a rise in ground-level ozone concentrations that irritate the mucous membranes, affect respiratory reactions, impair physical performance and intensify solar radiation, which can cause sunburn, skin cancer and corneal and conjunctival inflammation. An increase in solar radiation also gives rise to the production of blue-green algae or cyanobacteria in the water, which can produce toxic substances that can cause skin irritation and contribute to cholera, due to the symbiotic relationship between cyanobacteria and *Vibrio cholerae*.

A rise in temperature also usually accompanies an increase in the number of mosquito, tick and bug bites, as milder winters increase their survival rates, thus prolonging annual activity periods. These prolonged activities usually also lead to an increase in vector-borne diseases such as *Borrelia* resulting from tick-borne diseases, and mosquito-borne viruses such as malaria.

Flooding and excess rainfall can affect the existence of vectors, as water masses during flooding provide the perfect breeding ground for mosquitos. A study by the University of Pretoria, however, confirmed that malaria transmission has a higher correlation with temperature increases than rainfall. Severe storms, hail, heavy rainfall, floods, avalanches and landslides all have direct and indirect effects on health and on the loss of livelihoods and property. Some direct effects include

physical injury or death, and most indirect effects include hygiene-related diseases, which often correlate with rising temperatures.

As with flooding and heavy rainfall, drought can also correlate with the hygiene-related effects caused by a rise in temperature, and can lead to water shortages and to malnutrition, as agriculture and food production is affected. With the increase in population, deterioration in the macro-economic context and extreme drought experienced in the southern parts of Africa, food insecurity has also reached emergency levels in recent years in areas

such as Malawi and Zimbabwe. Droughts have also significantly affected crops in areas of Lesotho, Swaziland, southern Namibia and Mozambique.

Wildfires have direct effects on population health, such as smoke inhalation, physical injury and death. Another stress factor caused by these fires results from the fact that the rainforest produces up to 20% of the earth's oxygen, and with a rise in the carbon dioxide concentration in the air, other health effects increase for those who suffer from allergies, hay fever and asthma, with the risks of asthmatic

complications increasing even more so the last of which has increased risk when taking other air pollutants caused by fire into consideration.

In conclusion, it is clear that the impacts of climate change are felt most severely by vulnerable populations, as the effects are vast, and are all interlinked with health, infrastructure and food security. Climate action should therefore be prioritised by government structures on an international scale

References available on request.

Unpacking absenteeism

Modisane Lelaka, *employee relations advisor, SAMA Industrial Relations Department*

An absence from work may be either authorised or unauthorised. An employee who does not present him- or herself for work without prior approval shall be found to be absent without authorisation. Such an absence of 1 or 2 days is not taken too seriously; however, when absenteeism becomes the norm, or even perpetual, it is regarded as serious.

Authorised annual, study, maternity, paternal, sick, family responsibility or maternity leave may be taken. All leave requires prior approval, with the exception of sick leave. In the case of family responsibility leave, when a family member is sick, you need not request prior permission, but you must inform the supervisor, and show evidence of the illness on your return.

Absenteeism can take many forms, including, but not limited to, the following:

- late-coming
- leaving work early
- taking extended tea, lunch or toilet breaks
- attending to private business during working hours
- taking undue amounts of time in fetching or carrying tools.

If you are not at your workstation at the times when you are expected to be, you are absent. Absence without justification or permission warrants disciplinary action against the employee. It should be remembered that employees are contracted to render services to their employer, and to receive remuneration in return. Being absent from your post at the required time prejudices the business of the employer, unless arrangements are made to recover the missing period.

Patterns of absenteeism

Employees might be found to be often absent on Mondays, Fridays, the day after a holiday, birthdays or paydays. Such patterns are identified by supervisors, and used as evidence against the employees.

Leave in the public sector

Every organisation has a policy to combat absenteeism. Within the public service, the Basic Conditions of Employment Act No. 75 of 1997, the Labour Relations Act No. 66 of 1995 and directives for leave are used to manage absenteeism. It is therefore advisable that members familiarise themselves with these statutes, to better understand what constitutes absenteeism.

