

SAMA INSIDER

MARCH 2021

COVID-19

**Building treatment
capacity to respond to
COVID-19**

**A new dawn for
internship training**



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

**SOUTH AFRICAN
MEDICAL ASSOCIATION**

MEMBER BENEFITS



Medical Practice Consulting

Inge Erasmus

012 111 7001 | 074 031 5295 | inge@mpconsulting.co.za

MPC offers SAMA members FREE access to the MPC Online Medical Education platform. SAMA members further have access to Medical Scholarships through MPC for online CPD, CME and Short Courses as well as the attendance of international conferences. For more information, please visit www.mpconsulting.co.za



Mercedes-Benz

Mercedes-Benz South Africa (MBSA)

Caron Coetzee or George Barnard

012 677 6614 | carron.coetzee@daimler.com

012 677 5904 | 071 607 9708 | George.barnard@daimler.com

Mercedes-Benz offers SAMA members a special benefit through their participating dealer network in South Africa. The offer includes a guaranteed discount on brand new Mercedes-Benz vehicles



Momentum

Leandra Henery Liebenberg: Business Development Consultant

012 684 4891 / 083 609 7531 | Leandra.henery@momentum.co.za

Offers SAMA members a 20% discount on motor and household insurance premiums.



SAMA eMDCM | SAMA CCSA

Anton van Schalkwyk

012 481 2025 | coding@samedical.org

The first licence of the eMDCM is FREE to SAMA members in private practice (including limited private practice).



South African Medicines Formulary

Ladine Britz

012 481 2121 | ladineb@samedical.org

Published by the South African Medical Association, the South African Medicines Formulary is researched and written by members of the Division of Clinical Pharmacology of the University of Cape Town, in collaboration with health care professionals.

Prices exclude Vat and Courier Services

SAMA members – R 520.00

Non SAMA members and second SAMA purchase – R 720.00



Tempest Car Hire

Corinne Grobler

083 463 0882 | groblercorinne@gmail.com

SAMA members can enjoy discounted car hire rates with Tempest Car Hire.

The Unlimited

Natalie Young

065 031 3782 | nyoung@theunlimited.co.za

Tyren Long : New vehicle Sales Manager – Kia Centurion

The Unlimited offers R100,000 FREE Personal Accident Cover to ALL SAMA members

Members can activate their FREE cover at:

<https://lp.theunlimited.co.za/heroes/>



18/11/2020

CONTENTS

MARCH 2021



Source: Shutterstock: Ilstudio

- | | |
|--|--|
| <p>3 EDITOR'S NOTE
A sigh of relief
Diane de Kock</p> <p>4 FROM THE PRESIDENT'S DESK
A time for reflection as the
COVID-19 debate rages on
Dr Sizeka Maweya</p> <p>5 FEATURES
Building treatment capacity to
respond to COVID-19
SAMA Communications Department</p> <p>6 Allocating scarce medical
resources during COVID-19
Bernard Mutsago</p> <p>7 SAMA opposes COVID
Amendment Bill
SAMA Communications Department</p> <p>8 A new dawn for internship training
Prof. Zuki Zengela</p> <p>9 Making a hospital space feel
psychologically safer helped SA
health workers
Dr Hamieda Parker</p> <p>10 Measuring: An essential enabler
for improving quality in
healthcare
Jacqui Miot</p> <p>11 Maybe tomorrow will be a better day
SAMA Communications Department</p> <p>12 Know your rights: Breach of
contract
Bertha Shabangu</p> | <p>12 Section 59 investigation raises
serious questions
SAMA Communications Department</p> <p>13 Urgent legislation needed to
protect doctors at risk
SAMA Communications Department</p> <p>14 Organ and tissue donation: A huge
disparity
Bernice Bignaut</p> <p>15 Finding solutions to the
challenge of safe, sustainable and
adequate blood in Africa
SAMA Communications Department</p> <p>15 Nobel Peace Prize nomination
fails to recognise SA doctors
SAMA Communications Department</p> <p>16 BHF member schemes to fund
COVID-19 vaccine, but note
concerns
SAMA Communications Department</p> <p>17 SAMA mortality and morbidity
guidelines for CPD accreditation
2021
Lisa Reid</p> <p>18 WMA calls for international co-
operation in the fight against
COVID-19
World Medical Association</p> <p>19 MEDICINE AND THE LAW
Stroke after carotid surgery
The Medical Protection Society</p> <p>20 BRANCH NEWS</p> |
|--|--|



MEMBER BENEFITS



Automobile Association of South Africa (AA)

AA Customer Care Centre

0861 000 234 The AA offers a 12.5% discount to SAMA members on the AA Advantage and AA Advantage Plus Membership packages.

APLS

Cindy Maree

021 406 6733 | cindy.maree@uct.ac.za | www.apls.co.za

APLS offers SAMA members a 10% discount on the 2-day Advanced Paediatric Life Support Course.

Barloworld

Tender Smith : External Accounts Manager: EVC

011 052 0182 | tender.smith@bwfm.co.za

Barloworld Retail Digital Channels offers competitive pricing on New vehicles; negotiated pricing on demo and pre-owned vehicles; Trade in's; Test Drives and Vehicle Finance.

DLT Magazines

(076) 020-5280 or (011)304-7600

sales@dltmedia.co.za

www.dltmagazines.co.za.

Over 60 New titles to choose from. Over and above up to 60% off cover prices any SAMA Member will get an additional 10% of our packages as well as a free magazine rack valued at over R800. Use promo code SAMA10

Hertz Rent a Car

Lorick Barlow

072 308 8516 | lorick@hertz.co.za

Hertz is proud to offer preferential car rental rates to SAMA members. A range of value-add product and service options also available. No cost to register as a Gold Plus Rewards member to enjoy a host of exclusive benefits.

Inter Africa Bureau De Change

Jaco Brits

072 626 1687 | jaco@interafribabdc.co.za

Inter Africa Bureau De Change is a leading provider of foreign exchange. VIP Rate to all SAMA members

Inter Africa Bureau De Change offers a wide variety of products and services, those being: • Cash Passport (a prepaid currency card) • Transport Forex • Travel Forex • Xpress Money • Moneytrans (send and receive money around the world)

Labour Net

Herman Benadé

(011) 532 8802 / hbenade@labournet.com

20% Discount on Retainer Fees and 10% on ad-hoc services offered to SAMA Members Including recruitment, payroll, Industrial relations and litigation

Legacy Lifestyle

Allan Mclellan

0861 925 538 / 011 806 6800 | info@legacylifestyle.co.za

SAMA members qualify for complimentary GOLD Legacy Lifestyle membership. Gold membership entitles you to earn rewards at over 250 retail stores as well as preferred rates and privileges at all Legacy Lifestyle partnered hotels and further rewards back on accommodation and extras.





Diane de Kock
Editor: *SAMA INSIDER*

A sigh of relief

As SA begins to roll out vaccines to healthcare workers, an audible sigh of relief can be heard across the country. Getting the Johnson & Johnson vaccines in time to replace the AstraZeneca ones and vaccinate healthcare workers in mid-February, as promised, was testament to how effective working together can be in producing the desired result.

This month, we feature Border Coastal branch member Dr Craig Parker (page 5) and his team, who in March last year recognised the need for a breathing device to assist healthcare workers in their fight against COVID-19. He appealed for help on social media and was overwhelmed by the response – 7 weeks later, the first working prototype was born!

Bernard Mutsago (page 6) looks at the allocation of scarce medical resources during COVID-19 – “principles of social solidarity and universal health coverage must be strongly upheld” – and warns that it is imperative that this socio-ethical topic be thoroughly debated.

SAMA has been engaged and vocal about healthcare developments in SA: among others, opposing the COID Amendment Bill (page 7); raising serious questions about the section 59 investigation (page 12); and the fact that the SA government endorsed the Nobel Peace Prize nomination by the Norwegian government of the Cuban Medical Brigade for the Nobel Peace Prize (page 15).

Prof. Zuki Zingela unpacks the recent overhauling of medical internship training (page 8) to include 2 months of psychiatry rotation rather than the previous 1 month. “If we can ease the load by upskilling interns in ways that complement their ability to cope, we will make a tangible difference.”

Recently, a simple intervention (page 9) in a busy SA hospital reduced anxiety by consciously building more psychologically safe workspaces. “This kind of intervention provides organisations with a tool to activate the process of developing psychological safety ... and the cost of intervention is minimal.”

SA remains one of the poorest-performing countries in the world when it comes to organ and tissue donation (page 14). “Together, we can all make a difference: the SA public, simply by registering as a donor, and having a discussion with their family; awareness organisations; advocates pushing for changes to the legislation; and you, as medical professionals.”

The World Medical Association (page 18) warns that now is not the time for egotisms and nationalism in the fight against COVID-19. As we welcome the first vaccines in SA, may the WMA’s sentiments of sharing and acknowledging doctors as part of our life infrastructure come to the fore.

Editor: Diane de Kock
Head of Publishing: Diane Smith
Copyeditor: Kirsten Morreira

Editorial Enquiries: 083 301 8822 | dianed@samedical.org
Advertising Enquiries: 012 481 2062 | 021 532 1281
Email: dianes@samedical.org

Senior Designer: Clinton Griffin

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

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

Opinions and statements, of whatever nature, are published in *SAMA Insider* under the authority of the submitting author, and should not be taken to present the official policy of the South African Medical Association (SAMA) unless an express statement accompanies the item in question. The publication of advertisements promoting materials or services does not imply an endorsement by SAMA, unless such endorsement has been granted. SAMA does not guarantee any claims made for products by their manufacturers. SAMA accepts no responsibility for any advertisement or inserts that are published and inserted into *SAMA Insider*. All advertisements and inserts are published on behalf of and paid for by advertisers.

LEGAL ADVICE

The information contained in *SAMA Insider* is for informational purposes and does not constitute legal advice or give rise to any legal relationship between SAMA and the receiver of the information, and should not be acted upon until confirmed by a legal specialist.

