

SAMA INSIDER

SEPTEMBER 2020

**Corruption threatens
patient care**

**Paediatricians speak out
against school closures**



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

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Diane de Kock
Editor: *SAMA INSIDER*

Future preparedness

The COVID-19 pandemic has highlighted both the gaps in our healthcare sector and the need for future preparedness in SA.

It has also shone a light on institutionalised corruption, as detailed by SAMA President Dr Sizeka Maweya in his message (page 4): "The surge of fraudulent activities and corruption within the health sector is worrying." SAMA chairperson Dr Angelique Coetzee reinforces this message in her article (page 5): "There have been numerous reports of alleged wrongdoing and corruption ... corruption puts lives at risk".

The impact of the pandemic has taken its toll on healthcare workers. On 13 August, 27 360 healthcare worker cases had been reported. Of this number, 1 644 cases are doctors, 14 143 nurses and 11 545 from other categories of healthcare workers. To date, 240 healthcare workers have died as a result of COVID-19. In her article (page 5), Prof. Zingela says: "We can never be truly prepared for the stark reality of death and dying when it touches our profession." In a message to SAMA members, Dr Coetzee said: "Every doctor who dies represents a significant loss of talent, skill and resources ... it's a tough time for health workers, and we need to acknowledge their ongoing efforts to deal as effectively with this disease as they can." Pertinent to this message is Prof. McQuoid-Mason's article (page 10) on whether healthcare workers can refuse to work when not provided with PPE.

Prof. Dhali's article (page 7) looks at the need to invest in pandemic preparedness: "We should not allow the cycle of panic and neglect to continue," and Prof. Padayachee analyses (page 8) SA's response to the pandemic: "How a country prioritises its actions, interventions, infrastructure and budgets to manage a pandemic while protecting lives and livelihoods will depend on its preparedness for the future."

Preparing SA's children for the future is paramount, a sentiment echoed in the article (page 19) on SA's paediatricians urging government to open schools to all learners, and not allow fear or politics to harm the children of SA: "The benefits outweigh the risks."

We face a new "normal", and being prepared and informed is important for survival.

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Impact of institutionalised corruption by professionals in the health sector



Dr Sizeka Maweya, SAMA President

Corruption is a form of dishonesty, and a criminal offence when undertaken by a person or organisation in a position of authority for illicit benefit. This represents an abuse of power for private gain. The concept of corruption encompasses activities such as bribery and embezzlement. Corruption has become institutionalised in our health system and in our country in general, according to recent media reports.

Corruption erodes moral values, and it destroys trust in the authorities from the general public and society at large. Our health system has not been spared this scourge. By virtue of their status, professionals are generally not regarded as corrupt. However, there is no guarantee that corruption does not occur among them. Unethical conduct in the form of corruption and maladministration in the public sector is a global phenomenon, and a very serious public disease. Naude has stated that a country that allows corruption to take over loses its soul.

The most severe type of corruption among professionals lies in nepotism and patronage, where favouritism is shown to colleagues closely related to those in influential positions. In our public institutions, we find those favoured by the people in power taking part in many such forms of corruption.

Section 3 of the Prevention and Combating of Corrupt Activities Act No. 12 of 2004 gives the authorities the power to charge people who conduct corrupt activities to the detriment of the state, whether directly or indirectly.

In the health system, some of our colleagues perform remunerative work outside the public service (RWOPS) during official working hours, or involve themselves in fraudulent activities such as offering unsuspecting patients treatments that are not suitable for their

ailments, or overservicing their conditions. Undeclared private patients are serviced by health workers in public institutions, to the benefit of the treating health practitioner.

Some view this practice as a case of different sets of rules applying to different healthcare workers, but such inconsistencies defeat the goal of impartiality and the purpose of the rules in general. This is a form of corruption. There is nothing untoward about RWOPS in itself, as it is legislated: the problem in this instance is that the people performing the RWOPS are stealing time from the government. In addition to robbing the state of its valuable time, this practice also compromises the education of our future medical doctors in academic institutions.

Corruption undermines democracy and good clinical governance. In our health system, the flouting or even subverting of formal processes is treated as the norm by those who are in authority, and this type of corruption leads to substandard delivery of clinical care services, unaffordable quality healthcare, funds being misdirected for non-essential services, no accountability by health authorities and a lack of transparency and trustworthiness. Health workers who become whistleblowers are silenced, or threatened with disciplinary procedures for insubordination. The aim of such actions is the silencing of the voices of those who are helping the state by exposing this wrongdoing.

The effects of this general corruption are dire, as it gives birth to greed and skyrocketing self-enrichment behaviour, white-collar crime syndicates, the absence of an oversight role, inefficient supplies of essential consumables that benefit patients, misappropriation of funds from the purposes they were intended for and collusion between suppliers and authorities.

Corruption opens the door for multiple violations of human rights such as the right to access to healthcare, and the fundamental rights to life and dignity. Failure to report corrupt activities in the health system must itself be viewed as a violation of these rights. Section 34 of the Act states that failure by a person in a position of authority, who knows, or ought reasonably to have known, that certain crimes named in the Act have been committed, to report such offences to a police officer, is a serious offence in itself.

In the health sector, due to escalating corruption, many health establishments

experience shortages of human resources and equipment. There is no minimum level of essential equipment necessary to save the lives of patients and healthcare providers. A case in point is the outcry about the shortage of personal protective equipment (PPE) in the current era of COVID-19. Although there is a waiver in the SA Bill of Rights stating that the state shall provide access to health "within its available resources", this cannot be viewed as negating the responsibility to provide essential working tools such as PPE.

Due to alleged embezzlement and misappropriation of funds under the eye of the responsible authorities, public health establishments are rendered ineffective. In some public hospitals, there are claims that the maternity wards are not well designed, and do not meet the requirements set out in the National Norms and Standards. The rights to dignity and privacy are compromised when a pregnant woman gives birth in front of others, and this is traumatic for the primigravida about to deliver for the first time in her life.

In addition to this, casualty and outpatient departments are permanently overcrowded, rendering them death traps in the eyes of the public. In some hospitals, recovery rooms in theatres are far from compliant with the standards set out by the SA Society of Anaesthesiologists.

Corruption is cancer that must be eradicated in our health system in order to deliver quality healthcare to the poor people of our country. We are the custodians of the health of our nation. As health professionals, we are ethically bound to follow the prescripts of the constitution of our country and the HPCSA rules.

The surge of fraudulent activities and corruption within the health sector is worrying. It allows the creation of ghost workers, a practice that has not been decisively condemned by the authorities. The theory is that those involved are shielded under the pretext of behaving "in the best interests of the patients". We must deliver healthcare services to our people and separate politics from health issues, and let our conscience be the guiding arbiter, our patients the commanders in chief. Let us stop corruption, and let those involved in these hideous crimes be reported with immediate effect. Let us cut our coats according to our cloth, and live within our means.

Corruption threatens patient care

SAMA Communications Department

Ongoing reports of alleged corruption in government – specifically in relation to the provision of medical supplies, as a result of COVID-19 – are deeply unsettling, and pose a threat to the provision of proper medical care to patients. This is SAMA's view, and the association says improprieties in medical tenders not only damage the country's economy and reputation, but its ability to care for the sick.

"There have been numerous reports of alleged wrongdoing and corruption. The most recent high-profile case involves the spokesperson to the President. As a professional body representing doctors, we take a strong stand against these purported abuses," says Dr Angelique Coetzee, chairperson of SAMA.

She says SAMA concurs with the President that "More so than at any other time, corruption puts lives at risk," but that this sentiment remains hollow without meaningful, transparent and visible action, particularly from the highest office in the country.

"As doctors, we are on the frontline of fighting coronavirus every day – putting our own and our families' lives at risk every time we report for work to assist the sick. When medical equipment such as personal protective equipment (PPE) is the focus of an alleged wrongdoing, we expect immediate and urgent action. Unless it is done and seen to be done, irregularities will continue, and

continue to burden an already overstretched health sector," she says.

Dr Coetzee notes that the latest reports follow a string of similar incidents, including the disastrous medical scooter debacle in the Eastern Cape, lack of proper equipment in state hospitals across the country and companies being established specifically to do business with health departments to secure relief funding, even though they lack proper experience in the sector. "The list goes on and on. There is clearly no accountability in government nor, apparently, any political will to deal with corruption. If there was, we believe, the strong message would have been supported by equally strong action, which we do not see. There are many occasions where corruption is evident, yet no action is taken, and we are stunned by the seemingly non-interventionist approaches to these incidents," says Dr Coetzee.

Of particular concern to SAMA, in addition to the allegations of abuse, is the continued poor state of healthcare in the country, which is not improving and is in desperate need of significant funding to correct.

"The billions of rands allegedly siphoned off of legitimate channels has the effect that doctors and other healthcare workers are treating patients without proper PPE and are having to work without proper equipment to diagnose patients, and the patients themselves have to suffer more in the often



Dr Angelique Coetzee

pitiful wards of dysfunctional hospitals. We can simply not continue like this – something has to give," says Dr Coetzee.

Dr Coetzee says that in response, SAMA is again urging all healthcare workers and administrators who have evidence of wrongdoing to come forward and report abuse. She says it is also critical that where equipment is lacking, this is brought to the attention of those in charge.

"We have to begin taking stock in every hospital and every clinic in our country. If there are violations of procedure, and healthcare workers are struggling without the necessary equipment or medicines, we urge them to report this. Without this critical on-the-ground information, our situation may never improve," concludes Dr Coetzee.

If I were a magician

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



Being confronted with death in our line of work is difficult to balance with our core training in saving lives. Even as we recognise that death is the eventual end point of all life, it has a devastating effect on us when it does occur.

Wherever we are, the current COVID-19 outbreak has forced us to confront death and dying in intimate and close up ways. The death of our esteemed colleague, and beloved friend to some of us, Prof. Lungile Pepeta, executive dean in the Faculty of Health Sciences at Nelson Mandela University, has magnified the

devastation and heartbreak that the outbreak continues to wreak on the world. Whereas we may engage with the death of a patient in an empathetic but distanced way that our logic can process, when it is beloved colleagues, friends and relatives who are taken from us, we are left reeling. It is not only the finality of death that is deeply devastating, but also the loneliness of the journey towards this irreversible eventuality – lonely because the urgency to control the spread overrides our natural tendency to gather in support when someone is sick, to grieve and to comfort each

other through difficult times. As a group, we are in pain together every time we lose one of our members, yet now, the outbreak has made it such that we cannot cry together or mourn together, despite this pain. This means that the loss is multiplied in different ways and on different levels. With all our training and all our scientific advances, the helplessness that confronts us as we witness a patient's or loved one's struggle for the next breath is immeasurable. No amount of training can prepare one for that.