How do I request permission?

Employees must communicate with their supervisor about the type of leave required, so that the supervisor knows their whereabouts. Communication is very important: if you are off sick, you do not need to request permission, but it is important to notify your supervisor of your whereabouts, and to indicate when you will be returning.

On occasion, you may need to take urgent leave. This does not require prior arrangement, but it is important to communicate with your supervisor. Be clear in the communication, and on its outcome, to avoid misunderstandings.

Absenteeism due to ill-health

You may be unable to go to work due to ill-health, such as from depression or any other

disease. The process followed in this case is different from that following unauthorised absenteeism, but you still need to advise your employer about your condition.

Desertion/abscondment

This is another form of absenteeism, in which an employee is absent and has no intention to return to work. In the public service, after 30 days' absence without authorisation, the employee's service is terminated by law. Such a termination can only be challenged or remedied by the labour court. Should the employee return after termination, he or she would be required to make representation (not appeal) to the executing authority, stating the reasons for the absenteeism and explaining why he or she should be reinstated.

Abuse of sick leave

Employees are given sick leave days within a 3-year cycle. These days do not carry over at the end of the 3 years; they are forfeited on expiry. Employees may find themselves tempted to use up all their sick leave days, so as not to forfeit them. However, there are disadvantages to misusing sick leave in this way. After you have exhausted all of your sick-leave days through misuse, you may become sick in reality. In this case, you would have to apply for incapacity leave – which is at the discretion of the employer to approve either with or without pay, taking into account your previous leave pattern.

All employees are responsible for monitoring and managing their own absenteeism.

New JUDASA leadership looks ahead

Dr Muhammed Sheik, *public relations officer, JUDASA*

As we set our feet towards the horizon, most of us are enthusiastic about turning our heads and hearts to this new dawn of JUDASA. Building on the legacy of tackling the central matters that affect us, we look forward to building on the Safe Hours Campaign and the fight for zero tolerance for discrimination in the workplace.

Our vision is to maintain a harmonious and synchronous term of office to empower each other, inform and educate, learn and build and reignite the fire of young motivated healthcare practitioners across the country.

Many times, our spirit is dowsed by challenges revolving around the workplace, resources, dysfunctional administration, anxiety about placements and payment delays. As leaders, our term of office shall look at ensuring and maintaining efficiency in commissions set up to drive solutions to these challenges.

JUDASA has in previous years had sterling leadership examples who were always made to account for their decisions and



JUDASA leadership. Back, left to right: Dr Bonginkosi Mnguni, Dr Tshepile Tlali, Dr Siyabonga Mbatha, Dr Lerato Masenya, Dr Bridged Tshutshu, Dr Patricia Zondo, Dr Jarryd Lunn, Dr Muhammed Sheik, Dr Rebonethato Lesupi. Front: Girly Moseki, Dr Vusumuzi Nhlapho.

implementations. We expect no different from ourselves, and we hope that we can channel our energies collectively as one body for one community.

We welcome all valuable input, support, suggestions and advice during our tenure (please contact our chairperson: Dr Bridged

Tshutshu, at mokwena.bridged3@gmail.com). We hope and pray that our voices are heard throughout the various structures around us.

We want to ensure that we maintain morality, honesty, integrity and humanness. For without these, we cannot reap happiness and prosperity.

Obituary: Prof. Gboyega Adebola Ogunbanjo

SAMA Communications Department

It is with great sadness that SAMA Gauteng North branch informs you of the passing of the distinguished scholar, researcher, academic and senior academic administrator, Prof. Gboyega Ogunbanjo on 17 August. Prof. O, as he was affectionately known, had been a member of SAMA since 1993.

