

SAMA INSIDER

JULY 2021

**SAMA rallies
to support
global vaccine access**

**Effects of COVID-19
on junior doctors and
medical students**



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

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SAMAREC

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

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Diane de Kock
Editor: *SAMA INSIDER*

When?

The third COVID-19 wave has hit SA, and at the time writing the country has recorded over 15 000 new cases in the last 24 hours! When will it end?

In their article (page 6), doctors at Groote Schuur Hospital (GSH) look at the effects of COVID-19 on junior doctor and medical students at GSH. They ask: "Will the third wave be worse? Will we be able to cope? When will we all be vaccinated? What if there are few satisfactory answers for these questions?" These and many other questions are relevant at this time. When will they be answered, and will our fragile healthcare system be able to cope?

On page 4, SAMA president Prof. Risenga Chauke looks at ways to beat the odds when providing acceptable and effective health services to society. "We believe, as SAMA, that we can beat the odds if we work together as health stakeholders."

In his article, Brandon Ferlito (page 5) unpacks the numerous ethical issues around COVID-19 passports. "To avoid compounding existing societal inequities and widening the health divide, COVID-19 vaccine passports should be available and accessible to all." He reiterates that there needs to be a global ethical position devoting all political, intellectual and social resources to scaling up global vaccine manufacturing and providing vaccinations as quickly as possible. When?

Global vaccine access is essential, and will increase the likelihood of being able to answer one aspect of the question – when? SAMA fully supports the global initiative by the SA and Indian governments for a temporal waiver of the Agreement on Trade-Related Intellectual Property Rights (TRIPS) to increase global access to vaccines (page 5). "The world is only safe from the global COVID-19 pandemic when all global citizens are vaccinated, regardless of nationality."

SAMA continues to advocate for its members by, among other actions, reaffirming its stance on the proposed NHI (page 8), and expressing the associations concern about the recent HPCSA remarks on the funding mechanism (page 10).

Shelley McGee updates us on the debate and discussion on the introduction of so-called "low-cost benefit options" into the medical schemes environment (page 11), and SAMA's role in ensuring that any products that are developed meet the clinical needs of the patients they are designed to serve.

We will reach a point of safety from the pandemic when access to the vaccine is global and the majority of citizens agree to be vaccinated. The reality of vaccine hesitancy is addressed by Oxford University professor Daniel Freeman in his article (page 14) on new research that recommends spelling out the personal rather than the collective benefit to persuade people. "We need to listen, understand concerns and address them seriously."

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Beating the odds



Prof. Risenga Chauke, SAMA President

To achieve something against all odds means doing so against the likelihood of something happening, or “achieving results that looked unlikely to be achievable”. One needs to unpack the elements of such odds, which are:

- the balance of advantage
- superiority in strength
- superiority in power
- superiority in resources.

To beat the odds, one needs to be daring and bold. The pandemic has cast a spotlight on the health system's building blocks and its weaknesses. This begs the question, what are the odds of providing acceptable and effective health services to society? The odds of achieving set objectives depend on people, policies and procedures, infrastructure, and financial and human resources.

Norms and standards for resources are critical in the delivery of services, and planning should abide by the norms and standards that we set, benchmarked upon the best international practices. These standards should inform how infrastructure is designed and built, and where and how it is located. As an example, the WHO advocates that there should be a healthcare facility within a radius of every 5 km. Standards should also inform the training and education of future health professionals to ensure alignment between training outputs and expectations and the

needs of the health system. Training should integrate policy and guidelines such as the Batho Pele principles and national core standards to normalise and institutionalise standards.

Physical and information technology infrastructure challenges pose a threat to the Sustainable Development Goals, and therefore to the provision of universal health coverage (UHC). The state of roads and public transport has an impact on accessing health, as do air pollution and other social determinants of health. The COVID-19 pandemic has also highlighted the role that various sectors play in health. The National Department of Health cannot act alone in addressing some of these challenges, hence the need to adopt the “health in all policies” approach. It is stated in this approach that UHC is a smart investment for every country. The health in all policies initiative by the WHO describes how different sectors ought to work together to actively support health. Policies in these sectors, e.g. transport, housing, work, nutrition, water and sanitation, need to actively promote health in order to beat the odds.

The availability of financial resources has contracted over the years, and the situation has been exacerbated by the COVID-19 pandemic. Most governments redirected their financial resources to fighting the pandemic. This is expected to impact negatively on the teaching and training of health professionals, and the capacity for service delivery. The litigation crisis is also threatening the financial capacity of the health system, which does not create an environment for effective and acceptable health service delivery for our people.

Policies and procedures guide the delivery of safe, cost-effective and acceptable care. Care is acceptable when it is dignified and responsive to relevant expectations. We have laws and regulations governing the health system, and how the system should interact with its users. It is paramount that mechanisms for monitoring compliance and implementation of continuous improvement are prioritised to enable the realisation of these objectives.

The issue of human resources for health adversely affects the delivery of health services, especially in the developing world,

including SA. The need to actively train and develop health professionals is indisputable, including the need to actively retain them in the profession to reduce the attrition rate.

But this need is far from being realised, given the challenges faced by our country. These challenges range from administration to the foot soldiers on the ground, mainly influenced by the high rate of corruption. It is indeed true that until corruption is decisively dealt with and a system implemented to support ethical leadership and behaviour, the challenges shall remain. Both attraction and retention of people is critical for sustainability of the service, and also to secure the training capacity in health sciences training institutions. The WHO subscribes to the universal truth of “no health without workforce”.

We can beat the odds if we work together as health stakeholders

Leveraging on what advantages, superiority of strength and power our country has to offer to support health is important. SA has, for a long while, been regarded as a gateway to Africa. The abundance of sunlight and natural resources may be used innovatively to support health in all its forms, from primary to tertiary and quaternary healthcare, in line with the health in all policies philosophy.

What can SAMA offer?

We believe, as SAMA, that we can beat the odds if we work together as health stakeholders. We also have to uphold our advocacy, especially for health in all policies. If we allow ourselves to advise one other within our profession, it is possible to achieve our organisational and national objectives.

It is indeed heartening to witness the role played by the chairperson and vice-chairperson of SAMA in the media, advocating for our health professionals and for society at large. This is an effort by SAMA to beat the odds and actively play a catalyst role in the delivery of a better health service for our people.

COVID-19 and vaccine passports: Ethical issues

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

With millions of individuals receiving COVID-19 vaccines around the world, some countries have already begun to prepare for the implementation of “vaccine passports” – credentials that show COVID-19 immunisation, and are connected to the holder’s identity. The primary reasoning behind vaccine passports is to allow citizens to travel, attend large gatherings, visit public venues and return to work without jeopardising their own safety or the public’s health. However, there are numerous ethical issues around COVID-19 vaccine passports.

Vaccine passports are not a novel concept: they already exist, and are allowed under international health regulations. The WHO has approved certificates confirming yellow fever immunisation for admission into specific nations: “Unlike immunity passports which may, perversely, incentivise infection, vaccine passports incentivise vaccination. They can, therefore, be considered an international public good with benefits that extend to individuals as well as to the general population.”

Some ethical considerations

Ethical concerns persist regarding the potential for COVID-19 vaccine passports to create societal division. Vaccine passports could, for example, enable coercion and stigmatisation in workplaces, exacerbating structural disadvantages already present. To avoid compounding existing societal inequities and widening the health divide, COVID-19 vaccine

passports should be available and accessible to all, but vaccines are in short supply, and their access is unequal internationally and within countries.

The use of COVID-19 vaccine passports has been met with strong opposition for a number of reasons. Firstly, while vaccine supply remains limited, privileging people who are fortunate enough to have gained early access is morally questionable. While this might not yet be applicable in SA, it is a concern that deserves attention. Secondly, even if supply limitations ease, vaccination rates among racial minorities and low-income groups are likely to remain disproportionately low. Historically and socially excluded populations are less likely to be vaccinated, partly due to a lack of access, but also due to vaccine hesitancy based on lack of trust in government and past experiences of medical abuse. Third, the full extent of protection offered by vaccination, particularly against novel variants, is not fully known, as is the risk of viral transmission among vaccinated individuals. Fourth, prioritising the vaccinated may penalise those who reject vaccination for religious or philosophical reasons. Finally, there is no agreed-upon method for accurately confirming immunisation.

As the world embraces the fourth industrial revolution, vaccine passports will likely be digitalised. As a result, there are also concerns around data protection, confidentiality and privacy.

Can the use of vaccine passports be justified?

The principle of least infringement in public health holds that, in order to achieve a public health goal, policy-makers should use the alternative that has the least impact on individual liberty. While lockdowns may be necessary, continuing to restrict the civil freedoms of those who are immune and offer a low risk of spreading infection may be unethical, as lack of freedom of movement is one of the pandemic’s most ubiquitous negative effects. Vaccine passports may also serve to avert other health and socioeconomic consequences of lockdowns, resulting in individual and group health, economic and social gains.

Global justice in vaccine access

While the idea of implementing COVID-19 vaccine passports is gaining traction in many countries, millions of people throughout the world lack access to healthcare, financial assistance for maintaining quarantine or isolation, oxygen, medications and hospital beds. Although the vaccination rate is rapidly increasing globally, for millions of people, particularly in low-income countries, the likelihood of receiving the vaccine is almost zero. There needs to be a global ethical position devoting all political, intellectual and social resources to scaling up global vaccine manufacturing and providing vaccinations as quickly as possible.