Confronting the loss of a patient

To keep us going, miracle recoveries that keep us believing and keep our hope alive are things we tend to hold onto in the face of all the adversities we face in our profession. Yet we tend to refer to patient deaths in terms of "I lost a patient" rather than "a patient died". This implies a process that we as doctors are active participants in. We place the ultimate responsibility and blame squarely on our shoulders – this, even though when faced with the most hopeless-looking of cases, doctors try their level best to keep the patient alive. And when we think we have thought of every eventuality, death happens anyway. At such times, self-blame, guilt and self-recrimination only add to the burden we carry. A team approach to reviewing and discussing cases, as in for example mortality meetings, can sometimes help, especially if a learning rather than a blaming approach is adopted. Conveying empathy about the loss of a patient should not stop at family and friends in the waiting room, but should extend to team members who were involved in the patient's care, no matter how briefly. Although the team members are not related to the patient who has passed on, at the time of working and trying to save the patient's life, a connection is created. Finding space to express this in a supportive, non-judging environment is crucial to mending our grief-stricken souls. Family, friends, colleagues and peers can strengthen our support network, as long as we are willing to stay connected.

Confronting the loss of family and loved ones

Many of us will be confronted with this reality as a direct or indirect effect of the COVID-19 outbreak. As you continue your new journey of navigating life without your loved one, there may be days that feel heavier than others. That is to be expected. On some days, it may be difficult to remember how it feels



"For you my friend, I would simply wave my wand and death would be gone from here ..."

to have a lighter day. Have a "go-to memory" of your loved one that helps you remember the good days. In fact, have many, if you can. It may be a compilation of photos on your phone, some uplifting songs the person used to love, a poem, beautiful words, inspirational words they may have said, anything they made, a favourite piece of clothing, a favourite meal that brings back good memories, a walk to your favourite spot just to think about your loved one. Hold your good memories close to you, especially on difficult days when your whole being yearns for the person. Every difficult day you navigate is another step closer to acceptance and healing.

Conclusion

We can never be truly prepared for the stark reality of death and dying when it touches our profession. When at a loss, as we have been rendered by the COVID-19 outbreak, we often fantasise about how it would be if we had the power to change things. If I were a magician, I would make sickness and suffering disappear, and all doctors and nurses would realise their creative dreams in fields other than medicine. The world would see more painters, gourmet cooks, musicians and world-class sculptors, all born of our yet-to-be-expressed creativity, as doctors and nurses whose healing skills would not be needed any more. For now, all we can do is try and keep our feet on the ground,

Prof. Lungile Pepeta

Prof. Lungile Pepeta (left), executive dean, Faculty of Health Sciences, Nelson Mandela University, was born, educated and spent the bulk of his career in the Eastern Cape. Pepeta was a renowned paediatric cardiologist and, more recently, had helped spearhead the response to COVID-19.

He had been at the helm of the Council for Medical Schemes (CMS) since June 2020 following the death of former chairperson Dr Clarence Mini, who also succumbed to the virus.

Pepeta was also the former head of the paediatric department and paediatric cardiology at Port Elizabeth Hospital.

"Ever smiling, Prof. Pepeta was a passionate and committed patriot who poured his life into the service of others through his chosen profession. A health worker *par excellence*, Prof. Pepeta specialised in paediatric cardiology, introducing a non-invasive surgery to correct heart defects in children," the CMS said.

The CMS said Pepeta lived to see his greatest goal in recent years, which was the establishment of a medical school at Nelson Mandela University.

In a statement on Friday, Nelson Mandela University vice-chancellor Prof. Sibongile Muthwa said Pepeta's passing was a great loss for the institution, the Eastern Cape and the country.

Prof. Pepeta joined the university on 1 January 2017, as the vision for establishing a medical school that offers an alternative educational model to meet the country's growing need for health professionals was gaining momentum," Muthwa said.

"As a renowned paediatric cardiologist, he had extensive experience in working with key stakeholders in the health and higher education sector, provincially, nationally, continentally and beyond. More recently, he helped spearhead the university's response to COVID-19 within the institution, in communities and in society at large, working with healthcare professionals and education, business and political leadership."

focusing on the things that keep hope alive all around us.

Dedicated to Prof Lungile Pepeta and all the healthcare workers we have lost in the fight against COVID-19.

Pandemic preparedness: This is neither the first nor the last

Prof. Ames Dhai, *visiting professor of bioethics, School of Clinical Medicine, Wits*

The 1918 influenza pandemic infected one-third of the world's population, and it is believed that 50 million people died. At that time, the world's population was under 2 billion. This was in the era before intercontinental air travel and globalisation. The 1900s witnessed two more worldwide influenza outbreaks: the 1957 H2N2 Asian flu, and 1968 H3N2 Hong Kong flu, with deaths ranging between 1 and 3 million. The first pandemic of the 21st century was in 2009, with the first cases of the novel swine-derived H1N1 influenza, a virus detected in Mexico and the USA, in April 2009. By the end of that year, H1N1 had spread to 208 countries, with hundreds of thousands infected, and around 18 000 deaths. H1N1 was evidence that continuous global movement would not allow for local eradication, but would facilitate accelerated global spread of a new killer virus.

On 30 January 2020, the WHO declared the novel coronavirus outbreak a public health emergency of international concern, and on 11 February 2020, they announced a name for the new disease: COVID-19. In Africa, on 14 February, Egypt was the first country to record a COVID-19 patient. SA recorded its first patient on 5 March. As of 11 August 2020, there were 20 275 874 people infected, and 739 526 deaths globally.

Rapidly spreading infectious outbreaks have plagued the first two decades of the 21st century. Severe acute respiratory syndrome (SARS) infected 8 098 people and killed 774 victims early in the new millennium. During the Ebola virus epidemic between December 2013 and April 2016, there were more than 28 616 people infected, and 11 310 deaths in Guinea, Liberia and Sierra Leone. By 2017, 690 had already succumbed to Middle East respiratory syndrome (MERS), and Zika had infected over 1 million people in the Americas.

The International Working Group on Financing Preparedness, in its 2017 report, cites the reasons for the frequency and diversity of disease outbreaks increasing steadily since 1980 as follows: "First, recent advances in travel, trade and connectivity have led to rapid increases in speed and volume not only of humans, animals and commodities, but also of deadly pathogens. Second, there has been unprecedented increase in unplanned

urbanisation, because of which millions of people live in crowded spaces and unhygienic conditions, which can be perfect breeding grounds for diseases to spread. Third, civil unrest and war displace large volumes of people, who move to new places, carrying with them a variety of infectious disease organisms. And fourth, global warming is creating new belts of warm and moist environments, which are ideal conditions for the spread of disease vectors."

We should not allow the cycle of panic and neglect to continue

Human tragedy from rapidly spreading infectious outbreaks is profound, with extensive bearing on the health, economic and social sectors. Pandemic costs can be measured by monumental human suffering as a result of the accompanying health, economic and social disruptions. The painful statistic of lives lost is only the first measure of impact. Economic and social disruptions, sometimes of titanic proportions, lead to undermining of communities and governance. As the COVID-19 pandemic evolves, it is becoming clear that it will be with us for around 2 years or longer. With the increasing frequency of pandemics, we will probably see another one soon after. Therefore, investing in pandemic preparedness and response nationally, regionally and globally is critical. Our lived experiences and the many lives lost so early in COVID-19 are evidence that the costs of inaction when it comes to prioritisation and preparedness are immense. As the world starts the recovery phase from the calamity, the pandemic disaster should not ebb like a receding memory, and preparedness initiatives should not be overlooked in favour of other activities until the next outbreak emerges, as has happened thus far.

COVID-19, like the 1918 influenza plague, has underscored how vulnerable the world is. It has also highlighted people's universal vulnerability. Human vulnerability is understood as a spectrum, with one end being

all human life, conditioned by vulnerability because of our "embodied, finite and socially contingent existence", while at the other end of the spectrum, the term denotes more than the universal vulnerability of humanity. People vary in their exposure to risk, and in their abilities and resources to counter such risk. It is to these people with greater exposure to risk and decreased resources to counter it that greater duties of justice are owed, and specific moral obligations. Hence many vulnerabilities move beyond the universal and are context-dependent, and warrant ethical responses as a result of their significance within particular settings. For many, contextual vulnerability may manifest only after a pandemic has set in and measures for containment are instituted. COVID-19 containment has resulted in millions of people losing their livelihoods. Moreover, UNESCO draws attention to the fact that vulnerable individuals become even more vulnerable in times of pandemic, and in particular where the vulnerability is related to poverty, discrimination, gender, illness, loss of autonomy or functionality, older age, disability, ethnicity, incarceration, undocumented migration and the status of refugees and stateless persons. Isolation and quarantine could impact negatively on intrafamilial violence, and on people living in unstable economic situations. Moreover, psychological stress could be triggered by pandemic anxiety and confinement. Vulnerability in itself is reason enough to require preparedness for pandemics. Responding to outbreaks "on the run" costs far more in terms of lives, money and social harms.

Preparedness for pandemics would be a co-benefit for the healthcare sector: for example, surveillance and diagnostic capacities could be used for routine patient care. In the healthcare sector, this preparedness would mean investing in health systems geared towards universal health security. Health security refers to protecting people from threats to their health, i.e. the intrinsic value of protection against risk. Universal health security requires that everybody is protected from threats to their health, and it includes reducing the vulnerability of populations to threats of infectious outbreaks within and across national borders. During outbreaks,

genuine health security can only be achieved if everyone is protected. Achieving universal health security would be a substantive move towards universal health coverage, and should be integrated into the planning of resilient health systems. We are witness to the huge pressure our health systems have come under during the current pandemic, with non-

COVID-19 healthcare severely compromised as resources have been diverted to pandemic containment, and seen that the fear factor has resulted in patients avoiding seeking care.

As responsible global citizens, we should not allow the cycle of panic and neglect to continue as it has done during pandemics of the past. Collective action towards

preparedness for the next pandemic is essential. COVID-19 is not the first pandemic, and nor will it be the last. Investing in pandemic preparedness will go a long way towards avoiding human suffering, protecting lives and safeguarding livelihoods.

Source: S Afr J Bioethics Law 2020;13(1).

SA's response to COVID-19: Started with a cough, developed into a fever, but recovery is possible

Prof. Anshu Padayachee, SA Technology Network



If ever SA needed reminding that we live in an interconnected world, the coronavirus disease 2019 (COVID-19) pandemic has truly brought that fact home. COVID-19 has tested the integrity, strength and preparedness of societies, governments, communities and individuals to deal with a pandemic as a global community. In the WHO's 21 April 2020 media briefing, the Director-General contended that "all countries must strike a fine balance between protecting health, minimising economic and social disruption and respecting human rights." He went on to point out that the "unique and rapidly shifting challenges to the promotion and protection of health and human rights of people around the world" have presented countries with new difficulties as they attempt to respond to new issues.

