

# SAMA INSIDER

FEBRUARY 2021



## COVID-19 vaccines: Access and equity

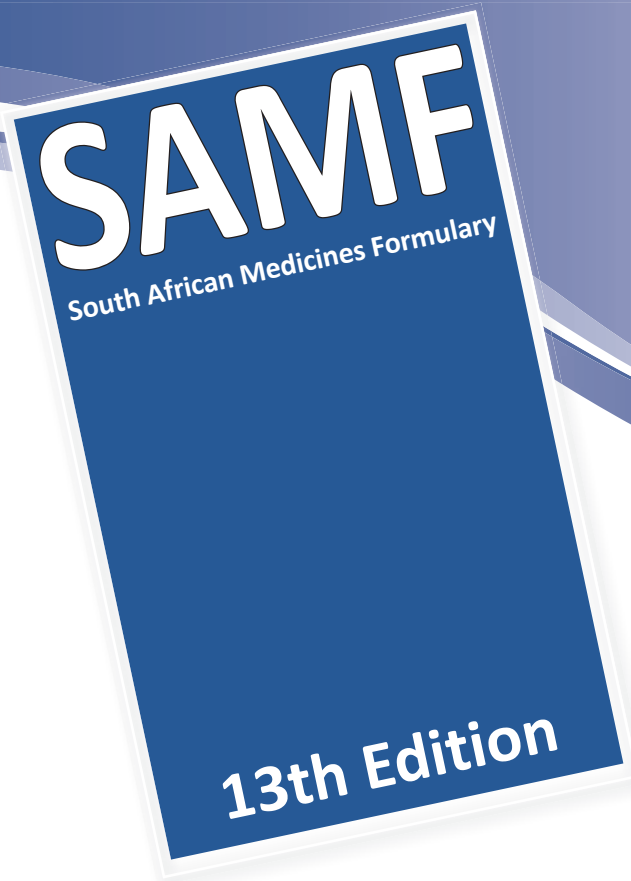
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## SAMAREC

The South African Medical Association Research Ethics Committee (SAMAREC) has been a well-established Research Ethics Committee (REC) in South Africa for the past 27 years.

As a registered REC with the National Health Research Ethics Council (NHREC), the Council reviews biomedical research proposals for research to be done in the private sector.

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**Diane de Kock**  
Editor: *SAMA INSIDER*

## A helping hand in 2021

**W**elcome to the first *SAMA Insider* of 2021, a year that promises to be as challenging if not more so than 2020.

This month we welcome new interns to SAMA (page 8), and hear from SAMA chairperson Dr Angelique Coetzee as she ushers in 2021 (page 4): "SAMA's major priority remains to serve our members to the best of our abilities as we continue to offer a united voice for members." SAMA has built relationships in 2020 that can only benefit the organisation and its members.

We report on a webinar, held in November last year, which looked at "COVID-19 vaccines: Access and equity". The webinar provided an overview of vaccine research, whether vaccines can be rolled out equitably from a practical perspective and how our communities will be involved and prioritised (page 5). As we move into 2021, these questions become of paramount importance. Speaker Mx Tian Johnson said: "This is the moment for science to do right and for the government to do right – and for communities to ensure that that happens."

Doctors are under huge pressure, a pressure not likely to decrease this year. One of *SAMA Insider's* aims is to assist doctors in dealing with these pressures by running a series of related articles. See Prof. Zingela's article (page 9) on dealing with failure and rejection in the face of the COVID-19 onslaught. Please let us know if there is any subject you would like us to address, or if you would like to submit an article for publication.

We look at two apps – Wardworx and Vula – that both aim to make a doctor's job a little easier (page 11 and 15), and MPS reports on a survey addressing the benefits of telemedicine in SA (page 13).

The journey to qualification is often extremely challenging – Dr Eurika Mogane (page 19) provides inspiration and guidance as she relates how she achieved her qualification as a medical/clinical researcher.

With this in mind we would like to invite members to communicate and share via *SAMA Insider*, your magazine.

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# SAMA chairperson ushers in 2021

Dr Angelique Coetzee, SAMA chairperson



Dr Angelique Coetzee, SAMA chairperson

On behalf of the SAMA board of directors (BOD), I would like to wish all our members a better 2021. SAMA's major priority remains to serve our members to the best of our abilities as we continue to offer a united voice for members, and with that, strength in numbers.

2020 has been an extremely challenging year for all healthcare workers in SA. Being a doctor in our country is and has always been challenging – poor working conditions, gender-based violence, violence against our members, poor safety conditions at public hospitals, intern placement problems, the NHI and litigation against doctors are some examples. But this year the challenge increased tenfold with the arrival of the COVID-19 pandemic. SAMA has played a vital role in meeting these challenges.

SAMA members and our other healthcare colleagues should be proud of the role they have played in caring for patients during the COVID-19 pandemic. We are all trying to adapt to changing circumstances while consistently going above and beyond the call of duty to ensure that we provide the same high-quality care we have always delivered. It has become important for all to recognise the stresses we are facing. Never before has the demand

been so high nor the need so acute to unite the profession and address its needs and challenges.

In September 2020, the Department of Health reported that a cumulative total of 32 429 healthcare workers had tested positive for coronavirus. Over 300 have succumbed to COVID-19. The loss of lives within the SA healthcare system is devastating. Not only have we experienced personal loss of friends, colleagues and mentors, but also the loss of a wealth of experience and essential specialised expertise, which will take years to regain. Healthcare workers are the true heroes in the fight against the COVID-19 pandemic. At no time has the spotlight on their role in society been more evident, and their role acknowledged, than during this period.

The impact of the second wave has once again highlighted the additional strain on our already over-fatigued healthcare workers in understaffed facilities. This is affecting other areas, and is raising problems in, for example, the fight against HIV/AIDS and TB. For example, in the Eastern Cape, more than 25 000 people living with HIV/AIDS have not collected their antiretroviral treatment during lockdown, and condom distribution fell from a projected 46 million to 26 million units. The freezing of posts is also not conducive to providing the necessary support. SAMA has addressed regulations and interacted actively in various committees and structures to influence decisions and policy relating to the profession.

## Healthcare workers are the true heroes

Intern and community service placements for 2021 have been a priority for SAMA, and we have influenced the outcome. We foresee that we will need to re-examine the current systems, or we run the risk of producing more doctors than we have the ability to place.

Financial management of medical practices and clinical competence will be a focus for SAMA going forward. We will be looking at some of these issues in the

planning of our CPD programme for 2021, and invite members to make use of our SAMA Legal Department for any assistance or advice. I would also urge our members to engage more when we ask for input and views on specific issues and policies in 2021. Our Knowledge Management, Research and Ethics Department needs member feedback to be representative of our members' views.

## The relationships we have built will only benefit the organisation and its members

SAMA aims to increase some of our member benefits this year that deal with issues important to members.

SAMA adapted quickly to the new way of operating, and began to play a much more visible role in providing the public and our members with information. This is part of the important role that SAMA plays in our society, a role that will remain crucial as the pandemic unfolds.

Our adapted approach has seen us become more vocal in addressing issues facing the profession, and we have found alternative ways of providing members with CPD-accredited opportunities, through our own webinar series and by partnering with others.

We have done all this while addressing internal problems with the trade union, and looking at restructuring the organisation to best serve our members. Although some of the challenges we face have not been resolved and more work is required this year, positive changes have occurred and a strong foundation is being laid for SAMA going forward. The relationships we have built with community organisations, government departments and other important stakeholders will only benefit the organisation and its members in the future.

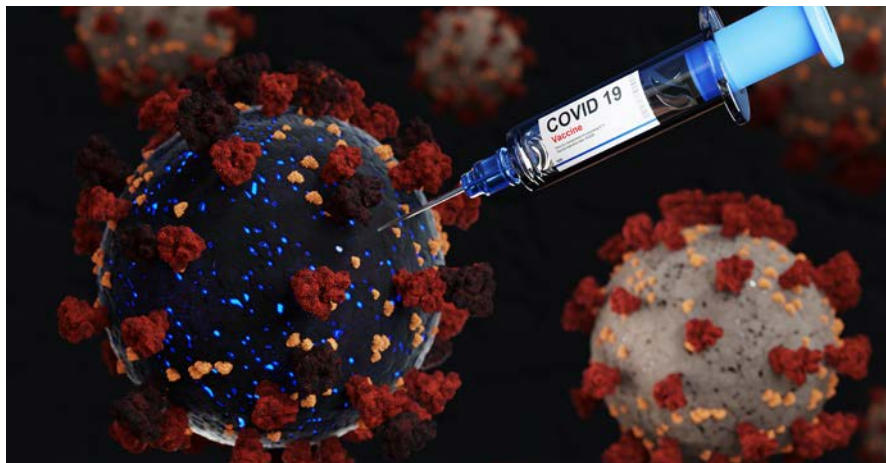
I would like to extend my sincere gratitude to all SAMA managers and staff, and together with the SAMA BOD, I am looking forward to a very busy and productive 2021.

# UNESCO NBC hosts webinar on COVID-19 vaccines: Access and equity

Safia Mahomed, Gail Andrews, Glaudina Loots, *UNESCO National Bioethics Committee*

On 25 November 2020, the SA National Bioethics Committee (NBC) of the UN Educational, Scientific and Cultural Organization (UNESCO) hosted a webinar entitled “COVID-19 vaccines: Access and equity”. Initially, news of several COVID-19 vaccine contenders had brought hope and relief to the global public; however, as questions around how lower-middle income countries (LMICS) would have equitable access to a vaccine started to unfold, we, as a nation, found ourselves asking whether once again, we would be last in the queue as rich countries raced to buy up and hoard vaccines, as has been the case in the past. The webinar was organised by Dr Gail Andrews, Deputy Director-General of Health, from the National Department of Health, Ms Glaudina Loots, Director, Health Innovation, from the Department of Science and Technology and Prof. Safia Mahomed from UNISA’s School of Law. All three are members of the NBC. The objectives of the webinar included providing an overview of vaccine research from a global perspective, with a focus on Africa and SA discussing the challenges associated with vaccine research, analysing whether vaccines can be rolled out equitably from a practical standpoint and how our communities will be involved and prioritised. A synopsis of the webinar follows below.