References available on request.

SAMA rallies to support global vaccine access

SAMA Communications Department

SAMA sadly notes that only 2% of the population in low- and middle-income countries are vaccinated. According to the WHO, the world requires at least 10 billion vaccines to prevent COVID-19 catastrophe in developing countries.

It is for this reason that SAMA fully supports the global initiative by the SA and Indian governments for a temporal waiver of the Agreement on Trade-Related Intellectual Property Rights (TRIPS) to increase global access to vaccines.

The association believes that the world is only safe from the global COVID-19 pandemic when all global citizens are vaccinated, regardless of their nationality.

SAMA intends to actively support these initiatives by establishing a special envoy (task team) to engage the Coalition of African National Medical Associations, the Indian Medical Association and ultimately the World Medical Association to rally behind all global initiatives that promote global access to vaccines.

SAMA welcomes the support from both the French and US governments, but the association intends to work with the SA and Indian governments to approach both the African Union and the BRICS block of countries (Brazil, Russia, India, China and SA) to openly support this initiative that seeks to address global health inequity.

The association will continue to rally all key stakeholders in addressing major global health issues, especially those that affect people in low- and middle-income countries.

The best and worst of times – effects of COVID-19 on junior doctors and medical students at GSH

Nectarios Papavarnavas, Petronella Frankenfeld, Prasun Singh, Henri Pickard, Gordon Audley, Ashley Jacobs, Qhamisa Mbalo, Nicola Steinhaus, Aadil Omar & Deborah Maughan, *University of Cape Town/Groote Schuur Hospital*

The COVID-19 pandemic has wrought havoc on healthcare systems around the world, with many healthcare workers suffering physically and emotionally, and some losing their lives to the disease. This article describes the experiences of junior doctors and medical students working in the COVID-19 service at Groote Schuur Hospital (GSH), Cape Town.

In March 2020 President Ramaphosa announced SA's first lockdown, as we waited anxiously for the arrival of the devastation already seen in Wuhan, Italy and New York. We heard our neighbours clap for us every night at 8 pm, and wondered if our already fragile healthcare system would be able to withstand the pandemic, and what it would mean for all of us.

The pandemic has come at great cost to the lives of many patients, families and friends. In addition, it has taken both a physical and mental health toll on healthcare workers.

First-wave team dynamics

We were fortunate in and appreciative of a whole-of-hospital response service model during the first COVID-19 wave, in which not only physicians but also colleagues from a variety of specialties and their interns became fully committed to the care of COVID-19 patients. Although the first wave at GSH was a difficult and emotionally traumatic experience, there were aspects of the response that are worth holding onto. The collaboration between traditionally distinct medical and surgical disciplines played a crucial role in distributing the burden of care across the hospital, fostered strong feelings of camaraderie and helped prevent burnout by leveraging the power of teams. This teamwork also facilitated a blurring of traditionally distinct hierarchical lines between senior and junior doctors, enabling better interdisciplinary relationships and optimising patient care. A large hospital became a smaller and friendlier space despite the increased trauma, demands and fatigue.

Deployment and mobilisation

Rostering a new service during the first wave was immensely challenging. The

most effective strategy was to create teams who mobilised together and supported one another. An ever-changing roster that started with 16 doctors in ward-based teams evolved to over 100 doctors covering 11 COVID-19-related wards and acute admissions, excluding the ICU, with shifts to cover critically ill patients after hours. Attempts to build rest days into the roster meant that days off were seldom over weekends. This inadvertently added to the emotional and social strain staff were already under.

Communication is key

To combat the ever-present uncertainty surrounding the first wave, clear communication channels, including daily virtual meetings and internet-based group messaging platforms, were accessible to all staff, optimising transparency and consistency across the multiple areas of the hospital dedicated to managing the pandemic. Clear communication with patients, their families, ward staff and consulting disciplines was the cornerstone upon which the hospital's response was based.

The mental health insults that the last year has brought should not be underestimated

Trying to keep up with the latest literature on COVID-19 proved challenging, and clear communication among healthcare workers who shared their knowledge allowed us to practise evidence-based medicine. As is to be expected, early in a new pandemic, case reports and series predominated – randomised controlled trials and systematic reviews came later. This resulted in "defensive medicine" in which, for example, doctors felt uneasy not prescribing antibiotics to all COVID-19 patients, in fear of "What if this isn't COVID-19?", but perhaps a community-acquired pneumonia. As healthcare workers

became more comfortable managing these patients, and more literature surfaced on the rarity of bacterial co-infection, unnecessary antibiotic use reduced at GSH. With an average of 367 COVID-19 articles published per week, and a median time from submission to acceptance of 6 days, it became difficult to keep up. This exemplifies just how fast the field was changing. Weekly digests of new research from colleagues at Stellenbosch University were particularly useful, and a good model for future operations.

The walls fall down

Days became filled with donning and doffing of PPE, taking bloods, clerking patients, writing death certificates and resuscitating critically ill patients. It was commonplace for heads of department, professors and senior consultants to be found clerking patients in the early hours of the morning, helping stabilise the critically ill and even assisting in portering patients around the hospital, as needed. Seeing our seniors feeling just as uncertain as we were, while watching them stride out to meet COVID-19 head-on, was the best example of leading from the front a junior doctor could hope for.

Amidst all the chaos and uncertainty, a beautiful thing began to happen. The hierarchy of medicine fell away, levelling the playing field. Consultants, registrars, medical officers, interns and students worked side by side, doing whatever they could to save patients' lives or at the very least practise good palliative care. This spirit of teamwork and support for one another ensured that despite the social distancing and PPE disguises, we never felt alone.

Collateral effects on training and teaching

At the beginning of the SA COVID-19 epidemic, a strict lockdown came into effect, which included the medical school trying to limit the amount of students coming to lectures, bedside teaching and clinical duties at GSH. This resulted in an important part of our team being withdrawn. As the pandemic took its toll, our medical students felt uneasy about not contributing to the cause, with

many requesting to rejoin the clinical platform and heeding a university call to join the clinical teams. Having the medical students was a tremendous help, even if only to run a blood gas, or take on the responsibility to update family members by phone.

Medical internship is a time in which newly qualified medical graduates gain the necessary skills and professionalism to allow them to work as independent doctors, while rotating through a number of different disciplines. Even before COVID-19, many experienced this as a stressful, exhilarating, exhausting, wonderful but also terrifying time – and then the structured and pre-planned internship of 3-monthly rotations fell away under the pandemic. It was not uncommon for doctors to be reassigned to COVID-19 wards at a moment's notice, resulting in reduced training time across the disciplines. We cannot be sure of the negative effects this may have on the doctors leaving internship and medical school. However, COVID-19 presented a unique, once-in-a-lifetime opportunity (hopefully) for interns to be part of a historic pandemic, and contribute accordingly.

Specialty and subspecialty teaching and training was also disrupted. CMSA exams continued in both the first and second waves. For those writing, working full-time in the COVID-19 service while trying to study for final exams added enormous stress.

Fitting into different shoes

At the start of the first wave, we were all out of our comfort zones, medical and non-medical colleagues alike. Becoming comfortable with not knowing all the intricacies of a disease is an important lesson to learn. As with all good teams, the whole proved greater than the sum of its parts. Each discipline was able to contribute in different ways beyond routine patient care: surgeons were able to assist in the management of surgical patients with incidental COVID-19; radiologists helped to decipher imaging and the differential diagnosis of COVID-19 pneumonia, *Pneumocystis jirovecii* pneumonia in HIV-positive patients, and contributions from comorbidities such as heart failure; and radiation-oncologists brought a wealth of knowledge and experience in palliative care.

Being alone

Being able to provide medical management took us only so far. We were also called upon to care for the emotional wounds inflicted by the pandemic. We are used to this, but the scale was different. Patients who one



COVID-19 has posed an immense challenge to junior and senior healthcare professionals alike. In this article, Groote Schuur doctors share their experiences – from left to right: Ashley Jacobs, Qhamisa Mbalo, Henri Pickard, Petronella Frankenfeld, Deborah Maughan, Nicola Steinhaus, Aadil Omar and Gordon Audley. Seated: Nectarios Papavarnavas. Absent: Prasun Singh

would normally see leave hospital healthy died – husbands, wives, sons and daughters together in the same ward. Often, we were the only connection for patients with the outside world. We had to update, reassure or console distressed families, whether through daily family phone calls, connecting patients' cellphones to the hospital WiFi or just spending time talking and encouraging the unwell – we had to become more than mere doctors. Despite the barriers of N95 masks, face shields, gloves and aprons, we became very aware that no man is an island. Many of us benefited greatly from weekly peer-support sessions facilitated by colleagues from psychiatry. These were invaluable as a means of debriefing, and proved to be a highly effective means of accessing mental healthcare support. For some of us, this support was what got us through.

Healthcare worker infections

The number of SARS-CoV-2 infections among healthcare workers in SA was astonishing, with roughly 27 000 infected across the country by the end of the first wave. The impact was dramatic. "Am I burnt out or infected?" was a common refrain. Seeing a positive SARS-CoV-2 PCR result for patients is rather different to seeing your own positive result. Putting this into perspective, with an HIV test, one undergoes pre- and post-test counselling. When working in a pandemic with a novel

infection, this process doesn't happen. Having witnessed the severe effects of COVID-19 in hospitalised patients, it is easy to jump to the conclusion that the worst outcome is most likely. Being SARS-CoV-2 positive comes with a barrage of questions, the foremost being, "How sick will I become?" and "Will my family become infected?" We had the added problem of knowing that our infection would put further strain on the health system and in particular, our colleagues, who would have to pick up extra calls, see more patients and take on further clinical duties while we recovered. This is an experience none of us ever want to relive.

