

SAMA INSIDER

OCTOBER 2022



**Criminalising medical
practice won't make
healthcare safer**

**The clean air
challenge in SA –
a medical perspective**



**SOUTH AFRICAN
MEDICAL ASSOCIATION**

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CONTENTS

OCTOBER 2022



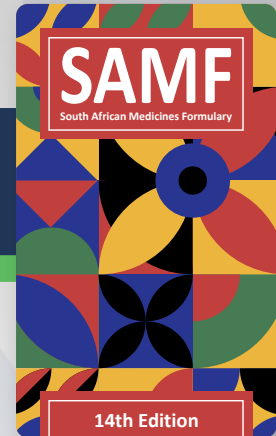
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- 3 EDITOR'S NOTE**
A heavy footprint
Diane de Kock
- 4 FROM THE PRESIDENT'S DESK**
Mind the step
Prof. Risenga Chauke
- 5 FEATURES**
SAMA's virtual and face-to-face conference 2022
Monde Süssmann
- 6 The clean air challenge in SA – a medical perspective**
Bernard Mutsago
- 6 Climate change can set back maternal health, says researcher**
Ufrieda Ho
- 8 Criminalising medical practice won't make healthcare safer**
Dr Brenda Kubheka
- 9 SAMA's policy position on changes to HPCSA rules**
Dr Mhlengi Ncube
- 10 Legal claims for medical mistakes are on the rise in SA: What's behind the trend**
Larisse Prinsen
- 11 Bouncing back – resilience in the face of change**
Prof. Bob Mash
- 12 Mobile app offers new learning tools for anatomy students. But tech isn't a silver bullet**
Omowunmi Isafiade, Christina Kotze
- 13 CPD accreditation: SAMA mortality and morbidity guidelines**
Lisa Reid
- 15 A junior doctor's battle to keep death at bay for state patients**
Bhekisa Team
- 16 Reviewing clinical research protocol for ethics approval**
Lisa Reid
- 17 Migrants in SA have access to healthcare: Why it's kicking up a storm**
Kudakwashe Vanyoro
- 18 WHO: Hepatitis outbreak in children**
Vismita Gupta-Smith
- 19 UCT awarded two new SAMRC extramural units**
Helen Swingler
- 21 MEDICINE AND THE LAW**
The "genetic link" requirement for surrogacy in South Africa
Thato Molefe
- 22 Good records in a worst-case scenario**
Medical Protection Society
- 23 BRANCH NEWS**
- 24 WELCOME TO SAMA**

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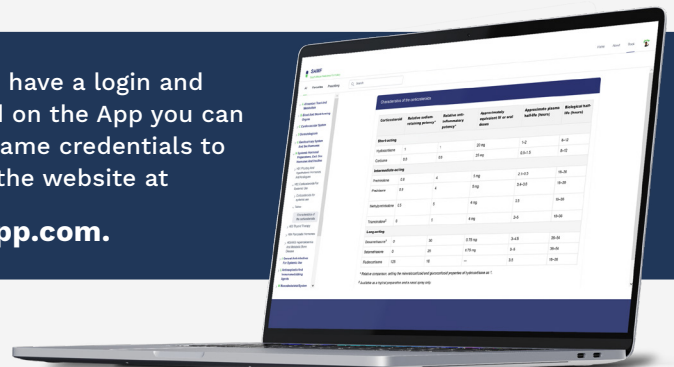


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Diane de Kock
Editor: *SAMA INSIDER*

A heavy footprint

Climate change and its impact on healthcare (page 6), criminalising medical practice (page 8), rising legal claims for medical mistakes (page 10), burnout in the public health system (page 15) and access to healthcare (page 17) are all placing a very substantial footprint on doctors in SA. The weight is heavy and the signs of strain are starting to show. As Prof. Risenga Chauke, SAMA President, says: "It is important that government and society at large do not create another step for medical professionals to mind, as this will have a highly detrimental effect on the health of the nation, which is already burdened by a shortage of medical professionals" (page 4).

Hidden among these weighty subjects are some interesting developments:

- SAMA recently released their policy position on changes to HPCSA rules, recommending the rules not be changed until certain conditions are in place and agreed to by all relevant stakeholders (page 9).
- A new mobile app, Anat_Hub, the result of collaboration between the departments of computer science and medical biosciences at the University of the Western Cape (page 12), shows that homegrown technologies can be developed to meet local needs.
- SAMA's CPD accreditation and research officer, Lisa Reid, updates us on mortality and morbidity guidelines (page 13) and the clinical research protocol for ethics approval (page 16).
- The recent outbreak of hepatitis in 35 countries is a cause for concern. Vismata Gupta-Smith (WHO) updates us on possible causes and the signs that we should be looking for (page 18).
- Four newly launched SAMRC extramural research units were awarded to develop critical health research. These will strengthen the country's health systems and counter diseases and pandemics such as COVID-19 (page 19).

Lift the weight; our doctors are beginning to buckle.

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Published by the South African Medical Association
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Erasmuskloof Ext. 3, Pretoria
Email: publishing@samedical.org | www.samainsider.org.za | Tel. 012 481 2069

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Mind the step



Prof. Risenga Chauke, SAMA president

Whether you are blind or not, while walking or running, if you ignore the step, you will trip and fall. It is a law of nature that one has to mind the step on the journey of life.

So it is with medical professionals. Throughout their training, they are warned to mind the step. Medical professionals are taught that the first and most important rule is "first do no harm".

It is not the intention of medical professionals, at least the majority, to cause harm to the patients they are trained to help. Not only do they want to see their patients doing well, their job also puts bread on their tables. It takes 9 years to train to be an independent medical professional in SA, and on average 13 - 14 years to qualify as a specialist. This is a very long time for anybody to want to throw away.