Prof. Safia Mahomed provided introductory remarks, where she outlined a number of specific questions that the public require clear answers to, including: what we know and do not know about the vaccines; where we stand as a continent and nation when the skewed imbalances regarding equitable access to a people’s vaccine are already at play; how we overcome conspiracy theories and hesitation towards a vaccine when misinformation and myths have cast doubt on the value of vaccines in recent decades, and even more so during the pandemic; whether we have the systems in place to manage vaccine rollout and delivery; whether our health systems will cope and our country afford to pay not only for the vaccines, but all the added costs involved in distribution and rollout; who will be prioritised in vaccine rollout; and who should and will receive the vaccine first. Another point was the shared responsibilities



of civil society towards ensuring access for all in solidarity with fellow countrywomen and men. Communicating in an open and transparent manner about how vaccines will be distributed, and when this is anticipated, is key to building trust. Currently, SA lacks a clear message from its leaders.

The first panellist, Prof. Salim Abdool Karim (director: CAPRISA and co-chair of the SA Ministerial Advisory Committee on COVID-19) analysed the latest COVID-19 vaccine results from Pfizer, Moderna, the Oxford trials and the early-phase Russian study. He provided an overview of what these results would mean for SA in the wake of positive cases growing exponentially with no signs of easing. He explained that all populations are at risk, and that the pandemic cannot be beaten by a single country. This virus has helped us understand our interdependence and interconnection in a globalised world. He cautioned that while the news of vaccines brought hope, at that stage, we did not know the full results and therefore could not compare study endpoints properly. However, different vaccine contenders using diverse technologies allow choice, should one contender be unsuccessful. In SA’s case, about one-third of the population displays vaccine hesitancy, and therefore, no matter how successful a vaccine is, we may find it difficult to achieve herd immunity due to this hesitance by our communities. He highlighted the issue of vaccine nationalism, where certain countries, for example Canada, have secured almost 10 doses of vaccine per person. This

indicates that high-income countries (HICs) are hedging their bets and pre-ordering vaccines, which leaves LMICs questioning whether they will manage to secure sufficient doses for their populations. COVAX, for example, had at that stage not even secured one dose per person. Prof. Abdool Karim left the audience with five key considerations in choosing the most appropriate vaccine for SA, the first being that we need a vaccine that is safe, and the second, that it is highly effective. We then need to consider the costs, ease of storage and administration and lastly, whether the vaccine consists of one or two doses. A vaccine in one dose would be greatly preferable for SA. A vaccine will tilt the COVID-19 toolbox enormously, and allow us to protect ourselves.

## SA lacks a clear message from its leaders

Mr Jens Pedersen (senior humanitarian policy and diplomatic adviser: Médecins Sans Frontières/Doctors Without Borders) questioned whether the COVID vaccines are another example of African exclusion. He indicated that we needed to accept that there could not be equitable distribution regarding access to a vaccine once it has been developed, when transparency is so limited. Transparency around the development of a vaccine is the norm; however, this is where

transparency stops, as manufacturing is a very closed process. There are strong reasons to be sceptical regarding equitable distribution when similar initiatives have failed in the past in other outbreaks – for example, Ebola, where development primarily lay in the hands of one manufacturer. Considering the history of lack of access to personal protective equipment in some countries, it is no surprise that this will be the case for distribution of the vaccines. In addition, how can we determine what a fair price for a vaccine should be, when we do not know what development costs really are? The issue of cost is usually a political one, and Africa needs to be more forceful in making demands – for example, a demand to manufacture its own vaccines. However, specific barriers exist regarding patents and intellectual property within the manufacturing process, which negatively affect equitable distribution. This influences all links in vaccine development, which makes it difficult for LMICs to proceed in the manufacturing challenge. Mr Pedersen stressed that the crux of the issue involves manufacturers who have argued that production costs are high, despite seed funding coming from governments and other institutions, in the main. In addition, certain manufacturers claim that quality is guaranteed through their processes (which occur outside of SA), and therefore manufacturing cannot be done in SA. However, this argument is flawed, and if we as a continent do not tackle the source of the problem, i.e. manufacturing, demand will never meet supply. We need to invest in structural mechanisms that allow us to manufacture the vaccines. Transparency must be maintained even after vaccines are developed, and the monopolies around who determines price and who controls supply must be challenged. Transparency

throughout the process could also counter vaccine hesitancy, as a large part of this problem results from a lack of information provided to communities. Trust is key, and we need to ensure that it is built up throughout the process.

### **This is a moment for science to do right and for the government to do right – and for communities to ensure that that happens**

Mx Tian Johnson (founder and strategist of the African Alliance, and founding member of the Vaccine Advocacy Resource Group) focused on accountability and agitation for equitable access from a community engagement perspective. Tian indicated that community engagement has become a sideshow, where communities are consistently side-lined and civil society blocked from tables where decisions are made. He asked: “What does equity actually look like in one of the most unequal countries in the world?” We need to remember that the vaccine is arriving in a specific context, and that equitable access cannot be realised in the dark. Therefore, the importance of access agreements should not be minimised. It should not be left to activists, with already strained resources, to fight for transparency and access. Will we rely on big

pharma to determine the end of a pandemic, the end of which opens the floodgates for the same big pharma to profiteer from COVID-19 vaccines for its shareholders? Research must also embody a conscious standard of care – not looking only at what is publicly available, but at what is ethical – what is the right thing to do by communities that make the science possible. We need to advocate for socially conscious regulators. How do we manage expectations around resourcing while agitating for conscious funding of access when in 2020, public officials in Nelson Mandela Bay Metro were arrested for corruption totalling 56.4 million rand? That equates to 94 000 Pfizer COVID-19 vaccinations. Tian left the audience with a few final thoughts, including on: support for a people’s vaccine; reformation of patent laws and intellectual property systems; strengthening SA’s engagements with the African Union; finding a cohesive response to vaccine hesitancy, and proactively addressing the spread of misinformation; no exclusivity or profiteering from the tools used in the COVID-19 response; and community engagement as imperative and not a luxury. Tian closed with the following: “This is a moment for science to do right and for the government to do right – and for communities to ensure that that happens.”

A robust discussion followed the presentations, and the audience had many questions regarding equitable access of an efficacious vaccine for SA. We need transparency throughout the process, coupled with a consistent message from our leaders regarding an effective rollout plan for SA. Trust, which must be built to counter hesitancy among our communities towards a vaccine, is key.

## **SAMA applauds vaccine procurement for healthcare workers**

*SAMA Communications Department*

**S**AMA applauds the National Department of Health (NDoH), and the Minister of Health Dr Zweli Mkhize, on the acquisition of 1.5 million doses of coronavirus vaccines.

Dr Mkhize says the acquisition of the AstraZeneca vaccine from the Serum Institute

of India (SII) will arrive in two batches: 1 million doses will arrive in January, and another 500 000 in February. He says these vaccines will be used for the approximately 1.25 million healthcare workers in the public and private sectors.

“We are naturally thrilled at this news and urge all our members – and all healthcare workers across the country – to participate in the rollout and to protect themselves against COVID-19,” says Dr Angelique Coetzee, chairperson of SAMA.

Dr Coetzee says that every single person in SA must be vaccinated against coronavirus, and it is critical that frontline healthcare workers who are assisting others receive it urgently.

In his statement earlier, Minister Mkhize noted, "We are happy that the SII/AstraZeneca vaccine has already been approved by various regulators and is being rolled out in other countries. Therefore, as part of expediting the regulatory process, SAHPRA [the SA Health

## We urge all our members to participate in the rollout

Products Regulatory Authority] is applying reliance on that regulatory work."

"This is a big step in the right direction, and is to be welcomed. While this process is unfolding, it is now necessary that further vaccines are procured to ensure that every person in the country is vaccinated and protected," says Dr Coetzee.

Dr Coetzee says that SAMA will engage with the NDoH and other roleplayers to ensure the effective rollout of the vaccine, particularly to private sector healthcare workers.

# GEMS on track to support COVID-19 vaccine rollout efforts for public service members

*SAMA Communications Department*

Following the announcement by the Minister of Health, Dr Zweli Mkhize, on the COVID-19 vaccine rollout strategy, the Government Employees Medical Scheme (GEMS) has affirmed its readiness to support government efforts to ensure broader reach of the vaccine for its members and their dependants, in line with the priority groups identified in the strategy.

## The scheme is ready and committed to paying for the approved vaccine

According to Dr Stan Moloabi, principal officer at GEMS, "the scheme is ready and committed to paying for the approved vaccine to the benefit of a large number of frontline workers, as our members are mostly frontline workers in the public sector, and the vaccine funding allocation will go a long way towards protecting them.

Once approval by the SA Health Products Regulatory Authority (SAHPRA) is obtained for the clinically appropriate vaccine that is being centrally procured by the government, GEMS will fund the vaccine(s) for all members who stand to receive the vaccine, in line with rollout strategy announced by the minister.

The funding will be prioritised for vaccination in line with the targeted population groups to support efforts to achieve herd

immunity through the three-phased approach announced by Minister Mkhize. The vaccine rollout will be guided by the protocols prescribed by experts assisting government.

"As a member-centric scheme, we are fully committed to our mandate, which is to provide equitable and affordable access to healthcare to public service employees," he said.

Dr Moloabi further confirmed that GEMS will continue to cover the COVID-19 vaccine as part of the prescribed minimum benefit (PMB) entitlements, in line with the pronouncements of the regulator, the registrar of the Council for Medical Schemes. Therefore, all costs will be covered as a PMB, and current member contributions and benefit allocation will not be affected.

Dr Moloabi highlighted the fact that although the cost of each dose of the vaccine is still unknown, and dependent on the outcome of government's COVID-19 vaccination centralised procurement process, which is currently underway, the scheme remains ready to fund the vaccine, as it had already committed a budget for the vaccine in its 2021 benefit entitlements, thus taking strides that will enhance the vaccination reach.