Born in Lagos, Nigeria, Prof. Ogunbanjo completed his basic medical training at the College of Medicine, University of Lagos, in 1982. Thereafter, he completed his family medicine training at the Medical University of Southern Africa (MEDUNSA) in Pretoria – now Sefako Makgatho Health Sciences University (SMU) – in 1996.

He was an active member of the medical fraternity through the roles he played in numerous associations, such as the SA Academy of Family Physicians, the SA College of Family Physicians, the Colleges of Medicine of SA, the Nigerian Doctors' Forum, and as head of the Department of Family Medicine and Primary Health Care at SMU and Dr George Mukhari Academic Hospital.

Prof. O was an academic at heart, and wrote many research articles. He played a significant role in the transformation of family medicine into a full specialty in SA.

As an established researcher and erudite scientific writer, he had more than 180 publications in local and international peer-reviewed medical journals, as well as book chapters. He has supervised research dissertations of over 90 Master's students, of whom 80 have completed their MMed degrees in family medicine. He served as external examiner for a further 96 Master's research dissertations from all eight health sciences faculties in SA, and in Malaysia, Uganda, Kenya, Botswana, Rwanda and Ghana. He was the recipient of the University Senate Awards for Research Excellence for the "best research output" (clinical) from 2002 to 2005, and from 2006 to 2008 for an "established researcher" in the School of Medicine, MEDUNSA.

Until recently he was also the editor-in-chief of the *SA Family Practice* journal. He was an



exceptional mentor and an inspiration to junior doctors, whom he encouraged to achieve their dreams and reach for higher goals. Prof. O was a regular plenary speaker at many national, African and global conferences on family medicine and primary healthcare.

Prof. O will be forever missed by all those whose lives he touched. He is survived by his wife, Priscilla, and two sons, Olusegun and Oluseyi.

May his soul rest in peace.

Mandela Day project brightens safe house

On Mandela Day this year, Cape Town branch visited Huis Hadassa, a safe house for children who have been removed from their parental homes. The children stay at the home for approximately 3 or 4 months, until the court decides whether they must go to foster homes.

The branch sponsored a new TV and a DVD player, and branch secretaries Chenienne Gericke and Emily Nel collected various items such as clothes, curtaining and crockery for the children, to help brighten up their home. The children were also treated to sweets and other luxuries.



Renier Lategan (SAMA head office), Ruan Vlok (SAMA industrial relations advisor), Chenienne Gericke and Emily Nel working and playing with the children

KZN Midlands attend CPD meeting

On 27 July, KZN Midlands branch was invited to attend and have a stand at the well-attended Mediclinic Pietermaritzburg CPD meeting held at the Victoria Country Club. It was the perfect opportunity for branch secretary Mandy Hattingh to chat to delegates and invite them to the SAMA conference, which was held in August.



The SAMA stand at the CPD meeting

Keeping up to date is essential

West Rand branch held a successful CPD symposium from 31 August to 1 September, which attracted over 300 delegates. A joint venture with MD Health Connections, the branch sponsor each branch member who attends, and this year welcomed delegates from Gauteng North and Gauteng Central branches to one of the best-attended events of its kind in Gauteng.

To provide the best medical care to their patients, medical doctors, nurses and allied health professionals need to be up to date with the latest developments in the world of healthcare. The SAMA West Rand CPD

symposium is an event that provides the medical fraternity with the opportunity to learn about cutting-edge developments across a broad range of clinical specialties.

Experienced and knowledgeable speakers provide best patient management principles and the most recent guidelines to the healthcare professionals who attend. In this way, doctors, nurses and allied practitioners are better equipped with knowledge of the latest and best practices, and can provide their patients with the best treatment and medical advice in keeping with international and national regulations and best practices.



Dr Jay Punwasi (chairperson) with Tracey Gurnell from SAMA West Rand branch



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.

SERVICES AVAILABLE

- South African Medical Association Continued Professional Development Accreditation
- **Our Mission**
 - Empowering Doctors to bring health to the nation
 - Excellent Service
 - Quick Turnaround
 - Efficiency