Given these reasons, it is highly unlikely for any medical professional to engage in criminal activity, especially something that compromises the life of a patient.

Criminalisation is defined in the Oxford dictionary as behaviour that turns an activity into a criminal offence by making it illegal, or the action of turning someone into a criminal by making their activities illegal.

Activities of medical professionals are not illegal. In fact, the medical profession is highly

regulated. It is unfair for the government to ask medical professionals to mind another step while in the service of citizens. An unhealthy nation results in a society that performs poorly economically. But this additional step means having to worry about being treated as criminals if genuine medical mistakes happen.

Mistakes do occur in medical practice. Deliberate mistakes need to be dealt with accordingly. But mistakes that happen genuinely cannot be treated as criminal offences.

The cases of Drs Beale and Munshi, and recently of a doctor in KwaZulu-Natal, who have been criminally charged without first establishing through an inquest the cause of death of their patients, is an issue of concern for medical professionals. It is hard for relatives to lose a loved one. It is also very hard for a doctor to lose a patient.

A lot has been written about criminalising the medical professions, from medical professionals' organisations to individual medical practitioners' points of view. A lot about problems with criminalising the medical profession has also been stated, from the legal point of view to the views of local and international organisations, including the view of the WMA in their 2013 resolution on criminalisation of medical practice, and the National Coordinating Council for Medication Error Reporting and Prevention in their 2020 statement opposing the criminalisation of errors in healthcare.

Mistakes that happen genuinely cannot be treated as criminal offences

Medical professionals are taught about weighing the risks against the benefits before intervening in managing a patient. Risk is defined as an identifiable possible negative outcome brought about by managing a patient, and benefit as the opposite of risk. If the risk is greater than the possible benefit, then a medical professional, generally, will implement what is regarded as palliative care, or leave things as they are. But the patient is informed about this. This is called informed consent. The patient is informed about what

the risks or benefits may be, in order to be able to consent.

Risk management is then employed. This is because there is always a risk, even if the benefits outweigh the risk. Risk management is a method that attempts to nullify identifiable causes of possible negative outcomes brought about by managing a particular patient. This means that a medical professional will go through a rigorous process of ascertaining that a particular intervention will be beneficial to the patient.

In today's world of an increasingly litigious society, medical professionals are already minding their steps

Hence it is imperative that should a negative outcome occur to the patient, a process is followed to check for gross negligence. If such gross negligence is found, then the concerned medical professional can be held criminally liable.

In today's world of an increasingly litigious society, medical professionals are already minding their steps in management of patients. They manage patients with a lawyer in mind, in case they are sued. Causing them to mind yet another step by criminalising their work will demoralise them even further, to the extent of them leaving the profession. This is seen among obstetricians and gynaecologists – they are increasingly leaving obstetrical practice and only concentrating on gynaecology due to them being highly litigated, as reported on Cape Talk by the SA Society of Obstetricians and Gynaecologists in February 2020.

It is, therefore, important that government and society at large do not create another step for medical professionals to mind, as this will have a highly detrimental effect on the health of the nation, which is already burdened by a shortage of medical professionals.

SAMA's virtual and face-to-face conference 2022

Monde Süßmann, HOD: SAMA Corporate Affairs

SAMA hosted a virtual and face-to-face conference on 6, 7 and 13 August 2022. The conference was hosted under the theme "Beyond the pandemic". The focus was on grappling with the new normal – the health issues that the world is contending with. The medical profession, having been in the forefront of the pandemic, pondered and charted the way forward on what the health sector will be like beyond the COVID-19 pandemic.

The format of the event was oral presentations from health experts in various medical fields. Expert facilitators steered each of the sessions mentioned below. The topics were expertly chosen by the leadership from Education, Science and Technology Committee (EST) to answer to the issues that the health sector is facing as we redefine the sector beyond the pandemic.

The sessions presented were maternal & child health, POPIA, internal medicine, positive ways forward for healthcare post pandemic, surgery, population and preventative health and updates in occupation medicine and health.

The keynote speaker Prof. Glenda Gray covered the COVID-19 research response in SA and internationally.

Conference programme

Attendance numbers indicate that of the 169 delegates who registered, 54% attended on all 3 days. The hybrid venues that hosted the

conference were SAMA head office in Pretoria and Life Rosepark Hospital in Bloemfontein. There were 13 CPD points earned from this conference – 11 clinical and 2 ethical points.

Advertising was done extensively on med-emails and social media platforms. Advertising was also taken with Independent Online (IOL) newspapers across the country and PowerFM. Average view impressions on IOL were above 7.6 k per day for the 11-day campaign.

The quality of the conference presentations was of a high standard with speakers presenting their latest research papers. The

topics and the content of the presentation reflected the theme of the conference – "Beyond the pandemic". The facilitators played a key role in introducing the sessions as well as their associations, which are linked to SAMA. The brand amplification for SAMA was reflected in the introduction of the conference by the SAMA leadership, as well as the branding of the recorded presentations. A recommendation for the future is for a face-to-face conference that will allow all delegates to engage in networking, and bring a human element to the conference.



Prof. Dirk Hagemeister (branch treasurer), Hannah Struwig (marketing manager, Life Rosepark Hospital), Sultana Hartzenberg (branch administrator) at the hybrid conference in Bloemfontein



Free State branch hosted a hybrid conference at Life Rosepark Hospital in Bloemfontein

The clean air challenge in SA – a medical perspective

Bernard Mutsago, *health policy researcher, SAMA*, Mhlengi Ncube, *head of Health Policy and Research Unit, SAMA*

SA's decarbonisation effort has seen the introduction of a number of pieces of air quality legislation. Among others, SA has the National Ambient Air Quality Standards in operation, as well as two key air-quality Acts, namely the National Environmental Management Act No. 107 of 1998 ("NEMA") and the Air Quality Act No. 39 of 2004.