SA swung into gear to deal with this pandemic by setting up its National Command Council and a ministerial advisory committee comprising of 51 scientists, and implementing the Disaster Management Act No. 57 of 2002. The sweeping powers exercised by the executive under this Act have put to the test the strength and resilience of the country's constitutional democracy. When

such emergency powers are invoked, there is a clear risk of violations of human rights and fundamental freedoms, and disrespect for the rule of law.

When President Ramaphosa declared a National State of Disaster on 26 March 2020 and announced a lockdown to contain the spread of COVID-19, the processes and responses that followed highlighted the underpreparedness of our country, and its inability to deal with the predicted impacts on lives and livelihoods. As we tried to deal with the COVID-19 pandemic, the stark reality of the extent of inequality in our society reared its ugly head once again, and revealed how underprepared the country was to deal with pandemics and, perhaps, national disasters in general.

Modern transportation and trade have enabled nations such as SA to be linked to the farthest reaches of the world, driving the global economy and creating opportunities for commerce anywhere in the world, and so have, as Thomas Friedman says, created an enabling platform to form a flat world. These same pathways of global commerce have become the highways for transmission vectors of the disease. The pandemic has shown that a sneeze in Durban could become a fever in Dublin with one flight, and within a single day. A major realisation over the last few months has been that the positives of a highly connected global economy also lead to large populations being at risk of infection, and of an accompanying economic downturn. However, the effects of this downturn are likely to be highly disproportionate across the globe.

Africa, with its experience in dealing with national health disasters such as the Ebola virus, SARS-CoV-1 2003 and HIV, should have been better prepared to manage this

pandemic. However, it has become starkly clear that neither developed nor developing countries were prepared for the impact of COVID-19. As early as 2006, the WHO urged every country to develop or maintain up-to-date national influenza preparedness plans, and provided guidance on the content on such plans. To date, many countries have yet to develop written plans, while those that have done so display variations in their comprehensiveness, quality and stage of completion. The 2019 Global Health Security Index, in its ranking of 195 countries on health security, also revealed that while there were top performers, healthcare systems around the world were, on average, fundamentally weak, and not prepared for new disease outbreaks.

It has become clear that while countries grappled with COVID-19, pandemic planning and priority-setting to deal with its impact during and after the pandemic was neglected. While SA made early strides toward containing the spread of the virus, how a country prioritises its actions, interventions, infrastructure and budgets to manage a pandemic while protecting lives and livelihoods will depend on its preparedness for the future. A recent position paper by a group of experts assembled by the SA Technology Network suggests that priority-setting is an important tool for underpinning and implementing preparedness policies and protecting lives, livelihoods and individual rights against unjustified state interventions that can arise during pandemic events and in post-pandemic landscapes.

Now, as we develop the blueprints for preparedness and knowledge around the pandemic, the information and experience gained must be banked, infrastructure enhanced and interventions sustained post COVID-19

to plan, prepare and prioritise actions for a predicted resurgence and, more importantly, for the protection of lives and livelihoods in the “new normal”. But while we prepare for the future, SA must learn from its past: the pandemic hit the country at a time when it was already in an economic downturn, and plagued by

university, union and civil society strikes and protests over the lack of infrastructure, and corruption and unemployment. The pandemic has exacerbated these challenges and compels decision-makers to carefully and strategically prepare the country for the new normal, and enhance and sustain the gains

made during the pandemic, such as increased water and sanitation provision, housing, security and a more agile manufacturing sector.

References available on request.

Source: Padayachee et al., SA Technology Network, May 2020.

COVID-19 – a doctor’s perspective

Dr Tshepile Tlali, community service medical officer, East London



I first engaged with COVID-19 in late March 2020. Back then, much was unknown about this virus and fear was the order of the day, and I started to feel suffocated by the ocean of confusion surrounding it. I started reading about the virus and the impact it was having in other countries. I felt that as a doctor, I needed to know everything about this virus so that I could alleviate the palpable fear surrounding me. I started using WhatsApp statuses as a tool for health promotion about COVID-19, and the response from my friends and colleagues encouraged me to read more and more.

It was not until we received a communication in our doctors’ WhatsApp group stating that the district had allocated our centre as a designated testing site that I felt real fear seeping through my body. I was terrified. All this time I had had the comfort of knowing that only the larger hospitals would be treating and testing suspected and confirmed cases of COVID-19, but now that comfort had been stripped away. I became nervous about PPE, and read up on and watched videos about donning and doffing, hoping that this would allay my fears. Not long afterwards our facility created an isolation area (“Isolation”) where we would see the patients under investigation. For a few days it was inactive, which was a relief for me. Then, one Friday afternoon, I received a call from a colleague who wanted

my advice about a patient who was sent to Isolation. The young lady had travelled from KwaZulu Natal to her home town in the Eastern Cape, in a bus “with people who were coughing”, and now was presenting with a history of chest pain, difficulty breathing and an intermittent dry cough. We looked at each other nervously as we realised that this could indeed be our first case. What happened next was one of most daunting experiences of my life. Having swabbed the patient, I felt as if I were radioactive, and unsure of what I would do when I got home as I feared the possibility of infecting my family. One thing I can say is that the fear dwindled with every suspected case I treated and swabbed. I took a liking to working with COVID-19 cases, and before I knew it was dubbed “Dr COVID” at my facility.

In mid-June 2020 we started to experience high volumes of patients presenting with COVID-19 symptoms, and each day brought more and more sick patients. My team, consisting of one staff nurse and two professional nurses, was not coping with the volumes. We spent the majority of the day tending to terribly ill patients, and never had the time to see patients with mild symptoms. Our oxygen cylinders were depleting at a rapid rate, and it seemed that we were heading for disaster. At that time, the death toll was rising, and patients, healthcare workers and relatives of colleagues and friends were dying. I could feel burnout creeping in, and I started to become anxious. I needed to take leave, but I felt that my services were needed most at this time. It was too crucial a period.

At this point I became numb. I shut out everything that related to COVID-19. I stopped watching the news, I stopped following the daily statistics, and all I yearned for were better times where people were not dying at the rate they were. Nonetheless, I continued to heed the call of the President to fight on the

frontline, as a fatigued soldier would in a war. I can say the same for the rest of the team in Isolation.

On 29 June, one of the professional nurses who had dedicated all her efforts to Isolation (I jokingly called her “Sr COVID”) started to develop cold symptoms. We had always worked together, and in fact that day we had travelled to the homes of colleagues who had tested positive to trace their family members (the district contact-tracing team was overwhelmed). Although we always wore masks and observed all the necessary protocol, I knew that if she was infected, so too was I. She indeed was, and so I went into quarantine and started monitoring my symptoms at home. On 2 July I started to develop symptoms, and went to be tested on 3 July. I was also infected. At the time, going home to quarantine, I felt strongly that this was a blessing in disguise, as I was in desperate need of rest.

At the beginning of this pandemic, sceptics said that this was “just a flu”, and nothing more. I can assure you that I have had my fair share of colds and flu in my life. Coronavirus infection was not just a cold or flu: I was bedbound for 8 days, with an unrelenting headache and fatigue. There was simply nothing I could do shake these symptoms off; no amount of analgesia and no amount of caffeine took them away. I had to lie in bed the whole day, staying hydrated and rested. The amount of support I received from family, friends and colleagues is unmatched, and I am profoundly grateful for the support they afforded me in their respective ways.

I am now a COVID survivor, along with family members, colleagues and hundreds of thousands of South Africans, and for that I am truly grateful. I am back working in Isolation, and I have newfound energy to fight this virus. The fatigued soldier is replenished and ready to fight. Now, the number of new cases seems to be slowing down, which for me is a dream come true.

May healthcare workers refuse to work when not provided with PPE?

Prof. David McQuoid-Mason, Centre for Socio-Legal Studies, University of KwaZulu-Natal



The HPCSA has introduced guidelines on the provision of personal protective equipment (PPE) for practitioners who may be exposed to the COVID-19 virus. The guidelines state that “employers and employing institutions should take all necessary steps to ensure that staff members are always suitably equipped and afforded PPE.” The guidelines mention that employers must provide staff with the necessary information to minimise the risk of transmission. In cases where PPE is not immediately available, the guidelines suggest that some of the factors that should be considered by employers are: (i) telemedicine consultations; (ii) whether treatment can be delayed; (iii) whether additional steps can be taken to minimise the risk of transmission; (iv) prioritisation of practitioners at a higher risk of infection; and (v) identification of action likely to result in the least harm under the circumstances (para 6). The guidelines also mention that practitioners who have concerns regarding their conditions of work and the risk to their health bring these to the attention of their employers, the HPCSA or the Office of Health Standards Compliance as soon as possible (para 6). The suggestions made for when PPE is not immediately available are similar to, but not as detailed as, those mentioned by the WHO in respect of a shortage of PPE.

The HPCSA professional rules of conduct state that “a practitioner shall not permit himself or herself to be exploited in any manner” (rule 22). There is no doubt that if allegations of health workers being forced to attend to COVID-19 patients without PPE are true, it would fly in the face of the HPCSA guidelines, and would be gross exploitation

of healthcare practitioners. On the basis of the HPCSA rules, healthcare practitioners who are being exploited would be ethically justified in refusing to work under such conditions.

Legal protection against life-threatening infections

The Constitution states that everyone has the right to an environment that is not harmful to their health or wellbeing (section 24(a)), and the right to fair labour practices (section 23(1)). In addition, the Occupational Health and Safety Act No. 85 of 1993 provides that every employer shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of their employees (section 8(1)). Similarly, the National Health Act No. 61 of 2003 imposes an obligation on health establishments to implement measures to minimise: (i) injury or damage to the person and property of healthcare personnel working at the establishment; and (ii) disease transmission (section 20(3)).

Therefore where the working environment is not safe and healthcare workers are not provided with the necessary PPE, or the healthcare providers and institutions do not follow the WHO recommendations, it would be reasonable and justifiable for them to withhold their labour. Where there is a shortage of PPE, the WHO guidelines still expect healthcare providers and institutions to provide healthcare workers who are dealing with COVID-19 patients with PPE.

May healthcare workers refuse to work?