Finally, concluded Dr Moloabi, it is the scheme's view that "this pandemic is a test to the systems that the country is developing to drive the implementation of national health insurance (NHI) in the country. By providing universal access to the COVID-19 vaccine in line with the country's priorities and individual healthcare needs, we have the opportunity to collaborate and demonstrate that we can



*Dr Stanley Moloabi, principal officer, GEMS*

realise universal healthcare coverage and provide equitable access to quality healthcare for the country."

GEMS, as a member of the Board of Healthcare Funders along with other schemes, will develop a detailed framework that will guide the industry and the member schemes of vaccine funding.

GEMS is the largest restricted medical scheme in SA, and covers the highest number of public service employees in the country, with over 754 000 principal members and 1.9 million beneficiaries. The scheme also has the broadest definition of beneficiaries, covering a comprehensive range of extended family members.

## SAMA welcomes 2021's new intern doctors

Dr Angelique Coetzee, SAMA chairperson

On behalf of the SAMA national council and board, I would like to welcome all new interns who have joined the ranks of our noble profession. We are all privileged to be part of a profession whose goals are to improve the health of our fellow human beings, and to prevent illness and death. Doctors practise medicine as members of a team, and those of us who have been in the profession for many years know that good medical care revolves around good teamwork. SAMA is part of that team, offering a united voice for healthcare professionals, and strength in numbers.

This is an exciting time – you are finally a “real doctor”, and at the same time you are probably filled with trepidation. Being a doctor in SA has its own challenges, as there are not enough of us. Some of you will work long hours and experience difficult conditions as a result of SA's high burden of disease. You may face unexpected challenges, and possibly some unfairness. Please remember that SAMA is here to look



after your interests – never hesitate to call and discuss your concerns. You can find your local representative in the hospital where you work, at the closest SAMA branch or in a senior colleague who is a SAMA member. More information can be found on the SAMA website: <https://www.samedical.org>.

We encourage you to take part in SAMA activities. As a recently qualified doctor, we also urge you to join the Junior Doctors Association of SA (a SAMA special interest group). This is a critical time in healthcare

in our country, and we hope that you will be an active member of your association. You have a unique opportunity to influence decisions and advocate for your profession, your patients and your community.

Medicine is known for the collegiality that exists among members of the profession, and this is the time to take advantage of that, as you will develop and nurture some lasting relationships.

SAMA wishes you all the best as you embark on your internship this year.

## Dr Coetzee wins Discovery Leadership Award

SAMA Communications Department

The year 2020 was a difficult one for many, especially those in the healthcare sector. A crucial part of overcoming the hurdles the year consistently placed in our way was strong and thoughtful leadership. To recognise exactly that, SAMA chairperson Dr Angelique Coetzee was awarded the Discovery KZN Doctors Healthcare Coalition Leadership Award “in honour and recognition of her exemplary and continued contribution to the profession and the healthcare sector at large”.

In making the award, Discovery noted of Dr Coetzee, “Her leadership continues to drive advocacy for issues that are pertinent to the sustained effort to improve access to quality healthcare in both the private and public healthcare sectors. Discovery applauds her efforts and encourages the emerging leadership among the profession to follow Dr Coetzee's impressive example.”

Through its Clinician Leadership Awards, Discovery aims to showcase exceptional clinicians who contribute to the country and society. It says others are encouraged to follow their example.

“From early on in her career, Dr Coetzee has committed herself to serving the profession, beyond the bedside, through her bold and collaborative leadership. Her years of service have culminated in meaningful contributions in advocacy, and positive change in the healthcare industry,” reads part of the citation to Dr Coetzee.

Dr Coetzee says she is humbled by the award and that it represents the work done by SAMA to unite the medical profession, and improve working conditions of doctors throughout the country.

“Of course this is an amazing honour and I am truly grateful to be recognised in this way. I am in a fortunate position where I can speak up on issues that affect our profession;



Dr Coetzee with her award

it's a duty I don't take lightly. It's great to win an award for leadership, but we must never forget that our goal is always to improve the working conditions of doctors and, ultimately, to improve the care we provide to patients,” says Dr Coetzee.

# Dealing with failure and rejection in the face of the COVID-19 onslaught

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



**T**he nature of our profession as medical practitioners demands that we give our all as we fight every day to save the lives of those we care for. These past few months have been harrowing, with our hearts and minds left reeling from the loss of trusted colleagues, friends, family and loved ones. The outbreak still marches on, unmoved by our plight. Add to that the usual life and career challenges, which have not stopped just because we are dealing with a pandemic, and one is faced with unrelenting pressure from all sides. It is no wonder some of us are at breaking point.

## It is no wonder some of us are at breaking point

Doctors are used to getting things right most of the time. Equally, we are used to saving lives instead of losing them. The outbreak has upended all we knew to be the norm. COVID-19-related deaths have confronted us with the limits of our powers, despite all our scientific knowledge and expertise. This situation brings with it an unprecedented and acute sense of failure, the proportions of which we last felt during the height of HIV-related deaths. Add to this the perceived lack of acknowledgement of our sacrifices from

the general public, who go around partying up a storm without masks on, and the fact that health workers, by virtue of being civil servants, did not get their usual annual salary increase in 2020, and one is left with a sense of futility and rejection as a frontline healthcare worker. We are buckling under the load of this onslaught, which understandably feels like a targeted rejection of our self-sacrifice and service as we fight to save the nation in a health system that was not fully prepared to deal with the outbreak. All the work we are doing, even in the face of danger to ourselves and loved ones, feels unappreciated and undervalued, mainly because actions speak louder than words. So whatever gratitude is expressed, however many times we may be called heroes, if the behaviour of those we serve overwhelms the already stressed health system and we are not supported with enough resources and personnel to do our job and save lives, then these become empty, meaningless words. The irony, however, is that we are the ones left feeling as if we are failing the public.

## Dealing with failure and rejection

Health practitioners have also not been able to continue with their lives as normal. Anything and everything had to be cancelled, from wedding plans to study plans, travel plans to job plans. Where the average person could at least be excused from carrying their usual responsibilities at work due to the lockdown, we have had even more strain at work because of having to carry additional responsibilities that came with the outbreak. In addition, the lengthy lockdown period placed immense pressure on the financial security of colleagues whose private practices could not continue functioning normally. Relationships with spouses and other family members also came under strain. The sense of failure and rejection due to the prevailing conditions within our work and personal space has been felt acutely, and adds to our current challenges.

It is also human to take failure and rejection personally. From a young age, we learn that these are to be avoided, that they bring with them humiliation and ridicule. So rather than

learning to deal with them early on, we spend a lot of time and energy avoiding them. But the nature of life is such that we all have our highs and lows, our moments of being accepted and welcomed alternating with moments of being rejected.

## Identify what is within your control to change, and target that

In dealing with these experiences, we need to move on from our tendency to perceive failure and rejection as a fatal personal flaw, to a state of recognising that they are a normal part of the human experience. Ours is to weigh the facts, to try and recognise what part we are responsible for in such experiences and to balance that with what we can ascribe to other factors that may have nothing to do with us. Even in cases where we may feel totally responsible for failure or rejection, these experiences are just one moment in what is essentially a lifetime of other experiences we may have. They do not define 100% of who we are, nor do they define our future. Failure today does not mean failure tomorrow. Rejection today does not mean rejection tomorrow.

We also need to know our strengths and weaknesses. This can help us to avoid putting ourselves in situations more likely to shine the spotlight on our weaknesses. Equally, the ability to recognise situations that will play to our strengths can help us to rebuild our confidence levels, which may often be dented by failure or rejection. So, if you find yourself facing rejection after rejection or failure after failure, the trick is to take a step back and identify what you have previously been successful at, what worked for you in those instances and what you could possibly do to recreate similar chances to showcase your strengths again. Identify what is within your control to change, and target that. If necessary, learn any new skill that plays to your strengths and may help you to adapt.

# Book review: *Bioethics, Human Rights and Health Law: Principles and Practice*, 2nd edition

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

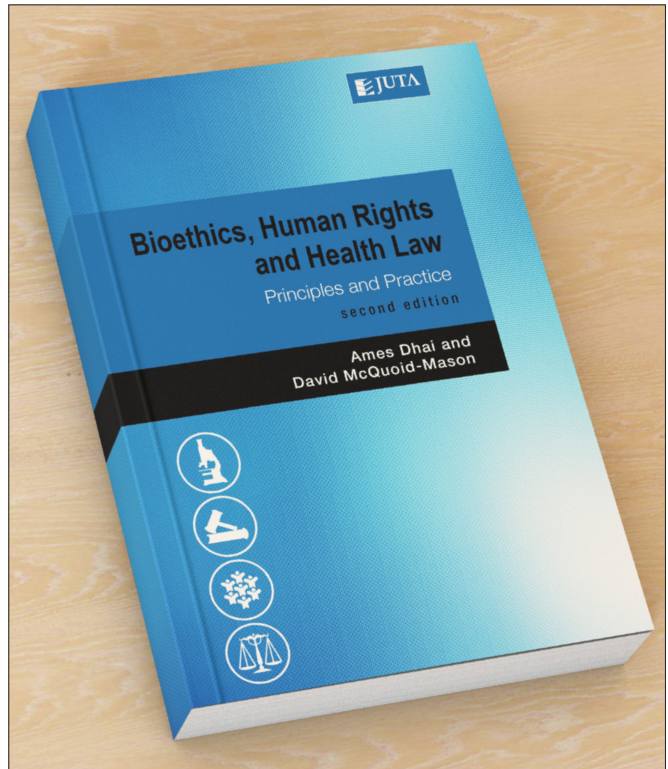
There are many bioethical issues and dilemmas raised by medicine, healthcare and science that are of great academic, professional and public interest. Building on the first edition, the latest issue of *Bioethics, Human Rights and Health Law: Principles and Practice* provides a highly original, practical and insightful introductory guide and resource for healthcare professionals, legal practitioners, healthcare students and law students seeking a deeper understanding of ethical and legal issues in the clinical environment. As a concise but authoritative text and reference book, it provides a unique perspective on bioethics, human rights and health law for the SA situation.

