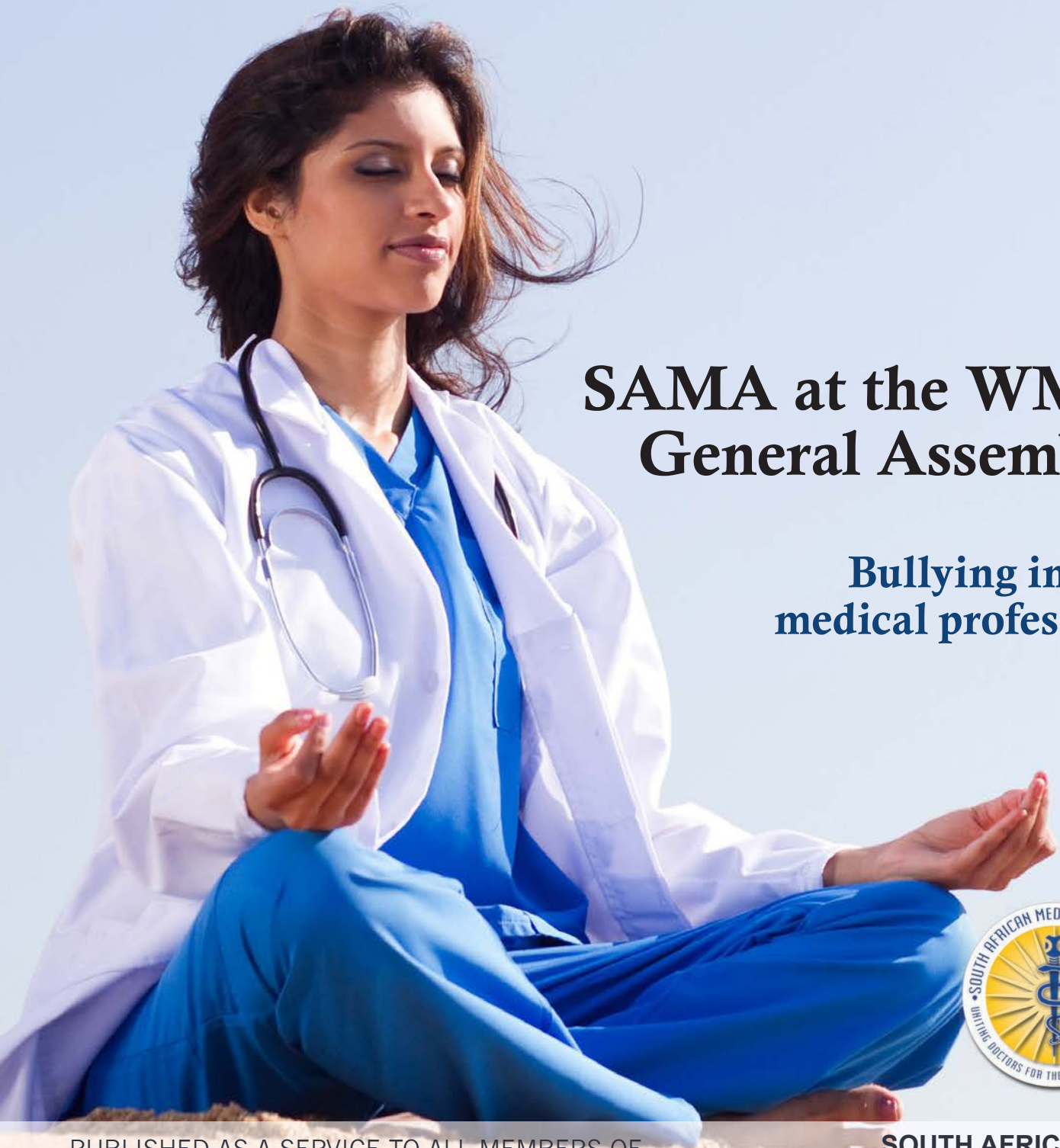


SAMA INSIDER

DECEMBER/JANUARY 2021



SAMA at the WMA General Assembly

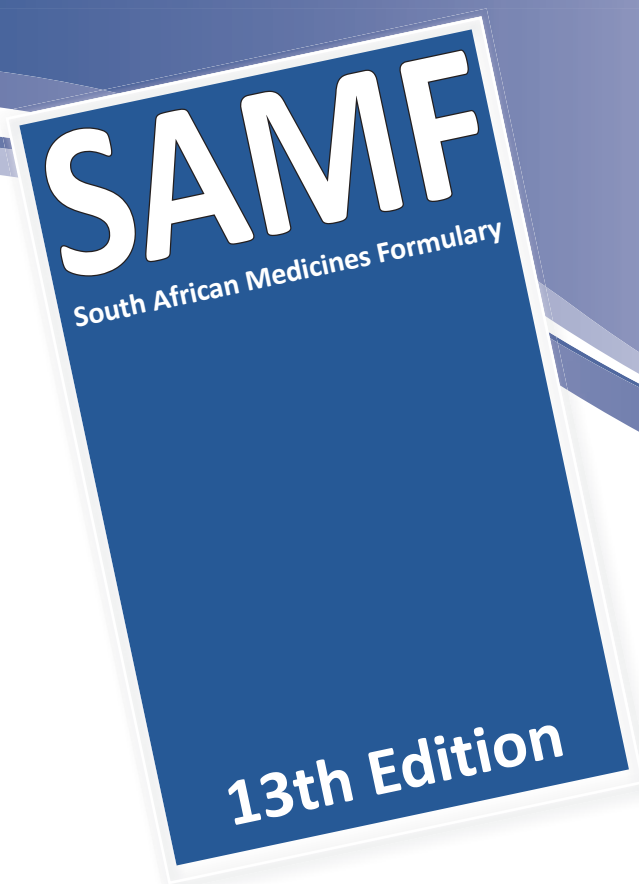
**Bullying in the
medical profession**



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SAMAREC

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Diane de Kock
Editor: *SAMA INSIDER*

Reflecting and moving forward

Welcome to the final *SAMA Insider* for 2020. In this issue, we reflect on the year that was – see SAMA President, Dr Sizeka Maweya's message (page 4) and Dr Vusumuzi Nhlapho's article (page 7). Both messages reflect a year that has been challenging, heartbreaking and successful.

2020 has brought into sharp focus the very real issues to be faced in 2021 and beyond. The fact that one in three doctors have suffered verbal or physical abuse during COVID-19 (page 17), the severe financial impact on SA practitioners (page 16) and the sad reality that bullying is still common practice at medical schools and in the first few years after qualifying (page 9) are some of the issues we consider. "It would appear," says Prof. Stoffel Grobler, "that our profession has a long way to go before bullying will universally be deemed unacceptable behaviour."

SAMA Insider will be publishing a series of articles in 2021 aimed at assisting young doctors in dealing with, for example, bullying, stress, burnout and discrimination. We welcome your feedback on these issues (dianed@samedical.org).

SAMA contributes to statutes and declarations that impact on the ethical practice of medicine throughout the world, reports Shelley McGee, who attended the online WMA General Assembly in October (page 5). "We are looking forward to more substantive participation on an international stage to promote the ethical and societal interests of patients and physicians."

The successful implementation of the NHI and advancement of universal health coverage in SA remains a challenge for 2021 (page 11) and "requires careful scrutiny, particularly by affected parties such as medical practitioners".

COVID-19 "has catalysed rapid telehealth adoption and changed healthcare delivery at a breathtaking rate," says Brandon Ferlito in his article "Telehealth and the risk of supersession" (page 13). It has also changed the way we do business – 86% of employed people now attend online meetings at least once a week. We hope the article "Six tips for more effective online meetings" (page 14) will assist readers to deal with these challenges.

In branch news this month, we feature Outeniqua branch and their chairman, Dr Wessel Vermeulen, who has written a children's book on COVID-19, and congratulate Border Coastal's Dr Angela Hartwig, who was awarded RuDASA's Rural Doctor of the Year award.

Let's keep communicating – may 2021 be better than 2020.

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A challenging year internationally, regionally and in SA



Dr Sizeka Maweya, SAMA President

2020 will be the year in their lifetime that everyone will wish to forget. It has been a challenging year internationally, regionally and in SA.

Some years will always act as the hinges of history; they will linger in the minds of people as pivots, years so momentous that they become the defining point when everything changed, as the past became the future. 2020 taught people that things could not remain the same, or be business as usual forever. People came up with slogans or coping mechanisms, and phrases such as “the new normal” appeared.

2020 was marked by a pandemic (COVID-19) which has had an enormous impact. Many people lost their jobs, and it became difficult to survive or to take care of loved ones and families. The economic downturn rendered the world difficult to live in, and rich countries tried to bail out their economies. In SA, the unemployment insurance fund (UIF) and temporary employer/employee relief scheme (TERS) were activated to protect businesses and their employees. However, these were not spared from theft and looting by the administrators of the funds. Many people were seen begging in the streets, losing their dignity and pride, all in the name of survival.

In SA, we witnessed hatred towards foreign nationals, as people assumed that

these people were stealing their jobs. South Africans were under the impression that foreign nationals were robbing them of opportunities to be considered for jobs by employers. We experienced the worst kind of corruption while people close to the resources meant for the poor looted those resources to benefit themselves, their friends and relatives. History has an unnerving habit of repeating itself, and there are important lessons to be learned – and passed on to future generations. Universities are still in limbo, while students are uncertain about their future. It will take many years to reverse the losses experienced in 2020 due to the impact of the pandemic.

The younger generation found themselves idling, not knowing what to do because the institutions of higher learning were closed. Some institutions did not even afford the courtesy of communication to their students.

