

SAMA INSIDER

JUNE 2020

**Healthcare
workers unite
against COVID-19**

**SAMA publishing – a
vital role in medical
education**



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

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MEDICAL ASSOCIATION**



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Diane de Kock
Editor: *SAMA INSIDER*

Let us stand together

"COVID-19 is not a single-specialty disease," warned Dr Nicky Longley at a recent webinar hosted by Discovery Health in conjunction with *MedicalBrief*, the Desmond Tutu Foundation, SAMA, the SA Private Practitioners Forum and the Unity Forum for Family Practitioners, and attended by 1 500 SA clinicians and healthcare workers. "Everyone has to collaborate, parcelling out work where resources are most needed and finding the best way to handle individual cases" (*MedicalBrief*, 21 May). Dr Longley is a one-time UCT-based infectious diseases fellow, now working in a London hospital. She said hospital staff and clinicians often felt helpless, scared and overwhelmed when facing the first flood of COVID-19 patients. A "buddy system" is important, for example, where "somebody else watches you put on and take off personal protective equipment each time, because you are stressed and tired."

An important message from Dr Longley: "This is not a sprint, it's a marathon. We have to be kind to our teams and ourselves."

This sentiment is emphasised by the joint statement from the Critical Care Society of SA (CCSSA) and the SA Society of Anaesthesiologists (SASA) (page 19), in which they note: "We have extremely limited resources and will have to apply all of our efforts collectively and innovatively to overcome the challenging times that lie ahead. Let us stand together – public sector, private sector, all disciplines and all care teams."

Reinforcing the need to collaborate at this time, Prof. Zuki Zingela's article (page 11) appeals to healthcare workers to unite against COVID-19. "All for one and one for all, united we stand, divided we fall. Alexandre Dumas immortalised these words in *The Three Musketeers*. For our health teams and systems to survive and remain functional in this time of corona, for our country to come out intact on the other side, we will all have to live by this motto."

In this issue, SAMA's Dr Coetzee unpacks the process of migrating existing SAMA membership payments by state-employed doctors from the Persal system to a debit order system (page 5).

Shelley McGee and Rosanna Naidoo answer frequently asked questions about COVID-19 (page 6) in a continually changing environment, while the Medical Protection Society (MPS) calls for assurance to support doctors and healthcare professionals in SA. "Now more than ever, doctors need to be able to focus on saving lives, not on avoiding prosecution," says Dr Graham Howarth, head of medical services, Africa, for MPS.

Doctors Without Borders/Médecins Sans Frontières (MSF) (page 15) have years of experience in dealing with emergencies and outbreaks. "Before, the health services ... were focused on individual care. Now they have to start thinking about public health in an outbreak context instead."

People are facing the challenge of changing the way they think and act. General opinion is that life after COVID-19 will be different – supporting each other and collaborating has to be the answer.

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Medical training: E-learning v. bedside teaching



Dr Sizeka Maweya, SAMA President

Distance learning, specifically e-learning, in medical training refers to the use of technologies for healthcare training at a distance, including electronic health, telehealth (e-health), telematics, telemedicine and tele-education. One question that we must ask ourselves is whether this could work in our rural communities – where there are challenges with regard to network coverage – or in medical training in general.

There are two types of education: formal, usually taught at school, and informal, taught at home. Education can also be understood as either following a banking model, where students are seen as containers into which educators put knowledge, or as using the didactic method, which follows a consistent scientific approach or educational style to deliver information to students. These two models have evolved over time into problem-based learning. This problem-based learning model has been tried in medical training, but never worked well.

Distance/e-learning has historically been conducted by UNISA in SA. This institution teaches only nursing administration and public health, of the postgraduate human sciences, while medical education, which by its nature is a pure human science, is not taught. There are nine medical schools in SA, of which six (Pretoria, Wits, UCT, Free State, Stellenbosch and UKZN) are historically advantaged in terms of human, health technology and infrastructural resources. The remaining three (Walter Sisulu, Sefako Makgatho and Limpopo) are historically disadvantaged, and lack basic resources for medical training.

Challenges in terms of accommodation, and the unaffordability of higher education, are forcing us to rethink how medical

students should be taught in the modern era. The COVID-19 pandemic, too, is forcing our education system to take a different approach to medical teaching.

SA is a deeply unequal country, however, and the education system is not spared this inequality. Most of the rural universities that provide medical training are not equipped to conduct e-learning for medical students. The administrative staff are still battling to train lecturers and co-ordinators in how to use modalities such as Blackboard, while their counterparts at historically advantaged institutions are already at an advanced stage. Most students who enrol in these rural or previously disadvantaged institutions are themselves from deep rural SA. The lecturers and students at these institutions are not fully conversant with e-learning; in essence, they lack capacity. It will be a long time before they catch up with their colleagues in better-resourced institutions, and a lot of time will be wasted before they are on par with them.

According to Masic, medical education means acquiring knowledge and psychological/motor skills, while medical training implies the acquisition of positive values and attitudes. Medical education and training are not useful unless the student acquires the nucleus or the minimum knowledge requirements (the cognitive aspect), the minimum of required skills (the psychological/motor perspective) and a minimum of obligatory conduct values (the affective dimension).

E-learning for medical students cannot work, considered in light of the issues raised above. There is no way a medical student can be taught the skill of examining a patient from the bedside without the presence of a patient. It would be challenging to teach medical students how to perform a particular examination via online instruction only. In addition, most rural communities do not have adequate network access: learning would be continually interrupted, or even terminated at times due to loadshedding.

There was a time when the dissection of human cadavers was conducted virtually; however, this failed dismally as a teaching method. The absence of hands-on training meant that students were unable to explore the various organs or begin to acquire surgical skills.

The role of a doctor is to be an organiser, communicator and therapist in the following five activities: health promotion; disease prevention; treatment of the diseased;

rehabilitation of the recovered; and constant learning. With distance learning, the acquisition of most of these skills cannot be guaranteed. It must be emphasised that most distance or e-learning also requires a well-disciplined student, and this sort of discipline is difficult to maintain.

There have been discussions about telemedicine in SA recently, and there are various schools of thought about the challenges. Some healthcare practitioners believe that it can only work in terms of patient follow-up. The modality cannot be used for rural patients, the majority of whom are illiterate and have no access to technology. Medical care also traditionally involves interaction with the patient, since non-verbal clues can guide the doctor towards a proper diagnosis.

The WMA refers to the medical education leading to the first professional degree (the title of GP) as clinical education, which is the preparation for general medical practice or for specialisation, and for the obligatory continuous, lifelong learning of each doctor. Via the medium of distance learning, a training institution will produce only a poorly trained doctor in this respect. Clarity in the transmission of messages will pose a severe challenge if modalities such as Zoom or Google Hangouts or Meet are used. The use of YouTube to provide demonstrations with real patients could breach doctor-patient confidentiality, as the lecturer would have no control over whom the student might share the video with. And how would a patient examination be demonstrated remotely? Would the technologists who operate the video sign an oath of confidentiality, or would lecturers be trained to use the equipment?

Another factor to be considered is patients' right to privacy. When using e-learning, how would this right be protected? Violations of human rights in this manner would increase levels of litigation. We are presently struggling to stimulate economic growth, so where would the money to pay for such litigation be sourced?

In conclusion, the fourth industrial revolution represents a new way of doing things in today's era. Medicine, however, cannot be taught by distance or e-learning. We must look for another way to use the new capabilities for medical training. E-learning may be the cheapest way to teach students, because universities are able to save in many ways, but it is not conducive to medical training.

Support your professional representation by migrating

SAMA Communications Department

SAMA has embarked on the process of migrating existing membership payments by state-employed doctors from the current PERSAL system to a debit order system. The move is to ensure that these members enjoy uninterrupted membership, and comes about after issues arose relating to SAMA and the SAMA Trade Union (SAMATU).

"The thrust of the issues has been an unintended misalignment between SAMA – which is a non-profit company – and SAMATU, which is a trade union registered in terms of the Labour Relations Act [No. 66 of 1995; LRA]. A big problem was the impossibility of both – in terms of the law – coexisting and properly functioning as two legal entities with seamless governance," says Dr Angelique Coetzee, SAMA chairman.

Dr Coetzee says the SAMATU did not comply with the Labour Relations Act and its own constitution, both factors that could potentially have caused a split in the association.