SA's air quality has been a mounting problem and is contributing to the climate crisis. The health sector is not exempt as a contributor to greenhouse emissions: globally, healthcare's climate footprint is equivalent to 4.4% of global net emissions. The health sector's climate footprint emanates from its carbon-intensive supply chain, chiefly including fossil fuel-dependent vehicle fleets, energy and heating systems, waste disposal including incineration, as well as production and supply of health goods such as pharmaceuticals and food. This footprint compounds the existing industrial and domestic sources of air pollutants, which contribute to the increasing levels of poor air quality, which in turn contributes to a variety of respiratory, cardiac and other diseases.

The deadly air covering SA cities and communities is on account of SA's heavy reliance on coal-fired power generation for industrial operations, as well as smog, carbon monoxide and other pollutants from vehicles in heavily motorised cities such as Johannesburg. In addition, non-industrial events or phenomena such as windblown



dust, waste burning, veld fires and burning of wood or coal for domestic use are common, and have a significant contribution to poor air quality. Data from SA's over 130 air quality-monitoring stations show many areas, notably the Mpumalanga highveld, to have air pollution of unacceptable levels, that is, ambient air pollution concentrations exceeding acceptable WHO thresholds.

Guaranteeing clean air in SA, Africa and globally is part of a fundamental right for all members of the global village to an environment that is not harmful to their health. Clean air will bear health dividends, as it will mean reduced acute and chronic exposure to health-damaging air-borne toxins. The burden of respiratory problems, cardiovascular diseases, cancers and other air pollution-related health problems will be minimised.

Deaths correlated with bad air quality will decline. This will translate to less burden on the country's already burdened health system, while ensuring better quality of life, economic participation and life expectancy for South Africans.

SAMA has in the past advocated – and will continue to advocate – for better air quality, clean energy use and early identification and treatment of health conditions related to air quality. In line with climate change policies of the WMA, of which SAMA is a member, SAMA encourages all physicians to commit themselves to understanding and reducing the healthcare sector's contribution to the overall carbon footprint. We encourage all health professionals and health sector-related professionals to reduce the health sector's contribution to the overall carbon footprint and climate crisis.

Climate change can set back maternal health, says researcher

Ufrieda Ho *for Spotlight*

Researchers around the world are drawing an ever-more distinct line between rising global temperatures and negative effects on maternal, fetal and infant health. One of these researchers is Prof. Matthew Chersich of the Wits RHI (Rural Health Institute), whose recent work has focused on using data science to understand

the effects of heat on pregnant mothers and their babies in Africa.

Chersich's first warning is that there is a double burden on Africa as the continent is already being hit hardest by climate change but also has fewer resources to mount a sophisticated, wide-reaching and sustained response.

"The continent is already warming faster than other regions in the world but is also a low carbon emitter," he said.

According to the Intergovernmental Panel on Climate Change, the northern and southern regions of the continent will become hotter and drier, while the Sahel region will have increased rainfall.

"Right now we are in a phase of climate choice – the 10 years we have left to do something and stop making nature our slave, or that choice will cascade so that we won't have a choice because nature will be at its tipping point," he said. Chersich was speaking to *Spotlight* after delivering his inaugural lecture at Wits University at the end of August.

How a medic came to study climate change

In the lecture, titled "How a medic came to study climate change", Chersich recounted how 7 years ago he and his family were living in a small hamlet in Italy among a subsistence farming community. Increased extreme weather events quickly turned to lived reality and lived anxiety for the community that largely lived off the land. He experienced how humans' continued ability to thrive on a planet pushed into decline was slipping towards a precarious edge.

"Climate change and public health already intersect in some key areas, which makes this field an important new area of research that we in public health must be turning our attention to.

"Some of the intersections with the public health response include how droughts and floods cause poverty and social disruption; there is also the response of emergency medicine in the case of increased extreme weather events that destroy infrastructure; then there's work looking at the effects on how climate change is shifting infectious disease patterns. All pathogens are temperature sensitive, which means we'll see malaria spread to higher altitude areas; and then there's work on maternal health, which is an area where Wits University and I personally have a lot of background, so this became an obvious area that I wanted to focus on."

Building on previous work

He said choosing to focus on maternal health was strategic because maternal health has been the starting point for many past public health interventions, including a massive reduction in mother-to-child transmission of HIV as well as interventions on nutrition and combatting malaria.

Added to this, Chersich said, there was established foundational work done by Wits researchers in the late 1990s that measured the maternal-fetal temperature gradient. "The research found that a fetus is about half a degree warmer than its mother, which might not sound like much of a difference but if the

mother's temperature rises with a fever to 40°, the fetus is at 40.5°, and that makes an enormous difference physiologically," he said.

Impact of heat

Data from his research colleagues in Kenya is now showing that heat can be linked to pre-eclampsia, pre-term births and complications in labour and childbirth – all of which can have knock-on effects for the mother and the child later on in life, he said.

Community health workers and women interviewed for Chersich and his colleagues' research have given revealing responses. These included: "The fetus is not at peace when it is hot; it only finds peace when it is born," or "it is difficult to push in the heat" and "the baby has come before its time because it is too hot."

"What is happening physiologically to cause these pre-term impacts related to heat are changes to the endocrine system; oxidative or inflammatory changes; changes in placental perfusion, which can change the circulation of blood flow to the fetus that regulates heat; and there is increased exposure and risk to infections that include food, water and vector-borne infections," he said.