Surfing waves differently

At the end of the first wave, we felt a sense of pride in the care we had delivered to patients. Having admitted approximately 2 000 laboratory-confirmed COVID-19 cases, our numbers came down to single digits inhabiting a single remaining COVID-19 ward. There was, however, the ominous awareness that our colleagues in Europe were starting to see their second wave. But even that could not prepare us for the variant-fuelled tsunami of patients that we soon experienced. The emergency departments were once again filled with breathless patients, and an eerie feeling of *déjà vu* descended.

The pervasive anxiety of the start of 2020 was gone, but it was replaced by exhaustion

and emotional trauma – as if a marathon runner, upon crossing the finishing line of a gruelling race, was ushered to the start line for the next race with burning lungs and heavy legs. Many healthcare workers suffered from depression, anxiety and PTSD. In the UK, ICU workers experienced higher rates of PTSD (39.5%) during COVID-19 than military personnel (6.2%).

The second wave came at the worst possible time, peaking sharply in late December at the beginning of the festive season. Gone was the first wave's whole-of-hospital response, and with it, the sense of "all in this together". The cumulative effects of 2020 meant that a large group of healthcare workers were exhausted, traumatised and suffering from burnout, with only a small fraction of the team that had stood up to meet the first wave there to meet the second. A sense of abandonment for those left behind was palpable, particularly for the junior doctors. Comments like "a viral pneumonia is a medical problem" were wounding. The demoralising effect of this, together with the increased load of sick patients and increased

mortality compared with the first wave, was overwhelming. A much smaller team needed to cope with a larger number of patients, particularly after hours, than in the previous wave. It left us with deep sadness and a sense of shame, a stark contrast to the pride felt in what the hospital had achieved during the first wave.

Conclusion

COVID-19 has posed an immense challenge to junior and senior healthcare professionals alike. It has given us insights into dealing with uncertainty, and over two waves, differences in pandemic response to reflect on. The formation of teams with seniors and juniors from different departments working equitably together was a highlight of working during the last 14 months, but was unfortunately marginalised to a large extent during the second wave. Our pandemic preparedness for the third wave should re-ignite the whole-of-hospital response that was successful in the first wave.

We are grateful for the opportunity to serve on the frontline and care for patients

admitted with COVID-19, as well as for the unexpected opportunities for personal growth and development it has brought us. We were able to serve the public in a historic global crisis, and are forever changed by it. It gave us an insight into and appreciation of SA's other recent epidemic, HIV, and what our senior colleagues may have experienced prior to the rollout of antiretroviral therapy.

We mourned the loss of patients and colleagues, and saw others pull through against unimaginable odds, celebrating those successes as they came. However, the mental health insults that the last year has brought should not be underestimated, and must be addressed in the hospital's *modus operandi* for the third wave.

Burnout and fear of recontracting COVID-19 pervade the wards and corridors of GSH. Will the third wave be worse? Will we be able to cope? When will we all be vaccinated? What if there are few satisfactory answers for these questions?

References available on request.

SAMA on its NHI submission to the health PPC

SAMA Communications Department

On 1 June, SAMA reaffirmed its stance on the proposed National Health Insurance (NHI) during its submission to the parliamentary portfolio committee (PPC) on health, saying that while it supports some provisions, others lack essential detail, which has far-reaching consequences for NHI implementation. In principle, SAMA supports universal health coverage (UHC), and the coverage of the whole population for a well-developed healthcare benefit that is not based on the ability to pay for care.

However, SAMA cannot support the NHI Bill in its entirety. The association expressed concerns in relation to the draft NHI Bill that is currently in Parliament, as it did for the draft 2018 Bill and the policy documents that preceded this piece of legislation.

It is challenging that much of the NHI detail will be in the regulations and rules, which are yet to be developed and therefore cannot be commented on.

In its submission, SAMA again stressed that it believes the legal establishment of an NHI office and structures will be of benefit

to driving the processes required for UHC forward. This office will provide dedicated staff and structures to address the NHI funding mechanisms, while leaving the staff within the National Department of Health (NDoH) to focus on their primary objectives – the delivery of healthcare to the nation.

SAMA cannot support the NHI Bill in its entirety

SAMA does not, however, support the governance structure as laid down in the NHI Bill, as it believes that the Minister of Health has too many unfettered powers in this structure. It further believes that the fund should be accountable to the NDoH and vice versa. This is closer to a true purchaser-provider split as originally envisioned in the NHI policy documents.

SAMA remains concerned about the current significant quality deficits in the

public sector, and believes that these will simply be incorporated into the new world of the NHI if significant strides in addressing these are not made first. As the parliamentary public hearings have served to emphasise, communities and facilities lack basic infrastructure, staff and support systems to run quality healthcare provision. SAMA remains engaged in multiple projects to improve the quality of healthcare delivery, but these appear to be divorced from the need for an NHI.

SAMA can also not support the Bill's approach to asylum seekers and illegal foreigners, given that these very vulnerable groups will only be entitled to emergency medical services and services for notifiable conditions. The children of these groups will also only have limited access to healthcare. Doctors do not distinguish the need for care on the basis of legal status in the country, and it would be unethical for them to do so. SAMA cannot accept the situation for these groups unless there is a proposal for how their care will be funded and provided.

SAMA is also concerned that the proposed payment and contracting mechanisms for healthcare providers are on the verge of being signed into law. SAMA is in favour of evidence-based policy and law, and there is far too little detail provided on these payment mechanisms to engage with them at this stage. The NHI pilots from 2012 to 2016 did not test these proposed mechanisms, and

SAMA believes that before these are signed into law, the NDoH needs to do significant work piloting these ideas and testing whether they will function for the positive benefits of patients under NHI.

As a membership organisation, SAMA remains worried about the uncertainty and anxiety that these vague aspects of the Bill are generating among its membership,

medical doctors in training and learners considering medicine as a career. SA already suffers from a shortage of medical doctors, and SAMA is of the view that it needs to work extensively with the government to ensure that the proposals for the NHI are feasible and developed further, for the sake of certainty as well as in the best interests of serving the public.

Surviving grief

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



Grief is an intensely private experience that is often on public display. It leaves us raw and exposed because it makes us vulnerable. Keep in mind that grief is a normal and universal reality that is part of the human experience.

How do we cope with the pain of grief?

Rather than denying it, it is better to acknowledge grief every day that it remains with you. It is similar to having to carry a heavy load to a specific destination. You cannot dismiss it from your awareness because the enormity of the loss and the pain permeates your experience of this loss. So you suffer the pain while walking with the heavy load, knowing there will be some degree of relief when you eventually reach the end of your journey. Even when you get there and can put your load down, you may still feel the after-effects of having had to carry that load, which may, for example, be sore and stiff muscles from the long road you walked

while carrying the load, but there should still be some degree of relief. Similarly, over time, you may adapt to living with the loss and grief, and you will most likely find a way to go on with your life, but the pain can linger long after. It is the acuteness of it that will blunt over time. Exactly when the acuteness of the pain becomes less prominent differs from person to person.

Tips

Take each moment as it comes. The pain usually comes and goes in waves, but the loss stays on your mind, even when you are not consciously focusing on it. There will be times when you feel a strong yearning for your loved one. That is normal. Treasure the good memories that will often come as you remember what you shared while they lived. If practical for you, start a memory box for yourself that you can fill with valued reminders that may have a special meaning for you or your loved one. Over time, you may fill it with photos, quotes or favourite sayings, songs or special moments. You may need to engage more and more with your memory box and these tangible things as the loss sinks in. Use as many of these reminders or tokens as is practical to feed your memory box, which can be something tangible such as a decorated shoe box with photos, a collection of photos on your phone, or birthday cards, for example.

Spend dedicated time per day, even if it is just a couple of minutes, honouring the memory of your loved one. Sometimes we reminisce with friends or family to help and support us through this. This helps the healing process. This is at the heart of the so-called "after tears" commemoration that is prevalent in some communities, where

loved ones get together to "party" in memory of the late relative or friend. Find some way of expressing gratitude for having shared the good memories with your loved one before they passed. This can be private or shared with other loved ones. More importantly, be patient with yourself, because getting used to living with the loss and adapting to your new life without your loved one takes time. Give yourself that time.

Surviving the pain of grief is the eventual goal, irrespective of what the loss is

It may help to view your healing process as similar to the development of a child who learns to sit, then crawl, stand and finally walk. By looking at the process of grief through the lens of milestones, you may be able to understand your progression through such milestones in a more patient way. Although getting through these milestones may not take the pain away, it can make it possible for us to bear the acuteness of the pain while it remains overwhelming. How we move through the milestones does not occur in any particular order. An example of the milestones of processing grief is outlined below:

- accepting the reality of the loss
- processing the pain of grief
- adjusting to the world without your loved one
- finding an enduring connection with your loved one despite them not being with you any more.