Until 2013, SAMATU's union functions were served through the Committee for Public Sector Doctors – a membership committee of SAMA NPC. This posed a problem, because to comply with the LRA, SAMATU needed to be sovereign and independent. Another issue was that because employed doctors could not be organised separately from the rest of SAMA membership, SAMATU could not satisfy the organisational structure requirements of the LRA.

"Obviously this was not a situation we wanted, so between 2013 and 2016, SAMA made several attempts to assist SAMATU to comply with the conditions of its establishment and with the LRA. At one point, SAMA also established a Trade Union Task Team to aid SAMATU to become more compliant. Our efforts, unfortunately, amounted to little as, among other issues, there were poor levels of participation by employed doctors relating to organisational trade union matters," says Dr Coetzee.

Following the failure of these interventions, an attempt was made to convene a national congress at which leaders of the trade union would be elected. Convening the congress, however, contravened the principles guiding legal legitimacy, and the attempt was abandoned.

In the end, SAMATU was placed under administration in October 2019; this was the culmination of a process that was informed by the misalignment between itself and SAMA.

As a professional association, apart from being its members' labour representative, SAMA fulfills a variety of vital, value-adding functions

"This is certainly concerning, because the majority of SAMA's members are employed by the state. Apart from ultimately being our members' labour representative, we also fulfill a variety of functions on behalf of members that include stakeholder representation, the hosting of CPD events with points-based accreditation, the provision of medicolegal advice and advocacy on a range of issues," notes Dr Coetzee. "As a professional association, apart from ultimately being its members' labour representative, SAMA also fulfills a variety of vital, value-adding functions on behalf of its members."

Among other services that are common to both SAMA and SAMATU are society representation (such as for specialists and GPs), access to Foundation for Professional Development training, the setting of treatment codes, providing bursaries and scholarships, and research ethics oversight.

For employed doctors, there are specific functions that SAMA fulfills. These include legal assistance, special interest groups (such as students, junior and senior doctors, registrars and academics) and strategic engagement with the National Department of Health on the drafting of public sector policies.

In addition to these services, SAMA also performs a number of functions for self-

employed doctors. These include coding trademark (SAMA is the only organisation in SA licensed to create/amend coding for doctors and specialists), Council for Medical Schemes representation, engagement with individual funders, strategic partnerships with the Board for Healthcare Funders, affiliation with most senior disciplines and strategic partnerships with the Compensation Fund and Road Accident Fund.

Another concern for SAMA in relation to SAMATU was that the restrictive conditions of the LRA placed the association (SAMA NPC) in a difficult position in relation to the conventional trade union model.

"Doctors, who are essential services professionals, cannot ethically embark on strike action, and those who work in managerial positions find themselves in the untenable situation of being union members and accountable officers. This poses a threat to the functioning of the profession in its primary duty of being stewards for health rather than stewards for rights," notes Dr Coetzee.

Since the imposition of the administration order by the courts, SAMA has had to review its strategy regarding serving state-employed doctors. Currently, these doctors' membership fees are deducted directly from their salaries on the PERSAL system, and paid to SAMATU.

"This is an unfortunate state of affairs for SAMA, and we have had to revise how we can continue to serve these members and provide continuity of membership. For this reason we've embarked on a process to move these doctors from PERSAL to a debit order system from their bank accounts. We believe this is the most effective way of adjusting the processes and keeping these doctors within the SAMA fold," says Dr Coetzee.

Dr Coetzee says that although SAMA had anticipated encountering problems with SAMATU, all its attempts at finding a resolution had failed.

"We knew there were issues, and we tried to salvage what we could. In the end, though, these attempts didn't work, and it is time now for us to look to the future, and ensure that we continue providing services to all our members. We believe the solution we have found now is the best way forward," says Dr Coetzee.

Addressing frequently asked questions

Shelley McGee, health policy researcher, SAMA KMRED, Dr Rosanna Naidoo, principal business officer, SAMA Private Practice Department

The development of issues related to COVID-19 has outpaced anything SAMA has previously been involved with. Policies, advice and even guidance on clinical disease features and management of cases seem to change almost daily, leading to a lot of confusion and uncertainty.

In addition, health authorities, hospital groups and professional societies all seem to have different approaches to infection prevention and control, staff safety issues and handling of suspect cases.

As a result, SAMA has spent a lot of time addressing high-level issues and answering individual queries from members. We present some of the most frequently asked questions here. Most of the early frequently asked questions were addressed by the SAMA COVID-19 basics series, which is available on the SAMA COVID-19 webpage at <https://www.samedical.org/covid-19/main>. We have also posted important guidelines with respect to clinical and practice management.

SAMA intends to publish the latest information for our membership. However, this is changing very rapidly, so the below may be subject to change as evidence and information evolves.

Are standard surgical masks sufficient for GPs when dealing with symptomatic patients/taking swabs?

SA has adopted the WHO's rational approach to the use of personal protective equipment (PPE), meaning that the appropriate PPE for any individual must be judged according to the work that they are doing, the roles that they play in a practice and the risk of exposure to COVID-19.

Your risk of exposure differs depending on what kind of contact you have with patients.

Remember, in a GP practice there are also measures that should be taken before using PPE, to help protect you and your staff. PPE should actually be the last line of defence against infection, and there is a lot that can be done to minimise the risk of exposure.

Administrative and environmental controls are important to make sure that symptomatic patients are channelled and managed correctly. This involves preparing the clinic by:

- encouraging telemedicine appointments
- staying connected with your health



department, to be informed about COVID-19 in your community

- rescheduling non-urgent appointments
- posting signs at entrances and in waiting areas about preventive actions
- placing chairs 1 - 2 m apart, where possible
- using barriers (e.g. screens), if possible
- if your office has toys, reading materials or other communal objects, removing them or cleaning them regularly
- screening patients for symptoms at the entrance, and separating those with symptoms
- allowing patients to wait outside or in the car if they are medically able
- frequent cleaning and disinfection of frequently touched surfaces such as counters, beds and seating, using appropriate disinfectants.

The WHO recommends that when consulting with or examining a patient who has respiratory symptoms, health workers should use a surgical mask, gown, gloves and eye protection.

Taking specimens from patients for COVID-19 testing is considered an aerosol-generating procedure, and requires full protection. Use standard, contact and droplet transmission precautions: long-sleeved gown, gloves, protective eyewear/face shield and an N95 respirator mask.

If a practitioner sees a patient for 15 minutes while wearing PPE, and that patient is

subsequently diagnosed with COVID-19, is the doctor considered a close contact, and does (s)he require isolation?

During April, the National Institute for Communicable Diseases (NICD) developed guidance on the issue of exposed healthcare workers.

There will come a stage during the epidemic when practitioners face frequent exposure, and repeated isolation becomes virtually impossible and potentially detrimental to the delivery of much-needed health services elsewhere. The NICD classifies four levels of exposure and management for exposed healthcare workers.

Scenario 4 is low risk, and involves contact >1 m away from a COVID-19 confirmed case for <15 minutes, OR within 1 m but wearing PPE (face cover, eye cover). The situation is also considered low risk if the COVID patient wore a surgical mask (source control).

For low-risk exposures to a confirmed COVID-19 positive case, practitioners can continue to work, with self-monitoring (taking temperature twice daily and daily symptom check) for 14 days after the last COVID-19 exposure. If the practitioner was wearing appropriate PPE during the exposure, (she) is not considered a close contact, and isolation is not required.

If not wearing PPE, then a risk assessment needs to be done. Judging the risk level of the exposure can be tricky.

SAMA recommends following the NICD guidance for these cases as closely as

possible: The full guidance is available on the NICD website, entitled "Guidelines for symptom monitoring and management of essential workers for COVID-19-related infection".

At the time of writing, the link to this guidance was available at <https://www.nicd.ac.za/wp-content/uploads/2020/04/Guidance-for-symptom-monitoring-and-management-of-essential-staff-with-COVID-19-related-illness-final-2.pdf>.

Are GPs required to carry out swab testing on patients, or can they be sent directly to an emergency department or pathology?

GPs can choose to collect swabs for COVID-19 testing if they use appropriate PPE and are comfortable with doing so.

Alternatively, the patient can be referred to an emergency department or a private pathology collection centre.