A time for reflection as the COVID-19 debate rages on



Dr Sizeka Maweya, SAMA President

As you may have already heard, I am leaving my position as President of SAMA. My last day is coming up at the end of February 2021. I wanted to take a moment to let you know how much I have enjoyed my time here – and how you have all played a part in that. It has been great working with you and getting to know you all. I want to make clear my gratitude, both professional and personal, over the past year, for without your friendship, support and collaboration, my time as SAMA President would not have been the same.

I want to take a moment to reflect on my term of office.

On writing these messages to *SAMA Insider*: as the President, it has been a great honour to be afforded the opportunity to write messages on my choice of topics. I would like to thank Diane de Kock for her guidance and editing of the messages, and for being patient with me in terms of submitting the messages on deadline. She has been highly instrumental in sharpening my writing skills throughout my term of office. I want to personally thank her for both her support and mentorship over the past year. I have grown as a professional thanks to her tutelage, for which I am very grateful.

I have also appreciated knowing her on a professional level, and very much hope we can continue this relationship beyond my final day as President of SAMA.

This has been the most challenging year in SAMA's history, during which we had to fight for our existence. The board, through the leadership of Dr Angelique Coetzee, have done an outstanding job. They stayed focused on steering SAMA in the right direction, even when things were not easy, including among themselves.

SAMA entrenched itself as a leader of opinion in the medical profession's voice regarding COVID-19 management. The SAMA board managed to establish the association as the medical profession's ambassador. Media houses seek SAMA's opinion on medical issues. The board members' leadership skills and inquisitive minds are beyond compare. They also question how the decisions they make will be considered by other medics in their ranks.

COVID-19 is here to stay with us for a very long time. The current vaccine debate is making us rethink and regroup in terms of our strategy. The vaccines have given rise to much and varied public opinion. Now more than ever, SAMA needs to take the lead in educating our communities of doctors, and healthcare workers more generally. The debate always centres on how the vaccines work, and their efficacy or credibility.

The knowledge taught at medical level needs to be simplified for the understanding of our communities. We, as doctors, need to understand the anxiety that our communities have when it comes to trusting the vaccines. There is much uncertainty around whether to take the vaccines or not. Vaccines prevent diseases that can be dangerous, even deadly. They significantly reduce the risk of infection by working with the body's natural defences to develop immunity to disease.

Debates about which COVID vaccine will work better are ongoing, creating much uncertainty for the general public. Widespread vaccination would mean that the virus will not infect as many people as witnessed in December 2020 and January 2021. This will limit spread through communities. Both Pfizer and Moderna report that their vaccines show

approximately 95% efficacy at preventing both mild and severe symptoms of COVID-19. It is challenging to educate the public about which vaccine is better (Johnson & Johnson, Pfizer, AstraZeneca or Moderna). The public has embraced scientific narratives like never before, but the debate about vaccines has made scientists realise that the general public cannot be left out of discussions.

This has been the most challenging year in SAMA's history

The new variant in our country has made these debates even more relevant than before. In the small-scale studies done previously, AstraZeneca showed that the vaccine worked slightly better against older, more established versions of the virus. It was concluded that in those with the older strain, the vaccine was effective in 84% of symptomatic cases and 81% of all cases. However, with the new strain in SA, studies have shown that its efficacy is at 22%.

The debates continue, while at the same time, the public is unsure whether to take the vaccine or not. During these trying times, the country is looking to doctors, and to SAMA in particular to give guidance to its members to enable them in turn to guide the general public. The public has minimal trust in politicians and the government, because people are still reeling from the shock of PPE corruption. The Zondo Commission has not improved the widespread scepticism.

I leave my position as the President of SAMA with all these issues in mind, and above all the responsibility to educate our doctor community. As John Maxwell once said, "Leadership is more disposition than position – influence others from wherever you are." I will continue to guide my colleagues from whatever position I hold in the society of doctors. "You never really know something until you teach it to someone else." With these few words, I would like to say *bon voyage* and fare thee well.

Building treatment capacity to respond to COVID-19

SAMA Communications Department

Border Coastal branch member Dr Craig Parker returned to SA from the UK in March last year just before the flight ban, with an idea to try and develop a breathing device to assist SA healthcare workers in their fight against COVID-19. He had seen the need, and was determined to help: "I was in the UK surrounded by chaos and systems collapsing." Dr Parker put out a call on local Facebook pages for volunteers and designers, and the OxERA was born. Within 2 weeks the design had been chosen, and after 7 weeks, the first working prototype was produced.

Dr Craig Parker works in the anaesthetic department as a medical officer in the East London public hospital complex. He was a mechanical engineer in the mining industry for 20 years before finding himself back at school studying medicine. He lives in East London with his wife (an ICU nursing sister) and two teenage children, and their two labradors. He started this project as he felt there was an obvious gap in the ability to provide respiratory-compromised patients with a solution besides intubation and ventilator support in the midst of the COVID-19 pandemic. The engineering side of his brain had some ideas that he thought could address this. At times in the past, he has been frustrated at why it took so long to find his true calling, but perhaps it was so that he would be useful at such a time as this.

Who is UMOYA?

"We are a group of volunteers, gathered under a common vision of saving lives in this COVID-19 pandemic by finding innovative solutions to assist with patient breathing. Engineers, doctors, designers, 3D-printing specialists and programme managers from across a host of industries (including mining) collaborated to develop innovative respiratory and non-invasive ventilator solutions that would fill the current gaps in respiratory therapy in our resource-constrained environments."

The team has applied agile concepts and systems engineering to build a number of unique respiratory solutions. Their mission is to increase the effectiveness, availability and affordability of respiratory treatment devices, for COVID-19 and beyond.



Dr Craig Parker

The early core team was based in East London, where the realities of resource constraints in the Eastern Cape are all too evident. The UMOYA team now consists of technical and manufacturing capability spread around SA. The group has also assisted with multiple national initiatives to address the shortage of mixers, traditional mechanical ventilators and other parts as a result of the COVID-19 pandemic. The OxERA has also been used in Zimbabwe and other parts of Africa.

The challenge

According to UMOYA, respiratory treatment in hospitals is administered on a continuum depending on the level of treatment required by the patient. Generally, the simplest form is face-mask oxygen or the high-flow nasal cannula, which has nozzles that are placed in/below the nose directing oxygen into the nostrils.

More sophisticated treatments are non-invasive ventilation treatments, namely continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BiPAP), with critically ill patients requiring intensive care invasive ventilator treatment administered by accredited ICU staff.

The goal is to treat hypoxia early and break the inflammatory cycle and lung damage that occurs. This gives the patient's immune system time to fight the virus without having to also deal with hypoxia.

COVID-19 has resulted in a common scenario globally, where approximately 6 - 10% of people infected with the virus require respiratory support treatment. About two-thirds of these patients do not recover with standard oxygen treatment alone, and deteriorate to the point where they require ICU invasive ventilator treatment.

It was clear that ICU ventilator capacity in SA was constrained by the shortage of skilled ICU staff and traditional mechanical ventilators. Supplying additional ICU ventilators was unlikely to adequately respond to the anticipated increase in demand required to treat patients due to COVID-19. Clearly, an alternative solution was required.

UMOYA's initial goal was to design standalone mechanical non-invasive ventilation solutions that could be used by general nursing staff. This has expanded to include a number of innovative respiratory solutions.

The UMOYA mission

The UMOYA mission was to address the gaps in respiratory therapy identified as being potentially problematic during COVID-19 in SA and other low-resource environments. This initially focused on the design and development of stand-alone non-invasive systems, but soon branched out into a number of other devices.

The philosophy was to design simple mechanical components that could be rapidly manufactured via 3D printing and scalable manufacturing methods, together with off-the-shelf components allowing for rapid assembly in developing countries.

The key to this mission was to start to address the exorbitant cost of medical devices, which limits their availability to large parts of the world (often where they are most needed) due to the unequal distribution of the burden of disease. By adopting a social enterprise business model, UMOYA hope to change the current pricing and profit paradigms in the industry.

Solutions

UMOYA's solutions are about bridging the gaps in current respiratory therapy and providing cost-effective local alternatives

to expensive imported components. These solutions are cognisant of the infrastructure and staffing constraints typically available in low-resource settings, but still have broad appeal in all clinical facilities. The initial goal was to develop solutions that would reduce the load on limited ICU facilities, and be useful in field and district hospitals. The assumption that oxygen supply would become one of

the biggest challenges meant that oxygen efficiency was key to these solutions.

To date, the team has designed the following solutions:

Licensed and ready for market:

- OxERA device – 100% O₂ via accumulator bag with adjustable positive end expiratory pressure (PEEP)
- adjustable PEEP valves

In development:

- fully mechanical non-invasive bi-level integrated pressure support and PEEP (BiPAP).

For more information, see <https://umoya.org.za/>. For the link to an interview with Dr Craig Parker and Alex Rossouw on Link FM, see <http://samj.org.za/public/sup/interview.mp3>.

Allocating scarce medical resources during COVID-19

Bernard Mutsago, *health policy researcher, SAMA Knowledge Management, Research and Ethics Department*

Rationing – the allocation of scarce medical and healthcare resources – is inevitable in most healthcare systems, but fraught with ethical complexities. It is a common feature in many health systems globally, and was so even prior to the COVID-19 pandemic, but has been highlighted in the current situation. For example, SA has long struggled with difficult choices in allocating scarce medical resources; the severe shortage of ICU capacity and hospital beds, and the long waiting lists for kidney transplants, are demonstrative of rationing realities in SA outside of the pandemic context. The certificate of need and, more recently, the preferential allocation of resources to COVID v. non-COVID patients are also clear examples. With the ongoing global scramble for COVID-19 vaccines, and the recent publication of SA's priority list for receiving the first deliveries of the vaccine, it is imperative that this socio-ethical topic be thoroughly debated.

Unpacking this contentious topic requires an understanding of the meaning of "rationing". The central idea in rationing or resource allocation is denying a potentially beneficial treatment to a patient on the grounds of scarcity.