Accepting and living with the reality of losing someone you love can be a very hard task to achieve, because our instinct is to deny, reject or refuse to accept the reality, often because it is too overwhelming in the beginning. Although we may take some time to accept the loss of our loved one, we are forced to accept the reality of the loss, because we are confronted with this almost immediately. From funeral arrangements to messages of condolences, the reality of the loss is never more in your face than immediately following death. It is okay to be numb, to not cry in the first few hours or days after the loss. That is how some of us cope.

How else can we cope?

- Take it one day at a time, from moment to moment.
- Accept all the help we can get, especially with practical day-to-day things that need doing after the bereavement.
- Take moments to be alone, however short, so you can breathe, cry, shout and do whatever you need to do to confront the pain as you process the loss. It will hurt. That is the nature of death and bereavement.
- Take time to be with loved ones who are experiencing the loss with you. Pain shared is not less acute but may be more bearable.

- In the beginning you will think of nothing else except the loss. Use it to help you bear the pain. Start the memory box for your loved one during the acute stages.

Surviving the pain of grief is the eventual goal, irrespective of what the loss is. How one grieves is an individual process that has no right or wrong path. The important aspect lies in recognising it as a process that takes time, and finally, in making sure that while you are going through it, you do so in a way that does not bring additional harm to yourself or others.

HPCSA remarks on funding mechanism for NHI concerning

SAMA Communications Department

Remarks on the funding mechanism for National Health Insurance (NHI) by the president of the HPCSA to the parliamentary portfolio committee (PPC) on health are concerning, and require clarification.

SAMA says it has written to the president of the HPCSA, Prof. Mbulaheni Nemutandani, and the HPCSA council seeking answers to the statements that were made.

Prof. Nemutandani was quoted by several media outlets as saying that the current reserves of medical aid schemes must be transferred to the NHI, that the Medical Schemes Act No. 131 of 1998 must be abolished and that the NHI should be the only health funding mechanism in SA.

Prof. Nemutandani was also quoted as saying that medical aid schemes should not be allowed to exist, and that healthcare should be funded entirely by taxes paid to the NHI by every employed person in the country.

"Prof. Nemutandani's remarks are concerning on several levels. Firstly, we are not aware of any consultation between the HPCSA and healthcare providers or funders on this issue. Submissions such as these have wide-ranging implications – especially from the most senior representative of country's health regulatory body. We have written to Prof. Nemutandani and the HPCSA council asking for clarification on these matters," says Dr Angelique Coetzee, chairperson of SAMA.

Dr Coetzee says that among the issues Prof. Nemutandani and the council have been asked to clarify are whether his remarks to the PPC on health are accurate, and whether they reflect his personal or the collective views of the HPCSA.

"If the comments by Prof. Nemutandani echo those of the HPCSA council, we have a right to know how they arrived at this decision. We have therefore asked for the minutes of the meeting where the funding mechanism for NHI was discussed and accepted. We've asked that those minutes also be shared with members of medical aid schemes to give them insight into how such a decision was reached," explains Dr Coetzee.

In the letter, SAMA has also asked how, if the submission was not sanctioned by the HPCSA council, but rather reflects the personal views of Prof. Nemutandani, the council will respond.

"If these are Prof. Nemutandani's personal views we believe he has acted *ultra vires* – he has overreached his mandate. If this is the case, this would be highly unacceptable, and Prof. Nemutandani would have to explain why he is using a platform granted to a public institution to make highly contentious personal remarks. He is the president of the HPCSA, and these sentiments will have enormous consequences for members of medical aid schemes, patients and doctors," notes Dr Coetzee.



Dr Angelique Coetzee

She says that SAMA remains committed to the achievement of universal healthcare in SA but that it has, on several occasions, through submissions to parliament and in comments in the media, made it known that certain key details of NHI remain unresolved, and could derail effective implementation.

Dr Coetzee further notes: "We have always supported the principle of NHI, but believe there should be the utmost transparency from all role-players on the best way forward. If bodies such as the HPCSA make far-reaching decisions that have such severe implications as outlined in Prof. Nemutandani's submission, we all have a right to know what motivates these decisions, and how they were reached."

CMS convenes the industry to debate introduction of low-cost benefit options within the medical schemes environment

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



The debate and discussion about the introduction of so-called “low-cost benefit options” (LCBOs) into the medical schemes environment has been a long one.

As far back as 2005, the ministerial task team on social health insurance and the Council for Medical Schemes (CMS) established a consultative investigation into low-income medical schemes (LIMS), with the objective to consult widely with health sector stakeholders in order to establish the main obstacles to extending medical scheme coverage to low-income households, and to propose solutions to overcome these obstacles.

The key recommendations of the LIMS consultative process were as follows:

- LIMS should be open to any formal sector employee or self-employed person who earns less than ZAR6 500 per month, in 2005 terms, and their dependents.
- New schemes and new benefit options within existing schemes should provide LIMS.
- Employers and employees should each make a 50% contribution to the premium, and the employee's share should not exceed 5 - 8% of household income.
- Government should directly subsidise LIMS membership contributions.
- The proposed LIMS minimum benefit package related to acute and some chronic outpatient or ambulatory care, and LIMS members, would be expected to obtain

inpatient care from a public hospital at no cost.

- LIMS schemes should be kept entirely separate, or ring-fenced, from other medical schemes, and no cross-subsidies with other schemes would be allowed or facilitated through a risk equalisation fund.

The LIMS recommendations were never implemented as part of an initiative to extend medical scheme cover to low earners, as the national government began to actively pursue the national health insurance (NHI) agenda after the national elections of 2009.

Then, in 2015, the CMS issued a circular announcing that it was considering the introduction of a guideline that would allow medical schemes to introduce LCBOs. The guideline would aim to provide schemes with the requirements of a proposed framework to be adopted by the CMS to allow the introduction of LCBOs in the medical schemes environment.

Similar to the objectives of the LIMS initiative, the LCBOs would aim to attract the approximately 6 million (or 15 million including dependents) people who were in formal employment at the time, but who did not have medical scheme coverage. This was in a bid to increase the proportion of the population covered at least to some extent by a prepaid mechanism of medical insurance.

This initial announcement was followed by several draft proposals and an LCBO framework, and even guidelines to medical schemes on how to prepare a business plan for LCBO options and apply for exemption from the current Medical Schemes Act No. 131 of 1998, to enable the implementation of these options.

In the interim, in 2017, the National Treasury released final demarcation regulations in the Government Gazette. The regulations were the outcome of the consultative process between the Minister of Finance, the Minister of Health, the CMS and the Financial Services Board (FSB).

These regulations affected medical insurance products operating outside of the Medical Schemes Act framework.

The regulations specified which types of contracts were to be regulated under the Long-term Insurance Act No. 52 of 1998 and the Short-term Insurance Act No. 53 of 1998 as health policies, as well as accident and health policies, and which were conducting the business of a medical scheme in terms of the legislation definition, and should thus be registered as such.

In effect, the regulations permitted insurers to continue to provide gap cover plans and hospital cash plans, provided they were structured in a way that complemented medical schemes, and were subject to strict underwriting and marketing conditions. The regulations did not allow insurers to continue to provide primary healthcare insurance policies, as these were considered to fall under the Medical Schemes Act, meaning that such schemes should be registered as medical schemes.

Also in 2017, the CMS granted a 2-year exemption for existing primary healthcare insurance policies, while further research was done in terms of developing a LCBO guideline, to allow such policies to be accommodated within the Medical Schemes Act regulatory framework.

A number of exemptions were granted to existing products at the time, but these had to be extended until March 2021, and again until March 2022, while the policy development process has been ongoing.

In 2020, the CMS announced its intention to set up advisory committees to undertake the processes of serving as a platform for engagements on the draft LCBO framework that the CMS had developed, and eventually providing the inputs on the LCBO framework before it is submitted by the CMS for approval by the Minister of Health.

The coronavirus (COVID-19) pandemic and subsequent national lockdown resulted in the delay of these processes, but committees were nevertheless established and began meeting towards the end of 2020.

By February 2021, four work streams had been established to work on various aspects of the introduction of a new framework to provide LCBOs:

- market affordability: to establish the quantum and ability to pay of the currently uninsured but employed market
- benefit package product development/pricing: to decide what can and should be included in such basic benefit packages, given affordability considerations
- legislative requirements: to examine the existing and necessary enabling and hindering legislative factors that may impact

- on the establishment of such benefit options
- implementation and risk: to examine the implications and challenges of implementation of the proposed plans.

SAMA has joined this process to contribute particularly towards the benefit package development and legislative package work streams, to ensure that any products that are developed during this process adequately

meet the clinical needs of the patients they are designed to serve, and to ensure that no legal structures that are developed would see medical practitioners put in a situation where they are expected or incentivised to act in contravention of HPCSA ethical rules.

Initial issue discussion documents are under development, and will soon be presented to the work streams at sessions set to take place in June 2021.

Self-care empowers patients to manage their own health

Dr Roopan Gill, *MSF women's health advisor, obstetrics and gynaecology*



The concept of “self-care” might sound like a strange one for a doctor and women’s health advisor such as myself to be discussing. But self-care is not just about spas and meditation – it’s also a form of healthcare. If you’ve ever taken an at-home pregnancy test, used a fertility tracking app or managed your asthma symptoms using a puffer, you’ve practised self-care.

Self-care sits within a patient-centred approach to health, which means caring for people in a way that is meaningful and valuable to them. Doctors Without Borders (Médecins Sans Frontières; MSF) is strengthening the patient-centred nature of our care to truly put patients at the core of our work. As the WHO highlights, this model sees people as active decision-makers in their health, rather than mere recipients of services.