As swabbing is considered an aerosol-generating procedure, appropriate healthcare worker PPE consists of gloves, gown (or apron), a fit-tested particulate respirator (N95 respirator) and eye protection (goggles or face shield), according to the NICD testing guidelines and the national infection prevention and control guidelines. These guidelines are available at <https://www.nicd.ac.za/diseases-a-z-index/covid-19/covid-19-guidelines>.

Can a practitioner use rapid blood tests for testing acute patients?

Currently, the recommended test is an RNA-PCR test of oropharyngeal and nasopharyngeal swab material. As for other respiratory viruses, a respiratory tract swab is the best specimen for virus detection.

While rapid tests have been developed for serum samples (testing for IgG and IgM), there is no diagnostic blood test at this time. SAMA, the NICD and the SA Health Products Regulatory Authority have all put out statements warning

against the inappropriate use of rapid serology tests for acute diagnosis.

Antibodies form in detectable levels several days after the peak of infectivity of COVID-19, and false negatives are very likely early in the disease process. While rapid tests may be very useful for epidemiological surveillance, the viral test is by far more important for identifying early cases for management.

How long after clinical infection is the virus cleared?

There is variability in clearance rates, and this is still being studied. The latest NICD guidelines allow that patients can be de-isolated 14 days after the onset of their symptoms (mild cases), or 14 days after achieving clinical stability (moderate to severe cases).

We continue to find ways to address, communicate and escalate any information requests and challenges

Patients can continue to shed SARS-CoV-2 from their upper airways for approximately 20 days (range 8 - 37 days), with mild cases showing viral shedding for a shorter period of time than severe cases.

However, viral shedding does not necessarily equate to infectiousness – viral shedding may decline to a level below the infectious threshold before it ceases completely, and/or non-viable virus may be shed.

The questions that SAMA has addressed as the epidemic has developed have been many and varied. We continue to find ways to address, communicate and escalate any information requests and challenges that are not already addressed by the existing guidelines.

What services is a medical practitioner permitted to provide during the different stages of lockdown?

Medical services have been considered essential since the beginning of the lockdown period on 26 March 2020. Many hospitals and practices scaled back greatly during April, and private practice incomes have dropped significantly as a result.

As the regulations and implementation have unfolded and developed, it has become apparent that it is necessary for medical practitioners to be in possession of a permit to perform an essential service, to allow for movement between metro areas and provinces. This also applies to support and other clinical staff.

The permit template has been widely circulated to all SAMA offices, and needs only a supervisor permission or practice or facility stamp to be valid.

The regulations do not discriminate between different medical services – legally, all medical services are permitted.

However, provision of services to patients needs to be balanced with the risks of COVID-19 exposure for both patients and practitioners (and their staff), so SAMA advises practitioners to carefully weigh up what they consider essential services in their daily practice, and decide what can be put off, and what cannot. This will be particular to each individual practice or environment.

Please send your queries to covid19@samedical.org and we will do our level best to address your questions.

HPCSA extends deadline for fee payment

SAMA Communications Department

In view of the current COVID-19 pandemic and the state of national disaster, the HPCSA acknowledges that this has affected some practitioners' ability to pay their annual fees. This situation has also affected the provincial departments in effecting the personal deduction and

payment of annual fees on behalf of state-employed practitioners. To this end, the HPCSA informs all practitioners that the due date for annual renewals and payment of registrations has been extended from 1 April 2020 to 1 July 2020. Practitioners should ensure that their annual fees are paid by 30

June 2020, and are encouraged to utilise the online portal for the renewal of their registration, where they will also access their annual practising certificate.

All annual practising certificates that expired on 31 March 2020 are now valid until 30 June 2020.

In the midst of a pandemic, remaining ethical is non-negotiable

Dr Selaelo Mametja, *chief research officer, GEMS*, Dr Stan Moloabi, *principal officer, GEMS*

Ethics are moral principles that govern a person's behaviour – guiding one to do the right thing at the right time. Certain ethical principles are key. Two of these are beneficence – always doing what is good, and non-maleficence – inflicting no harm, or the least harm possible to reach a beneficial outcome.

In a pandemic situation where little is known, behaving ethically requires an examination of organisational values, and most importantly, relying on one's intuition as an organisation, in knowing right from wrong.

The WHO has published a guideline on ethical considerations when developing a public health response to a pandemic. These considerations include balancing competing values and interests, prioritisation, equitable access to healthcare, allocation of resources, transparency, education and communication, moral and professional obligations, and principles of reciprocity.

In this article, we outline how the Government Employees Medical Scheme (GEMS) founding mandate, mission, vision and values have guided us in making ethical decisions during the outbreak. The GEMS mandate is to ensure that public service employees have adequate healthcare coverage that is efficient, cost-effective and equitable, and to provide further options for those who wish to purchase more extensive cover. The year 2020 started on a good note for GEMS. With excellent financial performance and adequate reserves, we were in a position to expand private hospital coverage to our entry-level option, Tanzanite One.

However, SA woke up to its first case of the novel coronavirus on 5 March 5 2020, and our first case at GEMS was identified just a few days later. There is nothing like a pandemic to test the foundation of your business.

From the onset, GEMS identified COVID-19 as a risk to the business, and we have monitored global trends in the epidemic, while equipping ourselves with knowledge and preparing for the imminent risks. We learnt in the process to plan for the worst and hope for the best.

The GEMS mandate

GEMS covers a wide variety of employees, from top government officials down to entry-level workers such as cleaners. Our strategy requires the provision of healthcare based on need, and contributions are differentiated by income. Level 1 - 5 employees may receive up to 100% subsidy from government, depending on their family size. Given our aspiration to enable universal coverage, the pandemic has put our funding mandate to the test.

“The true measure of any society can be found in how it treats its most vulnerable members” – Mahatma Gandhi

GEMS allocated a budget of ZAR900 million to enable access to COVID-related diagnosis, care and treatment. Decisions on funding for COVID-19 were influenced by the following major considerations: to what extent are our vulnerable groups (salary level 1 - 5 employees) adequately protected? Would COVID-19 diagnosis, treatment and care result in catastrophic expenditure for households? Would fear of the exhaustion of benefits result in less severely ill patients not seeking healthcare, and therefore spreading the disease? Would there be unnecessary utilisation of resources (moral hazard such as waste and abuse)? Would the scheme be able to afford the costs? What elements of care would potentially increase the costs? What are our best and worst-case scenarios?

We believe in providing value for our members, and we achieve this by providing comprehensive healthcare in accordance with national policy, the prescribed minimum benefits framework, the burden of disease and member needs. We aim to reduce out-of-pocket expenses and maximise outcomes.

According to the theories of the social gradient in health and social determinants of health, those in the lower socioeconomic strata of a society have the highest burden of disease, and are more likely to experience catastrophic expenditure. We believe that our allocation of additional resources will maximally protect levels 1 - 5 of government employees. We intentionally designed our strategy to be inclusive of all socioeconomic strata, beginning from the lowest.

Containing the pandemic involves a broad range of public health interventions, such as targeted screening, testing, isolation of positive cases and social distancing. We have committed to screening (self-screening) and testing of our members in accordance with national guidelines and fiduciary use of resources. At the start of the outbreak, high cost was a barrier to testing in the private sector, and for this reason the funding industry negotiated fees with several laboratories. Further exemptions and assistance from the government in successfully leading the price negotiation made it possible for GEMS to fund targeted screening and testing. However, if population-wide COVID-19 testing is adopted as a national strategy, the testing costs will need to be lowered further to enable schemes to afford testing coverage among their members. We believe this reduction of cost would be fair, due to economies of scale.

Our medical scheme, unlike any other in the country, has a high proportion of members for whom self-isolation at home is not possible, due to a lack of amenities such as private bedrooms and bathrooms. The admission of mild cases could potentially result in increased and unaffordable hospitalisation costs. To promote access to isolation facilities for mild cases, we are looking at innovative ways to contain the potential costs. Strategies include the use of step-down facilities and government field hospitals (while of course being cognisant of the imperative not to displace any indigent people who are already using the facilities).

Prioritisation of disease coverage

To stretch our health funds this year, we need to promote the adoption of cost-effective

interventions. We encourage all practitioners to offer vaccinations. While the influenza and pneumococcal vaccines will not prevent COVID-19 infection, they will reduce the burden and upstream costs of seasonal flu and pneumonia.