We experienced the implementation of the Disaster Management Act No. 57 of 2002. The lockdowns that were imposed were necessary to provide for integrated and co-ordinated disaster management at the time. However, there were unintended consequences, as in any crisis management situation.

Gender-based violence rose during lockdown because victims did not have escape routes from these hideous crimes committed in their homes. The impact of the lockdown in SA thus increased the rate at which domestic violence occurs, leaving both women and children vulnerable, in danger and with no chance of respite from their abusers during the quarantine. The SA government tried to empower women and children by prioritising their plight.

In the early days of the pandemic, in particular the first 100 days, there was a notable increase in social and political unrest in some countries in the African region. These protests were a reflection of pre-existing frustrations with social and political conditions. These problems were further exacerbated by the COVID-19 restrictions, especially in the spheres of health, education, politics and service delivery.

SAMA has not been spared the challenges of 2020. SAMA is a non-profit company (NPC), and must be guided by company rules. It is a professional association for doctors; it is not

a trade union. The resulting realignments rubbed some people up the wrong way, and they took SAMA NPC to court. The leadership of SAMA had to stand together and steer the organisation in the right direction. The leadership must be commended for their actions, because even during such trying times, they kept the hopes and future of SAMA NPC intact.

SAMA's vision and mission are to unite doctors for the health of the nation. 2020 was a real test of the association's mantra. The leadership constantly reminded members that SAMA's role as a professional association is primarily educational and informational. It is also to publish professional journals, to develop professional excellence, to raise public awareness on health issues and to influence health policies for the better health of the SA people. Most members embraced these functions, and decided to support the association.

2020 also taught us to rethink our communication strategies. Meetings now have to be held via virtual platforms. We have had to learn fast about the impacts of the fourth industrial revolution. Older people have learned to be tech-savvy in order to cope with the demands of the times, so as not to be left behind.

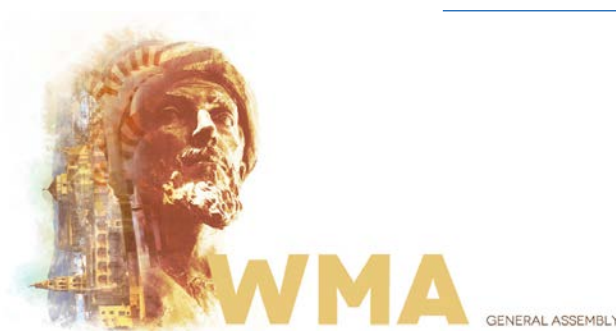
The general public have also had to learn to be more health-conscious. Hand hygiene, coughing/sneezing etiquette and social distancing were promoted in the name of survival. We were confronted with the real uncertainty of human existence, and the genuine vulnerability of our lives. We used to believe that we were the supreme masters of the world around us. However, 2020 put us to the test in challenging that assumption.

The coronavirus in the year 2020 showed us how terrible it is to waste our lives embroiled in endless battles for wealth, status and power. The disease does not differentiate between rich and poor in society, nor between wealthy nations and poor ones. We have all been fighting for survival, reminded every day of the devastation of the disease, hearing about those who died, those who became infected and how many were tested and waiting to hear their verdict.

All of the above helped us to recognise the real purpose of our existence. I am because you are: the true spirit of *ubuntu*.

SAMA at the WMA General Assembly

Shelley McGee, health policy analyst and acting head of department, SAMA Knowledge Management, Research and Ethics Department



The World Medical Association (WMA), of which SAMA is an active member, held its annual General Assembly as an unprecedented online event from 26 to 30 October 2020.

The COVID-19 outbreak had resulted in the cancellation of the planned WMA council meeting in April 2020, leaving a number of high-level planning, policy documents and ethical discussions to be held at the general assembly session.

About the WMA

The WMA is an international organisation representing physicians. It was founded on 17 September 1947, when physicians from 27 different countries met at the first general assembly of the WMA in Paris. After the experiences of World War II, representatives of the medical profession decided it was necessary to establish a new international medical organisation to develop medical ethics and to co-operate globally.

The organisation was created to ensure the independence of physicians, and to work for the highest possible standards of ethical behaviour and care by physicians at all times. Over time, the membership has grown to 114 national medical associations.

The WMA provides a forum for its member associations to communicate and co-operate actively, to achieve consensus on high standards of medical ethics and professional competence and to promote the professional freedom of physicians worldwide.

SAMA has been a member of the WMA since its inception, and has also been involved in the development of many ethical guidelines, including the seminal Declaration of Helsinki and the recently adopted Declaration of Taipei on health databases and biobanks.

The famous Declaration of Geneva (also known as the modern Hippocratic Oath) is one of the WMA's oldest policies, adopted by the second General Assembly in Geneva in 1947.

It also remains one of the most consistent documents of the WMA. With very few and

careful revisions over many decades, it safeguards the key ethical principles of the medical profession.

SAMA's inputs to the declarations, statements and resolutions of the WMA are generally prepared with input from the SAMA health policy and human rights law and ethics committees, with additional input from content experts where this is required.

Existing declarations and statements are frequently updated, and new issues are brought to the fore and debated, and formal positions and resolutions developed.

Some important new statements adopted

SAMA has been involved in a number of WMA working groups over the last few years. Generally, working groups are tasked with addressing a particular issue, such as updating an international declaration or statement, or investigating a particular issue with a view to developing a WMA position. In many cases, SA is a loan voice for the African continent, and sometimes for all doctors in the developing world, and so we take our role very seriously.

At the General Assembly of 2020, some of our working group involvement was rewarded through the adoption of statements revised or produced by our working groups.

The "WMA declaration on pseudoscience and pseudotherapies in the field of health" was adopted by the Social and Medical Affairs Committee and the General Assembly. SAMA has worked with the pseudoscience working group, led by the Spanish Medical Association (CGCOM), since 2018. The WMA declaration on pseudoscience and pseudotherapies aims to draw attention to the system of theories, assumptions, assertions and methods that are erroneously regarded as scientifically based treatments.

Pseudoscience and pseudotherapies may have significant potential risks and harms for a number of reasons, including the risk of patients abandoning effective and

proven medical treatments or prevention measures in favour of practices that have not demonstrated therapeutic value.

The declaration calls on physicians to continue to practise medicine as a service based on the application of critical scientific current knowledge, specialist skills and ethical behaviour. It also calls on national medical associations to work with governments to ensure that patients are protected against false claims and unethical application of pseudotherapies in healthcare.

SAMA contributes to statutes and declarations that impact on the ethical practice of medicine throughout the world

The "WMA Declaration of Cordoba on the patient-physician relationship" sparked lively debate between the represented medical associations, but was also eventually approved. This declaration was originally proposed by the CGCOM and the Portuguese Medical Association (OdM). Since 2019, SAMA has been part of a working group to develop this declaration, along with national medical associations from Australia, Spain, Brazil, the USA, the Vatican and the Junior Doctors Network.

The patient-physician relationship is a complex issue subject to myriad cultural, technological, political, social, economic and professional influences. Today, it is frequently under threat from influences both within and outside of healthcare systems. In some countries and healthcare systems, these influences risk alienating physicians from their patients, and potentially harming patients.

The declaration urges all actors involved in the regulation of the patient-physician relationship (governments and health authorities, medical associations, physicians and patients) to defend, protect and strengthen the patient-physician relationship, based on high-quality care, as a scientific, health, cultural and social heritage.

Resolutions relating to the COVID-19 pandemic: This year's WMA meeting could not have progressed without significant recognition of the challenges and impacts of the COVID-19 pandemic on physicians and healthcare systems worldwide.

SA was a co-signatory association on the urgent "WMA resolution regarding the medical profession and COVID-19".

The resolution advocates for sufficient provision of equipment, including personal protective equipment, for health professionals, and urges governments to adopt a multilateral and co-ordinated approach on a global scale to the crisis, to promote equality in interventions, access

to health services, treatments and future vaccines.

It also calls for recognition of SARS CoV-2 infection as an occupational disease, and for the medical profession to be declared a "profession at risk", as has been the case in SA. The resolution additionally urges governments to include health system strengthening and resilience as part of national COVID recovery plans.

A second urgent resolution, the "WMA resolution on equitable global distribution of COVID-19 vaccine", emphasises that no country should be left behind in the race to vaccinate its population, and stresses the need for balance between the desire of each country to protect its citizens and the need for the vaccine to be distributed worldwide.

The resolution also reiterates that all clinical trials must follow the ethical principles of medical research involving human subjects, as set forth in the Declaration of Helsinki, and states that longer-term, formal safety monitoring is necessary in cases where

clinical trials have been accelerated to fast-track vaccines for market authorisation.

The resolution additionally calls for co-ordinated efforts to increase public trust in vaccination in the face of disinformation campaigns and anti-vaccine movements that undermine the health of both children and adults.

SAMA is grateful for the opportunity, through our involvement in the WMA, to contribute to important statutes and declarations that impact on the ethical practice of medicine throughout the world.

SAMA's involvement in working WMA groups on the review of the International Code of Medical Ethics and reproductive health technologies continues into 2021, and we are looking forward to more substantive participation on an international stage to promote the ethical and societal interests of patients and physicians.

All the approved policy documents are available on the WMA website: <https://www.wma.net/policy/current-policies/>.

SAMA welcomes finance minister's structural and infrastructure reforms

SAMA Communications Department

SAMA says that it welcomes provisions announced by finance minister Tito Mboweni for structural and infrastructure reforms – including renovations at hospitals, and plans for new hospitals.

Minister Mboweni made the announcement during his Medium-Term Budget Policy Speech in Parliament on 1 November.