Chersich said the evidence points to a looming crisis for maternal health and infant health and means "public health must be more than about treating disease".

Chersich set out a multilayered intervention strategy. A critical layer is using data science more effectively. One of the projects Chersich is now involved in is a 5-year study that will span research teams across Africa and the USA.

"It involves individual participant data and will be the largest data science project of its kind. Analysing this data will help us unlock some of the key questions and shape our interventions," he said.

More deliberate engagement

Chersich also said there is a need for the public health sector to wake up to the necessity to enter more directly and deliberately into the climate change space. One initiative he helped establish is CHANCE (The Climate-Health Africa Network for Collaboration and Engagement), which is an initiative to bolster research that aligns these two disciplines.

"The health sector is ripe to intervene and this should include making submissions for funding from the Green Climate Fund to do the research and put in place the kinds of strategies that will help those who will be



Prof. Matthew Chersich's research focuses on using data science to understand the effects of heat on pregnant mothers and their babies in Africa (photo: Wits RHI)

worst affected on the continent," he said. "We in this sector understand the tricks and the tricksters. We know the playbook of big pharma, of the tobacco industry, the food manufacturing industry, the meat industry, and now also the fossil fuel industries," he said of the public health sector.

It's a terrible insight, but he argues that it could hold strategic advantage. It's a position from which to firm up boundaries with funders and call for more accountability and transparency where there is a conflict of interest. This while still compelling funders and donors – who may be industrial polluters – to fund research and support interventions to curb fossil fuel dependence and reduce emissions.

Public health, he said, also understands how to manage big global donors, citing long-standing PEPFAR and Global Fund projects on the continent. And public health initiatives are where a groundswell for policy change can also take root, Chersich said.

But even before policy, he said interventions need to start with awareness on the ground. It could be healthcare workers knowing to make cool water available for pregnant women, especially during labour and childbirth; better advice on planning pregnancy according to seasonal temperatures; building more heat-tolerant clinics and homes; and planting more trees. It is all underpinned by a fight still for poverty reduction and building more equitable societies, he said.

Personal moral choice

Finally, Chersich used his inaugural lecture to bring home the most uncomfortable message of them all, and that is the link between climate change and personal moral

choice. Behavioural change, he said, will come with personal discomfort and personal sacrifice. It's eating less meat, taking fewer flights, consuming more mindfully and accumulating less. For researchers and universities, he said, it is about questioning relationships with funders and companies and industries that advance the fossil fuel dependency agenda and pay not to

fix problems but for a blind eye turned, green-washing and silence.

"We have an abusive relationship with nature. It underlies our problems. We think we can eat and eat [from] nature and it will just replenish itself but there is no slowdown in emissions and we are on a trajectory of many places in the world being unliveable.

All this means if we in public health want to fight disease then we need to also [be] part of systemic change. We need to stop the eating," he said.

Source: Spotlight, 8 September 2022. <https://www.spotlightnsp.co.za/2022/09/08/climate-change-can-set-back-maternal-health-says-researcher/>.

Criminalising medical practice won't make healthcare safer

Dr Brenda Kubheka, founder and MD of Health IQ Consulting



The practice of medicine is inherently risky and, lately, can land the doctor in jail. Previously, the risk to the professional ranged from reputational, medicolegal to financial risks.

Doctors are held in high regard in society because of the considerable responsibility of saving lives and improving the quality of life of their patients. Be that said, they are human beings who are fallible, hence the saying "the practice of medicine is a science practised by mortal and fallible humans, not superhumans."

The arrest of a **KwaZulu-Natal surgeon** following a patient's death has caused an outcry in the medical fraternity. The outcomes of clinical practice are the sum of the processes, resources, expertise and patient factors too.

Some deaths are unavoidable

Medicine is a self-governing profession where peers assess cases against similar cases, practice standards and context-specific issues. The critical point is the differentiation

between unavoidable and preventable deaths in healthcare. Some deaths are unavoidable because of the unexpected progression of a medical condition.

We are in a country where the Constitution protects the right to approach courts. At the same time, we need to appreciate the harm that may result from the criminalisation of medical practice. When things go wrong in medicine, we experience the "blame and claim" phenomenon while advocating for open disclosure to uphold the value of truthfulness and rebuild trust where it is threatened. We will not debate the various reasons why patients or family members approach courts following unexpected clinical outcomes.

A learning culture that acknowledges errors and investigates the root causes of adverse events is the foundation for building a safer health system.

Blame and arrest of professionals following adverse events, including death, undermine patient safety, which should be a societal value. Fear of arrest will further promote defensive medicine, which is inefficient, costly, and may even cause practitioners to avoid treating high-risk cases, called "cherry picking". The few who will remain to attend to such cases will face litigation and criminal proceedings. We know of obstetricians and gynaecologists who have stopped practising obstetrics because of fear of litigation and the exorbitant costs of malpractice insurance.

Criminalisation of medical practice will discourage open disclosure of errors and even near misses, which becomes a missed opportunity for learning and strengthening the system. The system should make it difficult

to commit errors and have early warning signs to minimise or prevent harm.

In a book by Runciman, Merry and Walton (2016) titled *Safety and Ethics in Healthcare: A Guide to Getting Things Right*, they mention that "in healthcare, you may be exposed to risk by things going wrong when having appropriate investigations and care. Risk is influenced by exposure." Healthcare interventions come with corresponding benefits and risks. Schimmel in 1964 stated, "Healthcare used to be safe and ineffective and now highly effective but potentially hazardous."