During pandemics, resources may be directed away from other diseases. It is essential to expand screening for HIV and diabetes mellitus. Chronic diseases are associated with high mortality. GEMS is committed to continued funding of quality healthcare for our chronic beneficiaries.

Health education and communication

GEMS continues to educate its members about the pandemic, using multiple sources to include the most rural communities – internet, SMS, radio, social media and printed material.

Protecting vulnerable employees

As part of our strategy, we need to protect the health of our employees. Our client liaison officers (who interact with members face to face) and those using public transport were the employees most at risk of COVID-19. Fortunately, GEMS operations can be carried out remotely. During the lockdown, we will employ all necessary workplace measures to mitigate the impact of COVID-19. In 2020, we insourced our cleaning and security services, which has ensured that we protect the jobs of the most vulnerable in our society. As members, these employees also qualify for subsidised medical aid.

Principle of reciprocity

Ubuntu ethics, as a set of values, provides an opportunity for human beings to live according to principles such as reciprocity,

the common good and peaceful relations, with an emphasis on human dignity and the value of human life, as well as consensus, tolerance and mutual respect.

At GEMS, we are who we are because of our members, health professionals, trade unions, government and other stakeholders. We value the principle of social solidarity, and the law of reciprocity comes naturally to us. GEMS has made contributions to the Solidarity Fund, the initiative to provide telephonic consultations to all South Africans and the procurement of PPE for health workers. We recognise the professional obligation of healthcare professionals in pandemics, and appreciate that they put their lives at risk, and we do not take this lightly. It is imperative for us to support the provision of PPE to all health workers, and to prioritise the flu vaccine among healthcare workers.

Reassure doctors during COVID-19, MPS urges regulators

SAMA Communications Department

The Medical Protection Society (MPS) is calling for assurances to support doctors and healthcare professionals across SA, and the decisions they make during the COVID-19 crisis.

The leading protection organisation for healthcare professionals welcomes recent guidance from the HPCSA that any complaints against doctors will be reviewed in the context of the extraordinary conditions under which they are working. However, doctors remain vulnerable to criminal charges, and MPS is also seeking a commitment from public prosecutors that they too will show restraint in bringing charges of culpable homicide in relation to patient deaths during this time.

Doctors could be asked to work in areas outside their specialty, in environments that are very stretched. Doctors faced with a localised outbreak of COVID-19 may also be forced to make heart-rending decisions to withdraw or withhold treatment if the demand for ventilators temporarily exceeds supply.

MPS would like to see the commitment from the HPCSA matched by public prosecutors after doctors have expressed

concerns about their vulnerability to both criminal and regulatory investigations following decisions they may have to make in unprecedented circumstances.

The organisation calls on public prosecutors to provide urgent assurance to doctors that they will judge any case arising during this time reasonably against the clinical circumstances that doctors are working within.

Dr Graham Howarth, head of medical services, Africa, for MPS, says: "Healthcare professionals want the very best for their patients, and doctors across the country are doing the best they can, in especially challenging circumstances, to ensure that patients infected with COVID-19 get the best medical treatment possible.

"Doctors have been contacting MPS raising concerns about the decisions they may have to make in very challenging circumstances, and how they can be sure they are acting lawfully.

"It is simply not fair for doctors already under immense pressure to be asked to make difficult treatment decisions based on a hope that the courts or public prosecutors

will treat them favourably and protect them in the future if their decisions and actions are challenged.

"The overarching approach from both the regulators and the authorities must be restraint.

"MPS urges public prosecutors to issue clear and urgent reassurance that they will deal with any charges arising from this crisis reasonably, reassuring doctors that they will be protected, so that they can make decisions in the interests of their patients.

"With the spread of COVID-19 being better contained in SA than it has been elsewhere, now is the time to take action to protect healthcare workers, before the pressures continue to grow.

"Hopefully heart-rending decisions about rationing can be avoided by containing the spread of the virus, but we must be prepared. We must provide protection to our frontline healthcare teams to allow them to focus on the care they are currently providing to patients, and to make clinical decisions free from the fear of the risk of criminal charges. Now more than ever, doctors need to be able to focus on saving lives, not on avoiding prosecution."

Malaria prevention cannot be allowed to stall during COVID-19

SAMA Communications Department

These are disrupted, uncertain times. The COVID-19 outbreak has, once again, shown the need for robust health systems, and the importance of early detection. And it is natural that we should be doing everything we can to slow the pandemic.

Yet 5 000 children under the age of five are still dying from malaria each week. We must not let all the work that has gone into preventing the disease unravel. Malaria protection programmes are still vital; if anything, we need them now more than ever to prevent cases from rising in the wake of COVID-19.

Dr Benji Pretorius, founder of ERADA Technology Alliance, warns that recent progress made in the fight to end malaria will be undone if prevention methods are halted due to the COVID-19 outbreak.

His warning comes as the WHO urges countries across its Africa region – which has the highest malaria burden – to act swiftly in deploying malaria prevention and treatment tools while cases of COVID-19 remain comparatively low.

The WHO also warns that, in the worst-case scenario of all insecticide-treated net (ITN) campaigns being suspended, the estimated tally of malaria deaths in sub-Saharan Africa

in 2020 would reach 769 000, a return to mortality levels last experienced 20 years ago.

Having contracted and survived malaria himself, Dr Pretorius has first-hand experience of the need for swift diagnosis and treatment in order to save lives, especially in the most at-risk areas.

Dr Pretorius said: “At this time of global uncertainty, we need to ensure that the progress we have made in the fight against malaria is maintained. In 2015, after the Ebola outbreak in West Africa, cases of malaria increased substantially as prevention programmes were put on hold.

“We cannot allow this to happen again. So I am urging countries with high malaria risk to take heed of the WHO’s warning and keep their prevention programmes in place, while also ensuring that those working to implement these programmes have a safe environment in which to do so.”

The WHO has also issued guidelines on tailoring malaria interventions during the COVID-19 pandemic, including providing access to rapid diagnostic tests and ITNs, and encouraging early care for individuals displaying symptoms such as fever.

ERADA Technology Alliance, in partnership with global stakeholders, is committed to developing a saliva-based

rapid diagnostic test for malaria. The test identifies both the *Plasmodium* parasite in a person’s saliva, and a protein biomarker that it depends on for survival, thereby diagnosing the disease and facilitating early preventive medical intervention before symptoms worsen.

Further details of ERADA’s work are available at <http://www.eradatechnology.com>.

The WHO’s guidelines on malaria interventions during the COVID-19 pandemic are available at <https://www.who.int/malaria/publications/atoz/tailoring-malaria-interventions-covid-19.pdf?ua=1>.

About ERADA Technology Alliance Ltd

ERADA Technology Alliance Ltd (ERADA), founded by Dr Benji Pretorius and Dr Richard Schmidt, pioneers innovative, rapid diagnostic solutions for the early detection of infectious diseases, including malaria. Dr Pretorius, the company’s managing director, himself an experienced medical practitioner, is an expert in the field of malaria management, and has a long track record of working in the pharmaceutical, health, wellness and fitness industry.

COVID-19: National essential medicines list reviews potential treatments

SAMA Communications Department

In April, SAMA staff assisted the national essential medicines list team to address rapid reviews of the evidence for numerous proposed treatment options for COVID-19.

The committee evaluated evidence reviews for:

- remdesivir
- hydroxychloroquine/chloroquine
- intravenous immunoglobulin
- interferons

- tocilizumab
- lopinavir/ritonavir.

These have now been published on the National Department of Health’s website: <http://www.health.gov.za/index.php/national-essential-medicine-list-committee-nemlc/category/633-covid-19-rapid-reviews>.

The conclusion drawn was that for all independently reviewed treatments, there

is insufficient evidence for inclusion in any treatment guidelines or regimens at present.

A number of ongoing trials were identified, the results of which are eagerly anticipated. Ongoing updates of such reviews will be the norm.

Questions? Please email SAMA at covid19@samedical.org or contact us via our COVID-19 webpage, <https://www.samedical.org/covid-19/main>.

All for one and one for all: Healthcare workers unite against COVID-19

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



As we face the global challenge of COVID-19, countries are grappling with differing severities of the outbreak, but with no less devastating consequences. High death rates, debilitating lockdowns and strained or weakened economies have all pushed healthcare workers to the frontline of this global war whose end date is still undefined. Waking up to fight another day demands sustained stamina and an ethos steeped in the core values of medicine that cannot falter.