Recent developments have brought to the fore the complex realities of this concept. Concerns around inequitable global distribution of COVID-19 vaccines have surfaced in the midst of ongoing vaccine nationalism, in which wealthier countries are stockpiling the first available COVID-19 vaccine doses ahead of poorer countries – with the UK securing six times more doses than needed for its population size. In early February 2021, the UK had pre-ordered 367 million doses of 7 different vaccines, for its population of 60 million. Such libertarian approaches to acquiring vaccines cite autonomy as their

core principle, and assert the wealthy country's right to purchase health goods or services based on their purchasing power. On the African continent, SA was among the first few countries to receive the earliest batches of the COVID-19 vaccine in February 2021 – but this early vaccine will only be administered to prioritised groups of vulnerable people.

Scarcity is inevitable, and therefore so is rationing. Distributing finite resources demands an allocation system that is fair, consistent and ethical. Such a system, called explicit rationing, attempts to limit bias by the allocator, and is antithetical to the alternative approach, namely implicit rationing. SA's COVID-19 vaccination strategy is an example of explicit rationing, as it is based on a declared priority list. Implicit rationing, on the other hand, refers to, for example, the day-to-day discretionary decisions made by health workers in the course of providing care to patients, e.g. the amount of time a doctor devotes seeing one patient v. another.

Being explicit does not make a particular rationing decision justifiable. Are SA's priority-setting processes and decisions during the COVID-19 pandemic justifiable? The country's phased approach to administering the COVID-19 vaccine was announced as follows:

- phase 1: frontline healthcare workers (1 250 000 people)
- phase 2: essential workers; people in congregate settings; people >60 years; people >18 years with comorbidities (16 600 000 people)
- phase 3: other >18 years (22 500 000).

The question of who should receive the first doses of the COVID-19 vaccine in SA has received intense public debate. Some sentiments have been expressed about the

government's secrecy, corruption and failures around vaccine procurement and rollout. In the ensuing section, the country's vaccine rollout decisions are examined against some existing ethical frameworks, values and theories applicable in the field of public health. While the distinctions between medicine and public health are well known, less clearly understood – and strongly debated – are the variations between ethics applicable to medicine (bioethics) and the ethics relevant for public health practice. These variations are often blurred partly because some concepts and philosophies in public health ethics borrow from bioethics. The traditional bioethical principles of beneficence, non-maleficence, respect for persons and justice remain important in public health.

This article will discuss some of the frequently invoked theories, as outlined below:

- equality of opportunity (first come first served)
- prioritarianism (priority to the worst off)
- utilitarianism (maximisation of benefits)
- instrumental value (rewarding social usefulness).

Allocating COVID-19 vaccines randomly or on a first-come-first-served basis is, of course, out of the question. The country's current rollout plan appears to be supported by the three remaining principles. Frontline healthcare workers (HCWs) will be the first to receive the vaccine as they are clearly "worst off" due to their high risk of exposure to COVID-19. This is in line with the notion of prioritarianism. By November last year, 340 HCWs had died from COVID-19, and so it is hardly surprising that their prioritisation has not been met with public resistance. The principle of instrumentalism also seems to have been invoked for HCWs: they deserve prioritisation because their lifesaving efforts will benefit many.

The groups of people in phase 2 are also particularly vulnerable to infection, such as the elderly and those with comorbidities.

Suggestions by some that political leaders should be vaccinated first (and thus prove the safety of the vaccine) do not conform to prioritarian notions, but arise out of mistrust of the government, and vaccine scepticism.

The utility theory advocates for “the greatest good of the greatest number”. Hence the country’s ultimate aim of immunising 67% of the population in pursuit of COVID-19 herd immunity is justifiable on utilitarian grounds. Vaccines, and health itself, are public goods – and so is herd immunity. They are collective goods in that they are non-excludable and non-rivalrous. Expert argument suggests that being vaccinated is an individual moral obligation, as it is in the best interests of society. However, other ethical principles such as autonomy must be kept in view; President Ramaphosa’s announcement that COVID-19 vaccination will not be mandatory rightly honours the autonomy principle.

At a global level, there is growing consensus that the global threat of coronavirus demands global solutions firmly rooted in solidarity and equity. The COVAX facility is the key global mechanism to combat ongoing “vaccine apartheid” and to ensure equitable access to lifesaving vaccines. At a national and individual practitioner level, the just allocation of medical or healthcare is part of physicians’ ethical duties. Doctors must shield their patients from becoming victims of unequal access to life-saving healthcare on grounds of the patient’s status, including their nationality and ability to pay. That the vaccine will not be available to non-South Africans, as announced by the Minister of Health and the President, is remarkable. The SA Constitution stipulates that residents should be treated equally and equitably. While medical treatment outside the pandemic situation in countries such as SA is often determined by one’s ability to pay, a 2020 article in the *New England Journal of Medicine* suggests that a fee-based system

is not recommended in a pandemic – thus SA’s no-fee policy for the COVID-19 vaccine for non-insured patients, and its designation as a prescribed minimum benefit, are highly commendable.

The abovementioned article offers six succinct recommendations for allocating medical resources during the COVID-19 pandemic: maximise benefits; prioritise health workers; do not allocate on a first-come-first-served basis; be responsive to evidence; recognise research participation; and apply the same principles to all patients, whether or not they are COVID-19 cases.

In conclusion, in an extraordinary pandemic such as COVID-19, the principles of social solidarity and universal health coverage must be strongly upheld in the allocation of vaccines, as well as other lifesaving health goods such as oxygen, N95 masks and personal protective equipment.

References available on request.

SAMA opposes COLD Amendment Bill

SAMA Communications Department

SAMA is opposing an amendment (section 43) to the Compensation for Occupational Injuries and Diseases (COID) Amendment Bill on the grounds that it will place excruciating administrative, financial and legal pressure on the healthcare sector, and disadvantage injured workers and impair their right to quality medical care.

On 17 January 2021, the Parliamentary Portfolio Committee on Employment and Labour issued a public call for submissions on the proposed COID Amendment Bill [B21-2020]. Section 43 of the Bill prohibits the cession of medical invoices by medical service providers to any financial institutions and third-party administrators.

Dr Angelique Coetzee, SAMA chairperson, says: “Section 43 is deeply problematic. Medical service providers treat patients injured on duty immediately, but have to wait up to 2 years to be paid by the compensation fund. This is because of the systemic failure of both the IT systems and administration of the fund. It is unrealistic to expect a physiotherapist, doctor or small practice to wait this long for payment – they will simply go out of business.”

Given the fund’s dysfunction, medical service providers have, for over 20 years, used the services of third-party administrators. According to SAMA, these perform a critical service in helping the medical profession navigate the fund’s complex and often impenetrable systems, in order to secure payment for medical services rendered to injured workers. Third-party administrators also play a critical role in the sustainability of medical practices, as they pay medical service providers upfront for their invoices.

“Besides this critical upfront payment, which is facilitated through the cession of invoices to third-party administrators or financial institutions, administrators also save us time. The process of claiming from the fund is very time-consuming and in so many cases, impossible. The removal of cessions will mean that we have to spend more time on administration and fighting with a fund that is broken, and less time on treating our patients. It is quite unbelievable that the Department of Employment and Labour is proposing to remove the only cog in the wheel that actually functions,” says Dr Coetzee.

Even more concerning for SAMA is that section 43 will have a detrimental impact on the treatment and care that patients injured on duty receive.

“The purpose of the COID Act is to ensure that people injured on duty have access to quality medical care. The introduction of section 43 is in direct opposition to this. If you make it extremely difficult for medical professionals to manage the process of registering and processing claims through the fund, and then on top of that remove third-party cessions, it simply discourages medical service providers from treating these patients. As it is, not all medical professionals care for patients injured on duty, so by placing a massive, insurmountable obstacle in the way of those who do, the department will only serve to further shrink the pool of care that workers are able to access. This will have the additional unintended consequence of forcing more people into the public healthcare system, which is already buckling under pressure. It simply does not make any sense.”

SAMA has joined the Injured Workers Action Group and the United Domestic Workers of SA Union in calling for section 43 to be removed from the Amendment Bill.

A new dawn for internship training

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

Medical internship training has been recently overhauled, with a different rotation system introduced to include 2 months of psychiatry rotation rather than the previous 1 month. This has been a long time coming, in that psychiatrists have been aware for many years that exposure to psychiatry during internship has been minimal, resulting in a gap in clinical skills – in an environment in which mental health problems are increasingly affecting not only the general public, but also health professionals themselves. This presents us with a unique opportunity for interns to be guided not only in how to assess and manage mental health problems in patients, but also in navigating the triumphs and tribulations that are inherent to the profession.

Optimising learning

There are specific skills defined in the intern logbook that trainers must sign off on to confirm that the training has met the minimum requirements to progress. The additional month will ensure that more time is made available to develop psychiatric skills further, to ensure that when interns progress to community service level, they can manage the common disorders that they are likely to be confronted with. The mental health burden within the profession does not allow us to stop there, however, and there is an argument to be made for trainers to go beyond this. We have an obligation as trainers to empower interns with additional skills to enable them to take better care of their own mental health and overall wellbeing, and to identify early on when they are running into trouble. One could argue that by teaching interns about mental disorders, we are automatically doing this, to some extent. However, the way in which the content is delivered makes it seem that mental distress and mental health difficulties are distant problems that happen to somebody else, and not to you as a health practitioner. Add to this the issue of stigma, and one has a recipe for denial, with consequent lack of acknowledgement of mental health problems until it is too late. This means that in addition to what is prescribed in the intern logbook as essential learning, the expanded internship training in psychiatry should include essential life



skills for junior health professionals. With this in mind, we proposed a programme for interns allocated to Mthatha in the Eastern Cape, with additional topics in specific areas representing the usual challenges observed or reported by previous junior doctors,

A life skills programme for junior doctors

Examples of the challenges described include dealing with stress and burnout, substance abuse, bullying, problems with assertiveness and financial difficulties. This research has culminated in a short interactive programme that is delivered during the first 2 - 4 weeks of interns' rotation in psychiatry, covering the following sessions:

- professionalism in medicine
- reinforcing ethical practice
- the multidisciplinary team and optimal use of each profession's skills
- identifying and managing one's stress signature
- substance abuse and responsible drinking
- dealing with loss and grief
- budgeting and managing finances
- career options within the medical field
- the doctor as a business manager
- the doctor as a medical manager
- managing personal and professional relationships
- anger and assertiveness.