"We are hopeful that the reforms announced by the minister include, among others, much-needed security upgrades at public sector hospitals to ensure safer working conditions for all healthcare workers. We will also be watching with keen interest the developments and progress in the hospital projects announced by the minister yesterday," says Dr Angelique Coetzee, chairperson of SAMA.

Regarding comments by the minister relating to Tygerberg Hospital, Dr Coetzee says that these have overshadowed the positive initiatives.

"Tygerberg Hospital has been an example to other hospitals in SA during the COVID-19

pandemic, and frontline healthcare workers there must be commended for doing an outstanding job in serving the whole community. Politicians must realise that their comments have implications on staff morale and perceptions by the general public," notes Dr Coetzee.

We expected that frontline workers would be recognised for their valiant efforts

Dr Coetzee says Minister Mboweni's proposal to halt wage increases for public servants is a blow for healthcare workers in the public sector, and may drive many into the private sector at a time when their skills are sorely needed in public service.

Finance Minister Tito Mboweni, in his budget speech to parliament, outlined infrastructure and structural reforms that he said were at the centre of a recovery plan that would include renovations at hospitals. This included Tygerberg Hospital, which Mboweni said still had a black and a white section, structurally.

She says SAMA understands that the finance minister must walk a tightrope of tricky financial decisions, but that there are many public servants – particularly those in the healthcare sector – who have put and continue to place their own lives at risk to care for patients infected with COVID-19.

"We expected that these frontline workers would be recognised for their valiant efforts over the past 6 months, and not ignored, as appears to be the case. Health workers in public service have risked so much this year at great personal expense, and a pay freeze for them is devastating and disheartening," she says.

Reflecting on the year that was

Dr Vusumuzi Nhlapho, SAMA CEO/Acting General Manager



2020 has, to put it bluntly, been a difficult year. We are in the midst of the worst pandemic the world has seen in over a century, economies across the globe are struggling and people's lives have changed irrevocably because of COVID-19. It may take years to recover from the impact, and SA has not been spared. As part of the healthcare corps in our country, you will know better than most the effects that the past few months have had on our health system, and the dangers we continue to face, even though many believe the worst is over.

Many of us have experienced one form or another of mental anguish over the past few months, and it would be remiss of me not to thank SAMA's HR Department for preparing a mental health kit for surviving the lockdown, in collaboration with the Foundation for Professional Development (FPD), and for hosting a webinar on the topic. Interventions such as these were, and are, necessary to ensuring our mental wellbeing.

On a personal level, 2020 has been demanding. All of you are aware of my recent motor vehicle crash in which I sustained bilateral tibia/fibula fractures, among other injuries. I am grateful for the excellent treatment I am receiving; while my body may require extensive healing, I am thankfully still able to work. In fact I am writing this to you from my hospital bed, prostrate on my back, with the help of technology. The show, as they say, must go on, and it remains my duty to keep you informed on developments in our association.

As we mercifully wind down this year, with great anticipation of the positive changes we expect in 2021, it is critical to reflect on the year that was. This provides us with the necessary context to view the past 12 months, and gives us a starting point for the year ahead. This snapshot of the past year emphasises the hard work of each and every employee, and the dedication with which they tackle their duties, even though our status quo has been challenged in ways we could never have imagined.

We entered 2020 on a high note after the executive team had finalised SAMA's strategy framework 2020 - 2024, which was approved by the board. It was a long process that culminated in us better defining our business and, importantly, further solidifying the core values for which we stand, and which we seek to embody in everything we do.

As you will appreciate, moving forward in a year such as this one requires an immense amount of resolve, particularly with respect to finances. Together with the Finance Department, a plan of action for 2020 was adopted early on to ensure the continued sustainability of SAMA. This had to ensure a proper and workable response to COVID-19 and its impact on the workplace, as well as manage the inevitable break between SAMA and the trade union SAMATU. I believe we have achieved both outcomes well, and that the preparations we made will ensure our success going forward.

A critical element of our business is ensuring that we operate according to set rules, regulations and guidelines, and within the country's governance laws. SAMA's Governance Department is responsible for ensuring this. During the year, the department, through the board and the Constitutional Matters Committee (CMC), updated and approved the SAMA members code of conduct, and the SAMA member disciplinary procedure.

A final draft of an updated and legally compliant memorandum of incorporation relating to the association's governance structure was also submitted to the CMC, who will be recommending it to the board for approval. Other documents presented for board approval include the nominations procedure for non-executive directors, and the interim board rotation procedure.

As its name suggests, our Employee Relations (ER) Department performs a vital function. Despite the constraints of COVID-19 and the ensuing lockdown, this team excelled. Of specific concern were the issues raised in relation to the SAMA/SAMATU split, and a major highlight was the ongoing outreach to members on developments around this issue.

A significant outcome of the changes brought about by COVID-19 was the establishment in September of a Member Engagement Department (MED), whose function it is to communicate directly with members about developments at SAMA and challenges facing the association. The functions that now fall under the MED's purview have been performed for some time by the association under different designations. An important initial issue also tackled by this department was the SAMA/SAMATU split, keeping members informed about ongoing legal proceedings, developments in relation to how memberships are affected, and issues of migrating members to a debit order payment system from PERSAL. SAMA's decision not to deduct fee payments in addition to the PERSAL deductions was extremely well received.

A key imperative for the Corporate Affairs and Marketing Department in 2020 was communicating the effects of the split, and ensuring ongoing media engagement on the issue. The campaigns on traditional and social media dealing with this issue have been well received, and SAMA continues to be positioned as an association fighting for the rights of members in both the public and private sectors.

In terms of events, new opportunities were presented in the form of webinars (online seminars) that provided a good opportunity to engage members, and have imparted critical information, and which carried CPD points. An important element was the inclusion of non-members in the events, to allow them to experience what SAMA has to offer. The approach has proven to be extremely successful, with more than 1 000 attendees at the first three events.

In addition, SAMA hosted its first ever live-streamed press conference, which included the Minister of Health, who spoke on the government's response to COVID-19.

Not only was this a milestone event for SAMA, it positioned the association as a necessary touch point for comment on coronavirus information, and ensured ongoing positive media coverage of SAMA, and members' involvement in dealing with the pandemic.

The pandemic provided opportunities for the *SA Medical Journal* to grow in reach and significance, as COVID-19 research submissions had to be published quickly, before the scheduled publication dates. What developed was Online First (samj.org.za/index.php/samj/issue/view/263), a feature that will be retained for the future.

Online First resulted in a regular flow of COVID-19-related submissions that provided (and continue to provide) rapid access to the best COVID-19 clinical research, and information on related legal and ethical issues. Importantly, many local researchers who would otherwise have sought publication in international journals now chose the *SAMJ* for publication instead.

Local mainstream journalists now regularly reference submissions made on the Online First platform in their articles – adding enormous credibility to the site and its contents. In addition, the editor of the journal is regularly contacted for inputs by researchers across all disciplines, and the *SAMJ* team is praised for its professionalism and efficiency, another indication that this publication is at the forefront of research and innovation.

Our Private Practice Department (PPD) consists of a Business Division and a Coding Division. The Business Division assists doctors with operational issues (such as registering a private practice as a company with medical schemes, and forensic audits), while the Coding Division publishes the *Medical Doctor's Coding Manual* (MDCM) and the *Complete CPT for South Africa* (CCSA), based on the current procedural terminology (CPT).

SAMA coding is still the standard upon which all medical doctor coding in SA is based, and the work of this department cannot be underestimated. During the year, the department printed the MDCM, resolved 8 forensic cases (with 13 still in process), engaged meaningfully with medical schemes and assisted the National Department of Health (NDoH) to compile a list of unemployed doctors. The PPD further assisted the NDoH with contracts for GPs during lockdown, and co-ordinated consultative meetings regarding telemedicine.

The Knowledge Management, Research and Ethics Department (KMRED) was also busy during the year. It was responsible for

SAMA's projects in relation to the NHI and the Presidential Health Compact. It provided essential technical work on documents and proposals, and assisted other departments with information on important and relevant issues. During the pandemic, the department was able to provide frequent website updates, and engage quickly with doctors on content. In February, the department contributed to the first conference on the COVID-19 outbreak at the Council for Scientific and Industrial Research. KMRED also contributed substantially to the COVID-19 guidelines clinical response, as part of the National COVID-19 Clinical Guidelines Development Committee, and as an appointed specialist reviewer for the SA Essential Medicines List (EML) Committee sub-committee on COVID-19.

The acting head of KMRED, Ms Shelley McGee, was also a major and secondary contributing author to an article in the *SAMJ* on the COVID-19 EML processes. In addition, KMRED's research protocol on attitudes of SAMA doctors to euthanasia and physician-assisted suicide was approved for dissemination to members. I want to further acknowledge KMRED's contribution to various statements submitted by SAMA at the World Medical Association General Assembly.

2021 will be a great year for our association and our members

Given the economic fallout from the pandemic, it was inevitable that members would require legal assistance. It was imperative, therefore, that the Legal Department remained agile and responsive in dealing with queries. The department was called on to give members guidance on the Disaster Management Act and associated regulations. During the year, it assisted members in navigating issues such as telemedicine, contracts, business interruption insurance and labour law issues.

Of major import for members were the consent forms prepared and provided by the Legal Department for new types of engagements between doctors and patients. The department amended telehealth consent forms to make provision for remote consultations in line with the HPCSA's guidelines. The department also provided several legal opinions and articles to empower members, and assisted in advocacy and lobbying efforts involving government.



An important intervention was made by the Legal Department when Limpopo doctors were placed into forced quarantine, despite following WHO and NICD guidelines on self-isolation. The department approached the courts for relief to facilitate their release and, upon reading our opposing papers, the MEC agreed to their immediate release, a significant victory.