Mental health effects

Anxiety, fear and panic are normal reactions to any pandemic associated with high numbers of the sick and dying. The uniqueness of COVID-19 is that never has the human suffering been so well documented, down to the most minute detail. TB and HIV are prime examples of how devastating and disruptive outbreaks can be to health systems. But these were never instantaneously streamed to millions of homes across the world, as COVID-19 has been. The aftermath in health systems that are ill-prepared and overwhelmed by the outbreak has been beamed live into every health worker's immediate consciousness, revving up the expected reactions of fear, anxiety and panic to dizzying heights, accompanied by an overwhelming sense of doom.

In addition to post-traumatic stress disorder, depression and anxiety disorders described in frontline healthcare workers performing COVID-19 outbreak-related duties in China, there is an added increase in substance-use

and related disorders. Add to this the normal reactions of loss and grief brought on by the sudden changes we have to contend with, the isolation associated with lockdowns and physical distancing and the economic hardships that come with the country's response to the outbreak, and one has the perfect storm for an increase in the burden of mental disorders that will follow. As the first and last line of defence, health workers represent the country's hope to resisting the potentially crippling effects of this outbreak.

Tips and tricks

Self-care and team care are paramount to our survival as individual healthcare workers, and that of the systems we work in. We all know the standard requirements of self-care, but our usual coping systems and networks have been dismantled due to lockdowns and social distancing requirements. The trick is to use what you have access to, despite the limitations.

Accept these unusual times as the new norm for now, and prepare your family and loved ones by conveying the seriousness of the situation, without being alarmist, to encourage co-operation in adjusting to this new norm. Ensure that you and your family have what you need available at home. Identify a designated shopper, who will be armed with a shopping list when necessary to keep the stock you have at home at a reasonable level. Have a rota for daily chores for everyone at home, so that everyone has a part to play while locked down. Ensure that you take breaks from news and updates about the outbreak, so that you are not overloaded with the morbid details of each death and negative consequence. At least an hour or two away from the news can give your mind a welcome break from the constant stress. Encourage activities such as cooking together, baking together, gardening, board games and exercise (e.g. using exercise apps). Maintain a regular sleep and exercise routine and a reasonably balanced diet. Eat and hydrate regularly at work too. Identifying a private "calming space" at home that can be used by everyone when they need it. Despite being stuck together at home during lockdown, you may end up with less physical contact with others due to the need for physical distancing as an infection control measure. This

may be confusing for children, who are used to more physical contact like hugs from family members. Have a designated non-shareable soft toy or pillow for each younger child (or anybody else for that matter) that they can cuddle for comfort.

Self-care and team care are paramount to our survival as individual healthcare workers

Prioritise "me time" as a health worker, even if it is only 5 minutes for every 2 - 3 hours spent taking care of everybody else. Your survival and the survival of everybody else may depend on it! If you collapse due to exhaustion brought on by self-neglect, that takes one crucial person out of the chain of healthcare that we have to establish and maintain for those who will get seriously sick from the virus and need hospitalisation. Have a decontaminating area in your home, for example in the garage or behind your house, with a "contamination bin" where you throw away or store protective items or clothing.

Conclusion

This outbreak has brought on a sense of urgency and a demand for efficiency that was not evident before in our health institutions across the country. Never before have we seen such a co-ordinated, well-targeted response from our Minister of Health, National Department of Health and the whole executive of government, which has had to be synchronised across provinces and public and private services, as well as business and society at large.

"All for one and one for all, united we stand, divided we fall". Alexandre Dumas immortalised these words in *The Three Musketeers*. For our health teams and systems to survive and remain functional in this time of corona, for our country to come out intact on the other side, we will all have to live by this motto.

Bernard Janse van Rensburg – a quiet and extraordinarily decent colleague

Prof. Mark Sonderup

In the era of COVID-19 and its grip upon the globe and our country, times have been chaotic and uncertain. In the midst of this upheaval came the desperately sad news of Bernard's very sudden and untimely passing. Even in the somewhat numbed state in which one has found oneself over the last few weeks, the news penetrated through any external veneer, seeming quite unbelievable. I, like many others, feel a personal sense of loss, as I had come to know Bernard well over the last few years. Much has been written of his academic career and professional legacy, and so I will turn my reflection to how I knew him within SAMA. It is uncanny that Bernard's untimely passing comes 3 years after the death of another SAMA stalwart, and psychiatrist, Denise White. In fact it was Denise who was partly responsible for cajoling Bernard into SAMA, as she knew him well from psychiatry and SASOP (the SA Society of Psychiatrists) circles. I never questioned Denise's recommendations, and she was almost never wrong when she felt that someone would enhance leadership capacity within SAMA and the profession. That was her view of Bernard, and as anticipated, she wasn't wrong. I came to know Bernard via his branch representation, and over the last 2 years worked with him in the Academic Doctors Association of SA (ADASA).

Bernard championed the cause of the Life Esidimeni tragedy and as the quiet, determined activist that he was, ensured that SAMA lent its



support. He withstood enormous personal pressure for his stance on the matter, and his resolute and just approach was later to be fully vindicated. Perhaps when people of actual consequence are eventually, if ever, held accountable for this travesty, the matter can rest, and Bernard's work in this regard be completed. Within ADASA, Bernard was thrust into the chairperson role in 2018, and worked at incrementally resuscitating the association. He did this in his usual humble and resolute manner. It was not an easy task, but true to his essence, he was able to navigate, if not elevate, his way through all the shenanigans at play. Much progress has been made, and much work

lies ahead to reposition academic doctors into a proper position of senior leadership within the public sector component of SAMA. At the last National Council meeting in February of this year, he and I sat next to each other. Observing the proceedings, and the usual political vitriol, he turned to me more than once and asked, "What is actually going on here?" I tried to provide context, and his response was invariably one of disdain, if not distress, given the many more pressing issues that he felt warranted discussion and debate. This was the person I knew – someone who was not distracted by the superfluous, but wanted to focus on those things that ultimately matter and affect the patients we all care for, in addition to the mental health of the profession. He and I had several conversations about mental health issues in the medical profession, and his considered personal and professional views on this growing issue were insightful and valuable. This was a topic he felt strongly about, and we have lost a true champion in this regard. It is something that we as an association owe to his legacy to more fully address.

At a time when stalwart leadership is required in academia and in our profession, Bernard's death will be felt acutely, and the loss of his perceptive contribution is immeasurable in the long term. Most especially, we have lost a truly decent and humble colleague. Our sincere condolences are extended to his wife and family. Rest well, my ADASA comrade.

WHO lists two COVID-19 tests for emergency use

World Health Organization

The WHO has listed the first two diagnostic tests for emergency use during the COVID-19 pandemic. The move should help increase access to quality-assured, accurate tests for the disease. It also means that the tests can now be supplied by the UN and other procurement agencies supporting the COVID-19 response.

Both *in vitro* diagnostics, the tests are the genesig Real-Time PCR Coronavirus (COVID-19) and cobas SARS-CoV-2 qualitative assay for use on the cobas 6800/8800 systems.

"The emergency-use listing of these products will enable countries to increase testing with quality-assured diagnostics," says Dr Mariângela Simão, WHO assistant-director general for medicines and health products. "Facilitating access to accurate tests is essential for countries to address the pandemic with the best tools possible."

The emergency use listing procedure was established to expedite the availability of diagnostics needed in public health emergency situations. It is intended to help

procurement agencies and countries navigate the presence of multiple different devices on the market and, by assessing them, provide assurance of the products' quality and performance.

The genesig Real-Time PCR Coronavirus (COVID-19) (Primerdesign, UK) is an open system more suitable for laboratories with moderate sample testing capacity, while the cobas SARS-CoV-2 for use on the cobas 6800/8800 system (Roche, USA) is a closed-system assay for larger laboratories.

SAMA publishing – a vital role in medical education

SAMA Communications Department

The SAMA Publishing Department is based partly at SAMA head office in Pretoria and partly at their Cape Town office. The department joined SAMA at the beginning of 2018, having previously been the Health and Medical Publishing Group (HMPG), a SAMA subsidiary. “All the journals are published under the auspices of SAMA, but do enjoy editorial autonomy,” says head of department, Diane Smith.