The aim of these sessions is to share self-help skills that may come in handy in guiding interns through the challenges they will

face as they adjust to being junior doctors. The sessions also include the sharing of resources such as pamphlets containing useful contact information in times of need. This programme has only been running for 6 weeks, but the feedback has been very positive, with suggestions that it should even be offered at undergraduate level. We also cover additional challenges that come with transitioning from being a student to earning a sizeable income, which must then sometimes stretch to supporting extended family, while facing the challenge of having access to easy credit. The next step we will take is to audit the programme formally, to allow analysis of feedback from the interns as well as suggestions on how to improve or adapt it.

A way forward

Each intern training centre is unique, and may have different priorities when it comes to how best to arrange the expanded rotation in psychiatry. There may be other ways to guide and support interns toward improved self-care, mental health and wellbeing. This is the ideal time to re-examine how we get this right in a way that improves the chances of successful internship completion while maintaining mental health. Taking on a new role with huge responsibilities, which include life and death decisions at one's fingertips, is already daunting. If we can ease the load by upskilling interns in ways that complement their ability to cope, we will make a tangible difference.

Making a hospital space feel psychologically safer helped SA health workers

Dr Hamieda Parker, associate professor, University of Cape Town



Dr Hamieda Parker

In a busy SA hospital recently, teams of nurses and doctors were given an unusual task. They had to figure out who could build the tallest free-standing structure out of nothing but spaghetti sticks, and then balance a marshmallow on top of it. They had 20 minutes to work it out.

These were stressed individuals, not used to working together or communicating this much under normal circumstances, let alone on such a seemingly random task. They were feeling somewhat tense. But this would soon change. Their manager commented afterwards:

"My staff all went into it with apprehension and anxiety and fear of the unknown, and all of them without fail came out of it with a different vibe. They just had energy. It changed them. I don't know how in less than half an hour, but they definitely came out of it with a positive outlook."

The hospital staff were participants in a University of Cape Town Graduate School of Business (GSB) study on how creating psychological safety in workplaces can improve team morale and performance. And the team-building exercise that they were asked to complete as part of the study was the marshmallow challenge, a design thinking game used to foster team cohesion and communication.

Over the last decade, a number of conceptual articles have proposed that games and experiential exercises can help to improve team learning and team performance in the workplace. One study showed how a game could be used to develop leadership

skills, while another examined the use of a simulation to develop critical thinking skills.

In the GSB study, the marshmallow challenge was used as a catalyst for building trust in the unit.

Very few studies have investigated the use of games in healthcare contexts, and there are no empirical studies that the authors are aware of that look at the use of games as interventions to cultivate psychological safety and team learning in resource-constrained healthcare settings. This study addresses the gap.

Research globally has shown that creating a space where people feel safe to voice opinions, make mistakes and risk ridicule when offering an idea can have a significant effect on teams. Quite simply, an environment of trust and mutual respect is crucial if you want to get things done.

What we found

Hospitals in SA's public sector are characterised by resource constraints, high workloads and risks. These dynamics often hamper the development of psychological safety, and negatively affect the overall quality of work of healthcare teams.

Reduce anxiety by consciously building more psychologically safe workspaces

The SA study set out to test whether the use of a simple and fun game (the marshmallow challenge) could create conditions where psychological safety might take root – even in a highly stressed hospital environment. Specifically, the game helped expose teams to an environment – even if only a temporary one – that was optimised for idea-sharing and creative problem-solving.

Participants reported that team psychological safety improved directly after playing the game. And after the intervention, teams at the hospital communicated better, and staff interacted more freely and felt more

engaged and less anxious. This is especially significant in the current COVID-19 context.

The pandemic has ratcheted up pressure on hospital workers around the world. Healthcare workers work extreme hours under harrowing circumstances. Psychological safety is paramount.

Healthcare teams are required to draw on knowledge and learning from all parts of the system to make quick decisions, learn from mistakes and implement changes that facilitate the safe delivery of care. This cannot happen optimally unless teams are able to trust each other and the system sufficiently.

The SA hospital study is one of the first to indicate that simple team-based interventions, even in the highly stressed world of healthcare, can spark the development of psychological safety. Games can create a valuable learning experience for participants, which in turn may lead to improved levels of care.

What next

Of course this is not a panacea. Nor can psychological safety be delivered after a single intervention – it takes time to build and develop within an organisation. But this kind of intervention provides organisations with a tool to activate the process of developing psychological safety. Organisations already doing this can use it to support and strengthen their efforts.

The cost of the intervention is minimal, so it can be used effectively in resource-constrained environments.

As the pandemic continues to cause uncertainty and upheaval in professional and personal lives, leaders and managers can help to reduce anxiety by consciously building more psychologically safe workplaces. This benefits individual team members as well as organisations as a whole, and could build organisational resilience in these difficult times.

The study on which this article is based draws on an article co-authored with UCT GSB alumnus Dr Earle du Plooy.

Source: *The Conversation*, 14 January 2021. <https://theconversation.com/making-a-hospital-space-feel-psychologically-safer-helped-south-african-health-workers-152107>.

Measuring: An essential enabler for improving quality in healthcare

Jacqui Miot, chair, Health Quality Assessment Clinical Advisory Board



Jacqui Miot

There are many definitions of quality in healthcare – almost as many as the different contexts in which it is measured. But what most will agree on is that if you don't measure, you won't know how to improve the quality of care that you're delivering. At the heart of health quality measurement is the fundamental right of all people to have access to affordable, quality healthcare (section 27 (1) of the SA Constitution).

There are many reasons to measure quality, including improving access to and outcomes of healthcare, quality improvement within organisations, empowering and informing consumers and driving overall improvement through benchmarking. In a setting with limited resources, measuring the value of care provided (i.e. maximising health outcomes for each rand spent) becomes critical.

It is also important to understand what poor quality of care is, in order to direct actions for improvement. Poor quality of care typically occurs because of overuse, misuse or even underuse of healthcare services. The consequences are widespread, with the impact felt not just on the individual, but also within organisations and nationally, creating enormous financial and economic pressures through disability, impairment and lost productivity.

Health quality is commonly measured through a standardised set of indicators that provide a quantitative, documented measure

of quality of care, and that can be used as tools to monitor quality improvements over a period of time. Many quality indicators follow the typical Donabedian definition, incorporating structure (e.g. health systems, facilities, staff), process (e.g. access to cholesterol tests, HIV testing in antenatal care, prescribing statins in diabetes) and outcomes (mortality, morbidity and patient satisfaction). Improvement in outcome measures is the gold standard of healthcare quality, although process measures are equally important, and commonly used as an accurate and immediate measurement of improvements in care.

Measuring indicators for quality of care remains an academic exercise, however, until the information is used to action improvements. This is easier said than done, with many hurdles to achieving measurable improvement. The desire to improve healthcare quality can be driven by the intrinsic motivation of healthcare practitioners, providers or funders to act in areas where they see a potential for improvement. Further motivation to improve is driven by an informal selection process in which patients or funders select healthcare practitioners or service providers based on their perception of the quality of care provided. Comparative, systematic and transparent measurement is the highest motivator of all, where results comparing performance and benchmarks are published either in the public domain or within specific organisations.

Health quality assessment

Health Quality Assessment (HQA) aims to "develop a health audit report for the healthcare industry in SA that focuses on quality, with the goal of becoming the SA national standard for objective quality performance measurement."

Founded in 2000, HQA is a non-profit organisation that was established by the private healthcare funding industry in SA. HQA routinely collects data from medical schemes representing just over 80% of the beneficiaries covered, analysing trends going back more than 9 years. The quality and quantity of data based on member demographics and claims for services provides a rich dataset for measuring quality.

In 2019, the health market inquiry (HMI) released their recommendations for the

private healthcare industry, and proposed that an independent organisation, the Outcomes Monitoring and Reporting Organisation (OMRO), should be established to measure and report on quality of care, with a particular focus on clinical and financial outcomes for patients. They recommended that existing structures should be used to develop the initial OMRO, and specifically mentioned HQA, as it has more than 20 years' experience and infrastructure to expand on to include other stakeholders and to move toward measuring outcomes, as described in the HMI report.

Following this recommendation, the HQA board in 2020 amended HQA's memorandum of incorporation to include healthcare practitioners and facilities as participating members, and in its governance structures. Dr Angelique Coetzee, national chair of the SAMA board, was appointed to the HQA board last year. More such developments can be expected in the near future.

The right diagnosis followed by the right treatment in the right setting at the right time at the right price delivering the right outcome, every time!

Over the years, HQA has developed and refined a set of just under 200 health quality indicators, the results of which are used to create benchmarks across the industry so that schemes can compare themselves with the top performers (anonymised), as well as internally by benefit option. Key to the success of HQA has been the overarching desire of all its members to continually strive to improve healthcare quality.

The HQA Clinical Advisory Board (CAB) develops the indicators, with input from

members representing medical schemes, administrators, managed care organisations, pharmaceutical companies, doctor groups and hospitals, including representation from the Office of Health Standards Compliance and the Council for Medical Schemes. The ethos of HQA has always been inclusive and collaborative, so that development of indicators is driven by the priorities, expertise and input of CAB members. Rigorous development and continuous improvement of indicator metrics and methodologies provides a high level of confidence in the validity of the indicator results. Increasingly, schemes are using HQA reports to engage with their providers to drive improvements

in the quality of care they provide to scheme members.

Currently, the HQA indicator set is made up of process, utilisation and proxy outcome measures across four categories of care: prevention and screening; maternal and neonatal; hospitalisations; and chronic conditions. In order to include measures that are relevant and applicable to healthcare practitioners, HQA proposes a step-wise process starting with analysis of the current HQA dataset to reflect indicators that are of direct value to the doctor. Discussions with medical practitioner groups and the Clinical Advisory Board have resulted in a draft set of indicators for preliminary analysis.