The Legal Department also realised several achievements through the Education, Science and Technology and Human Rights, Law and Ethics committees. These included hosting a joint symposium with the Colleges of Medicine and SAMA, establishing an initiative to support researchers, and developing a leadership programme in collaboration with the FPD, a pledge for doctors in SA to recite at graduations, ceremonies and formal gatherings, comprehensive guidelines for doctor/patient engagement during the pandemic and guidelines for SAMA members and employees on whistleblowing.

Of course, our operation this year would not have been possible without a secure and reliable IT backbone. The IT Department early on identified the needs of staff working from home, and acquired the necessary technology to make this happen.

A great deal of gratitude also needs to be extended to the IT Department for their work on the association's website, connecting the branches and providing the infrastructure and guidance to manage the webinars that have become so successful.

Looking back on the enormous contributions of everyone at SAMA this year, I am confident that while we may be battered and bruised by 2020, we have the skills, knowledge and dedicated staff to ensure that 2021 will be a great year for our association and our members.

Bullying in the medical profession

Prof. Stoffel Grobler, *University of Pretoria*



The recent documentary “Behind the Frontline” highlighted the issue of bullying in the medical profession in SA. The phenomenon remains an elephant in the room, and the creators of this documentary deserve credit for their bravery, and for putting this matter up for discussion once again.

When asked to write a commentary, I did a quick Google Scholar search, and the results produced a whopping 24 600 articles, and those only published since 2016. I have been aware of bullying in my profession since my days as a medical student, when, sadly, it was judged to be “part of the process” if one wanted to become a doctor.

After a few conversations with young colleagues who I work with, I soon realised that bullying is indeed still common practice at medical-school level, as well as in the first few years after qualifying.

A few interesting remarks and questions arose from these conversations:

“Why do they think it’s okay to embarrass one in front of other people?”

“It has to do with our hierarchical structures.”

“Are they aware of the impact they have on the people around them?”

“Do they realise how vulnerable those below them in the pecking order are?”

“Why would you bully people from your own profession? We are in the helping professions! What does that say about us?”

“Do they behave that way outside of the hospital setting?”

And the most poignant remark was: “My friends and I, in our group at med school, used to remind each other that their power ends when they walk out the door.”

My Google Scholar search resulted in me reading a few articles from other countries as well as an interesting local MMed research article, and it wasn’t long before certain themes started to emerge. Firstly, in relation to the definition of bullying, there appears to be some uncertainty.

This issue was put to rest in a recent study in French hospitals, where bullying is a crime in French law, and defined as “repeated abuses and mistreatment perpetrated by professionals on colleagues, impacting the work environment and the dignity of the victim”.

Sadly, in spite of bullying being a crime in France, 42% of participants reported being victims. Furthermore, in the study, four departments were reported as being at increased risk of bullying: obstetrics and gynaecology, psychiatry, surgery and medical specialties.

Our example should not perpetuate and entrench abusive behaviour

The SA MMed dissertation found the prevalence of bullying to be 89% among final-year medical students at one of our medical schools, with female and black students experiencing higher rates of certain types of bullying.

Other themes encountered in my reading were:

- type of bullying: belittling, ignoring, throwing instruments or patients’ charts, yelling, public humiliation, intimidation and inaccurate accusations
- rationalisation of bullying: as unavoidable, a necessary evil, a rite of passage, teaching by humiliation, a functional educational tool
- increased risk for mental illness: major depression and anxiety disorder – a national survey conducted in Australia

found that junior doctors suffered from high rates of psychological distress, and attempted suicide more frequently than the general population

- witnessing bullying: culture of silence, fear, acceptance or denial and legacy of abuse
- effect of bullying on victim: decrease in learning and ability to provide safe patient care, poor self-esteem, inhibition of collegiality and co-operation, decline in empathy and ethical erosion over time.

From the above, it would appear that our profession has a long way to go before bullying will universally be deemed unacceptable behaviour, and certainly not an educational tool. Bullying still seems very much entrenched in the culture of medicine, and the legacy of abuse will continue to harm our colleagues and the image of our profession if we do not start speaking up when witnessing bullying behaviour, and expressing our support for victims.

In a study on medical students and the value of role models for developing “soft skills”, Joubert put it very well, stating that soft skills encompass “doing the right thing at the right time, nicely”. We teach medical students soft skills by virtue of our passion for our chosen career path, as well as by our example. Our example should not perpetuate and entrench abusive behaviour.

It is time for our profession to do some introspection and start “doing the right thing at the right time, nicely”. If you have power over another due to our hierarchical structures, be nice. There is really no reason in the world to abuse this power.

My question is this: Will it take a law against bullying in SA to eradicate it in our profession? Or are we mature enough to start addressing the elephant in the room, and do something about it?

References available on request.

This article by Prof. Stoffel Grobler is the first in a series to be published in *SAMA Insider*, which aims to assist interns and young doctors to deal with the challenges of the medical profession.

Let us know your thoughts?

Dr Angelique Coetzee, SAMA chairperson

Traditionally, this time of year finds us in the midst of completing projects, planning for next year, and preparing in anticipation of the upcoming holiday season. It seems, though, that we will be doing things a little differently this year. Post-COVID fatigue, and financial restraints brought upon us because of the lockdown, will, undoubtedly, influence the way forward, and it will be interesting to follow the trends as they unfold.

As we prepare to receive our newly qualified intern doctors at public health facilities, we are again reminded of the

ever-increasing challenges that these young people face. As a medical student once wrote: "The image of physicians as singular heroes, as saviours, remains deeply embedded in medical culture. As a newcomer to medicine, I feel intimidated by it all." Then, when qualifying as a medical doctor, and going into internship: "Bullying and intimidation are part of our teaching process. We are trained by senior doctors – who teach by humiliating junior doctors in front of colleagues and patients, so fuelling the cycle of abuse. Suddenly you look around you and you're surrounded by colleagues

who have become very disconnected. Who do you turn to? Saying, 'I am not coping' means you are not strong enough to be a doctor."

Taking from these lessons, we are obliged to ask ourselves whether we should not guide and support our future by providing interns with the means to cope with these challenges. In our view, this should start at universities, teaching life skills to assist young doctors as they step into this tough new environment. What are your thoughts on this? Please share your comments and input with us – it will be greatly appreciated and valued.

Raising awareness during World Stroke Awareness Week

SAMA Communications Department

SAMA says that all South Africans must actively seek to be better informed of the risks of stroke, and that medical doctors and other healthcare professionals must be part of a co-ordinated effort to educate citizens and raise awareness. The call came during World Stroke Awareness Week, which began on Wednesday 28 October, and ran until 3 November.

World Stroke Awareness Week, and World Stroke Awareness Day on 29 October, is aimed at raising awareness about the symptoms of stroke, and the importance of taking treatment for recovery.

"This year's commemoration is unique, because the world is facing the greatest global health emergency in more than a century: COVID-19. There is mounting evidence of COVID-related stroke among young patients in some parts of the world, and it is our collective responsibility as the health community to ensure that our patients, and citizens in general, are educated and aware of the risks and treatments available to them," explains Dr Angelique Coetzee, chairperson of SAMA.

The sad reality is that low- and middle-income countries are hardest hit by stroke. The WHO notes that stroke incidence in low- and middle-income countries has more than doubled in the past four decades. Nearly 240

South Africans suffer strokes daily, and 70 of these die. According to the SA Stroke Society, this makes stroke a leading cause of death and disability in the country.

Dr Coetzee says that being aware of the symptoms of stroke is critical for every South African. She adds, "Although mainly older adults suffer strokes, anyone at any age can have a stroke. The impact of stroke can be significantly reduced by an intensive education and awareness drive that targets both those with stroke risk factors and those without. As stroke is often not painful, warning signs of this devastating condition are often ignored."

SAMA says that citizens must inform themselves of their own risk of stroke, and that of those close to them. It says medical doctors and other healthcare workers must also raise awareness of stroke, not only during World Stroke Awareness Week, but at all times.

There are common signs and symptoms of stroke that people must be aware of. These include:

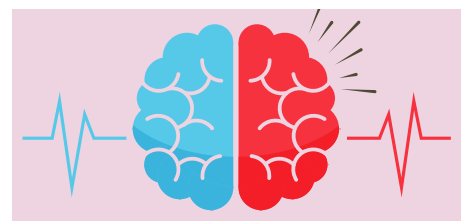
- paralysis or numbness of the face, arm or leg (usually on one side)
- speech difficulty and trouble understanding what others are saying
- sudden loss of vision in one or both eyes

- sudden, severe headache
- sudden dizziness, loss of balance, and trouble with walking.

Immediate medical attention must be sought when these signs are noticed, even when they seem to have disappeared. Early access to healthcare will save lives, limit the effect of disability and improve quality of life post stroke.

"The good news is that many people who have had a stroke make a full recovery, although full recovery is contingent upon many factors, including seeking medical care early. But, of course, preventing a stroke in the first place is vital. Further complications after a stroke occurs must also be prevented, in addition to seeking treatment, to prevent direct and indirect costs to the health system and the economy," notes Dr Coetzee.

SAMA says it is important to recognise and combat the controllable risk factors (smoking, physical activity level, alcohol use, blood pressure, body weight and stress) and uncontrollable risk factors (age, gender, genetics, family history and poverty) of stroke and heart diseases in general. This will help reduce the incidence of stroke, thus enabling individual South Africans to lead healthier lives.



Highlights of the National Quality Improvement Plan

Bernard Mutsago, *health policy researcher*, Shelley McGee, *acting head of department, SAMA Knowledge Management, Research and Ethics Department*

Serious attention to the quality of health services remains one of the most critical imperatives for the successful implementation of national health insurance (NHI), and advancement of universal health coverage in SA.