## The book is an essential and indispensable academic instrument

Authors Ames Dhai and David McQuoid-Mason methodically use their years of experience in bioethics, human rights and health law to develop a text that will equip students and professionals with the tools essential for an encyclopaedic ethicolegal examination. Drawing from modern research and incorporating case studies and real-life examples and scenarios, they illustrate how ethical concepts, human rights instruments and health law can be applied to different conflicts and dilemmas, from issues around consent and confidentiality to the use of human tissue and disputes around resource allocation. The authors have also ensured that regular reference is made to the COVID-19 pandemic and to tragedies such as the Life Esidimeni saga, indicating an appreciation of recent topics that may affect students and professionals alike.

The book is helpfully laid out in two parts. An introduction to bioethics, human rights and health law is given in part 1, and includes chapters on ethical principles, theories and values, the International Code of Ethics, health and human rights and basic health law. Part 1 serves as both an overview of bioethics, human rights and health law for those without knowledge or training in the field, and a refresher for even the most seasoned professionals and enthusiasts.

Part 2 deals with specific topics such as professionalism and healthcare, the practitioner-patient relationship, consent, confidentiality, reproductive health, HIV/AIDS and the law, medical malpractice and professional negligence, resource allocation, the use of human tissue, human health and the environment, healthcare aspects of business ethics, death and dying, and the ethics of research. Each chapter has an introduction that is then followed by an illustration of an ethicolegal dilemma or dilemmas that may be faced in a healthcare context, explains pertinent concepts, discusses their implications from an ethical, human rights and health law perspective and then offers realistic and applicable solution(s). Concluding remarks and questions on specific topics are provided, which allow readers to stay engaged and apply what they have learnt.



The relatable style in which this book is written makes it an essential and indispensable academic instrument for both the health sciences and the legal fraternity. The authors have made sure to avoid the unnecessary and tiresome terminology that is often evident in bioethics, human rights and health law, allowing the reader to effortlessly follow the text and discussion without losing the intention with which the book was written.

Below is a non-exhaustive list of new/updated information contained in the revised chapters:

- the SA Patient Rights Charter
- regulation of social media in healthcare
- telehealth and the regulation thereof
- issues around dual loyalty in healthcare
- consent by children to termination of pregnancy
- regular reference to the COVID-19 pandemic
- alternative dispute resolution
- ethical and legal issues regarding genomics and genetics
- palliative care.

Concerning its content and presentation, as a professional trained in the field of bioethics and health law, I have great regard for this book. I recommend it to anyone with or without previous knowledge of the subject who is interested in bioethics, human rights and health law.

*Dhai A, McQuoid-Mason DJ. Bioethics, Human Rights and Health Law: Principles and Practice, 2nd ed. Cape Town: Juta and Co. Ltd, 2020.*

# Wardworx – the task management app created for doctors, by doctors

Dr Peta-Anne Browne



Keeping track of where all your patients are and what ward work needs to be done for each patient is a problem we have all faced at some stage during our clinical rotations, internship, community service and beyond. The heavy patient loads and paper-based systems in SA's public hospitals have led most of us to solve this problem by creating a ward list of some description – from a written list on the back of a prescription to scribbles on the back of your hand.

The Internship Organiser is a diary that I created in 2016 during my final year of medical school in preparation for my own internship. It contains planners and patient task lists, and aims to simplify the daily job of an intern. I initially sold the book to my peers, and eventually gave myself the challenge of getting the book into the hands of all of SA's interns to help each and every one of them. By working with sponsors such as SAMA, Discovery Health, Adcock Ingram and Nedbank, the Internship Organiser has been gifted to every medical school graduate in the country for the past 3 years, bringing the total copies distributed to 7 723, to date. The Internship Organiser now also contains curated content that uplifts and empowers the interns of SA.

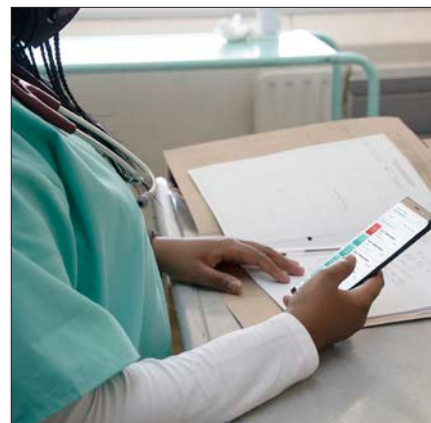
The world around us is starting to embrace technology, and medicine is no

different. In 2020, I noticed the rise of doctors making use of their cellphones to solve the problems they were facing while managing patients in a hospital setting. The more I researched and engaged with doctors on the ground, the more I realised that there was an overwhelming need for an innovative solution. In a survey, 81% of doctors were willing to use an app to keep track of their patient task management. And so began the adventure of founding a healthtech start-up.

January 2021 marked the launch of Wardworx – a task management app created for doctors, by doctors. Wardworx allows you to create and securely store lists of important patient information, including ward and bed location. Thereafter, tasks can be added, prioritised and completed for each patient, all while syncing this information in real time with doctors in a team, allowing for secure collaboration. Now every member of the team from consultant to intern can be on the same page, no matter where you are in the hospital.

In order to add value in the fast-paced hospital setting, making Wardworx quick and user-friendly was non-negotiable. We worked with a panel of doctors from around SA to create features and designs that doctors actually want. We then tested and validated those features with real doctors on the ground. The result: Wardworx is simple, easy to use and proudly South African. Did I mention it's free?

Six years of medical school doesn't really prepare you for the world of business, technology and start-ups, but I have been supported by an incredible technical team and have been welcomed by the healthtech community of SA. We were lucky enough to have encouragement and advice from Mohammed Dalwai, co-founder of EMGuidance, William Mapham, Founder of Vula Mobile and Andrew Davies, CEO of Signapps. Wardworx took part in the Gauteng Accelerator Programme hosted by the Innovation Hub, and was awarded second prize in the ICT category, giving us the opportunity to be incubated at the Innovation Hub this year. We look forward to what 2021 has in store for us.



 Try for free

Download Wardworx and let us know what you think. Your input shapes the way Wardworx grows – this is an app for you! We hope to inspire other young doctors to innovate. Together we can create a better SA healthcare system.

For more information or to download the app, visit [wardworx.app](https://wardworx.app).

Instagram: @wardworx\_app

Facebook: @wardworxapp

LinkedIn: wardworx

Email: [wardworxhelpdesk@gmail.com](mailto:wardworxhelpdesk@gmail.com).

# Criminalisation of medical practice does not prevent human error

*SAMA Communications Department*

SAMA says the criminalisation of medical practice does not prevent human error, and that a transparent, fair and consistently applied process must be used to investigate medical errors, and to respond accordingly to the results. The medical association takes this view in light of recent developments, where doctors have been arrested and summoned to appear in court without proper medical investigations first preceding these events.

SAMA says that doctors take a sacred oath to “first do no harm”, and that they understand the pain of losing a loved one; the association notes that doctors, too, are traumatised by the loss of a patient.

It says the mandate of the medical profession is to intervene in the natural course of a disease or trauma in the best interests of the patient, and that with any form of intervention, especially one involving surgery, the patient (or family or society) agrees that their doctor will perform a necessary controlled injury to the body, with the aim of producing a cure. The potential risks are carefully weighed against the benefits, and found to be acceptable to the patient, guardian and society at large.

For this benefit to society, the state agrees to suspend the usual laws that criminalise one person inflicting physical injury on another, on the basis of reasonable and good intent. This transaction of reasonability is what makes the practice of medicine possible.

## Doctors, too, are traumatised by the loss of a patient

But SAMA warns that should this transaction of reasonability not be present, and doctors start either to feel unsafe or that the potential for a possible adverse outcome may constitute an unavoidable risk to themselves, or if they feel that there is a significant risk of criminal charges being laid despite following accepted practice, the knock-on effects are immense.

These are:

- the decisions by prospective and current doctors to either enter or stay in the medical profession



- the significant danger that doctors will become risk-averse and avoid intervention, resulting in life-saving procedures being withheld
- excessive diagnostic interventions and increases in the cost of healthcare
- the potential refusal of doctors to provide interventions when necessary – this type of healthcare risks doctors becoming paralysed in their decision-making.

SAMA says that doctors who commit criminal acts that are not part of patient care must remain liable to criminalisation, as with all other members of society. Serious abuses of medical practice must be subject to the law, usually through professional regulatory processes.

The association notes that countries such as the UK classify a separate level of gross negligence, which implies a severe deficiency in the expected level of care provided by a doctor. However, any events that cause, or may cause, patient harm should be reported promptly and investigated thoroughly using established techniques to identify all possible causes and contributory factors.

Medication facilities, risk management, patient factors and organisational leadership are all partially responsible for determining whether negligence has taken place, and for helping to determine appropriate actions to help prevent further human error and ensure safe patient care.

In relation to the criminalisation of the medical profession, SAMA recommends:

- opposing the criminalisation of medical judgement
- opposing the criminalisation of medical decisions, including a doctor's variance from guidelines and standards
- implementing action plans to alert leaders, elected officials and the media about the detrimental effects on healthcare that result from criminalising medical decision-making
- supporting doctors' rights to professional autonomy and self-regulation
- developing a culture of shared accountability and leadership
- developing a framework to be utilised in future to protect doctors and their patients.

Further to the above, please see the following for additional resources on the criminalisation of the medical profession:

SAMA position statement on criminal charges, 2020: <https://www.samedical.org/cmsuploader/viewArticle/1017>.

WMA Resolution on Criminalisation of Medical Practice, 2013: <https://www.wma.net/policies-post/wma-council-resolution-on-criminalisation-of-medical-practice/>.

National Coordinating Council for Medication Error Reporting and Prevention Statement Opposing the Criminalization of Errors in Healthcare, 2020: <https://www.nccmerp.org/statement-opposing-criminalization-errors-healthcare>.

# SA doctors see benefits of telemedicine – though 9 in 10 concerned that some patients may be left behind

SAMA Communications Department

Many SA doctors see that telemedicine has benefits and will remain a fundamental tool in practice. However, 9 in 10 doctors are concerned that some vulnerable patient groups may be left behind if telemedicine increases post COVID-19, according to a survey by the Medical Protection Society (MPS).