The department publishes the *SA Medical Journal*, which was first published in 1884, as well as the other SAMA journals: the *SA Journal of Bioethics and Law*; the *African Journal of Health Professions Education*; the *SA Journal of Child Health*; the *SA Journal of Obstetrics and Gynaecology*; and the *Southern African Journal of Public Health*. It also publishes the *SA Medicines Formulary* (SAMF; published together with the University of Cape Town), and the monthly non-clinical membership magazine, *SAMA Insider*.

“The SAMJ is a premier vehicle for the publication of medical research in SA and beyond,” comments Diane of the monthly peer-reviewed open-access journal which includes the leading in-practice monthly, *Continuing Medical Education* (CME).

The Publishing Department also produces journals for various medical societies, which act as the official mouthpiece in the associated disciplines: the *African Journal of Thoracic and Critical Care Medicine*, the *Southern African Journal of Critical Care*, the *SA Journal of Plastic, Reconstructive and Aesthetic Surgery* and *Burns* and the *SA Respiratory Journal*.

Diane Smith, the head of the department, works at head office in Pretoria, but also regularly visits the Cape Town team for production and other meetings. “We are proud of our small and efficient team, who play a vital role in medical education and communication in SA,” says Diane.

“The SAMJ is a premier vehicle for the publication of medical research in SA and beyond”



Diane Smith



Reneé Hinze



Ladine Britz



Emma Jane Couzens



Claudia Naidu



Naadia van der Bergh



Emma Buchanan



Paula van der Bijl



Kirsten Morreira



Clinton Griffin



Azad Yusuf



Charmalin Comalie



Gertrude Fani

Reneé Hinze and Ladine Britz are also based at head office. Reneé ensures that the department's marketing, branding and advertising objectives are met, including organising events. She also handles the day-to-day general marketing and communication enquiries, as well as selling advertising space in the journals. Ladine is the department's publishing and sales administration assistant, and carries out clerical duties as well as managing and distributing information within the office.

In Cape Town, Claudia Naidu and Naadia van der Bergh are the managing editors of the journals, in charge of the pre- and post-acceptance processes, respectively. Emma Jane Couzens is the production and distribution officer, responsible for these processes for all the journals published by SAMA. Technical editors, Emma Buchanan, Paula van der Bijl and Kirsten Morreira copyedit the journal articles and

prepare them for layout, and then for print and/or online publication. Senior designer, Clinton Griffin, is responsible for the design and layout of all the departmental publications, for both online and print. Gertrude Fani has worked in the editorial office since December 2004, and is currently in charge of office administration, assisting the authors, reviewers, editors and researchers with the department's online platforms and other queries, and publishing all the journals online. Charmalin Comalie and Azad Yusuf are both client relationship officers working in sales. They are responsible for the sales of advertising in the *SA Medical Journal*, including for the online journal at www.samj.org. They liaise with clients, and also attend conferences in Cape Town, where they sell copies of the *SAMF*.

The SAMA Publishing Department is proud to be the largest publisher of medical journals in SA.

2020 COID annual tariff increase

Zandile Dube, senior medical coding consultant, SAMA Private Practice Department

The scale of fees for medical aid as published by the Department of Labour in respect of the Occupational Injuries and Diseases Act No. 130 of 1993 (also known as “injury on duty”) was published on 19 March 2020 in the Government Gazette no. 43111. These compensation for occupational injuries

and diseases (COID) fees are applicable from 1 April 2020.

Please go to <https://www.samedical.org/private-health/coid> to download the complete Government Gazette. Please note that the amounts published in the Government Gazette are VAT exclusive.

The medical tariff increase for 2020 is 5.6%. Unit values for the various groups and sections as from 1 April 2020 are shown in the table.

Contact SAMA Coding Division, Private Practice Department, for more information: telephone 012 481 2073 or email coding@samedical.org.

Compensation for occupational injuries and diseases (COID) fees 2020				
	Symbol	Description	VAT inclusive (ZAR)	VAT exclusive (ZAR)
1a	V	Consultation services codes 0146 and 0109	30.94	26.90
1b	VC	Consultation services codes 0181 - 0186, 0151 (COID only).	31.51	27.40
2	CL	Clinical procedures	30.94	26.90
3	A	Anaesthetics performed	144.54	125.69
4a	A	Section 19: Radiology	32.35	28.13
4b	MR	Section 19.15: Magnetic resonance imaging (MRI)	32.35	28.13
5a	RO	Section 20: Radiation oncology	34.03	29.59
5b	ROTC	Section 20: Radiation oncology: Technical component	34.03	29.59
6	U	Section 19.11: Ultrasound	30.57	26.58
7	CT	Section 19.9: Computed tomography	31.08	27.03
8	CP	Section 21: Clinical pathology	32.19	27.99
9a	AC	Section 22.1: Anatomical pathology: Cytology (items 4561 - 4566)	31.78	27.63
9a	AH	Section 22.2: Anatomical pathology: Histology (items 4567 - 4595)	31.78	27.63
10		5-digit radiology (specialist)	210.98	183.46

SAMA concerned about Cuban health specialists in SA

SAMA Communications Department

SAMA notes with concern the arrival of 217 health specialists from Cuba at Air Force Base Waterkloof on Sunday 26 April. The Cuban health specialists will assist in the fight to curb the spread of COVID-19 in SA.

The deployment of the Cuban specialists comes after a request by President Cyril Ramaphosa to the president of Cuba, Miguel Díaz-Canel.

“While we are not averse to the so-called Cuban Brigade assisting us, we feel strongly that the principle of not engaging with SAMA – as the biggest representative body of doctors in the country – is flawed and wrong,” says Dr Angelique Coetzee, chairperson of SAMA.

Dr Coetzee says that in light of the current poor economic environment in the country,

the money spent on bringing the Cuban specialists to SA would have been better spent first on employing local doctors who have the necessary skills and experience to drive this process, especially in rural areas. There are many unemployed doctors in SA, and many community service medical officers have still not been placed. In addition, many private practitioners have indicated their willingness to assist.

SA has many public and private health specialists, family physicians and epidemiologists who would have heeded the president’s call for assistance during this very challenging period. SAMA, through its various societies, would have been able to source local expertise before this was sought overseas, and the cost of

employing the outside expertise may have been mitigated.

“Retired doctors can be brought back into the service delivery system, even for a short time. They can also mentor younger doctors who lack the necessary experience and skills. Only when we had exhausted all our internal human resources should a consultative process between SAMA, the Department of Health and the Presidency have been initiated to bring the Cuban specialists to SA,” says Dr Coetzee.

She adds that SAMA finds it unacceptable that silo approaches have been followed with regard to the decision to bring the Cuban specialists to the country. She says SAMA will request a meeting with the Minister of Health to express its unhappiness with the processes followed.

MSF's global experience adds value during COVID-19

SAMA Communications Department

In March 2020, Italy became the epicentre of the COVID-19 outbreak. Doctors Without Borders/Médecins Sans Frontières (MSF) staff were based in four hospitals in the country's northern Lodi province, which was the worst-affected area at the time. MSF emergency co-ordinator in Italy, Dr Claudia Lodesani, explains how experience with other epidemics helped her give advice and tackle the challenges she encountered.

Our entire way of working is built around emergencies and outbreaks

"When we arrived in Lodi, it was immediately clear how traumatised many of the medical staff were. They wanted to talk about the crisis, about what they'd been through on the frontline of this emergency for 2 or 3 weeks. It was something they'd never experienced before. They were shocked by how quickly everything had happened.

The first step in tackling an outbreak like this is the protection of frontline staff. Without them, we couldn't respond to the pandemic. Thousands of them are falling ill across affected countries, so keeping them safe and free from infection is key.

We were able to listen and sympathise with the Italian healthcare workers because we know what it's like. Being able to talk like that, to cry in front of people who understand what you're experiencing, is really important. It helps you know you're not alone, and gives you the strength to keep working.

If MSF can add any value in a situation like this, it's our experience of operating as an organisation where our entire way of working is built around emergencies and outbreaks. The best impact we can have now is advising healthcare systems about the different approaches, strategies and practices that must be employed when confronting a pandemic like the coronavirus.

Before, the health services – here in Italy as in most European countries – were focused



Working in Lodi

on individual care. Now they have to start thinking about public health in an outbreak context instead. Making that sort of change is difficult for any health service. They have to change how they think and act – a complete change of approach.