According to the 2019 NHI Bill, all health facilities wishing to provide services for the NHI will be required to first meet the quality and certification standards of the Office of Health Standards Compliance (OHSC). Thereafter, facilities will need to be accredited by the NHI Fund.

Against this backdrop, the National Department of Health (NDoH), in collaboration with some members of the SA work stream of the Lancet Commission on High-Quality Health Systems, have developed the 29-page National Quality Improvement Plan for SA (hereinafter NQIP, or the plan). This NQIP was formally signed off in July 2020, and has already seen the issue of a tender to be awarded for the development of "quality learning centres" (QLCs) across the country.

The NQIP, which is clearly synchronised with the NHI preparations and the existing National Quality Framework, is a 5-year strategy that "seeks to transform existing service delivery challenges into learnings and opportunities for quality improvement." The plan makes it plain that the framework will serve as a testing ground for the NHI aspects of accreditation and provider contracting.

The plan emphasises "building on existing quality initiatives in the country", and a great bulk of it is devoted to laying out the history, background and context of existing quality of care and relevant structures in the country.

In a descriptive fashion, the NQIP sets out the quality-related challenges besetting both the public and private health sectors. Emphasis is placed on the need for integration across sectors (public/private), levels of care (primary, secondary, tertiary and quaternary), and types of services (preventative, promotive, curative and rehabilitative).

The history, purpose and accomplishments of the OHSC thus far, dating back to its creation in 2013, are outlined, among other contextual issues. The background also demonstrates that, based on previous quality assessments, health facilities have a poor record of compliance with the National Core Standards. For example, the cited 2016/2017 inspection report reveals that all assessed public facilities scored less than 50% of the required standard, while none of our nine

provinces achieved the target of an 80% score for another OHSC assessment on the six priority standards.

The NQIP will be system-based, encompassing hospitals, clinics, emergency services and family practitioners. Each of these entities must, for now, individually adhere to standards and meet accreditation standards, pending a multidisciplinary patient-centric team approach. The plan affirms that the pursuance of improved quality in the health system will be on an incremental basis. A notable aspect is the entrenchment of the previous quality standards into law – meaning that inspections and the inspection process will be governed by the force of law, unlike previously. The first subset of regulated standards was promulgated in February 2018, and came into effect 12 months thereafter. This legal framework applies to both health establishments and the OHSC.

The multiple and complex aspects of the plan require careful scrutiny

The NQIP is obviously inspired by the National Development Plan, which is the overarching policy blueprint of the country, and seems to have been conceived from a recommendation in the Presidential Health Compact, namely to "harmonise all the quality improvement initiatives ... into a unified system and nationwide quality improvement plan".

The Presidential Health Compact has a specific pillar (pillar 5), led by SAMA, that focuses on quality of care. Whereas pillar 5 interventions appear more granular and action-orientated than the NQIP, there are common threads running through both, including: a focus on primary healthcare; service integration; people-centredness; co-ordination across sectors; and addressing the determinants of health.

One important proposal of the NQIP is a multistakeholder approach to quality improvement. There is recognition of the value of involving a diversity of stakeholders in quality monitoring, namely the community, hospital boards, clinic committees, organised labour, all health workers, support staff, doctors, management and patients, as well as independent professional entities.

In addition, the plan's anticipation of a publicly available quality information dashboard, patient complaints system and whistleblowing system is commendable, as this will go a long way towards fostering compliance, accountability and transparency.

A central element of any quality initiative is measurement. Therefore, to address the current anomaly wherein the volume of services rendered by an establishment or healthcare provider is used as the standard measure of success, the NQIP intends to shift the focus towards outcome-based, value-driven measurements. This approach is in line with recommendations of the Competition Commission's private health sector health market inquiry, which was completed in 2019. The plan envisages that such a profile of improved outcomes will be built on a foundation of appropriate clinical guidelines and protocols, which will be assessed through clinical audits, in the spirit of evidence-based medicine.

In line with the NHI proposals, the NQIP presents provider contracting in a team-based arrangement as the best vehicle to achieving quality. This arrangement will be based on a tariff system designed to promote productivity and to discourage under- or overservicing. Peer review and benchmarking are tendered in the plan as the best mechanisms to share best practice.

The plan also proposes creating business units in each clinical department to ensure better governance and management. This is coupled with a stated commitment to build capacity at all management levels.

It is also proposed that four QLCs be established in each province, comprising a regional, district and private hospital (urban provinces), and three primary care facilities, including family practitioners and emergency medical services. The purpose of these QLCs will be to form a locally based point for learning, development and support to local facilities facing any challenges. The QLCs will be linked to each other to offer peer support and review, and to share best practice and learning.

Other key elements of the proposed quality improvement programme include focus on:

- strengthening NDoH capacity to monitor quality
- capacity building in provinces, districts and health establishments
- providing training to health facilities on quality improvement methodology

- linking public and private facilities to share learning and experience
- actively involving hospital boards and clinic committees in quality improvement.

With regard to human resources, the plan recommends lifting the moratorium on the

filling of critical and essential clinical and administrative posts, in order to stem the critical personnel shortages experienced in many facilities.

In conclusion, the NQIP has been quietly signed off during the COVID-19 pandemic, with solid steps already taken by the NDoH

towards its implementation. While it is not the intention of this article to argue whether this NQIP is fit for purpose or “good enough”, the multiple and complex aspects of the plan require careful scrutiny, particularly by affected parties such as medical practitioners.

Staying secure in the virtual age: How to protect your patients and practice from hackers

FPD School of Information Technology

Technological innovations in the medical field are creating fantastic new opportunities, but also bring with them unwanted risks. Cybercrime is a major threat. In SA, we experience 577 cyber-attacks an hour, according to *Business Insider*.

According to the Medical Protection Society, the newly implemented (on 30 June 2020) Protection of Personal Information Act No. 4 of 2013 is strict with regard to the collection, preservation and access control of patients' personal identifiable information. If breached, you are required to inform the patient as well as the information regulator, in writing. Failing to do so may result in prosecution, with a 10-year prison sentence, a ZAR10 million fine or both, if convicted.

Cybercrime is rapidly evolving in complexity and ingenuity, and most businesses are poorly prepared for the consequences of falling victim to this form of crime. Cybercrime not only places patient confidentiality at risk, but carries potentially devastating regulatory penalties.

The healthcare sector is not only targeted due to the sensitivity of information recorded, but also because hackers exploit the sector's lack of cybersecurity awareness, especially among busy professionals. Clicking on an innocent-looking link in an email that appears to be from a colleague, patient or supplier could release malware into your device, which then potentially spreads through your whole system. As medical practices embrace the internet of things, which is part of the fourth industrial revolution, every device and every person who uses it is a potential entry point for a hacker. Mitigating cybersecurity risks is increasingly becoming a standing item

of corporate governance, and as such, also the responsibility of a medical practice owner.

Medical practices can protect themselves with a few basic security measures:

- using antivirus software (Bitdefender, Kaspersky, ESET etc.)
- using a firewall
- creating strong passwords (10+ characters, using alphanumeric characters and capital letters)
- updating software regularly when prompted by your software supplier (e.g. Windows updates)
- backing up your patient data (securely storing it in a cloud-based solution, preferably never on site)
- being aware and wary of hacking practices.

Most cyber-attacks use deception to manipulate individuals into divulging confidential or personal information that may be used for fraudulent and exploitation purposes, e.g.:

- phishing: sending emails purporting to be from reputable companies to induce individuals to reveal personal and sensitive information
- spear phishing: same as the above, but targeting key individuals such as CEOs or business owners, to gain access to sensitive information to exploit companies
- malware: encryption software making devices obsolete – this is the source of the bitcoin debacle, where you consider paying the hacker to unencrypt your data, with no guarantee they will or even can do this
- pretexting: using a story, or pretext, to fool the victim

- *quid pro quo*: fraudsters impersonating IT technical support staff and spamming as many direct numbers that belong to a company as they can find
- tailgating: someone without the proper authentication following an authenticated employee into a restricted area, usually server rooms or filing cabinets
- baiting: innocent looking flash drives/USB storage devices left in the company parking lot, when picked up and plugged into a device, releasing malware and encrypting your data, making it inaccessible.

The rapid technological advantages in health-care delivery open up incredible opportunities for medical practices, but also bring substantial threats. As with most threats, the better you understand them, the better you can protect yourself and your practice against them.

The FPD School of IT continuously aims to stay at the forefront of responding to this threat by offering courses designed to help practitioners and their staff recognise threats and develop measures to protect their IT systems. The FPD offers an SA-developed cyber-awareness course that teaches participants about all the current threats in a connected world. All medical practitioners should consider this course, not only to improve their own knowledge and understanding, but that of everyone in their practice.

For more information, please visit <https://icted.online/Course/Details/329>.

References available on request.

CREATING VIGILANCE THROUGH EDUCATION

THE
CYBER
ACADEMY



Telehealth and the risk of supersession

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



The COVID-19 pandemic has altered our economy, society and healthcare system. Although this crisis has posed unparalleled challenges to the SA healthcare system, it has catalysed rapid telehealth adoption and changed healthcare delivery at a breathtaking rate.

The term telehealth applies to the entire continuum of activities used to provide care at a distance. Telehealth includes practitioner-to-patient and practitioner-to-practitioner interactions, and may take place synchronously (telephone and video), asynchronously (messages from patient websites, e-consultations) or through virtual agents (chatbots) and wearable devices.