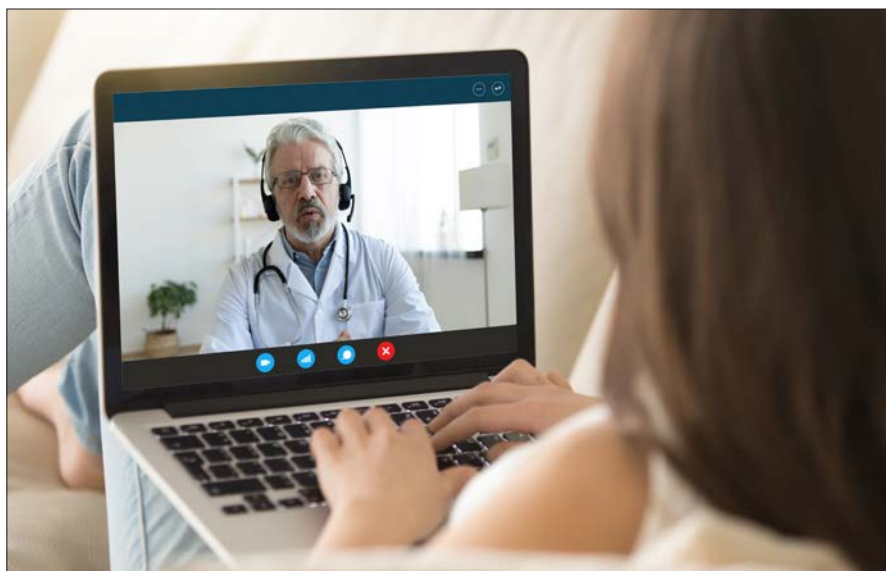
In the MPS survey of 512 SA doctors, 56% agreed that the benefits of telemedicine have been unquestionable during COVID-19, and that it will remain a fundamental tool. However, 94% raised concerns about patients whose access to remote services may be impacted by factors such as digital literacy, disability, language, location or internet connection.

A total of 93% of the doctors surveyed went on to say that they are concerned that if some patients feel excluded from telemedicine, this may result in a breakdown in the doctor/patient relationship, or conditions being left untreated. Additionally, 95% said that they are generally more worried about missing something in a remote consultation, with 79% saying they are more worried about a claim or investigation arising.

## A key concern for doctors is the potential for vulnerable patient groups to be left behind

MPS – the world's leading medical protection organisation, supporting more than 32 000 healthcare professionals in SA – said that the government and healthcare system must take a long-term strategic approach when it comes to the role of virtual care beyond the pandemic, taking into account doctors' concerns, patients' experiences and vastly different levels of access across SA.

Dr Graham Howarth, Head of Medical Services – Africa at MPS, said: "Telemedicine is not a new concept, and the use of technology in delivering medical services has been slowly evolving over the years. However, COVID-19



has fast-tracked large-scale adoption, and SA's entrepreneurial spirit has seen many innovative telemedicine solutions offered to doctors and patients.

"While there have been undoubted benefits during the pandemic, there are naturally concerns around its limitations, the need for support and training due to the different skills required when consulting in this way and the desired role of virtual care beyond the pandemic.

"A key concern for doctors is the potential for vulnerable patient groups to be left behind, and for health inequalities to grow, if there is desire for more patient consultations to be delivered online after COVID-19. Access to remote services could be affected by different levels of access across the country, as well as digital literacy and other factors.

"As doctors have highlighted in our survey, if patients feel excluded from telemedicine, this could lead to a breakdown in the doctor/patient relationship or to conditions going untreated. A significant number of doctors are concerned about the potential for medicolegal disputes and investigations to arise from this and other limitations of telemedicine.

"At earlier stages of the pandemic, MPS was vocal in seeking updated guidance from the HPCSA, which provided greater certainty on the use of telemedicine – or telehealth – during the pandemic.

"MPS has also been working with doctors to help them adapt to the significant increase in telemedicine and to mitigate risks through our risk prevention programmes on the medicolegal, ethical and communication challenges that telemedicine creates. But the burden should not be on doctors to address the digital inequalities across society.

## The government, hospitals and healthcare system as a whole must take a long-term strategic approach

"The government, hospitals and healthcare system as a whole must take a long-term strategic approach when considering the role of virtual care beyond the pandemic. This should be based on the experiences of patients, an ongoing evaluation of the barriers to accessing telemedicine and the concerns raised by doctors."

The survey was conducted by MPS. It ran from 22 October to 6 November and received 512 responses from doctors in SA.

# Resigning from employment: Rules and legislation

Ruan Vlok, employee relations advisor, SAMA Employee Relations Department



SAMA's employee relations department is approached by its members on a regular basis enquiring into the rules and legislation regulating resignations from employment. Instances exist where employed doctors are expected to work a longer notice period than required, while in some instances employed doctors wish to resign while working a shorter notice period. Employed doctors in the public and private sectors are subjected to two different sets of legislation and regulations in this regard. This article will discuss and provide employed medical practitioners with the relevant legislation and regulations on resignations from employment. The Basic Conditions of Employment Act No. 75 of 1997 applies to employed doctors within the private sector, while the Public Service Regulations of 2016 regulating such matters within the public sector.

## Legislation

The Basic Conditions of Employment Act determines:

- "37. Notice of termination of employment –
- (1) Subject to section 38, a contract of employment terminable at the instance of a party to the contract may be terminated only on notice of not less than –
    - (a) one week, if the employee has been employed for six months or less;
    - (b) two weeks, if the employee has been employed for more than six months but not more than one year;
    - (c) four weeks, if the employee –

- (i) has been employed for one year or more; or
- (2)(a) A collective agreement may not permit a notice period shorter than required by subsection (1).
- (b) Despite paragraph (a), a collective agreement may permit the notice period of four weeks required by subsection (1) (c) (i) to be reduced to not less than two weeks.
- (3) No agreement may require or permit an employee to give a period of notice longer than that required of the employer."

The Public Service Regulations determine:

"69. Resignation. –

- (1) An employee may resign from the public service, and for that purpose, shall –
  - in the case of any employee who has been employed for one year or more, give at least four weeks' notice of resignation;
  - in the case of an employee who has been employed for more than six months but not more than a year, give at least 2 weeks' notice of resignation;
  - in the case of any employee who has been employed for six months or less, give at least one week's notice.
- (2) Subject to Section 16B(6) of the Act, the executive authority and the employee may agree to a period of notice shorter or longer than the applicable period referred to in subsection (1).
- (3) An executive authority shall stipulate the manner in which an employee shall submit his or her resignation.
- (4) An executive authority shall conduct and record an exit interview with an employee who has resigned and record the reasons given by the employee for his or her resignation.
- (5) An employee who has submitted his or her resignation to the executive authority may only withdraw his/her resignation with the written approval of the executive authority, which approval shall be made no later than the last working day.
- (6) If notice of resignation is given in terms of subsection (1), the executive authority may require the employee to return all official equipment and documents, vacate his or her office and leave the department before the expiry of the notice period on a day stipulated by the executive authority, and not to perform any duties for the remaining notice period.



- (7) If the executive authority acts in terms of sub-regulation (6), the benefits of the employee shall remain.

## Case law

In the matter of Labournet Payment Solutions (Pty) Ltd v Vosloo (LC Case No J1086/08), the Labour Court found that where an employee gives less than the agreed or statutory notice period, this amounts to a breach of contract. The employer will be entitled to claim damages arising from such breach.

## Conclusion

Should an employee not provide the employer with the proper notice, the employer will have the recourse to recover any damages, as explained in the above case law. The onus, however, is on the employer to prove and quantify any damages claimed. Apart from this remedy, the employer will also be in a position to withhold any statutory monies owed to an employee to recover the shorter notice period.

It is also important to note that the above-mentioned notice period is applicable to the employer should they wish to terminate an employee's services. This notice period will be applicable to dismissals based on incapacity, or operational requirements of the employer, and on the expiry of a fixed-term contract.

The same principles apply to protect employees – an employer may not request an employee to work a longer notice period than contracted, as described above. Such an extension can only be made by an agreement between both parties.

# Vula – opening healthcare doors

SAMA Communications Department

An elegantly simple, free cellphone application (app) called Vula is revolutionising appropriate patient treatment and referrals between primary care facilities and tertiary hospitals, providing timely, accurate and detailed information to help save more lives.

Primary care doctors and nurses use the digital information network on their cellphones to get fast and efficient expert consultant input. They can now also far more accurately and appropriately refer patients upwards in the healthcare system, sharing X-rays, pictures, history and pathology lab records, and presenting symptoms via their secure confidential healthcare practitioner profiles. Consultants in hard-pressed tertiary trauma centres, which at their busiest (as during the COVID-19 lockdown or the current surges) see up to 64 referrals in a 24-hour period, are enthusiastic and grateful for the major changes Vula has wrought.

Emergency physician Dr Hennie Lategan, operational manager at Tygerberg Hospital's trauma unit, says that before Vula, the unit's telephone rang off the hook "around the clock", tying up medical officers for hours in jotting down referral data and/or sourcing the correct advice. Beds were taken up by patients inappropriately referred, triage was cumbersome and time-consuming and the entire patient sorting and treatment process was fraught, sometimes costing lives through sheer patient burden.

Since Vula was introduced in July 2020, the unit's referral phone has fallen almost silent, enabling those among the 14-strong medical officer corps to get on with urgent triaging and treatment of patients under the guidance of the attending consultants.

## "Groundbreaking"

Says Dr Lategan, "It's groundbreaking and has revolutionised the way we work. We're almost exclusively a referral centre, so it's the perfect tool."

Speaking in early December 2020, he said that since July, his unit had handled 3 500 referrals, averaging about 15 in a 24-hour period, but with several periods of intense peak demand.

"Not only can our medical officers now get on with their work, but Vula is amazing on many different levels. We can either accept

the patient or ask the referring healthcare practitioner to send them to a closer and/or more appropriate institution. We can vet referrals to the best care much sooner. We simply can't afford to see the small stuff here – we have to see the big stuff – and Vula enables that."