Self-care is an opportunity to improve patient-centred and quality care through empowering people with the knowledge,

autonomy and choice to access safe, effective and timely care, with support from a skilled healthcare provider if and when they need it. Under the WHO’s debut self-care guidelines (2019) developed for sexual and reproductive health (SRH), self-care ranges from health promotion to disease prevention and control to self-medication and other services involving medicines, devices, diagnostics and digital products, which are provided fully or partially outside of formal health services.

MSF has implemented self-care initiatives in several of our SRH programmes, including self-injectable long-acting contraception Sayana Press in the Democratic Republic of Congo, and a human papillomavirus self-sampling trial in our cervical cancer project in Zimbabwe.

In places where people are cut off from health facilities due to remoteness, conflict, poverty or a lack of infrastructure or resources, self-care can help to meet their health needs. For women seeking SRH services such as contraception or safe abortion care, which are often highly stigmatised, self-care gives them the tools to care for themselves in the privacy of their homes. It also helps women who face discrimination in the formal health system (because of their medical condition or identity) to have access when they may otherwise resort to unsafe care or none at all. Crucially, self-care promotes women’s agency to manage their own bodies.

For self-care approaches to be effective, however, we need to gather perspectives directly from patients on how the care works for them.

Evidence-based self-care is low risk and leads to good health outcomes when offered alongside traditional health services. In some contexts, women will choose self-care even when a trustworthy health provider is an option: it is important to provide the choice. As health workers, it is essential that we identify our biases, and MSF is driving training for our staff to help them integrate self-care options with existing models of care.

COVID-19 has been devastating globally, but has also presented opportunities to bring healthcare to people using innovative and novel patient-centred approaches. High-income countries such as Canada have removed regulations to increase virtual and telemedicine access to safe abortion care, for example. Self-managed medication abortion facilitated by hotlines, abortion accompaniment models (phone-based support by trained volunteers) and web-based tele-abortion services – already used in places where abortion is stigmatised or criminalised – have enabled this lifesaving care to continue during COVID-19.

MSF sees the potential for pioneering quality, patient-centred care for women in crisis-affected contexts, with self-care models facilitated through community-based programmes and digital methods such as telemedicine, hotlines, SMS services, mobile apps, web-based platforms and peer-to-peer support. We can truly place women at the centre of care by trusting them to play a more active role in decisions that affect their own health and bodies.

WMA policy provides guidance on dealing with family violence as doctors

Bernard Mutsago, researcher, SAMA Knowledge Management, Research and Ethics Department



Family violence is a grave universal public health and human rights problem that affects individuals regardless of age, gender, race, ethnic background, culture, religion, socioeconomic status or any other defining factors. It is a social determinant of health.

In these extraordinary times, characterised by a rising tide of violence, the World Medical Association (WMA) statement on family violence, first adopted by the 48th WMA General Assembly in Somerset West, SA, in October 1996, becomes an important guide to doctors. The statement defines family violence as “physical and/or emotional mistreatment of a person by someone in an intimate relationship with the victim. The term includes domestic violence (sometimes referred to as partner, spouse, or wife battering), child physical abuse and neglect, child sexual abuse, maltreatment of older people, and many cases of sexual assault”.

The statement rightly notes that family violence has adverse physical, mental, emotional and psychosocial consequences on the individual, as well as the family and community, and socioeconomic impacts. These impacts could be short-term/immediate or long-term/chronic impacts such as lifetime disabilities. They include physical harm/injuries, impact on reproductive health/miscarriage, dysfunctional families, educational disruptions and poor academic performance, sexually transmitted diseases, juvenile delinquency and homelessness, insomnia,

anxiety, depression, substance abuse and crime, post-traumatic stress disorder, homicide and suicide. Victims often become perpetrators of family violence, including violence against non-intimate members.

The statement suggests several interventions to deal with family violence, requiring the involvement of both medical associations and doctors in local and national activities designed to decrease family violence. At a national medical association level, doctors’ associations are expected to encourage and facilitate co-ordination of action against family violence between and among components of the healthcare system, criminal justice systems, law enforcement authorities, family and juvenile courts and victims’ services organisations. They should also support public awareness and community education, as well as encourage and facilitate research to understand the prevalence, risk factors, outcomes and optimal care for victims of family violence.

Doctors’ roles are at the crux of the WMA statement, which recognises their tremendous ability to influence victims and perpetrators of family violence. As such, the statement avows that “physicians should be encouraged to develop non-judgemental attitudes toward those involved in family violence ... the behaviour should be judged, but not the person.” Doctors are charged to be acutely aware of the need to maintain confidentiality in cases of family violence.

The statement places a high premium on doctors’ training for effective management of family violence. It recommends that all physicians receive adequate training in the medical, sociological, psychological and preventive aspects of all types of family violence. This includes medical school training in the general principles, specialty-specific information during postgraduate training and continuing medical education about family violence. Trainees must receive adequate instruction in the roles of gender, power and other issues of family dynamics in contributing to family violence. The training should also include adequate collection of evidence, documentation and reporting in cases of abuse.

Training will also enable other competencies recommended by the statement, namely the ability to take an appropriate and culturally sensitive history of current and past victimisation, as well as being able to routinely recognise and be sensitive to signs indicating the need for further evaluation about current or past victimisation as part of patients’ general health screening, or in response to suggestive clinical findings.

Addressing the root causes is critical in SA

It is also prudent for doctors to be aware of social, community and other services available to victims of violence, and use these routinely to refer victims. Furthermore, the statement places the obligation on doctors to consider reporting suspected violence against children and other family members who do not have legal capacity to the appropriate protection services.

Performing standard medical professional roles in the usual healthcare settings is not enough. The statement urges medical doctors to go a step further. Physicians are urged to participate in co-ordinated community activities that seek to reduce the amount and impact of family violence.

The WMA statement on family violence is an important policy guide for the medical profession in SA. It is encouraging to see the policy-level commitment of the medical fraternity in partnering with other players to reduce family violence. However, what seems to be overlooked in many settings is the importance of dealing with the underlying causes of family violence, that is, a preventive approach. This is the essence of the social determinants of health approach. Addressing the root causes is critical in SA, where violence against partners, women and children is vast in scale. SAMA can play a significant role of influencing the SA government to address the underlying structural causes of violence, and supporting existing initiatives against it.

COVID vaccine hesitancy: Spell out the personal rather than collective benefits to persuade people – new research

Daniel Freeman, *professor of clinical psychology, University of Oxford*

Approximately 10% of UK adults say they will never get vaccinated against COVID-19, or will avoid doing so for as long as possible. Scientists call this group the “vaccine hesitant”, though hesitancy may not seem the right term to describe views often held with clear conviction. People who are vaccine hesitant have often thought long and hard about whether to take a COVID-19 vaccine.

How can such views be shifted? Ideally, one would sit down with people, listen and discuss. In reality, public health campaigners have only mass messaging at their disposal: information disseminated through billboards, TV slots and social media. These are crude tools for tackling sometimes deeply ingrained personal beliefs. What messages delivered through them might really make a difference?

Over the past year, the Oxford Coronavirus Explanations, Attitudes and Narratives Surveys (OCEANS) team has tried to answer this question. We’ve worked to form a psychological explanation for vaccine hesitancy by canvassing the views of people for, against and undecided about vaccines.

We’ve found that hesitancy emerges from a nexus of beliefs, the most important being scepticism about the collective benefits of vaccination. The hesitant don’t accept that taking a vaccine means we’re all better off. They also tend to believe that COVID-19 isn’t a big danger to their health. And they worry that vaccines may be ineffective or downright harmful. The rapid development of COVID-19 vaccines reinforces these concerns.

Behind these specific ideas often lies mistrust. People who are hesitant tend to be suspicious of authority. But while it’s wise to make judgements based on evidence rather than blithely accepting what we’re told, in many cases we’ve found that the vaccine hesitant are susceptible to misinformation.

Fuelling this may be a sense of marginalisation. Vaccine-hesitant people are a little more likely to believe that they’re of lower social status. Feeling that society doesn’t care about them, they are unwilling to trust what they’re told by politicians and scientists.

Getting personal

Equipped with these insights, we decided to see whether we could craft messages that might shift negative attitudes. If people don’t appreciate the collective benefits of vaccination, let’s persuasively set out the case. Let’s explain that vaccines make it less likely we’ll pass on the virus, helping to protect others, particularly those especially vulnerable to the virus. And let’s make it clear that by reducing the risk of getting severely ill, we can help the country bounce back as quickly as possible. That should help shift attitudes, right?

To find out, in early February we surveyed nearly 19 000 UK adults, carefully selected to be representative for age, gender, ethnicity, income and region. Participants were then randomly asked to read 1 of 10 texts about COVID-19 vaccines.

Some texts focused on the collective benefits of vaccination, some on the personal benefits, some on safety and some on a combination of messages. One text contained only basic information about the vaccine and didn’t provide any detail on benefits, and was used as a control. After reading their allocated text, participants completed a questionnaire on their willingness to be vaccinated for COVID-19.

The results were surprising. Previous surveys had suggested that beliefs about the collective benefits of vaccination were pivotal to driving uptake. The extent to which people bought into this narrative seemed to determine their willingness to take a vaccine.