In terms of the Labour Relations Act No. 66 of 1995, the emergency services committee has designated emergency health services, nursing, medical and paramedical services, their supporting services and hospitals as “essential services”. This means that they may not strike in a manner that puts the lives or health of patients at risk. However, when the lives and health of healthcare practitioners themselves are at risk of COVID-19 infection, the common law doctrine of “necessity” may be used to justify their refusal to work. The doctrine states that necessity applies where people are placed in a situation of danger and

the law allows them to protect their interests by violating the rights of innocent third parties. This was based on the principle that the legal convictions of the community recognised that people’s own lives are considered more important than the lives of others.

The Constitution recognises that while everyone has a right to access healthcare (section 27(1)), such a right may be limited if it is reasonable and justifiable to do so. In circumstances where healthcare workers face being exposed to a life-threatening disease such as COVID-19 because of a lack of PPE, or a working environment that does not follow the WHO recommendations for dealing with shortages of such equipment, the courts may well hold that it is reasonable and justifiable for health workers to withhold their labour (section 36(1)).

Legal consequences of failure to provide PPE

The COVID-19 regulations impose numerous duties on the general public and healthcare providers, but impose no direct duty on health providers and health establishments to provide PPE for their employees. The regulations do however, state: “Any person who intentionally exposes another person to COVID-19 may be prosecuted for an offence, including assault, attempted murder or murder” (regulation 14(3)). It could be argued, therefore, that if health providers or health establishments do not provide PPE for healthcare workers who are exposed to COVID-19 because of a lack of PPE, such conduct amounts to intentional exposure of healthcare workers to COVID-19 infection.

Apart from being a crime in terms of the COVID-19 regulations, a failure to provide PPE in such circumstances may also be an offence in terms of the Occupational Health and Safety Act (section 38(1)(a)). Furthermore, in terms of the Compensation for Occupational Injuries and Diseases Act No. 130 of 1993, where such failure to provide PPE results in healthcare workers contracting COVID-19 or dying while working, such workers or their dependants may claim from the Compensation Fund.

Extract from David McQuoid-Mason’s article in S Afr J Bioethics Law 2020;13(1).

COVID-19 reignites tobacco and alcohol policy debates

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

The COVID-19 lockdown regulations and the bans on the purchase and sale of tobacco products and alcohol have been hotly debated topics during the state of disaster. The Department of Cooperative Government and Traditional Affairs has had to put significant effort into defending these bans in court battles that are ongoing at the time of writing (8 August 2020).

While the exact numbers and the impacts on health, society and the economy may be debated for some time, the bans have certainly negatively impacted retail revenue, excise tax collection and the expenses of those prepared to buy products on the “black market”, and have inevitably had knock-on effects on the hospitality and support sectors that serve these giant product markets.

The stringent measures imposed may not come as a surprise given the attempts over the last few years by the National Department of Health to regulate both tobacco products and liquor more strictly. Whether the extreme nature of the purchasing and sales bans can withstand legal scrutiny remains to be seen, but the approach taken definitively demonstrates the significance of the threat from these products, as perceived by the government, to the health of South Africans.

The draft Non-Communicable Diseases National Strategic Plan 2021 - 2026 (May 2020 edition), which SAMA has just reviewed and submitted comment towards, includes the intention to update and strengthen existing legislation for tobacco and alcohol, with the work on tobacco legislation starting immediately, and that on alcohol to commence in year 3 of the plan (2024).

In addition, the SAMA health policy committee will be engaging with several partners in the form of a preventive medicines task force, which will work to develop guidance on preventive medicine, and will therefore try to address the use of tobacco products and alcohol-containing products as risk factors for the development of various diseases.

It is worth revisiting the ongoing policy and legislative attempts at tobacco and alcohol control measures, which will most likely resume after the national state of disaster has ended.



Tobacco products and electronic delivery systems

In April 2005, SA ratified the WHO's Framework Convention on Tobacco Control. Through this treaty, the SA government has an obligation to protect its citizens from tobacco by implementing strong evidence-based tobacco control interventions.

Since the early 1990s, the smoking prevalence for adults has decreased from more than 30% to current levels of around 20%. This has been attributed to a combination of tightened legislation on tobacco products and steep increases in excise taxes on these products.

The Tobacco Products Control Act No. 83 of 1993 – the main legislation governing tobacco control efforts in the country – was amended three times over a 15-year period, gradually tightening legislative controls on the industry.

Most recently, the Control of Tobacco Products and Electronic Delivery Systems Bill was published in May 2018 for public comment. The Bill aims to regulate tobacco products and electronic delivery systems in a very similar manner, as well as introducing some additional restrictions on the packaging, sale and promotion of existing products.

The Bill specifically proposes that smoking of both traditional and electronic products be prohibited in enclosed public spaces, enclosed workplaces, enclosed common areas in multi-

unit residences, health facilities (except for rehabilitation facilities) and private dwellings where the dwelling is used for commercial childcare, domestic employment, or schooling and tutoring. Smoking was also set to be banned in motor vehicles where there was a child under the age of 18 present and more than one person in the vehicle.

Advertising and promotion of tobacco products and any part thereof (particularly important to hardware such as pipes and other consumable add-ons) was to be prohibited.

The new Bill additionally sought to introduce plain packaging, remove designated smoking areas in restaurants, ban outdoor smoking in public areas and prohibit retailers from displaying cigarettes and cigarette vending machines.

As with the arguments seen with regard to the current COVID-19 tobacco products ban, the tobacco industry has challenged the proposals in the Bill, arguing that the proposed measures would be detrimental to the SA economy, society and even public health.

The evidence for a number of the proposed measures was also criticised, with a number of research and evidence gaps identified by tobacco producers.

SAMA submitted comments on the new Bill at the time, and commended the attempts that were being made to regulate electronic tobacco products in particular. Much of

the evidence regarding the harms of these electronic products was yet to emerge at that time.

Warning labels on alcohol products

The Liquor Products Amendment Bill was introduced to the National Assembly in July 2016. The National Liquor Policy was published by the Department of Trade and Industry in September 2016.

The Bill sought to establish control over the production and sale of certain alcoholic products by changing the alcohol content of what was deemed as liquor from the current 1% of volume to 0.5%. It also looked to address the composition and properties of products and their labelling in order to safeguard consumers. The Bill would also include beer and traditional beer under the remit of the existing Wine and Spirit Board, and add controls for the import and export of certain alcoholic products.

The Bill recognised that a loophole in the Liquor Act No. 27 of 2003 allows any liquor product labelled as beer or ale to be manufactured and sold. This has led to the proliferation and uncontrolled sale of sugar fermented beverages and other concoctions.

In June 2020, the Presidency referred the Bill back to Parliament, the basis being concerns

about the Constitutionality of the proposed amendments.

The Liquor Policy of September 2016 also caused significant outcry and debate around its proposals, and their health impacts v. socioeconomic impacts.

The policy recognised alcohol as the most widespread drug of abuse in SA, and the most harmful drug at a population level. It was recognised as the third-largest contributor to death and disability after unsafe sex or sexually transmitted infections and interpersonal violence, both of which are themselves influenced by alcohol consumption.

The policy's most controversial proposals for liquor and other regulation included restrictions on advertising of liquor products, raising of the legal drinking age and strengthening registration conditions for suppliers and traders of liquor products.

It was proposed that the national minimum legal age at which alcohol can be purchased and consumed should be raised from 18 to 21 years, to delay the introduction of liquor consumption among youths.

The policy also proposed that liquor premises should be located at least 500m away from schools, places of worship, recreation facilities, rehabilitation or treatment centres, residential areas and public institutions, with additional restrictions imposed on the

premises that could be registered for liquor licences.

The policy also proposed that education and awareness around alcohol-related harms be strengthened. It was recognised that this would require co-operation with all tiers of government to intensify education and awareness.

It appears that the relevant government departments will continue to pursue these policy proposals, to convert them to law over time.

Conclusion

While we are currently experiencing the most extreme variants of health policy possibilities for tobacco and alcohol products, under the Disaster Management Act No. 57 of 2002 and the declared COVID-19 national disaster, the debates about how best to manage the use and abuse of both sets of commodities are likely to go on for some time.

The current bans have managed to highlight, under extreme circumstances, the potential for knock-on effects (both positive and negative) of increased regulation of these commodities.

Beyond the current extreme measures, the planned and proposed tightening of regulation of these products will probably continue for some years. The current crisis may well provide additional evidence to add to the policy discussions.

Employee versus independent contractor

Ruan Vlok, *employee relations advisor, SAMA Employee Relations Department*

SAMA has been inundated with queries from members regarding the status of their contractual agreements. Government departments and/or private companies in some instances rely on an independent contract to regulate the relationship between themselves and a medical practitioner. Such contractual relationships may not always reflect the true relationship, and this results in the "independent contractor" specifically being excluded from the application of the employment law in question. A person is presumed to be an employee should (s)he be able to prove to be compliant with one of the seven factors (a) - (g) listed in section 200A of the Labour Relations Act No. 75 of 1999, as amended. This article will discuss and provide medical practitioners who are

parties to such an independent contract with details of their rights in this regard, as per the applicable legislative framework and case law.

Legislation

The Labour Relations Act, section 200A, explains the presumption as to who is an employee: "(1) Until the contrary is proved, for the purposes of this Act, any employment law and section 98A of the Insolvency Act [No. 24 of 1936], a person who works for, or renders services to, any other person is presumed, regardless of the form of the contract, to be an employee, if any one or more of the following factors are present:

(a) the manner in which the person works is subject to the control or direction of another person;

- (b) the person's hours of work are subject to the control or direction of another person;
- (c) in the case of a person who works for an organisation, the person forms part of that organisation;
- (d) the person has worked for that other person for an average of at least 40 hours per month over the last three months;
- (e) the person is economically dependant on the other person for whom he or she works or renders services;
- (f) the person is provided with tools of trade or work equipment by the other person; or
- (g) the person only works for or renders service to one person."

The Act further defines an employee as:

- any person, excluding an independent

- contractor, who works for another person or for the state and who receives, or is entitled to receive, any remuneration; and
- any other person who in any manner assists in carrying on or conducting the business of an employer, and “employed” and “employment” have meanings corresponding to that of “employee”.

With reference to the above definition, it is clear that an independent contractor is excluded from any form of employee entitlement and rights as per the Labour Relations Act, hence the importance of comparing section 200A with your own existing contractual agreement.

Case law

In the matter of State Information Technology Agency (SITA) Pty Ltd v CCMA & Others (LAC

Case No. JA 16/2008), the labour appeal court found that when a court determines the question of an employment relationship, it must work with three primary criteria: (i) the employer’s right to supervision and control; (ii) whether the employee forms an integral part of the organisation with the employer; and (iii) the extent to which the employee is economically dependent upon the employer.