When Dr Lategan is away from the unit, he uses the Vula dashboard to monitor the number of referrals and their progress, allowing him to give his often-worried hospital CEO a real-time update on the situation at any given moment. The application also locks in all interactions and healthcare responses, enabling him to deal with patient complaints more easily, instead of having to rely on confusing and often contradictory verbal "he said, she said" evidence.

Dr Sue le Roux, an emergency medicine physician who runs the Karl Bremer District Hospital Emergency Centre, says the "forced fields" in the Vula app render doctors more accountable.

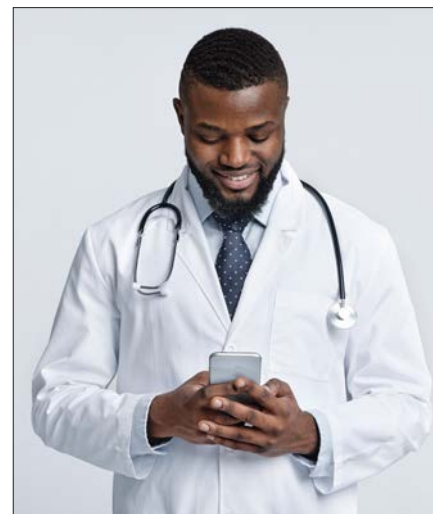
## Holds doctors accountable

Their colleague at Cecilia Makiwane Regional Hospital in the Eastern Cape, medical officer Dr Elisha Rhode, strongly agreed.

He adds, "With most medical history and treatment interactions captured, it's a great medicolegal tool, and makes medical practitioners examine patients comprehensively, holding them more accountable for what they say and do. It can also deter them from delaying a critical patient referral to the morning just for the convenience of dealing with one less patient in the night. All interactions are visible to the consultants, so you have to give the best possible advice."

Dr Le Roux illustrated how inappropriate referrals can be (she and other consultants interviewed said that this happens most often with GPs, many of whom seem reluctant to use the Vula tool).

"Just yesterday, we had a patient with a ruptured Achilles tendon. He was sent in with just an ultrasound report but no referral, at a time of day when no orthopaedic surgeon was available. Because of how our booking system works, we had to ask him to go back to the GP and be referred to the "right place at the right time". Vula would really have made



that patient's journey easier. We love Vula. I wish more people were on it."

She said the conversation recorded in the Vula "chat" benefits both the referral doctor and the sending doctor, as it is an undeletable record and allows monitoring of the doctors' responses.

In addition to this, it is a powerful teaching tool for nurses in primary healthcare clinics and community centres, because they learn more with every interaction.

The app, invented by Cape Town ophthalmologist Dr Will Mapham, was recently nominated for an international healthcare technology award, having already garnered a slew of social innovation, entrepreneurship and tech health awards in sub-Saharan Africa and further afield.

Dr Mapham said GPs are increasingly starting to use Vula, and account for 15% of its users thus far.

## Improving workflow

Dr Lategan said that tertiary trauma units nearly always struggle for bed space.

"When patients are seen and sorted, they often need to go somewhere else. Say, for example, a patient needs a femoral nail, he might stay with us, taking up a precious bed. However, what he needs is to be in an orthopaedic unit. This app has changed daily practice in our unit – it's all about the right patient for the right place at the right time."

He said that he and his colleagues normally respond to a Vula request (from referring

facilities) within 5 minutes: "If we don't, they're on the phone to us!"

Dr Tamsin Lovelock is an internal medicine specialist and lead clinician at the 336-bed-capacity Brackengate COVID-19 facility in Cape Town's northern suburbs, which was expected to reach maximum operational capacity by 16 December. Admissions quadrupled in the 3 weeks to 15 December 2020, and stratification and outward referral of patients would begin in earnest on Wednesday 16 December.

She said the Vula app was proving to be an invaluable tool.

### It's groundbreaking and has revolutionised the way we work

Statistics show that from its opening on 20 July 2020 to 15 December 2020, Brackengate had admitted 1 470 patients, discharged 1 014 home and transferred 118 to another facility – with a total of 64 deaths. Bed occupancy on the morning of 15 December stood at 318. Healthcare staff were working for up to 14 hours at a stretch.

The Cape Town International Convention Centre COVID-19 acute care facility closed down on 18 August after the pandemic waned, having treated close to 2 000 patients, nearly 90% of whom were discharged, with some 60 transferred to Brackengate.

Of Brackengate, Dr Lovelock said, "We serve the whole Cape Metro and beyond, with patients coming from as far afield as Worcester

and Caledon – infections are not clustered, it's sustained community transmission."

"Vula is not only convenient for the person who needs to refer but for the person receiving – it's so organised, the fields are all there to fill in, you don't have to remember everything, you just push a button and have a look," she added.

#### Transforming care

Dr Lovelock said that she wished Vula had been available when she was a registrar at Chris Hani Baragwanath Academic Hospital in Soweto a few years ago.

"I carried a pen and a scrappy piece of paper around, scribbling down details of each referral – I had nightmares I'd lose it. As a super-stressed reg, it would have been brilliant to just have all the info on my phone. What I also really like about Vula is that it makes it easier for more junior staff who might be a bit shy to ask for help from someone senior – it's accessible and non-threatening, especially when the pressure's on," she added.

Dr Rhode, who helped to initiate Vula at Cecilia Makiwane Regional Hospital's surgery department 4 months ago, said the standardised digital form made it easy to find precise and detailed patient information very quickly.

"It might be a bit smoother off the tongue to use the phone (when you can get through), but you can so easily be led astray, missing a critical heart rate for somebody with a badly fractured leg, or somebody bleeding out – these vital details can often be omitted over the phone," he emphasised.

All doctors spoken to agreed that Vula could accurately be described as a lifesaver,

never mind smoothing work and information flows. They could not imagine their lives without it, and some were even tempted to ask that it be made compulsory, but refrained because SA's constitutionally guaranteed freedom of choice prevents this.

#### Vula origins

The idea for the app came to Dr Mapham during his community service years and subsequent tenure at the remote Madwaleni Hospital, 100 km from Mthatha, where equipment shortages and systems dysfunction, plus the lack of consultant expertise that is familiar to doctors country-wide, were epitomised. A former vice-chairperson of the Rural Doctor's Association of SA, Dr Mapham spent 5 years in public health, and piloted Vula in his chosen discipline of ophthalmology, leading to its use across disciplines countrywide. In his junior doctoring years, he helped address healthcare staff shortages at his and neighbouring rural hospitals by holding popular slide shows on medical campuses and at congresses portraying the joys of the Eastern Cape coastal recreational lifestyle, not to mention the practical, hands-on learning and innovation chances that rural doctoring offers. He is today gifting South Africans with what is often described by national health minister Dr Zweli Mkhize as a "digital first" approach to addressing the country's human healthcare resource crisis.

Full details for downloading the Vula app and registering are available at [support@vulamobile.com](mailto:support@vulamobile.com).

## 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](mailto:dianed@samedical.org).



## Eyes wide shut for African WOC

SAMA Communications Department

2020 was going to be a big year for Dr Kgaogelo Legodi. The respected ophthalmologist had been elected as the first African to preside over the World Ophthalmology Congress (WOC), to be held in Cape Town in June. But coronavirus and its associated local and international restrictions prevented that from happening. Instead of hosting more than 10 000 delegates in the Mother City, Dr Legodi and the rest of the WOC team hosted the event virtually – an ultimately practical, but less eventful, alternative.

“This gathering was going to be huge for SA and Africa. The WOC is an opportunity to learn from the best in the world, and expose them to them to our country. One of the overriding aims of the Congress – one of the reasons we bid for it in the first place – was to eradicate blindness in Africa. Sure, we met virtually, but it really wasn’t the same,” says Dr Legodi.

The gathering of ophthalmology experts was first held in 1857, and is the longest continuous international medical meeting.

But the fact that this was the first time it would be hosted in Africa is not lost on Dr Legodi.

“It’s a huge honour to be chosen to lead the congress, and it was a good feeling. But although I felt personally great about this opportunity, I had mixed feelings. I had to ask myself why, after 163 years, this was the first time it was being held in Africa. In my mind, this is something that should have happened many decades ago already,” he notes.

Dr Legodi says the lead-up to hosting the event virtually was extremely stressful, and the fact that it wasn’t held “in person” was a missed opportunity for SA, and not an ideal outcome for the hosts.

“We didn’t really want it that way, but we had no choice. We managed to raise awareness in those areas we set out to highlight at the start, but it really wasn’t the same at all. I’m sure we will try to host this event again, and I’m actually quite positive that we will get another opportunity to do so – but hopefully we won’t have to wait another 150 years for that chance,” he says.



*Dr Kgaogelo Legodi was the first African to preside over the World Ophthalmology Congress in June*

## Treating the fever by quelling the hunger

SA Network

Poor and vulnerable populations are severely affected by shocks to food systems, due to their limited access to resources to cope with the loss of jobs and incomes, increases in food prices and the unpredictability of food availability. The most vulnerable groups include the urban poor, inhabitants of remote areas and informal settlements, migrants, the informally and unemployed, people in conflict areas and individuals with comorbidities and compromised health.

The COVID-19 pandemic has resulted in food supply systems servicing these groups being affected directly, through impacts on food supply and demand, and indirectly through decreases in purchasing power and the capacity to produce and distribute food. Therefore, a major lesson that has emerged from SA’s (and much of the developing world’s) COVID-19 experience is that in addition to saving lives and meeting immediate needs through medical interventions, the country needs to build resilience in food

supply chains, and promote food security at the community and household levels.

This inspired a collaborative project between the Institute of Natural Resources and the United Nations Development Programme in SA (UNDP SA) aimed at enhancing food security and nutrition in vulnerable households in the face of COVID-19 through the implementation of sustainable home gardens. The project used a train-the-trainer approach to capacitate individuals who have a passion for food gardening in KwaZulu-Natal to help vulnerable households install and manage a range of low-cost vegetable garden systems. The funding from the UNDP will eventually allow for these systems to be installed in more than 120 households across 9 communities in the province, including a number of informal settlements.