But the text that was most likely to change the minds of the vaccine hesitant (when compared with the control) emphasised not the collective but the personal benefits of vaccination. It pointed out that you can’t be sure that you won’t get seriously ill or struggle with long-term COVID-related problems, and that vaccination will minimise your chances of falling ill.

Months of media coverage in the UK has instead focused on collective responsibility – that we owe it to our fellow citizens to get vaccinated. But for the sceptical 10%, this hasn’t cut through, which is perhaps to be

expected. If you think vaccines are unsafe, then you’ll be worried about what getting the jab will do to you. Your decision-making then becomes dominated by personal risk.

The best way to counter these concerns, therefore, is to highlight the opposite: personal benefits – and our new research suggests this could well work. It’s also probable that for a group that’s more likely to feel socially excluded, messages that focus on the personal rather than collective ramifications of COVID-19 will be more compelling.

What about the view that the vaccines have been developed too quickly? It’s an understandable fear: these vaccines have been produced with unparalleled speed. In response to this, one text in our study explained that the speed of development reflects the exceptional commitment, investment and co-operation of scientists, governments, public health organisations and pharmaceutical companies – as well as of the tens of thousands of members of the public who volunteered to test the vaccines.

This text noted too that side-effects that affect a significant proportion of people don’t suddenly appear months and years after vaccination. Because of the way vaccines work – quickly training the body’s immune system to fight off a virus – any issues arise within a month and usually much sooner. Happily, this information did seem to reassure people and helped reduce hesitancy.

COVID-19 is unlikely to disappear in the foreseeable future, which means vaccination messaging will remain of critical importance. When it comes to persuading the vaccine hesitant, our research shows that we need to listen, understand concerns and address them seriously. No message will be truly effective if the messenger has not earned trust, nor if it doesn’t account for the desires and worries of those receiving it.

Source: The Conversation, 13 May 2021: <https://theconversation.com/covid-vaccine-hesitancy-spell-out-the-personal-rather-than-collective-benefits-to-persuade-people-new-research-160824>.

Overcoming cognitive bias through critical thinking

Dr Gustaaf Wolvaardt, Dr C J Henley-Smith, FPD School of Education

A health professional relies on years of training and experience to make judgement calls in moments of action and increased stress. This is more applicable during the COVID-19 pandemic than ever before. Often our gut instinct or “intuitive response” cannot be explained to someone else in detail, but when proven right repeatedly, we come to rely on this way of thinking, not only for work but in our other daily activities. But this intuitive response comes with a warning label! It can be influenced by cognitive biases.

A cognitive bias can be described as a systematic error in thinking that affects the decisions and judgements that we make. There is a danger in that our biases can influence our beliefs, and our beliefs can in turn shape our actions. Understanding our biases can help in moving away from relying purely on the intuitive response, and delving deeper into critical thinking. Critical thinking is described as disciplined thinking that is clear, rational, open-minded and informed by evidence.

Some biases that could unknowingly be influencing your thinking are confirmation bias, the halo effect and outcome bias.

Confirmation bias is the tendency to search for, interpret, favour and recall information that confirms or supports one's prior beliefs or values. We tend to surround ourselves with like-minded people, and to manipulate information subconsciously to confirm our existing opinions and beliefs.

We are also all guilty of the halo effect, where we may instinctively like or dislike everything about someone, even their decisions. The halo

effect is near instantaneous, and not based on things we may have observed. It therefore is based on extrapolation only.

The outcome bias activates when we evaluate the quality of a decision that was made in the past when the outcome of that decision becomes known, especially when the outcome has triggered criticism if it happens to produce a bad rather than good outcome. Once the outcome is known, you are unable to recall what you used to believe and based your decision on. Your memories are essentially “overwritten”.

Our intuitive response comes with a warning label! It can be influenced by cognitive biases

So how can you counter biases and the unintentional impact they could have on your decisions? First, you need to recognise your own cognitive biases. The best way to do this is by engaging with other people. We tend to be better at recognising someone else's intuitive errors than our own, and this can help reveal our own biases, such as confirmation bias. Make an effort to engage with a variety of people, to prevent inadvertently engaging only with like-minded people who share your bias. Self-reflection is also a key component to

evaluating whether any of your decision-making has been affected by cognitive biases.

To counter the halo effect, ask people to provide their opinions in writing before a discussion takes place, especially if a decision needs to be made based on the discussion. If you are recognised as a leader of the group, rather share your opinions at the end of a discussion.

When it comes to outcomes bias, the end effect is that your memories are overwritten, so it is important to ensure that the decision-making process is recorded or captured in the moment. Analysing the process after the outcome is ineffective.

Engaging in critical thinking requires more effort than relying on your intuitive response, but understanding your cognitive biases and other triggers that could be affecting your thinking can help you achieve critical thinking more regularly. Have you experienced situations where you are so focused on a task that time seems to slip by unnoticed? This is the basis of a flow state, and these are times when it is also easier to think critically.

If you would like to know more about how to overcome cognitive biases and achieve flow states to help critical thinking and your overall decision-making, the Foundation for Professional Development (FPD) offers a MasterClass on Critical Thinking. The course is offered either online to enable self-paced learning, or through a 2-day virtual session to engage participants in further discussion.

References available on request.



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What constitutes unfair discrimination in the workplace: Unpacking the legalities

Bertha Shabangu, legal advisor, SAMA Employee Relations Department

SA has a long history of dealing with issues around workplace discrimination. There are strong indicators that workers continue to suffer discrimination on various grounds at their places of work. Almost 26 years into democracy, despite the fact that in accordance with the SA Constitution, all persons are equal before the law and cannot be discriminated against on the grounds of race, gender, sex, pregnancy, marital status, age, religion and birth, among other characteristics, the Commission for Conciliation, Mediation and Arbitration (CCMA) and courts have seen an increase in discrimination disputes emanating from the relationship between employers and employees.

The fact is that directly or indirectly, employees experience discrimination in various ways in their places of work. Although discrimination is almost always deemed to be unfair, it may also be considered fair in some instances, and is then in accordance with the law. For instance, the Employment Equity Act may deem it fair to appoint a female candidate into a particular positions where affirmative action requirements were set. This article outlines what unfair discrimination means with particular reference to the workplace.

Direct and indirect discrimination

It is important to note that there are two forms of discrimination related to unfair discrimination, namely direct and indirect. Direct discrimination occurs when adverse action is taken against people specifically because they possess one of the characteristics listed in section 6 of the Employment Equity Act No. 55 of 1998 (EEA), or attributes akin thereto.

Indirect discrimination occurs when the employer utilises an employment policy or practice that appears neutral at face value, but disproportionately affects members of disadvantaged groups in circumstances where it cannot be adequately justified.

The concept of indirect discrimination has had a considerable impact in the context of employment law, challenging a range of neutral requirements or conditions set by employers for employment such as

transfers, promotions or other benefits due to employees. The court, in *Association of Professional Teachers & Another v Minister of Education & Others* (1995) 16 ILJ 1048 (IC), held that the prohibition of unfair direct discrimination makes it clear that the focus should be on the individual, and it precludes the treatment of individuals as implied components of a racial, religious, sexual or national class. The court further stated that “an intention to discriminate need not be present.” The impact of the discriminatory practice is the decisive factor.

Legislative provisions

SA labour law contains adequate legislation and regulations as well as case law that protects employees against unfair discrimination in the workplace.

Firstly, the Promotion of Equality and Prevention of Unfair Discrimination Act No. 4 of 2000 (PEPUDA) defines discrimination as “any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly:

- (a) imposes burdens, obligations or disadvantage, or
- (b) withholds benefits, opportunities or advantages from any person on one of more of the prohibited grounds.”

Section 6 of PEPUDA further provides that neither the state nor any person may unfairly discriminate against any person.

Secondly, the Constitution, the supreme law of the land, also makes provision for every employee’s Constitutional right to fair labour practice, as per section 23. Section 9 also makes it clear that:

“(1) Everyone is equal before the law and has the right to equal protection and benefit of the law.

(2) Equality includes the full and equal enjoyment of all rights and freedoms. To promote the achievement of equality, legislative and other measures designed to protect or advance persons, or categories of persons, disadvantaged by unfair discrimination may be taken.

(3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social

origin, colour, sexual orientation, age, disability, religion, conscience, belief culture, language and birth.

(4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.

(5) Discrimination on one or more of the grounds listed in subsection (3) is unfair unless it is established that the discrimination is fair.”

Thirdly, the EEA is particularly important considering that its purpose is to promote equal opportunity and fair treatment in employment through the elimination of unfair discrimination. As stipulated in section 6(1) of the EEA, no person may unfairly discriminate directly or indirectly against any employee in any employment policy or practice. Such discrimination includes race, gender, sex, pregnancy, marital status, family responsibility and age. The list is not exhaustive.

The EEA further states that harassment of an employee is another form of unfair discrimination, and therefore prohibited on any one or a combination of grounds of unfair discrimination listed in subsection 1 of section 6.

The courts’ approach to discrimination

The *Harksen v Lane NO and Others* (1997) 11 BCLR 1489 (CC) test requires the court, in its determination of an unfair discrimination enquiry, to consider first whether there has been discrimination at all. The Constitutional Court has said that if the differentiation in question is based on a specified or additional ground, it is presumed to be discrimination. The labour courts have adopted this approach for years, but it has been suggested that it is incorrect. This is because different treatment does not necessarily constitute an act of discrimination. Discrimination occurs when differentiation is made on illegitimate grounds. Once a claimant in a discrimination case has established differentiation, the basis of the claim has been laid.