In addition, a common factor in epidemics is the high number of patients who arrive at hospitals all at the same time. This can have a negative impact on even well-developed healthcare systems, which are not used to coping with these kinds of numbers every day. Adapting to this is not easy. We've met doctors and nurses in Lodi province who have been working tirelessly for weeks in an extraordinary situation.

The next step is realising that, although hospitals are vital to the response, home-based care and outreach are also really important. In an outbreak, you cannot focus only on hospital care; general practitioners and family doctors have a vital role to play as well. You have to take the wider community into account. For example, people in retirement and nursing homes are at huge risk from COVID-19, as the elderly are the most vulnerable and live in close quarters in these facilities, so it's important to reorganise the way they are run.



Dr Claudia Lodesani

In the places where I've worked with MSF [in the past], most of our patients have been children or young people. I've worked for MSF for 18 years and for me, one of the most difficult things to deal with in this crisis has been the suffering of elderly people.

This pandemic will leave all of us differently affected. The whole world will be different.

MSF stands in solidarity with medical colleagues around the world responding to COVID-19 and working to keep vital everyday health services running in these difficult times.

Accessing CPD points during lockdown

Lisa Reid, SAMA CPD officer

During lockdown, members are able to access CPD points online. All CPD activities that take place online can be accredited. If logins to webinars cannot be tracked, activities may include a multiple choice questionnaire (MCQ). The guidelines are explained below.

Aims of an MCQ

- The MCQ should assess the learning achieved through a CPD activity.
- The MCQ should assess the education received from the relevant reading material.
- No more than three questionnaires may be completed at a single activity or linked to a specific activity. If MCQs are part of a take-home activity, the points may not be advertised together with the live event.
- CPD points for MCQs may only be issued to delegates as a standalone activity. Points may not be allocated to delegates for completing MCQs and attending live presentations. Either the level 1 activity must be accredited, or the MCQ –not both within 24 hours.

- Accreditation numbers are only valid for a calendar year

Setting an MCQ

- The accompanying reading material should be made up of acceptable content or published scientific material, requiring approximately 1 hour of reading (approximately 10 pages).
- One individual should be responsible for compiling, marking and archiving questionnaires.
- Reading material, questionnaires and CVs of journal editor(s) should accompany applications for accreditation.
- Applicants may not issue points to medical professionals for level 1 and level 2 activities for the same learning topic within 24 hours. Level 1 applications must be separately accredited, and not in combination with a questionnaire.
- A mark of 70% is required to successfully complete a questionnaire.
- On successful completion of an accredited questionnaire, points are issued within HPCSA guidelines.

Accreditation applications should be sent to lisar@samedical.org.

MCQ content

- MCQs must be based on accompanying reading material, which should be published evidence-based material no older than 5 years.
- The questionnaire must contain a minimum of 5 multiple-choice questions.
- Each question must contain a minimum of 4 answer options.
- MCQs may be of the “single correct answer” or “multiple correct answer” formats.
- MCQs should contain no commercial product promotion or satire.
- A maximum of 20% of the questions may be the true-or-false type.
- Each individual questionnaire must be approved, rather than using annual accreditation numbers.

For further information on CPD accreditation please contact Lisa Reid on 0766446844 or lisar@samedical.org.

B4SA and SAMA partnership channels PPE to community-based healthcare workers

SAMA Communications Department

SAMA has been working with several groups with regard to the supply and availability of personal protective equipment (PPE) at primary healthcare level in SA. One of these groups has been Business for South Africa (B4SA). B4SA is an alliance of volunteer resources from across SA business bodies and organisations.

The B4SA public health workgroup's core mandate is to support the national response, including government and the private sector's public health efforts, in the fight against the COVID-19 pandemic in SA.

B4SA has developed procurement capabilities over the past month to substantially increase the amount of PPE coming into the country, and to supplement the procurement efforts of other stakeholders.

Based on guidance from the National Department of Health, PPE procured through the B4SA mechanism will be allocated between the needs of the public and private healthcare sectors.

Within the private sector allocation, PPE will be allocated between private hospitals, private laboratories and outpatient provider settings proportional to the number of healthcare, administrative and security staff working in each setting, adjusted for existing supplies available.

For hospital inpatient settings, PPE will be channelled to the hospitals, who will be responsible for ensuring that all relevant workers in their facilities are adequately provided with PPE. For this reason, health professionals working in hospitals should not

use the procurement mechanism described below.

To ensure that health professionals in outpatient settings (such as GPs, specialists working in rooms, and pharmacists) have access to PPE, B4SA has established a partnership with a network of wholesalers. The process of sale and distribution for health professionals working in outpatient settings is as follows:

- Health professionals working in outpatient settings will be able to purchase PPE from these wholesalers.
- The wholesalers have been selected on the basis of their geographic coverage, competitiveness on logistics and handling fees, and existing active accounts with health professional practices.

- The sale price of this PPE will be cost-recovery only. Neither the B4SA importing partner (Imperial Health Sciences) nor the wholesalers will make any profit on these PPE sales.
- Wholesaler partners will report back to B4SA on their pricing and buyers to ensure that PPE is reaching healthcare workers at the most reasonable price possible.

The wholesaler partners from whom PPE can be procured are:

- CJ Distribution Enterprises and Dischem Distribution (<https://cjdsa.com>)
- Kendon Medical Supplies (<https://www.kendonmedical.co.za>)
- Pharmed Pharmaceuticals (<https://www.pharmed.co.za>)
- Transpharm (<https://www.transpharm.co.za>).

To support health professionals working in outpatient settings in finding PPE, an additional list of wholesalers and distributors has been compiled that health professionals can also use to purchase PPE. Please note that unlike the four wholesalers named above, these wholesalers do not carry PPE stock procured by B4SA, and B4SA cannot take responsibility for the stock or pricing of these companies.

Unpacking constructive dismissal

Phumzile Gwala, *employee relations advisor, SAMA Employee Relations Department*

Under normal circumstances, when faced with a situation that makes the workplace unbearable, resigning might be one's first reaction. However, this may have a detrimental effect if the intention is to pursue the matter further by claiming constructive dismissal.

Section 186(1)(e) of the Labour Relations Act No. 66 of 1995 states that in circumstances in which "an employee [has] terminated a contract of employment with or without notice because the employer made continued employment intolerable for the employee", this constitutes a dismissal – in this context, a constructive dismissal. In other words, constructive dismissal may be defined as a situation in the workplace that has been created by the employer, and which renders the continuation of the employment relationship intolerable for the employee to such an extent that the employee has no other option available but to resign.

An employee might also resign in order not to appear at a disciplinary hearing for misconduct. In such an instance, with many factors to consider, such as whether the disciplinary action was unfair and part of the employer's attempt to force a resignation, the arbitrator hearing the matter might have a difficult task determining whether the resignation was in fact a constructive dismissal. An example of an intolerable situation is where the employer reduces the salary of an employee, changes the workplace rules to make it difficult for the employee to be on time for work or gives the employee job duties far below the employee's skill level. Any of these may not be intolerable alone, but if the employer also, for example, creates an unpleasant work environment, ignores the employee's requests or overlooks

the employee for promotion, then there may be a cause for resignation. However, if the employee can have the issue resolved through referral of the dispute, then there is still an alternative to resignation.

Requirements

For a case to be ruled constructive dismissal, the following requirements must be met:

- The employment circumstances must have become intolerable to the level where it would have been extremely difficult for the employee to have remained.
- The specific intolerable situation must have been the reason for resigning, and the employee must have had no other alternative to resolve the issue.
- The employer must have caused the intolerable situation, and must have been in control of the situation.

When to claim

Constructive dismissal can be claimed whether the employee has resigned with or without notice. However, when dealing with such a matter, the arbitrator considers the level to which the employer's conduct met the requirements for constructive dismissal. Even if the employee could, in theory, have remained in employment and simply referred the dispute for resolution to the relevant tribunal, the situation might have become so intolerable that the employee could not have stayed employed even if the dispute was resolved – and then constructive dismissal could apply. However, it is vital for an employee to seek advice from SAMA before taking any decision in this regard, so that they can be assisted in lodging a grievance or a dispute before taking the step of resigning because of intolerable workplace conditions caused by the employer.

Proving constructive dismissal

Unlike other forms of dismissal, when it comes to proving constructive dismissal, unfortunately, the onus is on the employee to prove that the requirements have been met. Constructive dismissal is extremely difficult to prove, and the success rate is rather low.