Importantly, given the need for vulnerable communities to have increased access to potable water for anti-COVID hygiene practises, the gardens also incorporate water-saving irrigation



*Keyhole garden in KZN (Photo credit: Sim'lindile Mahlaba)*

strategies such as greywater and drip irrigation. This partnership between the INR and UNDP has shown that joining forces to implement sustainable solutions is perhaps the best way for public benefit organisations to help our nation through these troubled times.

# Delayed diagnosis of renal disease leads to claim

Dr Sophie Haroon, *medicolegal consultant, Medical Protection Society*

**M**rs Z was 30 years old; unbeknown to her, she had congenital kidney disease. When she registered with a local GP practice she had a new patient check. Her blood pressure (BP) was found to be normal, but she had significant protein in her urine. She was advised to have the test repeated in a few weeks, but never did.

At a subsequent consultation with Dr A, no observation of BP and proteinuria was made. At a second consult with Dr A, Mrs Z's BP was noted to be slightly raised, but the previous proteinuria went unnoticed. She saw Dr A a third time that year, and a raised BP was again recorded. This time the previous proteinuria was seen, and Mrs Z was advised to have this test repeated. She never did, and this was not picked up. Mrs Z had no further investigations at this time.

Two years later, Mrs Z saw Dr B for a contraceptive pill check. Her BP was raised and her previous proteinuria was picked up. She was again told to have repeat urinalysis, but again this never materialised. She saw Dr B a further three times that year, and Dr A one more time. On each occasion her BP was raised. Dr A considered 24-hour BP monitoring but this was not arranged further. Mrs Z had no further investigations at this time.

Five years after her new patient check, Mrs Z had some blood tests done. Her eGFR was found to be 76. Later that same year, she became pregnant. The local hospital took over her antenatal care due to persistent raised BP and proteinuria. At one point during her antenatal care, she saw a nephrologist who ordered further blood tests, 24-hour BP monitoring, formal urine protein/creatinine testing and an ultrasound. The latter revealed a crossed fused ectopia of the kidneys, effectively forming a single kidney.

Mrs Z had her baby without event and was discharged. There was no follow-up arranged nor any communication given to her or her GP about the results of the investigations they had done.

The year after Mrs Z had delivered, she had several BP checks at a new GP practice. These consistently showed borderline or raised BPs. She voiced her concerns to Dr D, who noted them and ordered some blood tests. Her eGFR was found to have fallen to 52, and was filed with no action.

When Mrs Z's child was nearly 2 years old, she saw Dr E, complaining of low mood and

tiredness. Her BP was 177/118. Blood tests were ordered and the plan was either to do home BP monitoring or start an antihypertensive. Tests showed Mrs Z's eGFR to have fallen very slightly again, to 50. Dr E filed these with no action.

Mrs Z continued to present to her GP practice the following year. Further renal function tests showed her creatinine to be raised at 131, and her eGFR had fallen to 42. Dr D marked these as abnormal and for repeat in 3 months. When this happened, her creatinine was 147 and her eGFR was 37. Mrs Z was out of the country when the results came back, but Dr D marked them as abnormal and to be discussed with the patient on her return.

This occurred 4 months later, when again the creatinine had risen, now at 161, and the eGFR had fallen, now at 33. Dr D marked them for repeat in 3 months. Mrs Z circumvented this, however, and saw Dr E. He noted variable but often raised BP over several years, as well as Mrs Z's lack of compliance with any suggested home BP monitoring, and deteriorating renal function plus proteinuria. A referral to nephrology was made for stage 3 chronic kidney disease (CKD).

Nephrology confirmed Mrs Z's crossed fused ectopia of her kidneys, and also found scars in the upper and mid poles. They started her on an angiotensin receptor blocker, which stabilised her eGFR at 32 and improved her BP control.

Mrs Z's condition subsequently progressed. Her latest eGFR was 19, and she was to have a kidney transplant from her mother when she reached an eGFR of 15. She reduced her working hours due to fatigue.

## Mrs Z makes a claim

Allegations of negligence were brought against the hospital that had cared for Mrs Z during her pregnancy, and also her GPs over a period of 8 years. With respect to the hospital, it was alleged there was a failure to recognise her underlying renal condition and ensure that there was postnatal follow-up by a nephrologist.

Regarding the GPs, it was alleged that there were several missed opportunities to note and act on Mrs Z's proteinuria, hypertension and declining renal function, especially in someone as young as she was, and a failure to refer to nephrology early enough.

Mrs Z's solicitors went on to plead that if she had been started on antihypertensives,



then the onset of her renal disease, including her predicted end stage renal failure (ESRF), could have been delayed by up to 20 years. They accepted that ESRF was inevitable, but contended that the defendants' negligence had accelerated the progression of the disease and advanced its predicted onset. Their expert went on to predict when Mrs Z might need a renal transplant or, if not available or not successful, when lifelong dialysis might be required.

## How MPS assisted

Several GPs were involved in Mrs Z's care. Only one was a member of the Medical Protection Society (MPS), and expert GP evidence was sought. While not critical of the GPs' initial care at the start of Mrs Z's presentation, concern was raised about subsequent care and failure to manage Mrs Z's BP over a prolonged period of time, to act more aggressively on the deteriorating renal function and to repeat the urinalysis for protein. Additionally, a referral to nephrology was deemed mandatory from any point after Mrs Z had had her baby. Relying on best practice guidance for hypertension and CKD at the material time, the expert found that there were serial failures by the GPs to reflect such practice, and that this amounted to a breach of duty.

Turning to causation, expert evidence was again sought by MPS, and each of the other defence organisations involved, from various consultant nephrologists. The expert for MPS confirmed that while Mrs Z's underlying

renal disease was not amenable to a cure, there had been a missed opportunity of slowing progression to ESRF, that she had not benefited from careful BP control and that eventual deterioration to ESRF and renal replacement therapy was certain.

However, the real crux of this case lay in how much the decline could have been slowed by earlier treatment, and how much ESRF could have been put off – likewise dialysis or time to transplant. Overall, the various experts were less optimistic than the one presented by Mrs Z. Various predictions and models were proposed, all accepting that there was some difficulty inherent in the postulations due to lack of renal results from the very start of Mrs Z's story. However, figures consistently reducing those of Mrs Z were deemed, on balance, to be more likely.

Consequently, while all parties accepted their respective breach allegations, the extent of Mrs Z's causation argument was contested. It was also noted that Mrs Z's pregnancy had, in itself, accelerated the decline in her renal function, and that on several occasions she had showed non-compliance with medical instruction in terms of monitoring her BP at home, having blood tests or undertaking urine sampling.

Various damages for Mrs Z's case were considered by her solicitors. These would have covered matters such as pain, suffering

and loss of amenity, loss of earnings, expenses, care support, travel, future losses, future therapies and reduced life expectancy. The initial schedule of loss was significant. This did not include the solicitor's costs.

This was a case to be settled given the breach of duty and the fact that this had led to causation. However, Mrs Z's expert and the defendants' experts disagreed on the extent of that causation, and this in turn had an impact on the likely damages to be paid to Mrs Z. Taking this into account, a counter offer on behalf of all defendants was made, which was substantially less than what Mrs Z's solicitors proposed.

Arguments to reduce Mrs Z's damages were that her lack of compliance with previous medical instructions was such that she would have done the same if investigations had been offered to her, that she had yet to prove she would have been compliant with treatment if offered to her earlier and that ESRF had only been accelerated by approximately 5 years due to the delay – much less time than that proposed by Mrs Z's solicitors.

### Outcome

This was accepted by Mrs Z's solicitors. The defendants' expert evidence was overwhelmingly consistent in their conclusion. MPS settled the case for a small share of a moderate sum, which was substantially less

than the amount that Mrs Z's legal team had put forward.

### Learning points

Experts will turn to guidance for the material time of the claim to substantiate their conclusions on allegations. Being compliant with guidance is important, and if it is deviated from, you must be able to reasonably justify why.

Sometimes experts lack definitive guidance, and need to rely on previous research, models and predictions. These can result in different conclusions. Where there is parity of evidence, more strength can be given to those conclusions. Different defendants can work together where their evidence is similar, to mitigate the similar losses they face. It is also important that all parties have access to good, balanced experts whose knowledge is up to date.

The damages proposed by claimants can seem exorbitant. However, there is often a realistic prospect of mounting a counter offer, and efforts to do this should be made (even if this incurs some costs), as it can save much more in the long run.

Contributory negligence cannot form a complete defence, but is a useful tool in an argument to reduce damages.

## The health emergencies you didn't hear about in 2020

*World Health Organization*

**T**he WHO has had an extraordinary year leading the global battle against a once-in-a-century pandemic. But the SARS-CoV-2 virus that causes COVID-19 is not the only pathogen we've dealt with in 2020; this outbreak was one of many health emergencies on our books.

This year the WHO responded to more than 60 emergencies, including major outbreaks of chikungunya in Chad, yellow fever in Gabon and Togo, measles in Mexico, flooding in Sudan, storms in the Philippines and Vietnam, and much more.

After an 18-month struggle in the eastern Democratic Republic of the Congo (DRC), together with the government and our partners, we ended the world's second-largest Ebola outbreak on record. This was one of the

most complex health emergencies the WHO has ever faced, made even more difficult by the country's largest-ever measles outbreak. We're now counting down to the end of the latest Ebola outbreak in western DRC.

Following the devastating blast in Beirut in August, the WHO provided care for the injured and mental health support for health workers and communities, and helped to rebuild destroyed hospitals: <http://www.youtube.com/watch?v=LY4DdAlRntM>.

We provided urgent support to thousands of refugees and migrants in Greece after the fire at the asylum centre on Lesbos.

We continued to provide life-saving access to healthcare for people in countries facing conflict, including in Africa, the Middle East and the Caucasus.

Also in 2020, the WHO African region was declared wild polio-free.