Telehealth services tackle physical challenges in order to provide access to medical care for patients and caregivers. In the midst of stay-at-home directives and social distancing steps, and while reducing population and nosocomial spread, telehealth ensures the continuity of patient care during the pandemic. Telehealth is also useful for inpatient treatment, in particular, to help solve the problem of increasing demand on healthcare facilities, conserve the supply of personal protective equipment and provide isolated patients with connection to family and friends.

While the adoption of telehealth is encouraging, and its potential benefits are apparent, particularly during these times, there are some ethical concerns that healthcare practitioners need to consider. This article will focus on telehealth and the ethical conundrum of supersession. McQuoid-Mason

and Dada define supersession as “the practice of taking over the patient of another doctor without informing the other practitioner in situations where the patient has not terminated the other healthcare provider’s services”.

The HPCSA advises that, although practitioners may charge fees for consultations undertaken through telehealth platforms, it strongly cautions against practices that may amount to overservicing, perverse incentives and supersession.

Rule 10 of the ethical and professional rules of the HPCSA states:

“A practitioner shall not supersede or take over a patient from another practitioner if he or she is aware that such patient is in active treatment of another practitioner, unless he or she –

- (a) takes reasonable steps to inform the other practitioner that he or she has taken over the patient at such patient’s request; and
- (b) establishes from the other practitioner what treatment such patient previously received, especially what medication, if any, was prescribed to such patient, and in such case the other practitioner shall be obliged to provide such required information.”

This rule clearly shows that superseding, or taking over a patient, is, in fact, permissible where the requirements contained in the rule (in sub-paragraphs (a) and (b)) are met. However, in the realm of telehealth, it becomes easy for a healthcare professional to unknowingly commit the act of supersession. One example of how such a situation could occur is when a patient teleconsults with a new practitioner for a renewal of his or her chronic medication prescription. If the consulting practitioner does not (i) take reasonable steps to inform the other practitioner that (s)he has taken over the patient at such patient’s request, and (ii) establish from the other practitioner what treatment the patient previously received, especially what medication, if any, was prescribed, the new practitioner could be guilty of supersession.

Nevertheless, there is an additional crucial factor to consider – the principle of patient

autonomy. Botha explains that ethical rule 10 does not inhibit this concept in any way; rather, it strengthens it by obliging the “new” practitioner to take fair steps to contact the “old” practitioner and to obtain sufficient and relevant clinical information about the patient in question. Patient autonomy is a principle that pervades SA health legislation and is reinforced in our case law. Ultimately, it is the responsibility of the patient to select where (s)he receives healthcare. Therefore, it is the patient’s prerogative to make that decision.

Healthcare practitioners need to consider some ethical concerns

Ethical rule 11 of the ethical and professional rules of the HPCSA states: “A practitioner shall not impede a patient, or in the case of a minor, the parent or guardian of such minor, from obtaining the opinion of another practitioner or from being treated by another practitioner.” In essence, rule 11 prohibits practitioners from impeding a patient from seeking a second opinion, and possibly electing the practitioner who offers the second opinion or some other practitioner to continue their treatment.

This would certainly present most practitioners with an ethical dilemma – respecting the patient’s autonomy and the right to choose his or her practitioner, and upholding rule 10 of the ethical and professional rules of the HPCSA.

What, then, should practitioners do?

Practitioners who teleconsult with patients who receive treatment from another doctor should, to the best of their ability, abide by the HPCSA’s ethical and professional rules. Not only will this assist in preventing practitioners from conducting unethical practices, but it will also allow for efficient continuity of patient care.

References available on request.

Six tips for more effective online meetings

Gert Viljoen, VProf

COVID-19 continues to alter the fundamental ways we do business. While many organisations were already conducting some meetings online, the pandemic has brought this practice into sharp focus, and 86% of employed people now take part in an online meeting at least once a week. Furthermore, according to Forbes, from 2010 to 2020, there has been a 400% increase in the number of employees who work from home.

With meetings and even job interviews now largely conducted online, it is important to ensure that the message and purpose is not lost in the distractions of home life, bad connections, sound problems and any other number of possible hindrances. Below are six tips to make sure your online meetings are always a success.

While the capacity for digital meetings and interviews has been around for some time, they have only truly gained popularity this year. COVID-19 lockdowns around the world have forced companies to develop alternatives to their usual systems, and digital meetings have become an everyday occurrence for most in the workplace. The question is, do they work as well as regular face-to-face meetings? And when it comes to interviewing for new appointees, is something being lost in the system?

In April, one of the world's leading research and advisory companies, Gartner, conducted an in-depth analysis of hiring in the digital world and found that while the capacity for digital meetings and interviews to be as effective as real-world arrangements does exist, they often are not as effective, because simple errors are made that decrease their efficiency.

Consequently, meetings that eat up time without achieving much are more common online. Participants may experience connectivity problems and communication delays. They might also face problems in holding the discussion in a structured manner, and multiple people may start speaking at the same time.

When it comes to interviewing potential employees, these problems can exacerbate an already tense scenario for the candidate, thereby resulting in a less-than-ideal interview.

"There are several important strategies that HR functions must use to effectively conduct virtual interviews so as to ensure a positive candidate experience and effective assessment by the hiring manager or other interviewers," says Lauren Smith, vice-president in the Gartner HR practice.

"Meetings should be like salt – a spice sprinkled carefully to enhance a dish, not poured recklessly over every forkful. Too much salt destroys a dish. Too many meetings destroy morale and motivation" (Jason Fried, entrepreneur and author of *Rework*)

So just what can be done to make your online meetings and interviews more effective?

Invite as few people as possible: researchers at one of Europe's largest independent research organisations, SINTEF, stress that it is important to keep meetings as small as possible. Their work has led them to conclude that when meetings have more than 12 participants, most will be unable to speak, may disengage and will leave the meeting unsatisfied. Remember, the more participants, the shorter the time available for each to be an active part of the conversation.

Use video chat when possible: while our primary method of communication is our voice, one should never underestimate just how much is "said" non-verbally. Being able to see one another goes a long way to gaining trust and rapport with interviewees and

meeting attendants, and is also an important part of getting good data. According to research scientist Nils Brede Moe, it is much easier to feel a human connection when you can see someone's face, and it helps both of you read the situation and each other's feelings better.

The person conducting the meeting is also better able to control the flow and time issues if people can see these non-verbal cues.

Have a clear agenda and defined goals: holding meetings with vague agendas is never a good idea, but this is even more true online. Structure is vitally important online, so be sure to prepare a formal agenda with all the key issues to be discussed in the meeting, and sort them according to your business needs. Also clearly mention what role you expect from each participant in the meeting, and just how long the meeting will take. This agenda should be sent to each participant well in advance, so that they are able to accurately prepare. Setting a time limit for each agenda point will help to extract a lot more value in the limited time you have. If participants know a point only has 10 minutes for discussion, they will stay focused and the meeting will not go off track.

Open the meeting room early: Most meetings begin punctually at the appointed time, but SINTEF suggests that the meeting room should rather be opened 15 minutes before the indicated start time so that participants are able to test their audio and video before the meeting starts. Participants who log on after the meeting commences quickly disrupt the flow and interaction of the meeting, and so everyone should be in place and ready to go at the appointed time.

Share notes and record the meetings: given that employees are now conducting meetings from home and may therefore be distracted, or have sound or connection problems, it's a great idea to simply record every meeting and send people links to the recording at the end. Some online meeting services have a record function built in, whereas others may require you to download an extra app such as Pio Smart Recorder or GoToMeeting. Another good trick for the end of the meeting is to send each person



a list of the action points identified for each agenda item, along with the name of the person responsible for its delivery. This way everyone knows exactly where they stand,

and can look up the relevant areas that apply to them on the recording, if necessary.

Appoint a moderator: whether conducting a panel interview or a meeting, chairing

the discussion can be much harder online, particularly if not all participants have video turned on. It is therefore a good idea to appoint a meeting moderator who will give people permission to speak, and keep the conversation on topic. The moderator should also be aware of the words (s)he is using and attempt to be as clear and concise as possible. (S)he should use people's names when addressing them, as it is not always clear who is being spoken to directly, and instructions should be repeated at the end of each agenda point to ensure that everyone is on the same page.

V Professional Services (VPROF) is a medical practice administrator, medical bureau and professional accounting firm dedicated to supporting the business activities and patient care of independent medical practices around SA.

What has COVID-19 revealed about the way we handle global pandemics?

SAMA Communications Department

Dr Benji Pretorius, a practising GP, believes that "COVID-19 has taught us crucial lessons on how we as a global community react to and manage pandemics. It is essential that we learn from these lessons and protect vulnerable communities from the next disease outbreak, whenever that might be."

Throughout the COVID-19 outbreak, preventive measures for other diseases such as malaria have continued. As a survivor of malaria himself, Dr Pretorius has seen first-hand the need for early intervention measures to stay on track, and shares his thoughts on how the world can learn from COVID-19.

In October, the Global Fund to Fight HIV, TB and Malaria published its results report for 2020, which gave an important insight into the progress made in eradicating these three diseases. What is clear in this report is that even in the face of COVID-19, there are many achievements to take pride in.

For instance, in 2019, 6 million additional lives were saved as a result of malaria prevention methods such as mosquito nets, with 160 million now distributed across 38 countries with a high burden of malaria.

However, COVID-19 continues to threaten global targets to prevent diseases. As many as 75% of malaria projects have been either moderately or severely impacted by the COVID-19 pandemic, and there is the real prospect of malaria cases surging to levels last seen 20 years ago without these projects.

As well as highlighting the need to maintain current disease prevention measures, COVID-19 has also revealed the vital work of those on the frontline of these programmes. Many frontline workers are volunteers, selflessly giving their time and effort to support the most vulnerable organisations.