One of the first cases determined under section 6(4) of the EEA, as amended, is *Ndlela & others and Philani Mega Spar* (2016) 37 ILJ 277 (CCMA). Here, the question was whether

an employer who offered membership of a provident fund only to employees with 5 or more years of service unfairly discriminated against employees who had worked for less than 5 years. Accordingly, was discrimination on the basis of length of service justified? The applicants, all of whom were employed by the respondent for less than 5 years, argued that the differentiation based on length of service was arbitrary, and thus amounted to unfair discrimination.

The respondent sought to justify the differential treatment on the basis that offering membership of a provident fund to longer-serving employees was to reward them for long service, and to encourage them to remain with the company. The benefit was therefore designed as a retention and reward mechanism, and accordingly, it was argued, the differential treatment was reasonable,

logical and not unfair, and thus not without reason or justification.

The commissioner emphasised that the benefits connected to membership of a provident fund stretch further than other, more traditional reward and retention mechanisms, such as additional leave or a special bonus for long service. Although the EEA regulations recognise that seniority and length of service may be justifiable grounds for differentiation, the question was whether the provision to specific employees of a benefit that includes retirement savings and funeral and disability benefits, on the sole basis of length of service, was rational and justifiable. In this case, unfair discrimination could not be proven.

Often employees fail to prove that they have been victims of unfair discrimination beyond reasonable doubt because the

employer has produced sufficient evidence to disprove the alleged discrimination. In *Ntai v SAB* (2001) 22 ILJ 214 (LC), the labour court dismissed an equal pay claim on failure by the applicants to produce sufficient proof of alleged unfair discrimination on the grounds of race or alternatively arbitrary grounds.

Conclusion

I hope this article will adequately remind or educate employed doctors of their right not to be unfairly discriminated against, as well as their right to be protected against unfair discrimination. It is, however, worthy of note that not all acts of discrimination are unfair.

SAMA members are urged to get in touch with the Employee Relations Department for advice and/or assistance with work-related issues, at labour@samedical.org.

Mobile health service launched for remote workers

SAMA Communications Department

A partnership between Twinings, an international tea company based in the UK, and the Pebbles Project, a registered NPO, has been formed to provide access to healthcare services through a mobile health clinic. The partnership is part of "Sourced with Care", which is Twinings' responsible sourcing programme.

The mobile health service will support around 800 farm workers and their children on a number of UTZ-certified* rooibos tea farms in the Clanwilliam and Citrusdal area, with wellness screenings, routine health check-ups, primary healthcare support, health and wellness workshops and over-the-counter health products. Health workshops will be presented on topics such as family planning, maternal health, hygiene, TB and HIV/AIDS, substance abuse and lifestyle diseases. UTZ is a global certification programme, part of the Rainforest Alliance, that promotes sustainable farming practices, which includes attention to the working and living conditions of farmworkers and their families. The Pebbles Project has 17 years' experience in supporting farming communities in the Western Cape, and this will be Twinings' first project located in SA.

Sophia Warner, CEO of the Pebbles Project, says the lack of access to quality healthcare poses a major challenge for those working and living in farming communities in remote

areas such as Citrusdal and Clanwilliam, where Twinings sources indigenous SA rooibos tea.

"Many farm workers do not receive regular health check-ups or receive the medical attention or information that they need in time, and consequently suffer risks of more serious health conditions that could have been prevented if treated earlier. Lack of knowledge and information can also contribute to health challenges which can impact on the individual's ability to work and care for their family."

"The goal of the project is to enable rooibos tea farm workers to take control of their health and to receive the medical support that they need. The service will be managed by Sr Lenay Zimri, who has 9 years' experience in community health and a deep passion for the upliftment of the community. Office space for the project and secure parking for the vehicle has been generously provided by Rooibos Ltd in Clanwilliam."

Warner says that they are excited to be partnering with Twinings, enabling the Pebbles Project to expand their reach into a new geographical area while working alongside a company that is truly committed to giving back to local communities.

Céline Gilart, head of social impact for Twinings, says their Sourced with Care programme ensures that the company sources responsibly, but also acts as a force for good to



Sr Lenay Zimri will manage the service

improve quality of life in the communities from which they source around the world.

Our vision is for healthier, happier, empowered and sustainable communities in our supply chain, and this partnership, enabling better access to healthcare, will help us achieve our vision."

The Pebbles Project, established in 2004, provides support and intervention in the areas of education, health, nutrition, community services and social protection to around 1 400 children in the farming communities of the Western Cape.

For more information about the work of the Pebbles Project and Twinings' Sourced with Care, please visit the websites www.pebblesproject.co.za and www.sourcedwithcare.com.

High expectations

The Medical Protection Society shares a case report from their files

Mr O was a 24-year-old man who had just enjoyed a holiday overseas. On the return journey, he started vomiting. The nausea and vomiting continued after he arrived home, and he began to lose weight because of it. When his symptoms did not abate he made an appointment with his GP.

His GP documented a 4-week history of nausea and vomiting and, after reviewing normal blood tests, referred him to a gastroenterologist. The gastroenterologist wrote back concluding that he had found no significant pathology on endoscopy or ultrasound, and that he thought that anxiety was contributing to his ongoing symptoms. Irritable bowel syndrome was also considered to be a factor.

Mr O asked his GP for a referral to a neurologist, which he agreed to. The neurologist arranged an MRI scan, which was normal, and said that he felt that Mr O was suffering from a significant depressive illness from which he had partly recovered. Mr O did not agree with this diagnosis and felt that his symptoms had a physical rather than a psychological cause. He did, however, agree to see a psychiatrist, who concurred that his symptoms were due to anxiety and depression. He prescribed venlafaxine and arranged cognitive behavioural therapy.

Mr O was struggling with fatigue in addition to the nausea and was not coping at work, so he visited his GP again. His GP referred him to a specialist in chronic fatigue, who wondered if he might be suffering from post-viral fatigue syndrome.

Mr O was convinced that there was a physical cause for his symptoms, and demanded a second neurological opinion. This was sought, but nothing abnormal was found on examination, repeat MRI or lumbar puncture. He had mentioned some dizziness, and had an audiometric assessment showing abnormal canal paresis to the right. The neurologist concluded in a letter to the GP that "the only abnormality found in spite of extensive investigations was a mild peripheral vestibular disorder." The letter detailed that he had been seen by a physiotherapist who had instructed him in Cawthorne-Cooksey exercises, and that he had been asked to continue these at home.

Despite doing the vestibular rehabilitation exercises at home, Mr O failed to improve. He still felt weak and light-headed, and moved back in with his parents who were worried about him. They made him another appointment with his GP, who referred him for an ENT opinion.

The ENT consultant took a detailed history and noted the absence of tinnitus, vertigo or deafness. She could not find anything abnormal on examination, and thought that a labyrinthine problem was unlikely to be the problem. She repeated the balance tests, which were normal.

Correspondence is an important part of the medical record

Years went by and Mr O became very focused on his symptoms, feeling sure that a diagnosis had been missed. Opinions were sought from an endocrinologist, a professor in tropical diseases and a private GP. Nothing abnormal could be found, and no firm diagnosis was made. A neuro-otologist thought that his symptoms were due to a combination of "anxiety with an associated breathing pattern disorder, a migraine variant and physical de-conditioning". A joint neuro-otology/psychiatry opinion concluded that it was "a confusing story with nebulous symptoms, but it was probably a variant of fatigue disorder with a depressive element and derealisation."

Mr O was very frustrated at the lack of diagnosis or improvement in his symptoms. He felt that the sole cause of his symptoms was a peripheral vestibular disorder. He made a claim against his GP, alleging that he had failed to make the diagnosis, and that he had also failed to arrange vestibular rehabilitation.

Expert opinion

The Medical Protection Society instructed expert opinion from a GP and a professor in ENT. The experts felt that Mr O's GP had not been at fault.

The professor in ENT was sceptical regarding the diagnosis of a vestibular disorder. He noted that repeat audiograms and tympanograms had been normal, and felt there was no robust evidence that Mr O had a peripheral vestibular

disorder. He stated that there was no clinical history suggestive of vestibular pathology at the onset of Mr O's illness. He also commented that there had been no consensus among various specialists as to the true cause of Mr O's symptoms, and that to claim that a peripheral vestibular disorder was the sole cause was an overly simplistic view.

The GP expert noted that the neurologist's letter to the GP referred to Mr O having been instructed by physiotherapists in Cawthorne-Cooksey exercises. These are vestibular rehabilitation exercises, so it was wrong to say that there had been a failure to arrange the exercises or that this was the responsibility of the GP. The expert explained that GPs are not trained to instruct a patient in vestibular rehabilitation exercises, and are not likely to have direct access to specialist physiotherapists who could arrange these. The expert noted that a large number of specialists saw Mr O over a prolonged period, all of whom failed to reach a consensus on the cause of his symptoms. The expert's view was that the treatment provided was reasonable and that the standard that the claimant sought to apply was too high.

Mr O withdrew his claim before it went to court.

Learning points

- The defence of this claim was helped by the contents of the correspondence to and from specialists, which were relied upon to disprove some of the allegations made. It is important to take the time to write comprehensive referral letters and to read letters from specialists carefully. Correspondence is an important part of the medical record, as well as being important communication between clinicians.
- Mr O clearly had a very difficult time. There had been a protracted period of time with no clear diagnosis. However, in the circumstances of this case, this did not equate to negligence.
- This case highlights the standard doctors must meet in order to refute negligence claims – that of a responsible body of their peers (GPs in this case), rather than a specialist in the condition in question.