It is important that HQA is not viewed merely as an organisation for medical schemes, and collaborations are actively being sought with healthcare practitioner groups and healthcare facilities to further develop the quality indicators in a way that is relevant, actionable and appropriate for these stakeholders. Although still in the early stages of development, there is strong commitment and drive to move towards ultimately measuring outcomes for indicators that have been developed and measured by healthcare practitioners and facilities themselves. In future articles, we will discuss key clinical indicators, their results and the impact on quality of care.

Maybe tomorrow will be a better day

SAMA Communications Department

The following was a Facebook post on the Heroes of Groote Schuur Hospital page on 31 January 2021, by Dr Estie Meyer, surgeon, Groote Schuur Hospital:

"I am a surgeon in a sub-specialty that only works with a certain part of the body. We see very little blood and even less death. I work in a tertiary hospital and we were asked to go and help in the medical wards when the second wave arrived at our hospital. I was very scared, not sure if I could remember anything about normal medicine, worried I would be more of a risk to the patients, and of course very worried about getting COVID myself, as I have not had any symptoms since the disease arrived in our country.

This is what struck me the most:

(1) It is a very lonely disease. As hospitals are closed for visitors, you never see any family or friends while you are in hospital. A lot of patients do not have enough data to phone regularly, so they rely on the nurses and doctors to feed them information about the outside world, and they yearn for the short messages we telephonically get from their family. Imagine not having contact with anyone while you are not able to breathe and not sure if you are going to be able to fight this virus, while you also know that people like you, with co-morbidities, often do not make it. Birthdays and celebrations are often forgotten while you lie there – we as doctors look at their saturation levels – not the date of birth.



Dr Estie Meyer

(2) I worked in the high care unit where patients receive high-flow nasal oxygen. Should they deteriorate, the next step would be intubation and being put on a ventilator in ICU. But in order for you to tolerate a tube in your throat we have to sedate you. So we explain this to the patient and the family and we try to give them a last video call – often with our own phones – just so that they can say what they need to say before they go to ICU. They – and the families – realise that things have deteriorated. Often we have to hold the phone for them, as they are too tired. We have to witness, while bending at their

bedside, the most personal, raw, emotional conversations. I cry most of the time while holding the phone.

(3) This is a disease that affects families and friends ... people you were in contact with. So often more than one member of a family is affected and admitted, often in different wards or even different hospitals. Imagine knowing friends are sick but not how they are doing. And imagine how nurses and doctors must feel if they have to break bad news of a death in the family to a patient. My patient this morning told us her Down's syndrome son died 2 weeks ago of COVID, and he was her constant companion. How do you ask a patient like that to not to lose faith?

(4) Every morning I walk in there trying to be positive – just to notice two or three empty beds, and not because the patients got better. Some nurses and doctors like me chose career paths where we've never had to deal with death ... and now we are confronted with it every day. We have an amazing support structure at our hospitals, and the psychiatrists check on the patients every day. But it is difficult to remain positive. Imagine being a patient in our ward where you are constantly seeing curtains that are suddenly drawn and doctors running around, knowing someone like you just lost the fight.

I am seeing one or two empty beds. I am sure they will be filled tomorrow, but I am still hopeful. Maybe tomorrow will be a better day."

Know your rights: Breach of contract

Bertha Shabangu, *legal advisor: labour relations, SAMA Employee Relations Department*



Bertha Shabangu

The excitement of purchasing a new car or a new house, or even getting a new job offer, is often coupled with ignorance of the finer details contained in the relevant contracts. The terms and conditions – often written in very fine print – are extremely important. Accordingly, when an offer is presented, it is important to read and understand what employers' duties and responsibilities are, as well as the duties and responsibilities of the employee. As soon as both parties append their signatures to the contractual document, it is legally binding. A contract is an agreement between two or more people; in this article, reference is made to an agreement between the employer on the one hand, and the employee on the other.

"A journey of a thousand miles begins with a single step": in this instance, a single step that one can take in terms of knowing your rights is to read and understand before signing. The purpose of this article is to enlighten employees on their rights in the event that the employer does not comply with a legally binding agreement. In other words, what legal recourse does an employee have if the terms and conditions of, for example, an employment contract, commuted overtime agreement, performance management agreement or a collective agreement are not complied with?

What constitutes breach of contract?

In a workplace setting, a breach of contract is when a section or sections of one or more provisions of the contract are not complied with by either party. Should one of the parties to the agreement fail to act in terms of such agreement, or indeed act in contravention of any of its terms, without the agreement of the other party, then that party is said to be in breach of contract. In some instances, it might be interpreted that the party in breach has in fact repudiated the entire contract.

An example of a breach of contract is when a contract states that a notice period of 1 month is required by either party wishing to terminate the contract. However, the employer terminates the employment relations without notice, immediately, and without any good cause shown. This places the employer in breach of contract. As another example, if a contract of employment states that salaries or commuted overtime will be paid on a certain date, and the employer fails to pay on the agreed date without a valid reason, the employer will be in breach of contract. Essentially, any material breach of any term in the contract may place a party in breach thereof. Any infringement by one party to the contract on the contractual rights of the other party to the contract may constitute a breach of contract.

Employers are often reluctant to enter into written agreement, presumably because of its binding nature. Section 29 of The Basic Conditions of Employment Act is to date the only labour legislation that compels an employer to enter into a written contract of employment. The advice to employees is to insist on having a written agreement, signed by both parties. This is also useful in the event that there is a dispute between the parties. Employers, for various reasons, may terminate employment contracts. In some cases, the

termination constitutes a breach of contract, which at times constitutes an unfair dismissal or unfair labour practice.

Recourse for employees

A breach of contract by either party entitles the other party to either accept the breach or sue for damages, or to reject it and sue for specific performance. A material breach of contract constitutes repudiation where it evinces an intention on the part of the guilty party not to continue with the contract. The Labour Relations Act No. 66 of 1995 provides dispute resolution methods for cases of unfair dismissals and unfair labour practices. Labour disputes can be referred to bargaining councils or the Commission for Conciliation, Mediation and Arbitration (CCMA). If conciliation fails, the dispute is arbitrated by the council or CCMA, or adjudicated by the Labour Court, depending on the nature of the dispute. Also depending on the nature of the dispute, some claims are pursued at the High Court. The BCEA puts mechanisms in place for the recovery of outstanding payments.

Although there are forums such as the courts where labour disputes may be referred, it remains important for parties to first attempt to resolve issues through internal processes such as negotiations and grievance procedures. This will save time, and possibly legal costs.

Conclusion

Think before you leap. It is important to understand and know your rights before entering into any form of contract. It is equally important to know which forums to lay your complaints at in the event that the employer is in breach of its contractual obligations. SAMA's Employee Relations Department is readily available to advise and assist employed doctors with issues of this nature. If in need of labour-related advice, queries may be sent to labour@samedical.org.

Section 59 investigation raises serious questions

SAMA Communications Department

The interim report on the section 59 inquiry into allegations of racial discrimination by medical schemes against black healthcare

providers raises serious questions about racism among medical schemes, and requires urgent, honest and appropriate action by the schemes

and the authorities that govern them. SAMA says that the findings must now spearhead remedies for harmful administration processes by the

schemes and administrators, and the regulatory framework under which these practices are allowed to continue.

According to the interim report, the investigation focused particularly on the fraud, waste and abuse (FWA) systems “by the three main administrators – Discovery, Medscheme and GEMS”.

The report notes, “After considering all the evidence and responses, we find that between 2012 and 2019, black practitioners were more likely to be found to have committed FWA than their non-black (white) counterparts, by Discovery, Medscheme and GEMS. This means, for the reasons provided in this interim report, there was unfair racial discrimination.”

SAMA says the findings are unacceptable, shocking and disturbing, and require immediate attention by the implicated schemes.

“Not only is it clear that black doctors are discriminated against, but it is equally clear that the regulatory environment that allows this type of action to continue is still out of step with the realities of SA,” says Dr Mvuyisi Mzukwa, vice-chairperson of SAMA.

Dr Mzukwa says that SAMA's view is that the unfair administrative processes followed by the medical schemes must now become the focus of investigation.

“We concur with the investigators that these findings are degrading, humiliating and distressing, and there can be no justification whatsoever for these actions. It is now incumbent upon the authorities to take these findings further by investigating the regulatory framework that has allowed these practices to not only occur, but to flourish,” says Dr Mzukwa.

He says it is clear that the problems with this conduct by the medical schemes arises from an imbalance in the power structure between the big, well-financed administrators, and medical practitioners. This, he says, is evident where the report finds the interpretation of section 59 (2) and (3) vague and confusing. These two sections are used by medical schemes to withhold payments and force providers to sign acknowledgements of debt in order to continue to be paid.

“The report refers to the above practice as blackmail, which erases any doubt that the schemes must immediately review and rewrite their FWA processes; it goes without saying that the current processes cannot continue. The Council for Medical Schemes (CMS) and the HPCSA have some serious introspection to do in respect of their own regulations, which have allowed these schemes to operate within a legal framework they endorse. These regulations lie at

the heart of the problem the section 59 inquiry has identified,” he says.

Critically, Dr Mzukwa notes, the report criticises the HPCSA and the CMS for dereliction of duty in handling complaints by providers. He says it indicates that both associations must reorganise their regulations to such a degree that they offer better clarity to avoid abuses of the regulations by people seeking to use them to their advantage – and the disadvantage of providers.

Dr Mzukwa says SAMA is appalled that black doctors have been racially profiled in the way outlined in the report, and says the association will insist on not only a review but an overhaul of current scheme guidelines to ensure that these are fair and equitable for all medical practitioners.

“We applaud the section 59 inquiry for highlighting this most inhumane practice of racial profiling by the schemes and administrators. While the process of dealing with this is unfolding, we are duty bound to ensure a parallel process gets underway to clean up the harmful and often debilitating administrative processes of these schemes. Unfortunately, unless this root problem is addressed properly, this type of conduct will continue, and more and more, black doctors will face the same issues as their counterparts who testified at the inquiry's hearings,” concludes Dr Mzukwa.