But in carrying out this life-saving work, frontline volunteers and healthcare professionals have encountered significant obstacles. Sourcing personal protective equipment (PPE) has been one of the most pressing, not helped by the disruption to supply chains. This means that frontline workers are faced with either going into a high-risk area unprotected, or leaving communities already in danger without crucial medication or tests to combat the spread of various diseases.

When they do work in vulnerable communities, healthcare workers are often met



Dr Benji Pretorius is the founder of SA start-up Erada Technology Alliance. He is a malaria survivor and practising GP who has seen first-hand the importance of early intervention and prevention. His statement follows the publication of The Global Fund to Fight AIDS, TB and Malaria's 2020 Results Report.

with distrust and even hostility from people frightened at the prospect of contracting COVID-19. This fear also makes communities less likely to visit professional health facilities for other conditions such as malaria and TB.

In order for viruses to be controlled at a local level, volunteers and healthcare workers are the first line of defence. As such, we need to ensure that they have the necessary protection to safeguard themselves, the people they interact with and their own loved ones.

There is also a pressing need for rapid tests for infectious diseases to be made available for members of organisations carrying out frontline detection and treatment, so that, in the worst case scenario, if they do contract a disease, it can be stopped before spreading to other regions.

During the 2014 Ebola outbreak, healthcare professionals from across the world were drafted in to help stop the spread. According to an online survey published in 2015, 15% of UK healthcare workers were “considering” going to West Africa to lend their support; however, their concerns about contracting Ebola themselves, along with reservations from loved ones, meant that they delayed formally volunteering. A lack of information about the virus itself was also found to be a contributing factor in the slow uptake.

Although this is just one example, it does illustrate that alleviating frontline healthcare worker fears must be a priority, as should the provision of adequate PPE. And leaning on people’s desire to “give back” to the communities affected by pandemics can ensure that there is every likelihood of maintaining a constant source of dedicated individuals.

COVID-19 has also raised awareness of the need for rapid diagnostic tests to be made as widely available as possible. We have already begun to understand how crucial these tests are for diseases such as malaria, which displays many of the same early symptoms as COVID-19, and for containing the spread.

Malaria can be fatal if it is not treated at the earliest opportunity. Diagnostic tests that can be carried out in the field and swiftly provide an accurate result are fast becoming a key part of the arsenal used in the fight to eradicate it.

Technological advancements have been key to that. It is now possible for the results of a non-invasive test to be collected and analysed via a smartphone, therefore ensuring that time is not lost in analysing blood samples or

carrying masses of laboratory equipment into a locality. But these devices need to be available on a larger scale, which cannot happen without the support of the entire global community.

As the Global Fund’s report outlines, the potential for international co-operation is vast. Due to global efforts, including financial backing, more communities are able to access some form of protection against diseases such as malaria and TB. But these efforts need to continue even as we combat this new virus.

With the WHO warning that a second wave of COVID-19 is on the horizon, it is crucial that we now act on knowledge gained from the first COVID-19 outbreak, and from combating other diseases throughout history. There have been costly lessons along the way, but as a global community, we must continue to collaborate and learn together so that we are all ready for a future large-scale pandemics.

The Global Fund Results Report 2020, referenced in this article, is available at https://www.theglobalfund.org/media/10103/corporate_2020resultsreport_report_en.pdf.

Medical profession “severely” affected by pandemic

SAMA Communications Department

The COVID-19 pandemic has had a severe financial impact on SA practitioners, with some GPs, cardiothoracic surgeons and neurosurgeons losing up to 80% of their income and having to close their practices, according to medical indemnity insurer EthiQal.

Alex Brownlee, executive head of EthiQal, said in a statement that the insurer had recorded an almost 50% increase in policy cancellations during the pandemic period compared with the prior year, “albeit still small numbers”. These were related to early retirements, delayed starts in private practice and stopping clinical practising due to the impact of the pandemic.

“The income of many doctors has been significantly reduced due to hospitals restricting surgeries to emergencies and births, as well as patients putting off seeking non-critical treatment. The effects thereof have left some private practitioners with little choice but to reluctantly hang up their stethoscopes in retirement, and others to close their practice’s doors.”

Average reductions in income among specialists were evident at near 30%, with some severely impacted by up to 80% of income. Some of the worst financially impacted medical disciplines included GPs, cardiothoracic surgeons and neurosurgeons, Brownlee said.

“The psychological effects of financial uncertainty, cash flow problems and constant worry about the possibility of infecting family, friends and patients have taken a toll on the mental wellbeing of many doctors and nurses, with many still coming to terms with the impact of COVID-19 to this day.

Brownlee said that roughly 7 months and over 700 000 positive coronavirus cases after SA recorded its first coronavirus case in early March 2020, the pandemic continues to take a toll on the country’s health system, healthcare workers, the economy and its people.

“Medical practitioners stepped into wards and theatres to treat patients with the realisation that they could be exposed to infection, and would not only be putting their lives at risk, but also those of their families and friends. Back in August, as announced by the Minister of Health,

over 6 000 private healthcare workers tested positive for the virus, with a death toll of 37.

“During these times, many doctors were exposed to new conditions and required to work outside of their typical scope of practice. Telemedicine was allowed to be provided to patients beyond what was previously allowed for by the regulator.”

This introduced new challenges and medicolegal risks to doctors during a stressful time, and one in which practice income was severely impacted, which meant that EthiQal had to assist by extending cover and providing various financial relief initiatives.

“As much as becoming a doctor is a calling, no medical practitioner could have foreseen the dilemmas arising from an extreme and unprecedented event on the scale of the coronavirus pandemic. We owe it to our doctors, nurses and other healthcare workers for the bravery and dedication they have shown in caring for the citizens of our country and helping to stop the spread of the virus.”

Source: Medical Brief, 11 November 2020.

One in three SA doctors have suffered verbal or physical abuse during COVID-19

SAMA Communications Department

Almost a third (31%) of healthcare professionals in SA say that they have suffered verbal or physical abuse from patients, patients' relatives or members of the public during the COVID-19 pandemic, according to a recent survey by the Medical Protection Society (MPS).

The MPS survey results, which were announced at the organisation's annual Ethics for All conference, showed that 26% of doctors have experienced verbal or physical abuse from patients or patients' families during the pandemic. A further 5% said they had experienced verbal or physical abuse from members of the public outside of a medical setting.

MPS – the world's leading protection organisation, supporting more than 32 000 healthcare professionals in SA – described the survey results as "deplorable", and said that the abuse presents yet another source of anxiety for doctors at the worst possible time. In the same MPS survey, nearly half of SA doctors say that their mental wellbeing is worse than at the start of the pandemic.

Dr Volker Hitzeroth, medicolegal consultant at MPS, said: "These survey results make for sombre reading and demonstrate that many doctors feel under attack. While this is a frustrating and extremely stressful time for the public, it is sad and deplorable to think that one in three doctors who go to work every day in the most challenging circumstances, putting patients first, face abuse. Not only in their place of work, but in public too.

"Many doctors told MPS that they have faced abuse from patients and families when trying to enforce social distancing and mask wearing. Doctors and staff have also been abused by patients being triaged and waiting for treatment.

"This presents yet another source of anxiety for doctors at a time when many have expressed grave concerns about their mental wellbeing. In our survey nearly half – 45% – of doctors say their mental wellbeing is worse compared to the start of the pandemic.

"Healthcare professionals in SA already faced a myriad of daily challenges prior to



COVID-19. The pandemic has exacerbated these challenges; already burdened health resources are being stretched further, doctors are worried for the safety of their patients and their own families, and are now facing the compounding threat of abuse from the very people they seek to care for.

"Without support to address an array of mental wellbeing concerns – including those caused by verbal and physical abuse – doctors are at risk of becoming disillusioned, or will suffer in silence with psychological injuries, both of which put the safety of themselves and their patients at risk.

"Mental wellbeing is not just a challenge to be met by the government; hospitals and professional societies have a part to play. Many professional societies have stepped up with dedicated colleagues looking after the wellbeing of their members. MPS has, since the beginning of the pandemic, extended its free and confidential counselling service to members experiencing work-related stress (<https://www.medicalprotection.org/southafrica/help-advice/counselling-service>).

"A nationwide campaign to raise awareness and provide additional support

Anonymous comments from healthcare professionals

"I was robbed at my practice."

"I have had patients and their escorts who verbally start arguing that they are 'tired' of abiding to the COVID regulations and refuse to wear masks."

"A lot of patients seem to think that there is some big medical conspiracy. So difficulties are often targeted at outpatient doctors."

"Patients don't want to wait ... so they abuse my staff."

"People often verbally abuse doctors and nurses if they have to wait, even though they are green or yellow codes."

would help join up these efforts and ensure that those healthcare professionals who need specialist support can access it when they need it most."

Outeniqua branch chairman writes children's book on coronavirus

Dr Wessel Vermeulen, Outeniqua branch chairman

The area of the Outeniqua branch is one of the widest in the country, stretching from Swellendam to Plettenberg Bay (the whole of the Garden Route), and includes the Klein Karoo from Ladismith up to the Langkloof, as well as towns such as Prince Albert and Beaufort West. The area covers two mountain ranges, namely the Swartberge and Outeniqua.

Contact with members is difficult, and mainly made via technological means because they are spread over such a large area.

The area also has a large percentage of inactive and retired members who love to be kept informed, while the state-employed doctors only remain in the area for 2 years.

We really struggle to engage with the young doctors, and as such, we need to change our strategy. I think SAMA should definitely start to focus on medical students, and (as in years gone by) make it attractive for students to join for free during their clinical years. This way we can ensure that they are already members of SAMA when they qualify.