SAMA branches don their socks – let's save lives

Now more than ever, mental health among healthcare workers is paramount. And on 4 June this year, our SAMA branches focused on breaking the silence and the stigma around mental health issues in the medical fraternity.

Since 2017, doctors worldwide have worn "crazy socks" on CrazySocks4Docs (CS4D) day in June. It began when an Australian cardiologist, Dr Geoff Toogood, wore mismatched socks to work and heard sniggering remarks behind his back. In 2017 he started the CS4D initiative: "The message needs to get out there that doctors need to look after each other, so that we can look after everyone else."

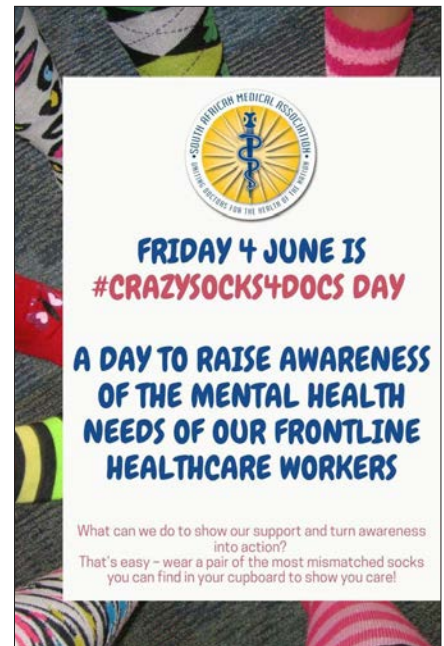
Why did he choose the word "crazy"? Because we often "call people with mental health issues 'crazy', and I wanted to make crazy fun – instead of the mental health connotation."

Crazy Socks Day has been acknowledged in SA since 2018, with doctors and medical students wearing colourful mismatched socks to promote awareness.

SAMA branches showed they cared this year and wore an assortment of colourful, "crazy" socks to work.



"This is the best job in the world, despite everything. Because of everything."



Doctors at Midland Hospital in Graaff-Reinet

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.



EP branch meet with NMU students

Eastern Province (EP) branch chair Dr Farhaad Khan recently met with Nelson Mandela University (NMU) first- and sixth-year students to chat about SAMA. The first-year students will be sending a representative to branch council meetings in the future, and Dr Khan will be addressing the entire class about the benefits of SAMA membership.

Dr Khan also met with two NMU sixth-year students from the Department of Health's Nelson Mandela Fidel Castro (NMFC) medical collaboration programme. "What impressive young ladies. They had obviously done their research and asked some tough questions," commented Dr Khan about Phumi Thwala and Prudence Sibuya. "They are both SAMA members now, and are willing to work with us to approach the rest of the group. Phumi was a nurse and left nursing to pursue her dream to become a doctor."



EP branch chair Dr Farhaad Khan with first-year NMU students, left to right: Nikiesha Jose, Yonwabani Mtyaphi, Anna Challis and Quasi Osman (MB ChB class representative)



Dr Farhaad Khan (centre) with the NMFC sixth-year NMU students Phuma Thwala (left) and Prudence Sibuya.

Renovating the tea room at Uitenhage Provincial Hospital



Dr Tintswalo Mabasa

SAMA Eastern Province (EP) branch recently took up the challenge when junior doctor Dr Tintswalo Mabasa approached them about renovating the tea room at Uitenhage Provincial Hospital.

"Moving to Uitenhage for family medicine posed a big challenge for us this year," said Dr Mabasa. "Being an entirely new programme, there have been a few hurdles to navigate in a very stressful environment. SAMA EP branch very kindly heeded our request for a space to enjoy our few breaks by renovating the



The newly renovated SAMA Doctors Lounge at Uitenhage Provincial Hospital

tea room together with a sponsorship from Investec Bank. It has now been repainted, and has beautiful curtains and appliances (coffee is an essential!)"



"This has helped our work relationships with our colleagues, and provides a beautiful space to unwind after a stressful day of being a junior doctor."

LocumBase: Simplifying the Locum booking process

LocumBase is an independent online booking, payment and management platform that provides real-time availability of and access to verified Locum medical professionals for pharmacies, medical practices, hospitals and clinics, at a fraction of the time and financial cost of traditional recruitment methods.

We are proudly South African, with a vision and mission to simplify the Locum booking process without any fee-heavy implications for practices and Locums. We ensure secure record-keeping and an "open-market" model that helps a practice to effectively grow its business, and ultimately assists healthcare professionals to utilise their skilled hours.

At LocumBase we believe that Locums need to be fairly compensated for their skilled hours against their experience. We do not charge a Locum to gain access to bookings via our platform, and you can sign up for free today at www.locumbase.com.

SAMA members who have their own practice receive a 1-year premium package for free from the date of sign up. This gives you access to the full LocumBase dashboard experience, and includes unlimited bookings at a discounted 10% facilitation fee. All of this great value because you are a registered SAMA member!

We see you

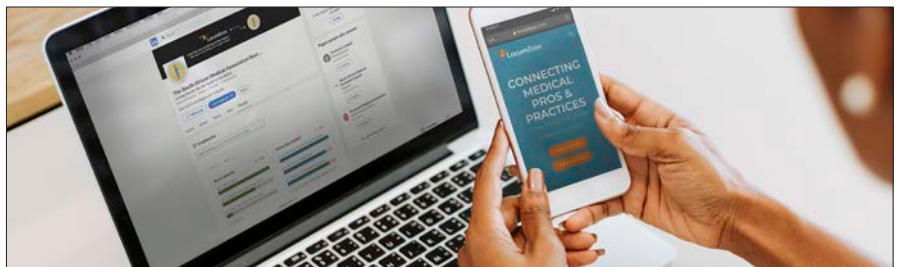
LocumBase empowers Locum medical professionals (independent contractors) to earn their worth in a flexible way. The LocumBase platform automates all admin, enabling confirmation, payments and reviews of a practice, and a Locum's service, at the click of a button. Not only a technical platform, LocumBase is a supportive ecosystem, a growing community on a mission to uplift the quality of healthcare in SA, while optimising pharmacy, practice and hospital businesses and enabling flexible earning opportunities for medical professionals nationwide.

Leading the Locum revolution

LocumBase is the first marketplace platform in SA that empowers both medical practices and medical practitioners, from optometrists and pharmacists to GPs and nurses. Your practice is a business that needs to keep caring for your patients while you take that much-needed break or attend a conference. We want you to empower you



Zulé Vuuren, LocumBase CEO and founder



with the best solution possible, whatever your needs are.

Showcasing success stories

With the focus on empowering medical professionals, primary practitioners and practice owners to do their best work in an environment of flexibility and taking the time they need to revive and recharge, LocumBase has helped practice owners and Locums in various ways.

Recently, an optometry practice owner was in a state of panic as she desperately required a Locum to take care of her practice while she focused on her traditional and modern wedding ceremonies and honeymoon for 2 weeks. She had been building her practice for over 2 years without taking any time off, and definitely deserved a break. She selected a Locum via the LocumBase platform, knowing that she could enjoy this very special time of her life without worry.

The medical space is all about people, and helping medical professionals live their best lives means that better care can be provided. With over 4 000 Locums (across professions) and over 600 practices on our system, the demand is there to work smarter with tools of the trade that weren't available only a few short years ago.

With the events in healthcare over the last year, we have seen the demand for continuous access to flexible healthcare rise. LocumBase is positioned to meet this need, with tools that empower both medical professionals and practices through a supportive ecosystem that brings various elements in the healthcare industry together to help you live your best balanced life.

The future of your business

The future looks bright, with LocumBase.

Our team is agile and able to continually improve the Locum booking process with the help of your review inputs, which are highly valued.

We look forward to welcoming you to the LocumBase family, and are happy to help with any questions you may have. Contact us at hello@locumbase.com or give us a call on 021 201 7390.

Our founder and CEO, Zulé Vuuren, says: "We are striving towards a healthcare sector where continuous quality care can be ensured by distributing the necessary healthcare skills to where and when they are needed most." You can find out more about LocumBase by visiting us on LinkedIn: <https://www.linkedin.com/company/locumbase>.

SIMPLIFYING THE LOCUM BOOKING PROCESS

STEPS TO SIGN UP

- 1 Create your profile and set your availability on your Locum calendar.
- 2 Check your profile regularly.
- 3 Accept and manage offers from verified practices and hospitals.

WHAT YOU GET AS A SAMA MEMBER:

SAMA members will receive a 12-month free premium subscription to the **LocumBase** platform, as a Locum and/or as a Practice, and a flat discounted facilitation fee when booking a Locum through the platform.

After 12-months your premium membership will be renewed at a 25% discount for all future use, year-on-year, while they remain an active registered member of SAMA.

Alongside this value, **LocumBase** will provide further benefits to each subscriber through indemnity insurance partners, annual tax assistance, and a fuss-free way of accessing all their working information through the **LocumBase** dashboard function.



LocumBase.com

WE WOULD LOVE TO HEAR FROM YOU!

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CPD

For further information
please contact the
CPD Officer on

012 481 2000 

cpd@samedical.org 

WHAT ARE WE ABOUT

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

SERVICES AVAILABLE

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