In the matter of Universal Church of the Kingdom of God v CCMA & Others (2014) 3 BLLR 295 (LC), it was determined that each matter must be considered on its own merits and its own facts to establish whether the parties intended an employment relationship. There need not be a written contract to establish an employment relationship. In this matter, late Judge Steenkamp had to decide

whether a pastor was an employee of the church, and had this to say in his judgment: “Everything in this relationship looks like an employment relationship. If it looks like a duck, walks like a duck and quacks like a duck, it probably is one.”

Conclusion

Should a person be able to prove with certainty to be compliant with one or more of the seven factors listed above, it would be advisable to explore the contractual relationship, and access legal advice. Should it be determined that a person’s role forms part of the presumption of who is an employee, that person will automatically become entitled to employee benefits, as determined by our employment law, to which an independent contractor is not entitled.

SA inquests: A medicolegal update explaining your risk

Dr Volker Hitzeroth, *medicolegal consultant, the Medical Protection Society*

As a matter of law, inquests are held in relation to deaths reported to be due to unnatural causes. When a patient dies, a healthcare practitioner must determine whether the patient died of natural or unnatural causes. If the practitioner determines that the cause of death was natural, then a notification of death/stillbirth form can be completed, and the body may be removed. If, on the other hand, the practitioner determines that the cause of death was unnatural, further legal processes must be followed.

Unnatural deaths are those in which:

- the death is due to a physical or chemical influence, whether direct or indirect, including any related complications (e.g. deaths associated with trauma, accidents, violence or poisoning)
- the death is procedure-related, including anaesthesia-related death (e.g. deaths that occur shortly after a medical procedure, or after an anaesthetic is administered to the patient)
- the death is sudden and unexpected, or unexplained, or where the cause of death is not apparent (e.g. deaths that occur in unexplained circumstances or where there is no pre-existing illness)
- the death would otherwise be classified as “natural” but it is suspected that the death

was due to a negligent act or omission on the part of another person (e.g. deaths that the practitioner believes to be the result of some negligent or criminal act or omission).

Death by suicide would be regarded as unnatural as it is usually “sudden and unexpected”, and likely due to a “physical or chemical influence, direct or indirect”.

Deaths that are believed to be due to unnatural causes must be reported to the police, and the practitioner therefore has a duty to report an unnatural death to a police official. The police will investigate the circumstances surrounding the death, and gather evidence (such as statements from witnesses, including healthcare practitioners, where relevant).

After concluding the investigation, the police official will submit his or her docket to the state prosecutor. If the state prosecutor believes that the evidence is supportive of proof that someone might be at fault for causing the death of the person, they may charge that person with culpable homicide.

Alternatively, if the state prosecutor decides not to charge anyone at this stage, they will refer the docket to a magistrate. If the magistrate believes that the death might

not be due to natural causes, (s)he must ensure that an inquest takes place.

A different magistrate then presides over the inquest proceedings (“the inquest magistrate”). The inquest magistrate will call for the medical records (in the case of a patient) and/or affidavits and statements from witnesses under oath (which may include healthcare practitioners involved in the treatment and management of the patient).

An inquest magistrate is charged in terms of the Inquests Act No. 58 of 1959 to make findings with regard to:

- the identity of the deceased;
- the cause or likely cause of death;
- the date of death; and
- whether the death was brought about by any act or omission that, on the face of it, involves or amounts to an offence on the part of any person.

An inquest may take the form of an informal (or “paper”) inquest, without calling witnesses. This may occur where the inquest magistrate completes his or her investigation by concluding that the death has not been caused by the negligence of any person, and hence decides that a formal inquest hearing is unnecessary and oral evidence is not required.

If the inquest magistrate determines that an inquest will be held, (s)he is responsible for directing its proceedings, and parties apply to the magistrate to subpoena witnesses to be examined during the inquest, if oral evidence is required. Nevertheless, an inquest is an inquisitorial, as opposed to an accusatorial, process.

It is mandatory for the state prosecutor attend the inquest. Other parties who are invariably present (and may have legal representation) are the family of the deceased person, and witnesses who are at risk of being found to have caused the death by an act or omission on their part, which *prima facie* amounts to an offence on the part of that person. The family of the deceased can choose whether or not

to participate in the inquest, except where they are persons of interest, in which case the inquest court can compel their testimony. If the family participates, they are entitled to legal representation and can examine any witness testifying. It is not uncommon for the legal representative of the family of a deceased person to examine witnesses vigorously.

Practitioners may be at risk if an act or omission on their part is found by the inquest magistrate to have caused the death of the patient, and which on the face of it amounts to an offence. An inquest magistrate may find that a practitioner has committed such an offence where it is believed that the death was brought about or caused by the practitioner's negligent conduct. A practitioner's conduct is considered negligent where:

- a duty of care was owed to the patient
- this duty of care was breached (the care given was not of the standard required under the circumstances).

In such an instance, the inquest magistrate reports their findings to the National Prosecuting Authority, who may then decide to charge the practitioner with an offence – usually culpable homicide or murder.

If you are requested to assist the SA Police Service (SAPS) with a disclosure of confidential patient information in the form of a report, statement or affidavit, or are requested to prepare for and attend an inquest, you should seek immediate advice from your indemnifier. You may also require legal representation.

Electronic Communication Guidelines focus on ethical responsibilities

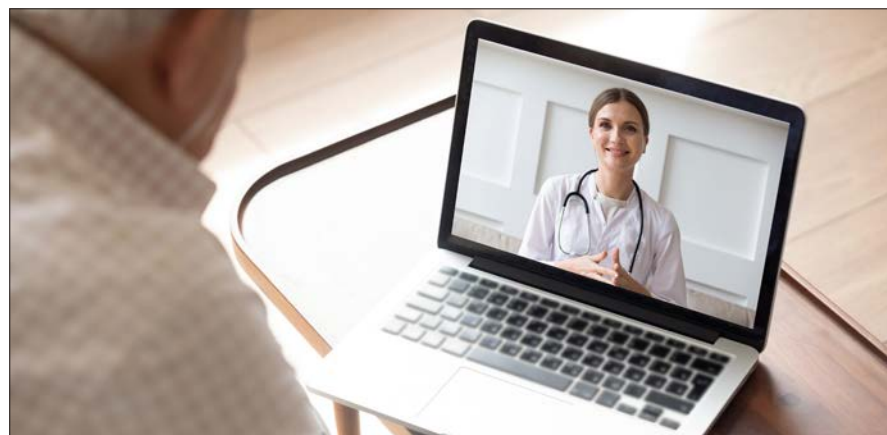
Brandon Ferlito, *bioethics researcher, SAMA Knowledge Management, Research and Ethics Department*

Electronic communication (EC) has fast become a major vehicle for health and medical care and is having a profound effect on the practice and business of medicine in SA. EC is viewed as an innovative way of practising medicine and offering related services and advice. However, as with any innovation, there is uncertainty and a lack of guidance around it.

EC between doctors and patients has many advantages over direct interactions. One of the main advantages is the transmission of information electronically, and the management of certain ailments and illnesses without the need for direct interaction – a major advantage in light of the COVID-19 pandemic.

While there are many other advantages of EC (e.g. convenience, comfort and speed), it is important for medical doctors to recognise their ethical responsibilities when using EC to conduct their day-to-day duties. As a result, SAMA has published the Electronic Communication Guidelines for their member doctors, as part of the association's continuous efforts as "the custodians of a growing advocacy platform that will unite, guide and support members for the health of the nation."

Based on these guidelines, this article will highlight some of the ethical and other



responsibilities that doctors need to be aware of when using EC.

Ethical responsibilities

Doctors ought to always be guided by ethical principles, whether communicating face-to-face or via EC. The ethical principles of (i) respect for autonomy, (ii) beneficence, (iii) non-maleficence and (iv) justice apply to EC as they would in face-to-face situations. Doctors, therefore, have an ethical obligation to ensure that when they use EC to conduct their day-to-day duties, they do not unknowingly breach their ethical obligations towards patients.

The doctor-patient relationship

The doctor-patient relationship is usually based on a personal (face-to-face/hands-on) examination and adequate knowledge of the patient's medical history, and as such, EC may alter the patient-doctor relationship – some aspects of EC will enhance the bond, and others will threaten it.

Doctors need to be aware that EC may take the place of some face-to-face interactions, and this risks losing some of the (emotional, mental) benefits of a direct doctor-patient relationship. Face-to-face interactions often give the doctor a rich and profound appreciation of a patient's

needs and personal preferences, something EC undoubtedly cannot provide. The SAMA guidelines therefore recommend that EC be used only when an already established doctor-patient relationship exists.

The guidelines also recommend that the primary doctor ensures that patient confidentiality, privacy and data integrity are not compromised. Data obtained during an electronic communication consultation must be secured to prevent unauthorised access and breaches of identifiable patient information, through appropriate and up-to-date security measures as per local legislation.

Confidentiality and privacy

Confidentiality and privacy are of the utmost importance when it comes to EC. Doctors need to ensure that the confidentiality and privacy of the patient are respected and maintained at all times, both during and after EC is employed.

Informed consent

With regard to EC and informed consent, the guidelines state that for informed consent to be considered valid, all necessary information regarding the distinctive features of the EC system or platform should be fully explained to patients and should include, but not be limited to:

- how EC, e.g. WhatsApp, works
- how to schedule appointments electronically
- privacy concerns
- risks, including the possibility of technological failure and confidentiality breaches
- protocols for contact during electronic consultations/visits
- prescribing policies and co-ordinating care with other practitioners, explained clearly and without influencing the patient's choices
- an explanation that the patient will agree to mediation before litigation in the event of a dispute arising.

Record-keeping

The SAMA EC guidelines further advise that a doctor EC, where advice is sought through the

use of EC should keep detailed, meticulous records of the advice (s)he delivers, as well as the information received, on which the advice was based, to ensure traceability.

Quality of care

The WHO defines quality of care as "the extent to which healthcare services provided to individuals and patient populations improve desired health outcomes". The SAMA guidelines state that healthcare quality-assessment measures must be used regularly to ensure patient security and the best possible diagnostic and treatment practices during EC consultations. The decision to use EC must be made in the best interests of the patient (beneficence), and the use of said communication must not harm the patient (non-maleficence).

Continuity of care

Continuity of care is a mechanism by which the patient and his or her doctor collaborate in the ongoing management of healthcare towards a common goal of high-quality, cost-effective medical care. According to the guidelines, the doctor must seek to ensure that the patient has understood the advice and treatment suggestions given, and take steps in so far as possible to promote continuity of care. The doctor should be aware of, and respect, the special difficulties and uncertainties that may arise when (s)he is in contact with the patient via EC. Doctors also ought to be aware that EC platforms may be unaffordable and inaccessible to certain patients, and hence could impede access to care – the ethical principle of justice must be duly considered.