The branch has held several successful mini-congresses, and presented CPD lectures over weekends. All were well attended, and we managed to secure non-pharmaceutical sponsors, which attracted spouses and families. This included a smart High Tea, at which there were lectures on beauty and gynaecology, and musical performances. A successful family weekend was also held, which included 4 x 4 trails, walks, cycling and mountain climbing in the Langkloof. Adventure and nature companies held exhibitions during this weekend.

In my view, it is important that efforts are made to include spouses and families in activities; doctors spend long hours working, and it is therefore important to present SAMA as a family-inclusive organisation.

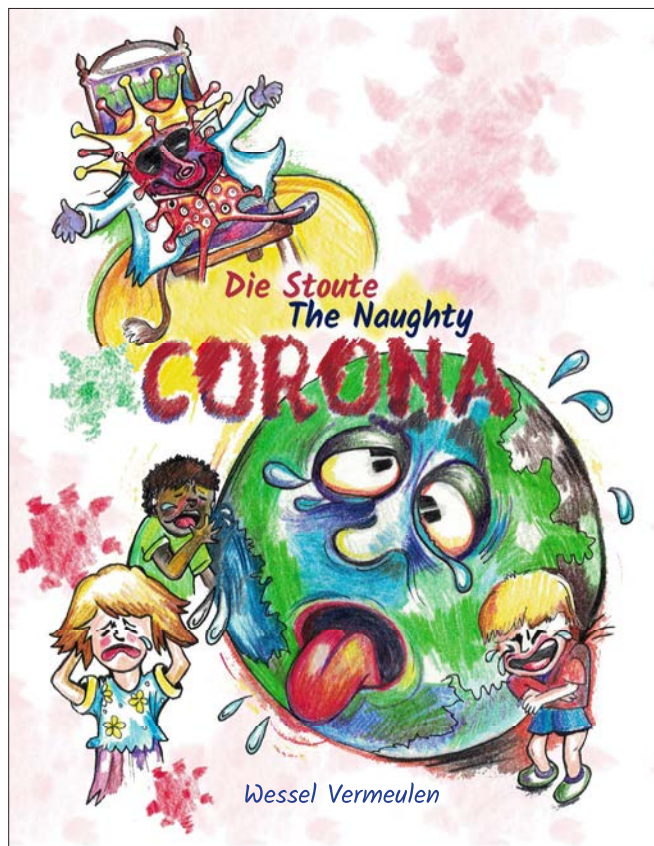
The COVID-19 pandemic has affected us all on a wide front. Many of us have lost dear friends, colleagues and patients, and it is very traumatic for our families. I am particularly sad about the unnecessary draconian restrictions on the elderly, who have passed away in isolation, feeling sad, and that their children have rejected them. In my view, their grandchildren and family, with the necessary precautions in place, did not pose as high a risk to them as the nursing staff and caregivers who were looking after them. If I was given a choice, at the age of 85, either to see my family for a week and then pass on, or never to see them again, I would choose the week.

The hidden fears, uncertainties and worries of small children affected me deeply. My youngest grandchild's prayer that "God must come help because we are losing the game" motivated me to write a story, literally in between seeing patients.

This is how the *The Naughty Corona* came to be. What started as a charity/fundraising project without an income or profit motive simply exploded inside 3 weeks.

At this stage, over 10 000 books have been printed.

The primary aim was to put children first. Schools and old age homes received the book for free, and there are schools that have used it as a week-long project for grades 1 - 7 for comprehension, oral, reading and



The *Naughty Corona* has to date been translated from Afrikaans into English and isiXhosa



Dr Wessel Vermeulen with his 8-year-old granddaughter, Marley, who inspired him to write the book



Members at a branch conference

questionnaire tests. At the end of the week, prizes were handed out in all grades.

Companies buy books at cost and distribute them among clients; many books

have been distributed to under-resourced schools and rural communities.

The book has been translated from Afrikaans into English and isiXhosa. One

Dr Wessel Vermeulen qualified in 1976 and started working in Oudtshoorn as a GP in June 1979. He has been a member of SAMA since 1976, and has been involved in management, having been the chairman of the Outeniqua branch for the last 20 years.

Dr Vermeulen is involved in his community as a management member of sporting bodies, as well as team doctor for the SWD Eagles.

He has three children: Sunet (agriculturist), Wessel (radiologist) and Wikus (urologist), and eight grandchildren, around whom his happiness revolves.

colleague in KwaZulu-Natal has offered to do the isiZulu translation, and a request has been received from Italy for an Italian translation.

This is an example of how something straightforward with good intentions can unexpectedly work wonders.

Copies of the book can be ordered from Dr Wessel (drwessel@vermeulenpraktijk.co.za) or from the branch (samaoqb@samedical.org, or telephone 044 871 2131). SAMA members pay printing costs plus postage (not more than ZAR10 a book).

Gauteng North supply PPE to members

The SAMA Gauteng North branch had so many plans for 2020 – various CPD functions, our annual High Tea for our life members and the year-end function. Unfortunately, due to the global COVID-19 pandemic, these plans had to be cancelled. The branch realised that it still needed to be relevant to its members during these uncertain and challenging times, and embarked on one of its biggest projects to date: to supply reusable personal protective equipment (PPE) to its members.

The reusable PPE pack consisted of a pair of goggles, a face shield and a pair of boots. As an additional bonus, we were able to supply each member with four N95 masks. The branch decided, for logistical reasons, to supply PPE only to those SAMA Gauteng North branch members in good standing who responded to the email and SMS requests regarding PPE.

The project took months to complete. We had to ensure that we had the correct physical



The reusable PPE pack

address and shoe size of our members, that quality PPE was supplied and that the supplier could deliver the PPE to all our members across the country. It was a mammoth task. But we succeeded.

The SAMA Gauteng North branch recognises and appreciates the role our members



Dr Michelle Lombard in the SAMA PPE

have played and continue to play on the ground in the fight against COVID-19. This project enabled us to give back to our loyal members who help to keep our branch and the national body resilient and relevant in all healthcare practitioner issues.

#SAMACares.

Border Coastal congratulate Dr Angela Hartwig – Rural Doctor of the Year

SAMA Communications Department

Congratulations to Dr Angela Hartwig from SAMA's Border Coastal branch, who has been awarded Rural Doctor of the Year by the Rural Doctor's Association of Southern Africa (RuDASA).

Over the last 18 years, six doctors from the Eastern Cape have received this award. Dr Angela Hartwig is the third recipient from the Amathole district. The Pierre Jaques RuDASA Rural Doctor of the Year award was first awarded in 2002, and is usually presented at the annual Rural Health Conference. Due to the COVID-19 pandemic, the conference was not held in the usual format in 2020.

Her citation, written by a previous winner, Dr Jenny Nash, read: "Angela Hartwig studied medicine at Pretoria University. She did her internship at Mthatha and Frere hospitals and then completed community service at the Church of Scotland hospital, Tugela Ferry in KZN. She worked in Greytown, KZN for 4 years in a variety of jobs, including as a substitute Life Science teacher for 3 months! She and her family also volunteered in Malawi for 5 months in 2019.

"She has a postgraduate diploma in clinical management of HIV/AIDs from UKZN, and a Master's in Public Health from the University of Liverpool. She is currently enrolled in a postgraduate diploma in community and general paediatrics through UCT.

"In March 2020, Angela and her family (husband and two children) moved to Adelaide in the Eastern Cape. In the first month of working at the hospital, she was the only doctor. Shortly after commencing work, COVID-19 lockdown started. The next few months were a whirl of activity – Adelaide became a hotspot for COVID-19, resulting in many patients being admitted needing oxygen. Angela was pregnant and also contracted COVID-19. She was admitted in the ward and continued to help manage patients from her ward!

"Angela worked tirelessly during this time, including during her maternity leave. There were only a few days during her maternity leave when she didn't come into the hospital. She encouraged support to the clinics, health education to the staff and sent an encouraging voice note each day to the hospital staff. Her most memorable moment over this period? When the hospital staff came to stand outside



Angela receives her award from Amathole district manager Mrs Sindiswa Gede, while the acting CEO of Adelaide Hospital, Mr Magalele, looks on



Dr Angela Hartwig with her husband and daughter

her window with a message of support after she tested positive.

"She attended many Zoom meetings to discuss COVID issues – where you could sometimes hear a little baby's voice in the background!"

Angela was nominated by RuDASA for the *Mail and Guardian's* 2020 Top 200 Young South Africans, in the category Heroes Editor's choice (one of eight people selected in this category). Her words in the midst of trying times are: "Don't let yourself become frustrated by things out of your control; you may not be able to change the circumstances around you, but work to make a difference in the areas you can control. Do what you can with what you have, do it with joy, and don't feel bad about what you can't do."

RuDASA presented Dr Angela Hartwig with this award, recognising the excellent work that she has done over the last few months in pursuit of clinical excellence. "She is constantly reviewing indicators and trying to find ways to improve support to the surrounding community. She is concerned about food security, mental health services and child safety and protection. She has also been advocating for more allied staff to work in the hospital. We recognise her belief in teamwork and her desire to encourage others around her, including those in the community, to strive towards change."

In Angela's words: "I want to not only inspire but empower people to bring change to their workplaces and communities, to know that everyone doing their part, together, can make a difference."



CPD

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

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Celebrating A DECADE

The Divisions of Pulmonology & Neonatology of the Tygerberg Children's Hospital have pleasure in announcing the 10th conference titled "A decade of Here be Lungs".

We will navigate newly described & insufficiently explored neonatal, infant & childhood lung conditions as well as cardiac & pediatric intensive care related lung conditions through state-of-the-art lectures in the respective fields. The subject of COVID-19 will be extensively covered.

We invite you to exhibit or join us in what promises to be a superb scientific program.