Case law

In *Ntsabo v Real Security CC [2004] 1 BLLR 58 (LC)*, the employee had been sexually harassed by a co-worker and reported it to management, and yet nothing had been done about the matter. The resignation by the employee was found to constitute constructive dismissal. The court held that an employer is expected to take action to protect victims of harassment.

In *Jooste v Transnet Ltd t/a South African Airways [1995] 16 ILJ 629 (LAC)*, it was held that for a constructive dismissal dispute to succeed, one requirement is that the employee must prove that (s)he had not previously intended to terminate the employment relationship, but was faced with no option but to do so as a result of the employer's unacceptable and intolerable behaviour.

In *Chabeli v Commission for Conciliation, Mediation and Arbitration and Others (JR2241/08) [2009] ZALC 126*, the commissioner found that the duty to establish a constructive dismissal rests with the employee. The employee must establish the fact of the constructive dismissal by showing that (s) he terminated the employment relationship because the employer made continued employment intolerable.

CCSSA and SASA issue joint statement on COVID-19

CCSSA and SASA EXCO

The Critical Care Society of SA (CCSSA) and the SA Society of Anaesthesiologists (SASA) are volunteer associations, not for gain, whose purposes are to enhance the practices of anaesthesia and critical care, in the interests of best patient care. The members of these two organisations will be called upon to play a critical role in the treatment of patients needing hospital care in addressing the COVID-19 pandemic.

Furthermore, as the technical experts, with access to and information from our international colleagues who are further along the infection curve than SA, we have unique knowledge and skills that we must apply in preparing the country for COVID-19 and steering us through the pandemic. CCSSA and SASA are not, however, the only skilled clinicians at this time, and we welcome the input and collaboration of all other clinician groups.

Current status

Both organisations have formed task teams to provide guidelines, guidance and commu-

nication to members. We have active leadership and working groups, applying themselves night and day in the development of position statements and guidelines, and driving focused efforts.

Let us stand together – public sector, private sector, all disciplines and all care teams

It is specifically noted that these teams are not working in isolation from one another. While SASA and CCSSA already have a standing memorandum of understanding to collaborate, this is also not a time for separation or duplication. As such, members from both organisations are working closely with one another and are engaging collaboratively in each working group.

Co-ordination and collaboration

SASA and CCSSA will be publishing guidelines from their own organisations to their stakeholders. However, these will also be endorsed, as appropriate, by one another, and shared on the other's platforms. Members will see numerous co-branded documents.

Both organisations also urge all members to work closely and collaboratively with one another at a regional and local level. We will need to lean on one another, support one another and jointly take the lead in our environments.

We call upon any other clinician group to join these collaborative efforts.

Conclusion

We have extremely limited resources and will have to apply all of our efforts collectively and innovatively to overcome the challenging times that lie ahead. Let us stand together – public sector, private sector, all disciplines and all care teams.

Meet SAMAREC's Dr Thabo Lengana

Adri van der Walt, SAMAREC officer

Dr Thabo Lengana was appointed to the SAMA Research Ethics Committee (SAMAREC) in 2017, in an appointment strictly guided by the National Health Research Ethics Council, as described in the National Department of Health's 2015 *Ethics in Health Research: Principles, Processes and Structures*. In following these guidelines, the committee proudly strives to appoint versatile individuals such as Dr Lengana, who is a permanent member in a clinical capacity.

Inspired by family and friends as well as his childhood doctor, Dr Lengana pursued a career in medicine after graduating from high school in 2000. On obtaining his MB BCH from the University of the Witwatersrand, he became a medical intern and medical officer at Leratong Hospital. He worked first in the department of anaesthesia at the hospital, and then moved to the West Rand public health clinics, while continuing to work in the anaesthesia department during his overtime.

His extensive experience later led him to become a medical advisor at Discovery Health.

Following his passion for diagnosis, he pursued an MMed with a specialisation in nuclear medicine at the University of Pretoria. Concurrently he became a Fellow of the College of Nuclear Physicians of SA and the Colleges of Medicine of South Africa.

Passionate about gaining knowledge, he went on to obtain an MSc Med in Bioethics and Health Law.

He has various publications to his name, most notably, contributions to the *Journal of Nuclear Medicine* and *Nuclear Medicine and Molecular Imaging*.

Dr Lengana is an accomplished musician who plays the bass guitar.

Currently active at Unitas Hospital, he is completing his PhD studies, with a focus on prostate cancer.

The Soweto-born doctor was featured in a recent publication on Sowetan LIVE:



Dr Thabo Lengana (photo credit: SowetanLIVE)

<https://www.sowetanlive.co.za/news/south-africa/2020-02-17-dr-thabo-lengana-hits-the-right-note-with-nuclear-medicine>.

Young, eager to learn and a man with plenty of experience, Dr Lengana is a huge asset to SAMAREC.

The GP harassed by a patient

The Medical Protection Society shares a case report from their files

GP Dr S contacted the Medical Protection Society (MPS) about a complaint from a patient who was frustrated with the practice's new appointment system. The patient said she was struggling to make an appointment with her preferred GP, who was often booked up for a couple of weeks ahead.

Dr S spoke with an adviser from the MPS advisory team, who talked him through the process of handling complaints in the practice. She advised Dr S to acknowledge the complaint and formulate an appropriate response, sending him the MPS guide to managing complaints and guidance to assist him. She also reviewed the proposed response before it was sent to the patient.

Dr S contacted MPS again several weeks later in relation to a letter he had received from the same patient. She had written to the practice asking for Dr S to be made her named GP. The practice manager had shared the letter with the partners as it contained a number of compliments about Dr S. They had discussed the issue at a meeting, and were unsure how best to manage the situation.

After a discussion with MPS, Dr S decided to agree to be the patient's named GP, as he felt that they had established a good doctor-patient relationship while he was managing her complaint, and he did not feel any of the comments in her letter were of a personal nature.

Several years later, Dr S contacted MPS to request further advice regarding this patient. He explained that he was moving practices for family reasons, and that when the patient had been advised of this, she had emailed him directly to ask where he was going so that she could register there. Dr S explained that he was moving out of the area; however, the patient was persistent in trying to find out where he was going, to the extent that she tried to obtain this information from other members of staff at the practice.

Understandably, Dr S and the practice found this situation challenging, particularly as the patient was by now refusing to see any other GPs at the practice. After discussing events with MPS, the partners decided to write to the patient, explaining that as Dr S was leaving the practice, she would be assigned an alternative named GP. The patient was offered a



meeting to discuss matters further, should she wish to do so.

It appeared that the matter had been resolved, as the patient accepted the change in GP, and Dr S moved shortly afterwards. However, a few weeks later, he began to receive cards at his new practice in which the patient expressed her wish to meet with him. Dr S contacted MPS again at this stage.

MPS advised the GP to ask the original practice to write to the patient and to invite her to meet with a GP there. Regrettably, matters escalated, and the patient began sending more letters to Dr S, and calling the practice continuously to try to speak to him; she was also seen in the car park on a couple of occasions. The patient subsequently visited Dr S at home, twice shouting from outside his door at him and his family.

At this stage, MPS instructed attorneys to review the case, and they wrote to the patient advising her that should she continue to harass Dr S in any way, they would issue civil proceedings for harassment against her.

Dr S also contacted the police, who advised Dr S that if the behaviour continued, they could consider further action under harassment laws.

Outcome

Fortunately, after receiving the correspondence from the attorneys the patient made no further attempts to contact Dr S.

Learning points and commentary

MPS is frequently contacted by members seeking advice and support about challenging doctor-patient relationships. This may involve a breakdown in a relationship with a patient due to their behaviour, where a doctor is seeking guidance about whether it would be appropriate to end the relationship, or, as in this case, seeking advice about a patient who may be forming an inappropriate attachment to their GP. Fortunately, not many cases escalate to the extent of the one described above.

If a patient pursues a sexual or improper emotional relationship with you, you should treat them politely and considerately, and re-establish a professional boundary. If trust has broken down, you may find it necessary to end the professional relationship.

These can be emotive situations and can put a doctor under a significant degree of stress. It is not always apparent what a patient's intentions or motivations are, particularly in the earlier stages.

As highlighted in this case, MPS can also instruct attorneys to write to patients who are harassing a doctor to set out the possible consequences of their actions.



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