Medicine is a self-governing profession where concerns need to be investigated by peers before engaging the legal system. Self-blame, emotional burden and depression, to name a few, are experienced by practitioners following adverse events.

I believe practitioners leave home planning to save lives, and I expect that none of them leave their homes and go to work planning to harm a patient.

The clinicians blame themselves for failing their patients and the profession and doubting their competence. Practitioners must account for their recklessness and mechanisms to explore what constitutes expected complications and unexpected clinical outcomes due to patient, practitioner and other relevant factors. Adverse events must first be subjected to professional adjudication to benefit the profession, the health system and society.

Source: News24, 13 September 2022. <https://www.news24.com/news24/columnists/guestcolumn/opinion-brenda-kubheka-criminalising-medical-practice-wont-make-healthcare-safer-20220913>.

SAMA's policy position on changes to HPCSA rules

Dr Mhlengi Ncube, Head of Unit: SAMA Health Policy and Research



Dr Mhlengi Ncube

SAMA strives to unite doctors for the health of the nation and is therefore supportive of laws, rules, regulations and policies that create an enabling environment for doctors and other healthcare professionals to achieve the best health outcomes for patients in SA and beyond. We have analysed the proposed changes to the HPCSA rules 7, 8, 18 and 23 from a quality of care perspective and with the patient and the doctor in mind.

The WHO, of which SA is a member, advocates that patient care must always be effective, safe, people-centred, timely, equitable, integrated and efficient. SAMA recognises that the amendments of the HPCSA seek to "to enhance the quality of healthcare services to patients" through "express agreement(s), arrangement(s) or model(s) of rendering multidisciplinary based healthcare services to patients which (are) structured to contain costs, enhance access to appropriate, high-quality healthcare services or products to patients".

SAMA also recognises that the above will be preserved through a regulatory body from which permissions will be sought.

While the motivations to change the rules are noble, the proposed rule changes, if implemented in their current form, will regress the quality of care and ethical practice achievements that the HPCSA, SAMA and other stakeholders have made in the past decades. The effectiveness of the changes to achieve their intended purpose is guaranteed

by the HPCSA, providing oversight by being the exclusive regulator and approver of the "express agreement(s), arrangement(s) or model(s) of rendering multidisciplinary based healthcare services to patients." The HPCSA, however, has not provided any models or guidelines by which this oversight will be implemented. Without any detailed criteria and guidelines, none of the positive intentions of the rule changes will be achieved. Instead, the opposite will likely happen. Opportunities for market grabbing through collaborations of rare expertise could drive up the costs of care and reduce access to care for the majority of the population.

By allowing in rule 7 that "a practitioner may share, charge or receive fees from another practitioner, provided that in such an instance, there is an express agreement, arrangement or model of rendering multidisciplinary based healthcare services, to patients which is structured to contain costs of rendering healthcare services, enhance access to appropriate, high-quality healthcare services or products," and in rule 8 that "a practitioner may provide collaborative healthcare services with other practitioners provided that the primary aim will be to enhance the quality of healthcare services to patients, and further that there is an express agreement, arrangement or model of rendering multidisciplinary based healthcare services to patients which is structured to contain costs, enhance access to appropriate, high-quality healthcare services or products to patients," these new rules implicitly foster integrated delivery of healthcare services. A study of 200 hospitals in China showed that integration of care improved efficiency in the hospitals. That "such agreement, arrangement or model of rendering multidisciplinary based healthcare services to patients has been approved by council prior to its implementation" is a vague assurance that collusion will be prevented, without details of how the council intends to provide such a guarantee to patients and to the doctors who service them. These rules leave patients at the risk of being undertreated while simultaneously overbilled.

A desire for safety and efficiency by the rules is again seen in rule 8A, and once more authority is granted to the HPCSA to permit the sharing of rooms under specified circumstances. There are even more regulatory responsibilities that

the HPCSA will assume in the amendment of rule 23A. Focusing on the cost to the doctor: the HPCSA has recently hiked fees to a point that has caused discomfort to many healthcare professionals. It is prudent to expect that the increases were motivated by operational costs within the HPCSA. Any additional responsibilities at a national level should be expected to add to the operational costs of the HPCSA and subsequently the fees that doctors have to pay to keep the HPCSA delivering the services that it does. The chronic inefficiencies within the HPCSA are known to most healthcare professionals and, while SAMA respects that efforts are probably being made to address those challenges, we cannot ignore the very high risk that those operational inefficiencies could expose patients, with respect to the tenets of quality of care that the HPCSA, SAMA and other stakeholders subscribe to, should these rules be implemented in their current form.

The amendment to rule 18 sets conditions for doctors to be employed. SAMA can comprehend how it could be possible to have contracts for doctors that "(are) not designed to extract profit for the benefit of the practitioner or their employer to the detriment of patients". It is, however, highly improbable that most such contracts will be adhered to. The amendment to this rule represents a move toward the corporatisation of healthcare, the likely consequences of which are the erosion of human resources capacity in the public sector, reduced population-wide coverage of healthcare due to capped working hours, and unfair NHI positioning advantage by big corporates.

SAMA, therefore, in the best interests of the quality of patient care, recommends that the rules not be changed until the following are in place and agreed to by all the relevant stakeholders:

- the processes, procedures and guidelines on how the HPCSA will make approvals with respect to the amended rules
- evidence of capacity to ensure that the amended rules are implementable within the HPCSA's operational systems
- evidence of how the risks of corporatisation of healthcare that could be facilitated by amendments to rule 18 will be prevented
- evidence of the impact that the administrative costs of implementing these rules will have on doctors' annual fees to the HPCSA.