We have seen this past year that countries with robust health emergency preparedness infrastructure have been able to act quickly to contain and control the spread of the COVID-19 virus. The 73rd World Health Assembly will consider a draft resolution (EB146.R10) that strengthens member states' preparedness for health emergencies through more robust compliance with the International Health Regulations.

This resolution calls on the global health community to ensure that all countries are better equipped to detect and respond to cases of COVID-19 and other dangerous infectious diseases.

## Dr Eurika Mogane's challenging journey

SAMA Communications Department

**D**r Eurika Mogane, a member of our Lowveld branch and a medical researcher, was nominated as a Golden Key International Honorary Alumnus. A virtual ceremony of celebration was held on 3 November 2020 via the Golden Key International Honorary Society.

In her speech, Dr Mogane looked back on her challenging journey to become a doctor: "I am Dr Eurika Thabile Mogane – a born-again Christian who believes in Christ Jesus, a person who used a very unconventional or non-traditional route to bearing the official title as a doctor. I grew up in Nelspruit, Mpumalanga, and was from a middle-class family. However, after some time, my father who was the sole breadwinner at home, was retrenched, and he had to resort to making use of his God-given skills to make ends meet. As a result of this loss of income, my mother left us.

"We did not lose hope. Our father decided to become a taxi driver, and that meant leaving the house at 2 am and coming back around 10 pm just so that we could have food on the table. When I was accepted to study at the University of Pretoria in 2010, my father asked with a broken heart, "How will we afford your studies? Are you sure about leaving Mpumalanga?" I honestly was not sure, as I did not even have a bursary. It would have been much better if we had a university in Mpumalanga that allowed one to study medicine – but we did not (even now in 2020, we still don't have that luxury).

I left Mpumalanga and went to the University of Pretoria to start my medical journey – I was enrolled in the BSc Medical Sciences programme. My first year was tough – but I worked so hard that the university and NSFAS [the National Student Financial Aid Scheme] offered me a bursary and paid for everything. My second year was another rough journey – thankfully, my marks were really good, and I was awarded another bursary from NSFAS. I was thrilled when I got a letter stating that I was an official Golden Key International Honorary Society member. I did not even understand what that was, but I was happy. The day came for us to receive our official certificates at the ceremony. I looked around and all the recipients were with their family members to support them. My family could not afford to



travel from Mpumalanga to Pretoria where the ceremony was being held. I remember seeing my peers being fetched in nice cars and smiling with their families, while I had to wait for a school bus to take me from one campus to the next. I was so broken – it started raining that same day and I was drenched in cold raindrops. I arrived at the ceremony venue and stood my ground.

We were asked to fill in forms for our photos, but I told them that I couldn't afford to pay. They made me wait on the side while those who could afford to pay took more photos with their families. We were called up

**Do not give up,  
because many will  
benefit from it**

for the standard photos and told that maybe once we had money, then we could get them.

I felt so torn, so broken and wasn't sure if being a Golden Key member was something to be proud of. If my own family couldn't come to support me, then why should I be happy about it?

I was keen on pushing ahead, but the year 2012 was the hardest because I had to travel more frequently from the main campus in Hatfield and go to the UP medical campus, which was over 30 km away. I used to walk

to that campus at times, just so that I could attend practicals. Sometimes, I would miss my lectures at the main campus so that I could be in time for the practicals in the Prinshof medical campus. It would hurt when we would get there at times and were told that practicals were cancelled.

I even resorted to using my hands, my skills to make extra income. I saw what my father did and did not want to give up. I used my skills and started braiding other students' hair at the residence. I was able to have money to travel to the other campus using a taxi – and what an accomplishment that was for me. My eldest sister tried hard to purchase textbooks for me, which cost over ZAR5 000.00 per semester – including other practical medical tools.

Through it all, I chose to remain happy. I started missing more classes because I spent time raising funds to fund my studies, and eventually in 2012, I broke down. I was no longer able to handle all the pressure, and was so overwhelmed. I dropped out and headed back to Mpumalanga.

My father didn't look down on me – he welcomed me back with loving arms and understood the predicament we were in. He felt so bad that he could not afford to support me. In 2012, I spent the rest of that year at home and trying my level best to deal with being a labelled a "drop-out".

I have since then spent the last 8 years working hard to finish my studies. My partner Apostle Peter Jones encouraged me to continue with my studies, which I did. I was fortunate to receive scholarships from abroad to complete most of my studies. Thankfully with technology, one can also now complete a Master's online – while I continued to volunteer at numerous local organisations to enhance my researching skills.

On 3 November 2020, I was fortunate enough to be selected as one of the few the represent Mpumalanga as a Golden Key Honorary Alumni recipient. It came at a time where I am also close to finalising my DMedSc, and what a push it is. Although I am currently a researcher, I hope to soon shift into being a clinical physician so that I may enhance my current knowledge. It is really humbling to know how international and national studies can be combined to complement and earn someone a better way of life.

My key personal statement or life motto is, "If the pen can convey the intended message, then don't let the ink run out." This means that if you have something that can bring about a solution in this day and time, then be sure to sharpen that skill or offering to the very best

of your ability. Do not give up, because many will benefit from it.

I am now able to proudly introduce myself as Dr Eurika Thabile Mogane, a medical/clinical researcher who loves my medical journey. I am currently focused on switching over to clinical

support and not just medical research writing. I am sincerely looking forward to seeing what the future holds. I hope my journey has encouraged you to never give up."

We congratulate Dr Mogane on an outstanding achievement.

## Tygerberg thanks councillors

After 8 months of being unable to hold a branch meeting at our offices, while meetings were held on Zoom, we got together on 9 December, with partners, for a social event at Durbanville Hills Wine Estate to show our appreciation and thank councillors for all the time spent and work done for SAMA. The function was a good opportunity for members to share ideas and discuss the impact of the COVID-19 virus on their individual practices and their private lives.



*In attendance, from left to right: Dr Gerald and Heidi Paris, Dr Wynand and Esther Goosen, Dr Johan Lamprecht, Mr Nino Ferrone, Dr Anita Jacobs, Ms Sandra Ferrone (branch secretary), Dr Wim and Anneri Beukes*

## Gauteng North donates masks to Daspoort Clinic

On 12 November 2020, the SAMA Gauteng North branch donated 108 N-95 masks to Daspoort Clinic as part of its corporate social responsibility. The masks will be used by community health workers (CHWs) doing community-based care in and around the area, as well as the Daspoort staff. Dr Chandré Balie presented the donation to Kenny Mafala and Rebaone Madzivhandila.

Daspoort Poly Clinic was established in 1964 by medical students from the University of Pretoria to support the local community and to gain practical work experience. The clinic temporarily closed between 2005 and 2007. When it reopened, it had the support of the Department of Health. Today, Daspoort Clinic provides primary healthcare services to the community around it. The clinic and community-orientated primary care activities are run by



*Dr Chandré Balie, SAMA Gauteng North branch, presents the donation to Kenny Mafala and Rebaone Madzivhandila*

the Department of Family Medicine at the University of Pretoria.

University of Pretoria students in medicine, dietetics, physiotherapy, occupational therapy, speech therapy, audiology and nursing come to the clinic on a rotational basis for practical experience in their chosen fields.

Daspoort has a functional community-oriented substance use programme to assist substance users, with a needle exchange programme that is part of the harm reduction strategy, and helps with stopping substance use. This multidisciplinary team consists of doctors, a clinical associate, a counsellor, a social worker and peers.

The clinic also does outreach to the community, with the assistance of CHWs in the Daspoort area, as well as informal settlements such as Melusi and Zama Zama. #SAMACares.

## Jaguar Land Rover Experience hosts final branch council meeting

On 29 November 2020, the SAMA Gauteng North branch held its final branch council meeting at the Jaguar Land Rover Experience in Johannesburg. There are only two Jaguar Land Rover Experience venues in the world: in Moscow and Johannesburg.

The venue in Johannesburg has an adventure park, a children's play area, conference facilities, a dining area and the Kingsley Holgate Expedition train.

### All SAMA branches are offered the chance to spend some time at the Jaguar Land Rover Experience

After the meeting, the branch council members and a few SAMA staff members had an opportunity to drive several vehicles through the adventure park and Kingsley Holgate Expedition Trail: the Defender D240, Defender P400, Discovery TDV6 HSE, Range Rover 2.0 PHEV Vogue Se and Range Rover Sport PHEV.

Under the patient instruction of Christo van Loggerenberg, Marcel Veeran, Rainer Ferenczy and Shaun Taylor, drivers had the chance to drive heart-stopping inclines and nail-biting downward slopes. The words "It's a Land Rover" rang in the drivers' ears as they drove down these steep inclines without stepping on the brakes. The afternoon off-road drive was relaxing, and made us forget that we were in the city. We each left the Jaguar Land Rover Experience with memories and a Jaguar mug.

"It was a wonderful day!" to quote the SAMA national chairperson, Dr Angelique Coetzee. Dr Lindi Shange, the SAMA Gauteng North branch chairperson, said, "We enjoyed everything about the day, but especially the instructors, who helped put us at ease and participate in an experience of a lifetime."



*The SAMA Gauteng North branch council*



*Dr Chandré Balie*

The SAMA Gauteng North branch would like to thank Jaguar Land Rover, especially Christo, Jessica, Marcel, Megan-Jade, Palesa, Petronella, Rainer and Shaun for assisting in making this once-in-a-lifetime opportunity come true.

SAMA and Jaguar Land Rover have an affiliation. All SAMA branches are offered the chance to spend some time at the Jaguar



*Baldwin Diale and Richard Matambo from the SAMA Finance Department*

Land Rover Experience for a break from the hustle and bustle of life, and to take a breather and to recharge. If you would like your branch to take up this opportunity, please contact Vernon Kinnear, head of the Member Engagement Department at SAMA.

#ItsALandRover  
#SAMACares.



## CPD

For further information  
please contact the  
CPD Officer on

012 481 2000 

[cpd@samedical.org](mailto:cpd@samedical.org) 

## WHAT ARE WE ABOUT

Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association is one of the institutions that have been appointed by the Medical and Dental Professions Board of the Health Professions Council of SA to review and approve CPD applications.

## SERVICES AVAILABLE

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