Autonomy and privacy

EC may potentially infringe on a doctor's privacy, due to 24/7 virtual availability. The treating doctor should inform patients about his or her availability, and recommend services such as referral to the nearest hospital or clinic casualty department when care or communication is inaccessible.

Other responsibilities

When EC is employed, it should primarily be employed in situations where a doctor cannot be physically present within a safe and acceptable timeframe. It can also be used in the management of chronic conditions or for follow-up consultations after initial treatment, where it has been proven to be safe and effective.

Security concerns

Any EC platform or service on which medical practitioners communicate with patients must be protected by one or more of the following security measures: a password; pin; pattern and/or fingerprint; or voice or face recognition. The guidelines state that doctors should ensure that access to the EC platform or system is restricted and highly protected.

Information cannot be deleted with certainty

There is no certainty that recipient(s) have not seen message(s) or information before it has been deleted. As a result, doctors need to exercise extreme caution when communicating electronically with patients to make sure that the appropriate recipient(s) receive the correct information.

Conclusion

Although there are many advantages of EC, doctors need to recognise the legal, ethical and security implications of using it to conduct their day-to-day duties. It is the responsibility of doctors to educate their patients about these implications, as well as to respect the human rights of patients and uphold ethical principles when both parties agree to use EC.

The full, comprehensive SAMA Electronic Communication Guidelines can be accessed on SAMA's website: <https://www.samedical.org/file/1282>. The guidelines are only available to SAMA members.

References available on request.

At 91, Dr Govender has no plans to slow down

SAMA Communications Department

Dr Perisamy Govender is unstoppable. At 91, he is arguably one of the oldest practising doctors in SA, and he has not

yet decided when he will end his formal career. Formal, because it is apparent that whether he is involved in a medical practice or not,

Dr Govender will not easily retire from serving his community, or being a part of the lives of the people he has treated for close to six decades.

"Look, one needs something to do. What happens when one retires? One dies mentally and intellectually. I still have a contribution to make, patients still need me, and I'll carry on serving them as long as I can," says Dr Govender.

Dr Govender – who served as president of SAMA in 2003 and 2004 – attributes part of his longevity as a professional doctor to his routine. He wakes up at 4 am daily, watches news, meditates, and then has breakfast before heading off for work. It's a routine he has been following for years and, he says, the discipline is important to him.

"We must continue to serve"

Dr Govender began his professional career as a teacher at Umzinto Secondary School in KwaZulu-Natal, which he describes as a little country high school. There, he says, he enjoyed teaching coloured and Indian children.

"But in 1957, the government forcibly removed the coloured children from Indian schools, and that didn't go down too well with me, so I resigned. I had thought I'd then go into law, but my sister convinced me I'd be a better doctor, so I studied medicine," he says.

Dr Govender started his medical studies aged 28, which, he says, wasn't much of a challenge at the time, as many other medical students followed the same path by having worked in other careers before starting their medical journeys.

And it's been quite a journey for Dr Govender ever since. Along the way, he has collected a number of awards and citations, among them (in 2018) a SAMA Merit Award, and a Lifetime Achievement Award from the KZN Coastal branch. But for him, the highlight of his career has – naturally – been in the service of others.

"In 2015 there were xenophobic attacks in Chatsworth, and foreigners ended up in a

football ground because they had nowhere else to go. We had to rally round them and give them shelter and tend to their health needs. There are approximately 125 practising doctors in Chatsworth, and I was the only one who came to help. I set up a marquee tent and provided meds and facilities at my own cost. I think this was the highlight of my career because I was able to make a difference to so many," Dr Govender says.

Dr Govender rendered similar humanitarian service in 1976 and 1987, when the Umgeni River flooded the shack land on its flood plain.

And it is this involvement with the community, and his inherent drive to do what is right, that is a golden thread throughout Dr Govender's life. He has been involved in protests, pickets and petitions. As the president of the Durban South Guild, he championed the cause of the sick and vulnerable.

He has, he says, done what any doctor should do: serve the community. As the president of SAMA, he led a delegation to Parliament House in January 2004 regarding HIV and AIDS genesis denial by President Mbeki and his then-Minister of Health, Dr Manto Tshabala-Msimang.

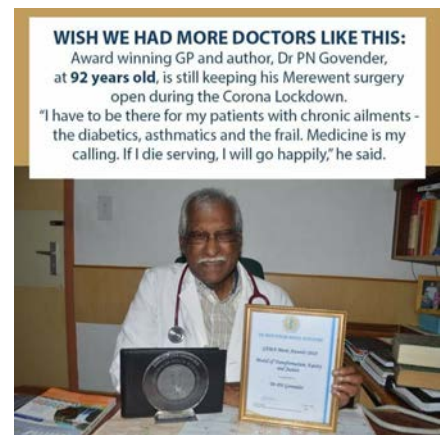
Now, of course, that service is a little different, because the challenges faced by COVID-19 are on a different level and a different scale, says Dr Govender.

"Of course we take it very seriously, and we take all the necessary precautions and observe all the necessary protocols. This is certainly very frightening, because I don't think anyone understood the impact all of this would have. But we must continue providing medical services – we owe it to the patients," notes Dr Govender.

Dr Govender shows no signs of relaxing or letting up, even though his wife of 58 years, Vasagee, wishes he would. He says she worries about him, but she understands that he has a job to do.



Dr Perisamy Govender



Dr Govender has been featured in many publications

"I can't ignore patients and I have to give my best all the time. It's not something you can simply walk away from," he says.

On the subject of retirement, Dr Govender says doctors do not die, they simply fade away. In this regard he is reminded of the 88-year-old Dr Urbino (from Gabriel García Márquez's *Love in the Time of Cholera*), who was left to treat patients alone when younger colleagues disappeared during a cholera epidemic. When asked why, he responded: "There will be plenty of time to rest when I die."

Reinstatement of SAMATU deductions against the wishes of SAMA public sector members

From the Office of the General Manager and SAMA Board of Directors

The administrator of the SAMA Trade Union (SAMATU), seemingly aided by the Registrar of Labour Relations, and Department of Public Service and

Administration, has used the judgment of the labour court to obstruct the migration process and the wishes of our members by reinstating Persal deductions for SAMATU,

even after resignation from SAMATU has taken place.

The judgment had the effect of declaring all SAMA members who paid via Persal

automatic members of SAMATU, meaning that although those members had never signed up to a union separate from SAMA, they now had to terminate their membership in accordance with the rules applicable to trade unions.

SAMA has done all it could to make the migration process as easy and convenient as possible for our valued members. Lamentably, we have been hindered at every step:

(i) The account details for all Persal deductions were changed from SAMA's account to that of the administrator without notification. This meant that all SAMA members who pay their fees via Persal, now had their money end up in the union's account. SAMA has no access to this money, yet has still continued to deliver all services and benefits to our affected members, to ensure that members are not left in the lurch.

(ii) SAMA endeavoured to give effect to the wishes of our members – migrating their payment method from Persal to debit order. However, in May, SAMA was informed by Treasury that it would no longer be able to effect terminations

to the Persal system on behalf of our members.

(iii) Compelled to abide by the court's decision and the Labour Relations Act No. 66 of 1995, SAMA sent members termination letters to submit to the employer and union (if members are deemed union members, they have to cancel their SAMA membership, in terms of the Act).

Members raised concerns that human resources departments were not willing to assist. In addition, the administrator made every effort to ignore or refute these legitimate termination requests in order to continue to deduct money from members' salaries, and also implemented a reinstatement of Persal deductions that had already been cancelled.

SAMA is doing all it possibly can to fight this pernicious, unscrupulous (seemingly political) campaign. It has become clear that forces intend to divide the medical profession by all means possible.

We believe it is important that our members are made aware of these developments. Unfortunately, whether by collusion or coincidence, the actions of the administrator and authorities involved are threatening to destabilise SAMA at a time when a strong united profession is needed most.

SAMA will continue to fight for its members, but now, dear valued member, we need you to also fight for SAMA.

Doctors are already a relatively small group in the healthcare sector, and need to stand together and stand firm to have their voices heard. SAMA believes that it will be severely detrimental to the profession if members are divided by the Registrar of Labour Relations merely because doctors do not fit into the traditional "shop steward" mould, and paid membership fees through the Persal system. It is terribly sad that a trade union that was meant to benefit members of SAMA now poses a risk to it and to a united profession.

SAMA leadership will engage with all SAMA members via online platforms.

Brenda Fineberg – seasoned SAMAREC member

SAMA Communications Department

An essential requirement of the National Health Research Ethics Council (NHREC) is the presence of a lay member on the committee. This member plays a vital role in representing the general public by ensuring that the studies approved are ethically sound and layperson-oriented, especially in terms of understanding the procedures to be performed and terminology used, and also confirming that they are in the public interest. The SAMA Research Ethics Committee (SAMAREC) is very fortunate to have Brenda Fineberg as its lay member.

After matriculating from Jeppe High School for Girls, Brenda obtained the following qualifications from the University of the Witwatersrand (Wits):

- BSc – botany and zoology
- Zoology Hons – medical entomology, entomology (biocontrol) and parasitology
- Higher Diploma in Education – methodologies: biology and mathematics.

Her vast work experience includes working as a student research assistant at the Nylsvley

Nature Reserve, a laboratory demonstrator at Wits and an educator at various prestigious schools, including Jeppe High School for Boys, Jeppe High School for Girls and recently, St Mary's DSG in Pretoria.

Keen to continue learning in various fields, Brenda also completed a journalism diploma and the Leadership Development Programme at Wits Business School, and has also been actively involved in a health, safety and environment role at her current school.

Showing her leadership skills, she is the life sciences subject head, a head of grade and the head of the department of science and technology at the school. In the current work environment, online teaching has become a focus, and Brenda has been developing and presenting educational materials for this purpose.

On a personal note, she enjoys travelling, and has visited numerous African countries, as well as venturing further abroad to South America, Europe and the USA, though her heart lies in the African bushveld.



Brenda Fineberg

As the lay member of the committee since 2006, she is very well acquainted with medical research, and is extremely valuable not only to the committee but to the community at large in representing a layperson's perspective on the evaluation of medical research studies.

World Brain Day 2020 raises awareness about Parkinson's disease

Neurology Association of SA

On 22 July, the Neurology Association of SA (NASA) partnered with the World Federation of Neurology (WFN) and the International Parkinson and Movement Disorder Society to support the 6th Annual World Brain Day. This year, World Brain Day was dedicated to raising awareness of Parkinson's disease (PD). PD is a neurodegenerative disorder that affects multiple regions of the brain and produces the most well-known symptoms of tremor, slowness, stiffness and problems with walking and balance. Symptoms generally develop slowly over years. The cause remains largely unknown. Although there is no cure, many highly effective treatment options exist.