Legal claims for medical mistakes are on the rise in SA: What's behind the trend

Larisse Prinsen, senior lecturer in law, University of the Free State

Medicolegal claims – claims based on medical negligence or malpractice – have skyrocketed in SA. Recent figures indicate a **growth rate of 23%** for medicolegal claims in the public sector since 2014. In the past financial year, more than **ZAR6.5 billion** (over USD390 million) was awarded in medicolegal claims.

This is not just a SA issue but a global and regional one. In [Ghana](#) and [Malawi](#) litigation for medicolegal issues has also become more prevalent.

The number of claims as well as their value have increased. One possible reason could be that medical and technological advances are increasing life expectancy. These advances are good in general. But they may inflate the size of claims as factors such as future maintenance, loss of income and future healthcare are considered when calculating damages.

The cause of the sharp increase in claims – and how to address it – has been investigated and debated by various scholars and authorities in SA. This is important because money spent on these claims from the health budget is money not being spent on essential healthcare priorities.

What's driving the rise in claims

Scholars and the [South African Law Reform Commission](#) have identified a variety of factors driving the rise in medicolegal claims.

The first and most obvious cause relates to the quality of healthcare services and clinical errors. Cerebral palsy-type claims make up **around half** of medicolegal claims in SA. [Cerebral palsy](#) refers to a group of disabilities caused by damage to the brain. It's widely **assumed** that where there is poor healthcare provision, there are high numbers of cerebral palsy cases. While poor quality of care during labour is indeed one risk, there are multiple other potential causes of cerebral palsy.

Other medicolegal claims include negligence in [applying proper care](#), failure to take reasonable steps to [prevent stillbirth](#), [misdiagnosis](#) and delayed treatment.

But issues in the healthcare system go beyond individual negligence. Healthcare practitioners are expected to perform their

duties according to the degree of care and skill reasonably expected of them. This may not always be possible due to environmental factors. For example, equipment may be old and deficient, or facilities may be understaffed.

The quality of care is affected by a number of factors. Maladministration and mismanagement have the biggest impact. The availability of resources in already strained national and provincial health budgets also affects care.

The legal profession, too, has been identified as contributing to the rise in claims. Arguments have been made that malpractice legal practitioners are actively encouraging and targeting the public to seek legal recourse in the event of something going wrong.

It has also been argued that the 2008 amendments to the [Road Accident Fund Act](#) are a contributing factor as they reduced the payout levels. This could have pushed legal practitioners towards new avenues of personal injury law in the form of malpractice litigation.

The [Contingency Fee Act](#) No. 66 of 1997 may be another contributing factor. The Act provides for a "no win, no fee" system. This allows people who would not normally be able to afford litigation to do so. It may also lead to inflated claims.

Other developments – such as a much more patient-centred approach to healthcare – have made patients more aware of their rights. Patients also have higher expectations. They are demanding more of their doctors and are less likely to tolerate indifference or poor management of any complications.

Possible solutions

Because there is no single cause, there is no single solution. This is a complex matter.

The SA Law Reform Commission has proposed a three-tiered strategy to reduce medicolegal litigation.

The first is at the primary level. In a bid to improve the quality of care, the government has regulated [a set of care standards](#). These span a wide spectrum from clinical standards to the working environment, infrastructure, human resources and technology to ensure better and safer patient experiences and clinical outcomes. Healthcare facilities will have to develop quality improvement plans.

Secondary prevention relates to the management of complaints and the importance of early engagement. It includes establishing an independent health complaints committee, strengthening systems to monitor adverse outcomes, moving from a culture of blame to one of learning and receiving feedback from medicolegal claims.

Tertiary prevention, lastly, would entail:

- professional and comprehensive management of all medicolegal litigation
- fast-tracking the resolution of low-value claims with minimal expenditure
- just compensation of injured patients or bereaved families
- assisting plaintiffs "in kind", for example by securing school placement of disabled minors
- securing settlement awards in trusts to ensure appropriate accounting and payment of funds for future medical care
- return of unspent funds to the national health department in the event of premature death
- challenging false or opportunistic practices that artificially drive up the value of claims
- ensuring that all public money spent on settlement of valid claims is just and appropriate.

More could be done. For example, the government should publish annual medicolegal claims reports with relevant data. This would make it possible to identify trends that can guide future policy.

An obvious solution is improving the healthcare system and quality of care. The government could implement its own [Human Resources for Health Strategy 2030](#), which might alleviate the understaffing of many healthcare facilities.

Reducing claims also requires the government to ensure that healthcare facilities are properly funded and staffed. And it should suspend medical licences in instances of gross negligence resulting in death. Charges of culpable homicide might even be considered.

Legislation alone cannot address the causes of the rise in claims. But some legal reform and the development of fit-for-purpose legislation might be helpful. This would address procedure, create bodies or authorities to

deal with some of the causes, create novel interventions and change the method and timing of compensation.

Lastly, the method of compensation might also be reconsidered. It could move away from

lump-sum payments to structured settlements consisting of payment for harm already suffered, periodic payments for future medical or other costs, or even payment in kind, such as healthcare services provided by the state.

Source: The Conversation, 15 August 2022. <https://theconversation.com/legal-claims-for-medical-mistakes-are-on-the-rise-in-south-africa-whats-behind-the-trend-187393>.

Bouncing back – resilience in the face of change

Prof. Bob Mash, Division of Family Medicine and Primary Care, Stellenbosch University, and South African Academy of Family Physicians

Bouncing back – resilience in the face of change was the theme of the 24th National Family Practitioners Conference on 19 - 20 August, organised by the SA Academy of Family Physicians (<https://saafp.org/>). Because of COVID-19, this was the first time in 3 years that we were able to host a face-to-face conference, and the family medicine community were excited to see each other and engage with the issues. Participants commented:

"I could not believe how incredible the conference was ... I learnt so so much! The lineup of speakers! Excellent! Such an authentic conference!"