Urgent legislation needed to protect doctors at risk

SAMA Communications Department

The Medical Protection Society (MPS) has urged the government to introduce COVID-19 disaster legislation to protect healthcare professionals in SA from legal challenges relating to clinical resourcing decisions they may have to make during the crisis.

MPS says that many healthcare professionals are concerned about having to make extremely difficult decisions on how limited resources are allocated, and feel vulnerable to the risk of prosecution for unlawful killing.

Dr Graham Howarth, Head of Medical Services – Africa at MPS, said: “Doctors have a range of guidance they can refer to on administering and withdrawing treatment, whether it be from the HPCSA, their employing hospital, specialty society or a local ethics committee. The Critical Care Society of Southern Africa has also published guidelines dealing with the allocation of scarce resources for situations in

which critically ill COVID-19 patients require ICU admission. However, while this guidance is incredibly valuable, it neither provides nor claims to provide legal protection. It does not provide a clear statement of law.

“As a result, not only might a huge humanitarian burden be placed on doctors that may cause moral injury and long-term psychological damage, but they also face the risk of personal accountability if and when legal challenges arise.

“We call on the government to urgently consider introducing legislation or regulations as part of the disaster management programme in SA that would enable healthcare workers to know they are legally protected – with a statutory defence – when making difficult decisions in very challenging circumstances.

“Let us be clear: healthcare professionals should not be above the law, and the

legislation we propose should only apply to decisions made in good faith, in circumstances beyond their control and in compliance with relevant guidance – it would not apply to wilful or intentional criminal harm, or reckless misconduct.

“We appreciate that given the Constitution, the introduction of such legislation may indeed be complex, and the Disaster Management Act [No. 57 of 2002] may be the best place for this provision to sit. Legislation to protect doctors during the pandemic is not without international precedent. “We do not underestimate how difficult this issue is. The range of ethical and legal challenges that have been and will be raised by this pandemic will involve difficult discussions over time, including consideration of a wide range of different perspectives. In the meantime, this crisis is upon us, and healthcare professionals need support now.”

Organ and tissue donation: A huge disparity

Bernice Blignaut, *programmes director, Organ Donor Foundation*

Although the first heart transplant in the world was performed by our own Prof. Christiaan Barnard, in 1967, and despite the fact that we have world class specialists and facilities, SA remains one of the poorest-performing countries in the world when it comes to consent to organ and tissue donation. This has led to a huge disparity between the number of organs available for donation and the number needed, with many patients on the waiting list but dying before an organ becomes available.

As there are more than 500 000 deaths every year, of which 12% are of a violent nature, one has to question why we still have a consent rate of less than 100 out of the 60 000 deceased potential organ and tissue donors.

The answer is complex, and the challenges of addressing it are extremely difficult. That said, the most obvious way to overcome this obstacle is to increase public awareness and education, and to make it easier for South Africans to register as donors. This is exactly what the Organ Donor Foundation (ODF) continues to do, through its diverse range of awareness campaigns, and by educating South Africans from under-resourced areas through the Uluntu project. The project educates patients at healthcare clinics and state hospitals, and learners attending senior secondary high schools. The ODF has also made it easier for the public to register as donors, a process that is very quick and simple, via visiting the website at www.odf.org.za, clicking the register link and providing one's name and contact number. Thereafter, a call centre agent makes contact to complete the registration. It really is easy to do.

The other factors that play a role are more challenging. A comparison between SA and Spain, which enjoys the highest organ donation consent rate in the world, illustrates glaring disparities between our model and theirs. Spain has 480 procurement officers, half of whom are medical doctors – in contrast, SA has only 22.

SA legislation also plays an important part, because regardless of whether a potential donor is registered or has expressed a desire to be a donor, the ultimate decision rests with their next of kin, who have the final say when approached for consent. It is also not mandated by law



for medical professionals to refer potential donors, with many never receiving training as to who qualifies as a potential donor or how the referral process works. Increasing awareness in this area would make a tremendous difference.

An organ donation takes place after a person has been declared brain dead, but is still being supported on a ventilator, whereas tissue retrieval can take place hours, and in some cases even days, after death, with most donations taking place at hospitals, mortuaries and funeral homes. Organ donation is the more complex of the two processes, with a variety of factors coming into play. Firstly, in those instances where a patient has been declared brain dead, a transplant co-ordinator, who is a registered nurse, will approach the family to obtain consent; however, this step is reliant on a referral from a medical professional. In far too many instances, potential donors are not referred to transplant centres, and the opportunity to request consent is lost. Secondly, after a referral has been made, it is of critical importance that a specially trained transplant co-ordinator approach the family for consent, because if this step is not performed with the utmost care, the next of kin are always more inclined to say no rather than yes, and another opportunity to save a life is lost. Both these steps play a significant role in increasing the number of organs available for donation, by referring potential donors and ensuring that a trained co-ordinator asks for consent.

SA remains one of the poorest-performing countries in the world

The ODF provides a basic booklet with information on organ and tissue donation, and urges all medical professionals to enrol in the free online course offered by the University of Cape Town called "Organ donation: From death to life" available at <https://www.coursera.org/learn/organ-donation>. This course deals with the science behind death determination, and when it is possible for deceased organ donation to take place. The lectures cover medical standards at the end of life – from brain-death testing, to requesting informed consent from a grieving family.

Together, we can all make a difference: the SA public, simply by registering as a donor, and having a discussion with their family; awareness organisations; advocates pushing for changes to the legislation; and you, as medical professionals.

The ODF booklet is available electronically, and will be forwarded upon request from Ms Karlien Pienaar – please send your request to karlienp@samedical.org.

This is an initiative by the members of the SAMA Human Rights, Law and Ethics Committee.

Finding solutions to the challenge of safe, sustainable and adequate blood in Africa

SAMA Communications Department

On 11 November 2020, a collaboration of stakeholders in the public and private sectors across sub-Saharan Africa launched the Coalition of Blood for Africa (CoBA) on a virtual platform. This reflects a growing consensus that progress toward adequate, safe and sustainable blood in Africa requires multi-stakeholder, multi-pronged and innovative approaches to impact lives across the continent.

Coalition of Blood for Africa is the first of its kind on the continent

Blood is a vital healthcare resource. It is most often used in Africa to treat pregnancy-related complications and severe childhood anaemia caused by a variety of contributors, including malaria and sickle-cell disease. Blood is increasingly important for patients with kidney failure who are on dialysis, and cancer patients.

The WHO states that the number of units of blood needed to sustain an adequate level of health is equivalent to 1% of a nation's population – 10 units per 1 000 people. Yet many African countries fall well short of the minimum goal. The lack of infrastructure and equipment for collection and processing

of blood components is a key impediment to providing a sustainable blood supply. Though blood and safe transfusion services are essential parts of any strong health system, the safety, sustainability and adequacy of blood remains a major health challenge in many African countries.

"Today is about mobilising action, as we convene the first ever CoBA," said Antoinette Gawin, president and chief executive officer, Terumo Blood and Cell Technologies. "The coalition's goal is to support the WHO's commitments (WHA63.12), and aligns with our global mission to serve more patients. Providing safe access to blood in Africa is one way to achieve this."

The coalition is anchored on three pillars:

- reflection – supporting informed decision-making with research, policy analysis and data collection
- dialogue – creating awareness about the need for blood and blood safety
- action – providing technical assistance to support initiatives, capacity-building programmes and activities such as blood collection drives, and helping with technical inputs to strengthen blood-related legislation and policies, such as guidelines for the management of sickle-cell disease.

The coalition brings together an unprecedented array of health experts, including public sector research institutes, ministries



of health, academia, not-for-profit research and development organisations, NGOs, international organisations and funders, all committed to finding solutions to address the challenges facing access to safe, sustainable blood in Africa.

"The scale of the challenge is clearly beyond the scope of a single organisation, and I am confident that the coalition will facilitate a co-ordinated approach to address the challenges facing blood in Africa and find sustainable solutions," says Gavin Evans, executive director, Global Blood Fund.

The launch of CoBA was convened by Terumo Blood and Cell Technologies, a global leader in blood component, therapeutic apheresis and cell technology, in collaboration with the Global Blood Fund, Africa Practice, Africa Health Business and Siemens Healthineers.

Nobel Peace Prize nomination fails to recognise SA doctors

SAMA Communications Department

SAMA says it is disappointed that the efforts of the thousands of doctors who risk their lives on the frontlines of the COVID-19 pandemic in SA continue to go largely unrecognised by the SA government, while at the same time the Cabinet endorsed the nomination by the Norwegian

government of the Cuban Medical Brigade for the Nobel Peace Prize.

During his address to the nation on the latest news regarding the COVID-19 pandemic in the country, President Ramaphosa noted, "True to its history, this small island nation (Cuba) has demonstrated solidarity with the

hardest-hit countries, and sent more than 3 700 Cubans throughout the world to assist in the fight against COVID-19.

"In recognition of this effort, the SA Cabinet has approved a proposal by the Norwegian government to nominate the Henry Reeve International Contingent of

Doctors Specialised in Disaster Situations and Serious Epidemics – or as they commonly are known, the Cuban Medical Brigade – for the 2021 Nobel Peace Prize.”

Dr Angelique Coetzee, chairperson of SAMA, says “SAMA acknowledges that the Cuban Medical Brigade does amazing work throughout the world. We certainly do not dispute this fact. We have never questioned their abilities, nor their commitment to assisting others. We are certainly not criticising the Cuban doctors. What is disappointing is that our own doctors appear not to enjoy the same level of gratitude from their own government.”

She says it is particularly jarring for doctors to hear that Cabinet is approving the nomination for such a lofty award while at the same time local healthcare workers have to work without proper or sufficient personal protective equipment, or in

medical facilities that lack even the most basic of resources.