Dr Marcelle Smith, a Johannesburg-based neurologist, comments that "the African continent has been experiencing rapid changes in recent decades, with increases in life expectancy. The average healthy life expectancy increased from 46.1 years in 1990 to 55.2 in 2017. This is still far below the average life expectancy in high-income countries of over 70 years; however, it has been sufficient to increase the burden of age-related and neurodegenerative conditions such as PD". There is a belief that PD is less prevalent in African countries, but incidence or prevalence studies for Africa are lacking. Most available studies are specific to individual countries.

African countries experience unique challenges when it comes to diagnosis and treatment of PD. Firstly, there are far fewer neurologists in African than in high-income countries: 0.03/100 000 in Africa v. 4.84/100 000 in Europe, according to the WHO Neurology Atlas. The WHO recommends at least 1 neurologist per 100 000 people. Approximately 270 million Africans live in countries in which there are fewer than 5 neurologists per country. Less than 50% of sub-Saharan African countries have a neurological society. This limited access to neurologists leads to underdiagnosis and treatment of patients with neurological disorders such as PD.

SA's population is estimated at 59 308 690 people at mid-year 2020, according to UN data. Between 16 and 17% of these have

private medical insurance, while the rest are dependent on state facilities for healthcare. SA has a crude estimate of 1 neurology service provider per 400 000 population.

Many African countries are also overburdened by malaria, TB, HIV and other infectious outbreaks, e.g. Ebola. Hence very few facilities and resources are dedicated to non-communicable illnesses. Medication is only available to 12.5 % of Africans with PD, compared with 79% in Europe. 60% of Africans live on less than USD2 a day, and are unable to afford the necessary treatment. Treatments range from medication to highly selective surgical procedures (deep brain stimulation) supported by physical therapy, exercise programmes and social and psychological support.

Medication is only available to 12.5 % of Africans with PD, compared with 79% in Europe

According to Dr Patty Francis (NASA president), while the distinctive symptoms of PD are shaking and slowness of movement, the disease also affects sleep and cognitive ability, causes pain and gastrointestinal issues and provokes anxiety and depression, reducing motivation and quality of life. Early diagnosis and access to effective treatment are vital in order to help patients find relief and to enhance their quality of life.

"PD affects more than 7 million people around the globe – that's nearly equivalent to the entire population of New York City," explained Prof. Tissa Wijerante, the World Brain Day chair. "Our goal is to raise awareness for PD and its impact on society in an effort to improve access to quality neurological care and life-changing treatments."

"More than one in four people living with PD were initially misdiagnosed," said Prof. Wolfgang Grisold, the WFN's secretary-general. "Many symptoms of PD are poorly

recognised and undertreated, which is detrimental for those living with the disease. There is a profound need for improved standards of care across the globe."

Move Together

"The impact of PD extends throughout the whole body, and reaches every corner of the world," said Claudia Trenkwalder, MD, president of the International Parkinson and Movement Disorder Society. "With 60 000 diagnosed each year in the USA alone, it is critical that patients have access to quality care."

COVID-19 is a dramatic reminder that healthcare is a global issue. Let us remember that PD is also a daily challenge faced by all ages and people, but mainly by the elderly.

To advocate for patients, World Brain Day is spreading awareness by asking people all over the world to "Move Together to End Parkinson's Disease" through the use of the hashtags #WorldBrainDay and #WBD2020.

"Brain health has never been more vital or relevant," said WFN president Prof. William Carroll. "When the world unites against this crippling movement disorder on World Brain Day, we will demonstrate the power of advocacy and awareness."

Throughout the coming months, NASA will stand together with other organisations in asking patients, caregivers and loved ones around the globe to share their stories about PD on social media. We will also be providing vital information on how to navigate COVID-19 while living with PD.

"When we all move together, we raise the voices of those impacted while uniting the world in a mission to end PD," said Prof. Carroll. "The WFN's World Brain Day aims to energise those with PD to drive research, improve standards of care and advocacy for the 7 million people living with this disease today, and those who will one day be diagnosed."

Joining more than 126 global organisations, NASA is committed to supporting WFN in advocating for improved patient care, education and additional research for those living with PD, and their caregivers.

Paediatricians speak out against school closures

SAMA Communications Department

As schools welcomed only grade 12 learners back, the Paediatrician Management Group and the SA Paediatric Association (SAPA) together urged government to open schools to all learners, and not to allow fear or politics to harm the children of SA.

Speaking out against government's decision to close public schools again, local paediatricians say that the decision is not based on scientific evidence, and the benefits to children of attending school outweigh the risks to both children and the broader community.

With no clear evidence that closing schools significantly reduces community transmission or overall deaths, local paediatric doctors call for all grades to be allowed to return to school as

A COVID-19 modelling study done in the UK based on the previous H1N1 epidemic and the SARS outbreak predicted that school closures alone would prevent only 2 - 4% of deaths. This is much lower than the effect of other social distancing interventions.

"Those school communities that are at risk, either due to high local transmission rates or poor infrastructure, should be identified and supported immediately to mitigate their risk so that they can reopen as soon as possible. Where schools are unable to reopen, the Department of Basic Education (DBE) must still ensure that all learners continue to have adequate academic material via radio, television, cellphone applications and all other means necessary. Educators must be held accountable for providing ongoing academic support and material at all times," the paediatricians said.

Children's risk lower than adults

Spokesperson Dr Fiona Kritzinger, a paediatric pulmonologist at the Christiaan Barnard Memorial Hospital in Cape Town, said children aged 0 - 18 years in SA account for only 5% of COVID-19 cases.

"Children and young people have a lower susceptibility to SARS-CoV-2, with 56% lower odds of being an infected contact."

SA data on COVID-19 case distribution by age shows that children 5 - 9 years old have an incidence of 15 cases per 100 000



population; 10 - 14-year-olds have an incidence of 22 per 100 000 population, and in children 15 - 19 years old, it is 38 per 100 000. In comparison, the incidence in the 20 - 60-year-old groups varies between 94 and 228 per 100 000 population.

A recent media statement released by the Western Cape Education Department (WCED) confirmed that only 0.1% of all learners who had returned to school had tested positive for SARS-CoV-2, and no deaths of learners were reported to the department.

Dr Kritzinger said that although this percentage is affected by the current Western Cape testing strategy, "it is nonetheless reassuring that the reopening of schools has not resulted in any significant outbreaks at a population level".

Risk to transmit lower than adults

"Family cluster and household studies showed that children are rarely the index case, and that children seldom cause outbreaks. It has been confirmed that children were only responsible for household transmission in 9.7% of households.

"In the Italian cohort of [a study by] Garazzino, 67% (113/168) of children had at least one parent who tested positive

for SARS-CoV-2 infection, and in 78% of cases, the symptoms in relatives preceded the symptoms in the child, confirming that children are rarely the index case in a household," she said.

Contributing to school and community outbreaks risk low

Dr Kritzinger said that evidence points towards very limited spread of COVID-19 between children. "There are no reported large outbreaks in schools in any country. This supports the argument that asymptomatic children attending schools are unlikely to be significant spreaders of the disease."

The reopening of schools had, in addition, not resulted in any significant outbreaks at a population level, said Dr Kritzinger. "In the Western Cape more than half of the schools have not reported a single positive case despite very high community transmission in the province at the time of the reopening of schools. In the schools that have reported a case, 72% reported only one or two cases. As of 16 July 2020, there were only 333 (0.8%) active COVID-19 cases among WCED staff, indicating that teachers are not at greater risk than other essential workers. There have been no reported outbreaks in Western Cape schools, and weekly new staff cases have been decreasing since the

reopening of schools, despite ongoing high community transmission rates.”

Serious disease or death risk extremely low

Dr Kritzinger says studies from China, Italy, the UK and the USA all report very low numbers of critically ill children and deaths in children under 19 years of age, with children experiencing much milder disease than adults, and deaths extremely rare.

“By 9 June 2020, only 2.6% of all COVID-19-related admissions in SA were for children aged 0 - 18 years and only 0.4% of all COVID-19 reported deaths were in children 0 - 18 years old.

“SARS-CoV-2 has caused fewer childhood deaths than influenza since the onset of the pandemic. Research from 7 high-income countries on 42 846 confirmed paediatric COVID-19 cases showed 44 COVID-19 deaths, v. 107 influenza paediatric deaths during the current pandemic.”

She said that SA children remained at greater risk of death due to injury or pneumonia in 2020, with paediatric mortality from unintentional injuries, pneumonia and COVID-19 infection at 0.77, 0.22 and 0.03, respectively, per 100 000 childhood population.

“Reviewing Statistics SA data from 2016, Prof. Servaas van der Berg and Dr Nic Spaull estimated the regular mortality risk for ages 0 - 19 in SA as a 1-in-1000 chance, while the projected COVID-19 mortality risk in the same age group is 1 in 76 000 (0.001%).

“Even though there are scant data on the role of comorbidities in children, the DBE has already made provision to allow high-risk learners to stay at home. In addition, all school staff members with comorbidities

have also been allowed to stay at home without any loss of income. Therefore, those who have been and would be attending school are, by definition, not high risk.”

The major harms of school closure

The paediatricians argue that although basic education is a human right in the SA Constitution, the majority of learners will have missed half of the school year by the end of August, depriving them of this right.

“Only about 20% of school children have access to online schooling, according to the DBE, and it is estimated that only 10% of households have internet access. This lack of access to education is disproportionately affecting vulnerable and disadvantaged children.

“The knowledge and skills gap between those with access and those without will only continue to increase, and this loss of education will have long-term and far-reaching economic effects. The DBE has not implemented any meaningful strategies since March to mitigate any of these effects, and a significant percentage of learners have not received any educational material since March 2020.”

Dr Kritzinger said that the emotional and psychological effects on children during and after lockdown have been immense. Recent international reviews show that lockdowns, school closures and natural disasters raise levels of substance abuse, depression, domestic violence and child abuse. A recent study in Hubei in China reported that 25% of 8 - 12-year-old children had developed depression during lockdown.

“In SA, many learners are already under immense emotional and psychological

stress due to poverty, malnutrition, crowded living conditions, child abuse, gender-based violence and other violent crime. The OPTIMUS study in 2016 reported that 42% of 15 - 17-year-old children reported some form of maltreatment.”

In addition, school closures increase childcare obligations, especially of healthcare and other essential workers. It has been estimated that if mortality rates for COVID-19 increased from 2.00% to 2.35% as a result of healthcare worker shortages, school closures would result in more deaths than the lives gained due to slower COVID-19 spread.