"I left the conference with such hope, contentment and peace ... that's how good it left you feeling."

The conference looked back at the experience of family medicine and what has been learnt from the COVID-19 pandemic. Prof. Glenda Gray, president of the SA Medical Research Council, in her opening address, confirmed that COVID-19 is now in an endemic phase and the focus is on finding vaccines that can prevent transmission. Current vaccines prevent hospitalisation and death. Prof. Keymanthri Moodley from the Centre for Medical Ethics and Law at Stellenbosch University explored some of the ethical and professional issues raised by the pandemic. For example, the moral injury and trauma experienced by healthcare workers and the need for public health ethics, where the "common good" is balanced against individual rights and autonomy. She was a proponent of mandatory vaccination during the pandemic.

In addition, a panel discussion explored how digital technology and solutions came to the fore during the pandemic. Four panellists explored the use of remote patient monitoring, telehealth, patient education via WhatsApp Chatbot and the power of integrating routinely collected patient data



Prof. Honey Mabuza, president of the College of Family Physicians; Prof. Glenda Gray, president of the SA Medical Research Council; and Prof. Bob Mash, president of the SA Academy of Family Physicians, at the 24th National Family Practitioners Conference (source: SAAFP)

in the public sector. Multiple data sources, such as hospital discharge summaries, clinic attendance, community health worker household visits and laboratory results, can be combined for clinicians, using a unique identifier, to create a more complete picture of the patient's journey and medical history.

Prof. Mark Heywood, a well-known voice for human rights and co-founder of the Treatment Action Campaign, spoke about the viewpoint of civil society during the pandemic. He emphasised the importance of community engagement with health services, which is a key aspect of primary healthcare. The absence of such engagement and collaboration in primary healthcare made it difficult to develop appropriate public health measures and gain the trust of communities. He also noted that the voice of family medicine, with its commitment to person-centredness and quality primary healthcare,

is not strong enough in the public and policy discourse.

After looking back, the conference also looked forward to the future. Prof. Bob Mash, president of the SA Academy of Family Physicians, outlined the national position paper on the future of family medicine in the country. This promotes the placement of family physicians (specialists in family medicine) at all public sector district hospitals, community health centres and subdistricts (without such centres).

Family physicians are ideal as the clinical leaders of healthcare teams in these settings. Not only can they bring much-needed clinical expertise to these teams, but they can also lead clinical governance to improve quality and patient safety, and build the capability and confidence of the whole team. The academy is actively engaging policy-makers to clarify the role of family physicians,

especially as recent strategy documents on human resources for health misunderstood their contribution. To meet the current gap of 400 family physicians in the public sector, the number of registrar posts must be increased, the throughput rate in training must be improved and provinces must retain family physicians by creating posts incrementally over the next 10 years.

He also spoke about the need to engage the Board of Healthcare Funders on the appropriate registration of specialists, who often work in multidisciplinary teams and with non-specialists. Medical schemes must also appropriately remunerate family physicians and recognise their scope of practice. The academy has established a [private sector](#)

[forum](#) to better understand and represent the needs of these members.

Also looking to the future, Dr Nicholas Crisp, the deputy director general for National Health Insurance (NHI), reminded us that the National Department of Health (NDoH) is still on the road to implementing NHI. The NHI Bill is being discussed clause by clause by the Parliamentary Portfolio Committee on Health, and will come back soon to the National Assembly. The NDoH will be employing a team of 44 people and will start piloting the introduction of contracting units for primary healthcare (CUPs) in selected districts.

Finally, Dr Rubeshan Perumal, from the Inkosi Albert Luthuli Central Hospital, University of KwaZulu-Natal, spoke on long

COVID and outlined some of the science. There is emerging data that autoimmunity may play a role in the development of long COVID. He informed us that vaccination substantially reduces the risk of developing long COVID, and may also help reduce symptoms in those that have it.

The conference closed with an address by a Brazilian family doctor, Dr Mayara Floss, who spoke about the next public health challenge – climate change. Climate change is already with us, as exemplified by the “rain bomb” that recently hit Durban, killing over 400 people. Family physicians and primary healthcare need to develop resilient facilities and services to face these future challenges, by drawing on some of the lessons learnt from COVID-19.

Mobile app offers new learning tools for anatomy students. But tech isn’t a silver bullet

Omowunmi Isafiade, senior lecturer in computer science, University of the Western Cape, **Christina Kotze**, lecturer in anatomy and physiology, and researcher in invertebrate reproductive biology, University of the Western Cape

For most people who finished school or university even a decade ago, the idea of virtual reality (VR) in the classroom probably seems like the stuff of science fiction. But immersive technologies like VR, augmented reality (AR) and mixed reality – which all aim to marry the physical and digital worlds – are increasingly being used to [bolster teaching and learning](#).

Its proponents [argue](#) that immersive technology could be especially useful in low-resource settings. No laboratory equipment at school? Can’t afford pricey field trips? No problem: mobile phones and tablets could take entire labs and libraries into schools and universities.

Those opposed to an all-out migration to such technology point out that poorer countries’ education sectors already have serious resource and infrastructure constraints.

The [COVID pandemic](#), with its resulting lockdowns and university closures, forced countries to shift towards online teaching and learning. But it didn’t miraculously improve infrastructure issues – if anything, it made them worse. Still, it seems likely that some element of online learning will become the norm in many parts of the world.