“How can we forget that over 200 junior doctors either did not get paid at all the end of January, or were paid short, in some instances. In other instances, qualified SA doctors are forced to work as unpaid supernumeraries due to post freezes and other logistical challenges. These doctors are treating very ill ICU patients for free. How is that fair or even reasonable?” asks Dr Coetzee.

She says that irrespective of the work done by the Cuban Medical Brigade in other countries, SAMA has to query the basis on which Cabinet is endorsing the nomination in the context of the SA situation.

“The President mentioned that at the end of November 2020, the Cuban Medical Brigade of 187 doctors had treated more than 38 000 patients in SA. That’s less than 5% of

the total number of around 800 000 cases we had at the end of November – does that warrant a nomination for a Nobel Peace Prize?” asks Dr Coetzee.

She says SAMA is also taken aback by the nomination given the fact that the contingent of doctors came with a price tag.

“We understand the Cuban doctors here form part of a larger initiative, but let’s not forget, the SA taxpayer is paying more than ZAR400 million to have these doctors here, so we can really not understand why they should be nominated for the Nobel Peace Prize if they are being paid to deliver a service,” says Dr Coetzee.

Dr Coetzee says SAMA expects the SA government to withdraw its nomination for the Nobel Peace Prize for the Cuban Medical Brigade, and instead make more of an effort to recognise its own doctors. Making a concerted effort to improve the working conditions for SA doctors will make all the difference.

BHF member schemes to fund COVID-19 vaccine, but note concerns

SAMA Communications Department

The Board of Healthcare Funders (BHF), a not-for-profit representative body of the healthcare funding industry representing 56 medical schemes, administrators and managed care organisations, has confirmed that it has been engaging with its members to chart a way forward on the ZAR6.8 billion that government has requested from medical schemes to fund COVID-19 vaccines.

The BHF has confirmed that medical schemes will pay for COVID-19 vaccines for their members as a prescribed minimum benefit (PMB), in line with the Medical Schemes Act No. 131 of 1998 regulation amendment that declares the medical prevention and treatment of COVID-19 as a PMB.

Funding will be prioritised for vaccinations for targeted population groups, to support efforts to achieve herd immunity in the country.

Regarding the additional funding required to support health citizens who are not medical scheme members, the BHF has noted that several reports have indicated that medical schemes have made this funding available. However, there are several restrictions to this, as the Medical Schemes Act does not allow for funding healthcare services for non-medical scheme members.

Dr Katlego Mothudi, managing director of the BHF, explained that “the BHF recognises that we need to achieve herd immunity of at least 67% for any efforts being made with the vaccine to be of national impact. To this end, the BHF is collaborating with government to find an appropriate solution to fund health citizens who don’t belong to a medical scheme to meet the target of 67% herd immunity.”

He said, “We are also engaging with our members to consider a framework within the Medical Schemes Act and medical scheme rules to support government.

“In principle, BHF member schemes support the concept of social solidarity. However, several considerations need to be made around the proposed funding mechanisms, to ensure that this can be done above board, following a sound governance framework and within the prescripts of the Medical Schemes Act as well as the individual medical scheme rules.”

Dr Mothudi noted that medical schemes function under the Medical Schemes Act and the rules registered by the Council for Medical Schemes, and these guide and control their businesses’ functioning. The Act and scheme rules are binding, and are designed to ensure

The Board of Healthcare Funders (BHF) is a representative body of the healthcare funding industry. Its motto is “Serving medical scheme members”, which guides its work. The organisation aims to ensure the sustainability of the healthcare sector by enabling medical schemes, administrators and managed care organisations to provide accessible, affordable, quality healthcare to medical scheme members. BHF members include medical schemes, administrators and managed care organisations throughout the Africa region. The BHF currently has membership in SA, Lesotho, Zimbabwe, Namibia, Botswana, Mozambique, Malawi and Swaziland.

that medical schemes act in the best interests of their members.

“At this point, the government still has not provided a clear indication of the cost of each dose of the vaccine and the price at which medical schemes will procure the vaccine from the Department of Health. However, funds are available to provide cover for medical scheme members,” noted Mothudi.

SAMA mortality and morbidity guidelines for CPD accreditation 2021

Lisa Reid, SAMA CPD officer

The SAMA Continuing Professional Development (CPD) department has released the following information on mortality and morbidity guidelines for CPD accreditation in 2021.

The aim was to establish a routine, structured forum for the open examination and review of cases that have led to complications or death of a patient, in order to collectively learn from these events and to improve patient management and quality of care, and to provide continuing professional development.

The guidelines are as follows.

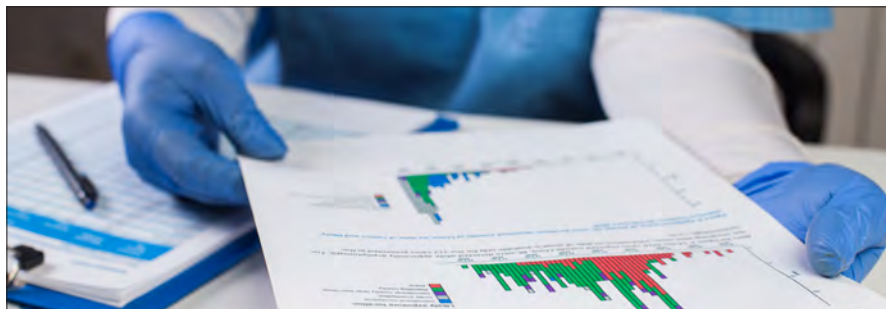
Roles and responsibilities should be clearly defined, and accreditation obtained from SAMA at cpd@samedical.org.

Mortality and morbidity (MM) meetings should have a chair or facilitator. One person, chair or secretariat should be responsible for co-ordinating the meetings. All members should be encouraged to contribute their views. Meetings should be regular and organisationally convened, predominantly involving medical practitioners (though they are increasingly multidisciplinary) who gather to discuss selected cases for the purposes of clarifying medical management, and to provide a forum for teaching and learning, focusing on patient safety and quality improvement, including the identification and reporting of errors. They should identify key events resulting in adverse patient outcomes, and foster open and honest discussion of these events.

During the meetings, participants should identify and disseminate information and insights about patient care that are drawn from individual and collective experience. The meetings should reinforce system-level and individual accountability for providing high-quality care. Meetings should create a forum that supports open and honest discussion through the provision of a just, patient-centred culture, and that contributes to clinical governance processes.

Content of the meetings

MM meetings should occur onsite, and be chaired by a senior doctor who takes responsibility for the process and has an ability to engage with clinical colleagues and facilitate change by improving processes of patient care. This may be the medical director,



unit/department head or a delegate. Where possible, MM meetings should be regularly scheduled to maximise participation.

Members of other clinical disciplines, such as nurses, pharmacists, physiotherapists and junior medical staff, should attend. Cases for discussion should be identified by senior doctors raising specific cases, or via referral from other MM meetings.

In order to provide sufficient time for adequate discussion, no more than two cases should be discussed per hour, although aggregating cases presenting similar issues into a block discussion may be appropriate.

Doctors and other clinicians actively involved in the care of the patient to be discussed must be made aware of the intention to discuss the case at least 72 hours in advance, and must be made aware of the date, time and place of the meeting. If they are unable or unwilling to attend the meeting where the case is to be discussed, the case should be referred to the appropriate medical lead for further investigation or action. Cases must never be discussed in the absence of the senior doctors with primary responsibility for care of the patient.

Cases should be presented in verbal format in a de-identified fashion, describing only the facts of the case.

The major issues should be identified during the presentation, with the chair providing further clarification if required. The chair should ensure that following the presentation, the key discussion points are agreed. These should always include:

- what went wrong (or right)?
- how did it go wrong (or right)?
- why did it go wrong (or right)?
- what could be done differently in future?
- what are the key lessons for the organisation?

A consistent approach to problem-solving should be used to discuss the case.

The chair should ensure that any discussion relates to the facts of the case and not to personal issues. This is not a meeting to attack or openly criticise individuals who have contributed to patient care – doing so impedes the development of a ‘just’ culture.

If major performance issues relating to an individual senior doctor become apparent at any stage during the discussion, the chair should immediately halt the discussion and refer the issue to the relevant medical lead (medical director, unit head or equivalent), who should then initiate the organisation’s usual performance development processes. Discussion around other matters pertaining to the case may continue.

At the completion of the discussion, action points should be agreed and prioritised by all present in the meeting. Responses to these issues should be presented at subsequent meetings.

Minutes should be kept, with patient and doctor details de-identified.

An action list and appropriate accountabilities should be generated, and circulated to all participants and to appropriate organisation-level clinical governance structures, as well as evidence-based guidance to correct/prevent future incidents.

For further information on CPD accreditation, please contact Lisa Reid on 012 481 2082 or cpd@samedical.org.

Minutes of the meeting must be sent every 6 months to your accreditor for auditing purposes.

Please note that medical professionals whose job description involves hosting MM meetings should not accumulate CPD points for attendance or hosting.

WMA calls for international co-operation in the fight against COVID-19

World Medical Association

A warning that now is not the time for egotisms and nationalism in the fight against COVID-19 has come from the WMA.

Speaking at a ceremony in Vienna on 31 January 2021, where the WMA was presented with an award honouring physicians around the world for their fight against the pandemic, Dr Otmar Kloiber, secretary-general of the WMA, stressed the need for international co-operation.

"Together, we have been able to work on strategies to mitigate the pandemic's consequences and develop therapies and vaccines. Alone, no nation would be able to cope; no scientist would make the breakthrough, no doctor could provide the necessary care. Co-operation, international co-operation is the key. And as we progress together, we have to share together. To leave no one behind, no frail person, no frail state. Now is not the time for egotisms and nationalism."

His final message was to all his fellow citizens: "You can help your doctors, nurses and other caregivers: reduce contacts, maintain distance, wear masks, follow hygiene rules and most importantly: get vaccinated. This is our best and only chance to get back what is worth calling a 'normal life'."

WMA president Dr David Barbe said: "Physicians have demonstrated their professionalism by willingly placing themselves in grave personal danger by caring for patients with COVID-19 – often under less-than-ideal conditions. Untold

tens of thousands of doctors have become ill and thousands have died as a result of their commitment to their patients and society.