“By reopening the economy while keeping schools closed, many parents/caregivers are forced to leave their children at home unattended. Less than one-third of children live in households where both parents are present, and almost 42% live in households where the mother is the only parent present, according to Statistics SA. It is estimated that more than 2 million children aged 0 - 15 years will be left at home unattended, increasing their risk for accidental injury, abuse, fear, anxiety and isolation.

Dr Kritzinger said that paediatricians view the benefits of attending school as outweighing the risks, and that public schools should be allowed to reopen.

“It seems illogical to close all schools in all provinces and districts if community transmission rates vary so significantly. Allowing school communities to monitor and manage their risks based on local transmission would enable more schools to continue with their school activities, and limit interruptions over the next 12 months.”

References available on request.

Letters to the Editor

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

Please note that letters:

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

Please email contributions to: Diane de Kock, dianed@samedical.org.



A tale of greed and dishonesty

Dr Dawn McGuire, *medicolegal consultant*, Marshal Ahluwalia, *claims manager*, Medical Protection Society

Mr F was a 30-year-old painter. During the 2010 swine flu epidemic, he received a course of Tamiflu after developing fever and flu-like symptoms. His symptoms deteriorated and he became short of breath and was bringing up dark sputum. He consulted Dr A, who diagnosed H1N1 flu and advised conservative treatments. Three days later, Mr F was admitted for suspected pneumonia, with a heart rate of 120 and an oxygen saturation of 85%.

Mr F was subsequently diagnosed with severe pneumococcal pneumonia, complicated by multilocular empyema and acute renal failure. He required a thoracotomy for complete decortication of his empyema.

The claim

Mr F brought a clinical negligence claim against Dr A for failure to admit him to hospital. Mr F insisted that Dr A had not examined him at all. Dr A could not recall the details of the consultation as he saw many patients with similar presentations during the swine flu epidemic. There was no recorded evidence that Dr A undertook an examination of Mr F's heart rate, respiratory rate and oxygen saturation. The Medical Protection Society (MPS) therefore agreed to settle on behalf of Dr A, as the brevity of consultation record was inadequate to assist in defending this claim.

Poor record-keeping could have resulted in a far worse result

Mr F, however, rejected the proposed settlement offer, as he was hoping for a substantially higher offer. Mr F alleged that he had developed complex post-thoracotomy chronic pain syndrome, making him almost housebound with disability, cold intolerant, deeply depressed, unemployable and a social recluse. Mr F's initial demands escalated to a multimillion sum.

The MPS legal team carried out due diligence on Mr F, which exposed his normal active lifestyle of playing cricket and tennis even in the coldest months of the year, frequent family outings and regular social events.



Our team submitted that Mr F had fraudulently exaggerated the extent of his injuries and intentionally provided inaccurate and misleading evidence to the experts. Subsequent enquiries with the relevant government departments also exposed Mr F's similarly misleading account of his fabricated disability, which earned him an enhanced rate benefit to assist with his daily living and mobility needs. Mr F said that he had had a sudden remarkable improvement but had not disclosed this to all relevant parties in time; he reduced his claim demand by 66%.

MPS rejected this and contended that we were no longer able to assume that Mr F's account of the 2010 consultation (in particular, that he recalled that no examination had been undertaken) honestly reflected his genuine recollection. Mr F then confirmed his intention to discontinue his claim, but refused to accept our terms of discontinuance. At trial, the judge permitted the claim to be discontinued and awarded a costs order in Dr A's favour. MPS had incurred defence costs to instruct panel solicitors, counsel and experts to assist Dr A, and managed to recover half of these from Mr F's insurers.

The MPS legal team also considered contempt proceedings against Mr F and the possibility of taking steps to recover the outstanding legal costs incurred in defending the claim, but Mr F subsequently sold his house, which he owned jointly with his wife, and filed for bankruptcy. Nonetheless, the outcome of the claim was an excellent one for Dr A, as he was completely exonerated of any culpability.

Learning points

- The process of handling a claim can be a long one, with numerous developments along the way. In this case, Dr A's legal team became suspicious of Mr F's demands and, when it became clear he was behaving fraudulently, we were persistent in taking the right steps toward achieving a good outcome for Dr A.
- Although we were successful on this occasion, the poor record-keeping demonstrated could have resulted in a far worse result.

The Unlimited offers up to R100 000 free personal accident cover to all SAMA members



SAMA Communications Department

SAMA, together with The Unlimited, is giving all members, as essential services workers, free personal accident cover. Since the lockdown began, medical professionals have proven how selfless they are by reporting to work even when the risk is bigger than the reward.

The Unlimited acknowledges this and, as a token of appreciation for all the heroes risking their lives and going above and beyond the call of duty, has generously offered this cover free for 12 months. SAMA appreciates and has accepted this gesture of kindness on behalf of our members.

The Unlimited recognises that these heroes are often the ones who need that extra bit of help the most. Moreover, they understand that selflessness deserves to be rewarded. "We as The Unlimited pride ourselves in providing our customers – who are our family – with remarkable value by making them feel like their lives are unlimited. We're guided by the belief that business has a responsibility to do

better for the society in which it operates. This is why we decided on an offering specially made to protect essential workers while they take care of us," says Andrew Wood, chief executive officer.

Thank you, our heroes – what can't be expressed in words is shown in action

As an essential services worker, you receive personal accident cover that pays out up to ZAR100 000 towards accidental hospital cover: should you be injured in a motor vehicle accident on your way to or from work, The Unlimited will pay out ZAR1 000 for every 24 hours that you are in hospital, for a maximum of 100 days.

We also know that you need to use your phone more than normal during these extraordinary times, to stay connected to your loved ones as you take care of our nation. You will receive a free SIM card on which you will get double the airtime and data that you load to it. There is no waiting period for this benefit from the time that you receive the confirmation SMS.

As a SAMA member, you can activate your free cover at <https://lp.theunlimited.co.za/heroes/> as well as learn more about this opportunity. The activation is incredibly simple. The Unlimited pays the premium, you get the cover, at no obligation to you.

In a time of increasing poverty and financial limitations, businesses should play their part to solve societal problems. The Unlimited urges businesses to put people before profit by coming together and assisting those in need – "protecting the heroes that protect us".

For more information, visit www.theunlimited.co.za.

Thank you SAMA members.

CLICK HERE to get your **FREE** Personal Accident Cover of up to R100 000

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QUERIES

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Discount to SAMA members on all botulinum toxin courses

Dr Aniali Aucamp-Nel, *Transform Medical Aesthetic Institute, Centurion*



Recently trained aesthetic practitioners only realise how much more they have to learn about identifying various facial characteristics when they start seeing patient after patient at a busy aesthetic clinic. During training sessions, most doctors are told where and how much to inject, and the markings are made for them, with little or no education on anatomy or the mechanisms involved in facial movements. Therefore, newly trained aesthetic practitioners feel unsure which muscles to focus on and which to avoid. They are certainly not equipped to customise treatments for asymmetrical or atypical facial movements. This gives rise to incorrect actions, where all patients are injected with equal doses, and more or less in the same manner. This results in many patients being dissatisfied. In an attempt to customise treatment approaches, horrendous mistakes are made, with resultant ptosis of prominent muscles.

Botulinum toxin is an extremely important part of aesthetic practice, and it has evolved so that great things can be achieved when it is administered correctly.

I have designed 3 botulinum toxin courses for foundation, intermediate and advanced levels. They are all accredited for clinical and ethical CPD points. My aim is to provide practitioners with in-depth knowledge of how the nerves and muscles of the face act together to create specific facial expressions – for example, a strange-



looking eyebrow; an eyebrow that is lower/higher than usual; flat, low-set eyebrows; or a droopy corner of the mouth. This knowledge will enable the practitioner to create a well-designed and pleasing appearance. The trainee will also be taught how paralysis of specific muscles may reduce grinding of the teeth, sculpt facial contours, reduce twitching and increase the intervals between migraine attacks.

A good filler administrator requires an in-depth knowledge of injection techniques, and how to use combinations of different techniques and injection planes to obtain the desired results. Excelling at botulinum toxin injections is less about perfecting the injection technique than about understanding the theory behind muscles and nerves. For this reason, I spend up to 75% of each botulinum toxin training session on theory, and the remaining 25% on injection technique – focusing on which muscles to paralyse in order to allow other muscles to dominate, and which danger zones to avoid to prevent unwanted ptosis.

When you come to understand the actions of facial muscles and nerves, creating

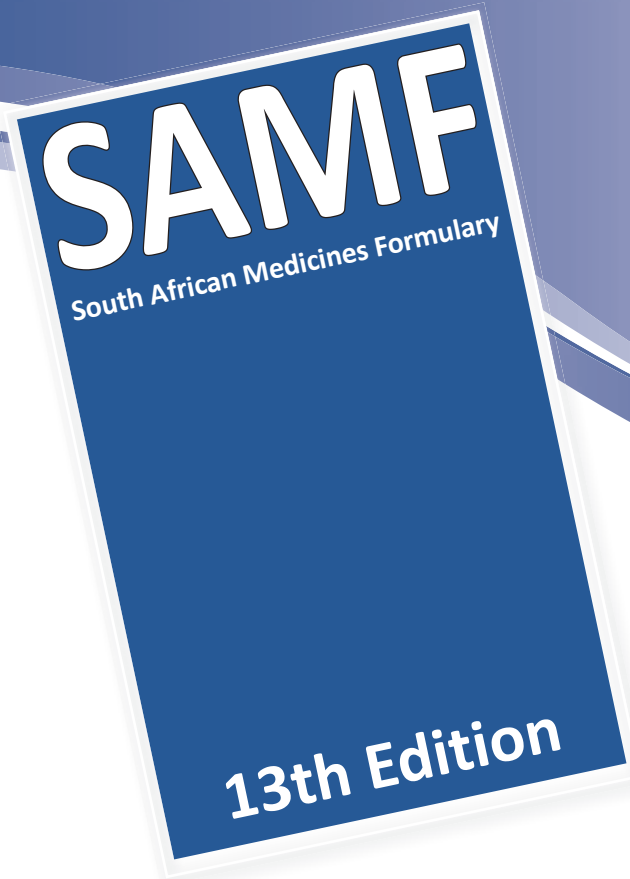
Dr Aniali graduated as a medical practitioner from Stellenbosch University. She obtained aesthetic certifications in advanced botulinum toxin and filler techniques, microsclerotherapy, laser and lipolysis in the UK, where she worked for 10 years. She completed her training in advanced silhouette soft techniques in SA.

Botulinum toxin is an extremely important part of aesthetic practice

a specific appearance or result or rectifying a defect may feel similar to applying the final touches to a painting.

Please visit www.trainingattransform.com for course information, training dates and to register, or send an email to training@transformmedical.co.za for any enquiries. SAMA member will receive a ZAR500 discount on all courses.

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