"Physicians have been vocal advocates for their patients and their colleagues in calling for adequate personal protective equipment, improved access to hospital care, equipment and life-saving treatments, rapid deployment of vaccines and responsible social policies to reduce the burden of disease, save lives and bring an end to this devastating pandemic."

Alone, no nation would be able to cope; no scientist would make the breakthrough, no doctor could provide the necessary care

Dr Kloiber also criticised governments for short-sighted cuts in healthcare spending, which was now leading to a "deadly payback" of many deaths and damaged economies.

"Stronger healthcare systems are better than weaker ones. Universal health coverage is even more critical in times of pandemics. High-quality healthcare accessible to all requires proper investment, meaningful

financing and resilient reserve capacities. Over the past years, we may have made some savings in streamlining healthcare systems for strict cost-efficiency. We have even squeezed some healthcare systems to the minimum with austerity measures.

"These have been short-sighted economic strategies, which have led to a deadly payback with so many lives lost and tremendous damage to our economies."

The Golden Arrow Award was presented to the WMA at the 18th Vienna Congress. The award recognises people's achievements in their life's work, and those of institutions for their social relevance. Previous winners include several Nobel laureates, as well as former presidents of Israel and SA. The award was the highlight of the 2-day congress, held under the patronage of the chancellor of Austria. During the congress, international medical and scientific experts discussed life after the pandemic.

Tributes to the medical profession were paid by several speakers. Václav Klaus, former president of the Czech Republic, said: "I would like to thank doctors all over the world for their services, and hope that they all will hear about this thank you from the heart of Europe," while Dan Shechtman, Nobel laureate and vice-chairman of the award advisory board, said, "Doctors are part of our life infrastructure. They are there when we need them. And we need them often. The medical profession is at the forefront of the war on the virus. For us, for our health and our freedom."

Letters to the Editor

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

Please note that letters:

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

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



Stroke after carotid surgery

The Medical Protection Society shares a case report from their files

Miss C, a 30-year-old accountant, developed an asymptomatic left-sided neck lump. A CT scan revealed a 23 x 17 x 27 mm mass at the carotid bifurcation consistent with a carotid body tumour. Miss C saw a vascular surgeon, Prof. A, who noted there was no significant medical or family history and confirmed that she was normotensive with no neurological signs.

He explained that this was a rare tumour with the potential for malignancy, and recommended surgical excision, which he undertook the following day. Miss C signed a consent form completed by Prof. A for "radical excision of left carotid body tumour".

During surgery, the carotid bifurcation was damaged, resulting in rapid blood loss of approximately 1 100 mL. Prof. A recorded that the bleeding was controlled by clamping the common carotid artery three times, for a total of 16 minutes. The injury was repaired "with difficulty" using a 5/0 prolene suture, and at the end of the procedure there was good flow in the internal carotid artery.

Postoperatively, Miss C was transferred to the ICU where she was extubated, and initially appeared drowsy, but had no obvious neurological deficit. She remained stable overnight, but the following morning appeared drowsier and was noted by the nursing staff to have profound right-sided weakness.

Dr B, an ICU anaesthetist, reviewed Miss C and attributed her drowsiness to opiate toxicity, and prescribed naloxone. Miss C's condition did not improve and when Prof. A saw her, he arranged an urgent MRI scan. This demonstrated a large left middle cerebral artery territory infarction with complete occlusion of the entire extra-cranial left common carotid, internal carotid and external carotid arteries. Despite further intervention by the ICU team and neurosurgeons, Miss C suffered permanent brain damage with severe hemiplegia and cognitive impairment, requiring continuous nursing care.

The family of Miss C initiated proceedings against Prof. A and Dr B, as they were critical of numerous aspects of their care.

Expert opinion

Expert opinion agreed that arterial bleeding from excision of a carotid body tumour is a well-recognised and inherent potential risk of such surgery, and that Prof. A had handled



this complication in an appropriate and timely manner. Although questioning the need for three periods of carotid clamping, it was felt that the total time of potential cerebral ischaemia was relatively short, and the alternative approach of arterial shunting carried its own additional risks.

Postoperatively, Miss C initially appeared neurologically intact, and experts therefore felt that the stroke had occurred several hours after surgery, as the result of thrombus formation at the site of the carotid arterial repair and/or the site of clamp application. It was also agreed that while anti-coagulation may have prevented thrombus formation, such a strategy would have carried a high risk of major haemorrhage and was contraindicated.

The experts raised concerns regarding the failure of the nursing staff to inform the medical team immediately when Miss C demonstrated neurological deterioration. Dr B was also criticised for not performing a full neurological evaluation and wrongly attributing the decreased conscious level simply to opiate toxicity. It was speculated that the resulting delay in the diagnosis and treatment of Miss C's stroke may have led to a worse neurological outcome.

However, the main focus of criticism centred on the consent process. Experts questioned why Prof. A carried out surgery the day after the initial consultation, given the slow-growing nature of carotid body tumours. Miss C's family felt that the process had been rushed and that she had not fully understood the magnitude of the risks of surgery.

Learning points

- Communicating within the team is important – the nursing staff did not inform the medical team of the patient's deterioration. Consider a team approach for raising concerns.
- Good communication and documentation are essential in the process of consent. Patients must be made aware of the risks of surgery and their implications. This should include common complications as well as any serious adverse outcomes, including rare complications, that may result in permanent disability or death. Patients need to be able to weigh up the benefits and risks of medical intervention so that they can make an informed decision as to whether they want to proceed.
- Complications can and do occur, and are not necessarily a sign of negligence.
- Litigation can be prevented or successfully defended if patients are warned about the risks in advance, and this discussion is recorded.

Indeed, there was no documented evidence that any of the potential major complications had ever been discussed, and Prof. A accepted that the process of informed consent had been inadequate.

The case was settled for a high sum, reflecting the severe neurological outcome and the need for continuous care.

KZN Midlands hold virtual intern orientation



Dr Pfeiffer happily poses with her SAMA bag



Dr Nkambule with her goody bag



These bags were handed out to all interns who joined SAMA

On 29 December 2020, KZN Midlands branch held a virtual intern orientation to which all the Pietermaritzburg Hospital Complex interns were invited.

Branch secretary Mandy Hattingh invited all interns who had signed up as SAMA members to collect a goody bag from the SAMA office. The goody bag included a pen, tourniquet, doctor's car sticker, lip ice, headgear and member benefit list.

Dr T P Nkambule and Dr M C Pfeiffer were the first members to collect their bags after completing the application forms.

Mandy Hattingh took the time to interact with each member. All new interns will be followed up with for recruitment.

Dr Ellis awarded life membership

SAMA KZN Midlands branch recently awarded Dr Chris Ellis a life membership certificate. Now retired from clinical practice, Dr Ellis is currently doing postdoctoral research in phenomenological and Socratic dialectic methodology as applied to medical science.

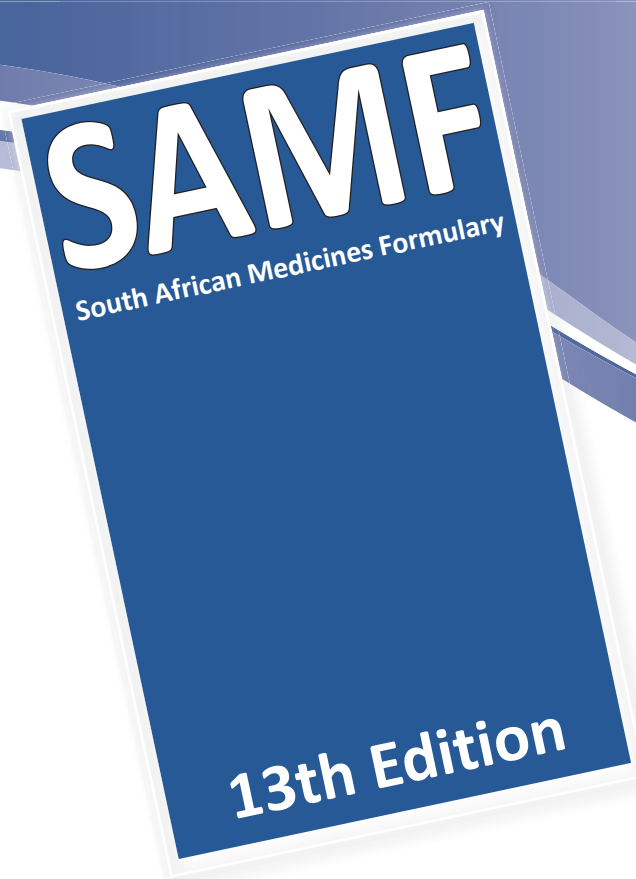
Before retirement, he worked as an associate professor of family medicine at the University of the United Arab Emirates, and as a specialist family physician in Pietermaritzburg.

SAMA congratulates and thanks Dr Ellis for his service and dedication.



Dr Chris Ellis

SAMF 13th edition now available



The ESSENTIAL MEDICAL REFERENCE for every healthcare professional!

The convenient pocket-sized design enables you to fit it comfortably into your hospital bag or coat pocket, so it can always be at hand for ready reference. South African Medicines Formulary (SAMF), a joint initiative of the University of Cape Town's Division of Clinical Pharmacology and the South African Medical Association, provides easy access to the latest, scientifically accurate information, including full drug profiles, clinical notes and special prescriber's points. The thoroughly updated 13th edition of SAMF is your essential reference to the rational, cost-effective and safe use of medicines.

To order your copy of the new
SAMF 13th edition:
visit online at: www.samedical.org/products





SAMAREC

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

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

Ethics review is done on any type of biomedical research, including full-scale clinical trials, observational studies, device studies, surveys and registers.

If you are planning to publish your study or ensure that you comply with good clinical practice – SAMAREC is the way to go.

We offer a completely paperless system, and guarantee a quick turnaround time.

SAMAREC has a designated officer to keep you up to date with the progress of your application.

For more information, please contact the SAMAREC Officer

012 481 2046 or samarec@samedical.org