How might educational institutions in poorer contexts adapt without leaving students behind?



Our experience in developing an immersive mobile phone application for university anatomy students offers some insights.

The departments of computer science and medical biosciences at SA’s University of the Western Cape collaborated to develop [Anat_Hub](#) for two reasons. First, we wanted to reach students who were no longer on campus because of the pandemic, and create an avenue for self-paced learning. Second, practical training in medical biosciences has

been hampered by resource constraints and limited teaching staff. In anatomy, for instance, there is a [global lack of cadavers](#). That makes practical training difficult.

In a [recent paper](#), we outlined how students experienced the app as well as the constraints and problems they faced.

An immersive experience

Anat_Hub is a practical immersive AR technology for the musculoskeletal system. It

teaches the names, attachments and actions of muscles of the human musculoskeletal system. The app provides detailed graphics of both the upper and lower limbs. The models can be viewed in four different sections: the shoulder and arm; forearm and hand; hip and thigh; and leg and foot.

In the AR mode, the animation functionality built into the app allows the student to view and interact with the model from different sides. As with the 3D version, users can start by looking at the muscles of each limb, and peel away layers down to the nervous system.

The application, based on the Android operating system, offers a wide range of useful features intended to promote active and self-regulated learning. These include 3D mode, a glossary, and a quiz where students' cognitive abilities are tested on the material covered.

Anat_Hub is about 300 MB in size, and internet access is needed for it to be downloaded and installed. However, it can be used offline once it's downloaded. Internet access was a foremost consideration in the app's development process given its African context. It has [been reported](#) that some 82% of university students in sub-Saharan Africa do not have internet access. In SA, a survey by publishers Juta found that 32% of responding students struggled with internet access.

We piloted the system on a group of volunteer first-year undergraduates from

several anatomy-related disciplines. Then we evaluated their experiences of the app's functionality and usability. There were, ultimately, 53 respondents. Only 13.2% had used AR prior to seeing Anat_Hub. Most had relied on lecture notes (96.2%), internet resources (77.4%), videos (75.5%) and textbooks (56.5%) to study anatomy. Few had turned to alternative sources such as mobile applications (24.5%), anatomy atlases (11.3%) and e-learning software (7.5%).

Students rated the app well. Nearly two-thirds of the volunteers scored it a 4 or 5 on a scale of 1 - 5 ("poor" to "excellent"). Nearly 70% of the respondents particularly liked the app's 3D mode. Many found the glossary useful. And 96.2% told us they would recommend the app to others. This all hints at the potential and opportunities for such technology.

The digital divide

Of course, there were problems too. These largely centred on faulty or missing features, user interface and navigation, 3D elements in the navigation bar and difficulty with the AR mode. These issues could possibly be ascribed to the type of mobile device used not meeting the app's required specifications (Android API level 26 - 30 with a mobile screen aspect ratio of 16:9).

This is a reminder that not all mobile or smartphones and computer tablets are made equal. They are not all configured the same

way, and some students simply cannot afford the high-end phones that are more likely to meet the app's specifications. This emphasises SA's [deep digital divide](#) and its [high poverty levels](#). Many students at our university, and others in SA, come from households with no basic infrastructure and where parents have neither the education nor means to provide them with a technology leg-up.

This is not the end of our work with Anat_Hub. For one thing, future research will aim to determine whether students' performance in anatomy tests and examinations will improve as a result of the app. Further effort is planned to optimise and reduce the size of the app. The ultimate goal is to roll out the app as a learning tool for anatomy within the University of the Western Cape and other institutions.

Applications like Anat_Hub show that home-grown technologies can be developed to meet local needs. But the availability of the technology itself is no "cure" for shortcomings elsewhere in the education system or society more broadly.

Prof. Okobi Ekpo and Marjorie Smith contributed to this article.

Source: The Conversation, 16 August 2022. <https://theconversation.com/mobile-app-offers-new-learning-tools-for-anatomy-students-but-tech-isnt-a-silver-bullet-185919>.

CPD accreditation: SAMA mortality and morbidity guidelines

Lisa Reid, SAMA CPD accreditation and research ethics officer

The following article aims to provide mortality and morbidity (MM) guidelines for CPD accreditation.

A MM meeting should consist of a routine, structured forum for the open examination and review of cases that have led to illness or death of a patient, in order to collectively learn from these events and to improve patient management and quality of care.

Set up

Roles and responsibilities should be clearly defined and accreditation obtained by SAMA: cpd@samedical.org. Meetings should have

a chair or facilitator. One person should be responsible for co-ordinating the meetings. All members should be encouraged to contribute their views.

It should be a regular, organisationally convened meeting, predominantly involving medical practitioners (but increasingly multidisciplinary) who gather to discuss selected cases for the purposes of clarifying medical management and to provide a forum for teaching and system-level learning – focusing on patient safety and quality improvement, including the identification and reporting of errors.

The meeting should identify key events resulting in adverse patient outcomes, and foster open and honest discussion of those events. The purpose is to identify and disseminate information and insights about patient care that are drawn from individual and collective experience, and reinforce system level and individual accountability for providing high-quality care.

The aims are to create a forum that supports open and honest discussion through the provision of a just, patient-centred culture, and to contribute to clinical governance processes.

Content of the meetings

MM meetings should occur onsite. They should be chaired by a senior doctor who takes responsibility for the process, and in doing so, has an ability to engage with clinical colleagues and to facilitate change at the patient care level. This may be the medical director, unit/department head or delegate. Where possible, MMs should be regularly scheduled to maximise participation.

Members of other clinical disciplines and junior medical staff should attend.

Cases for discussion should be identified by:

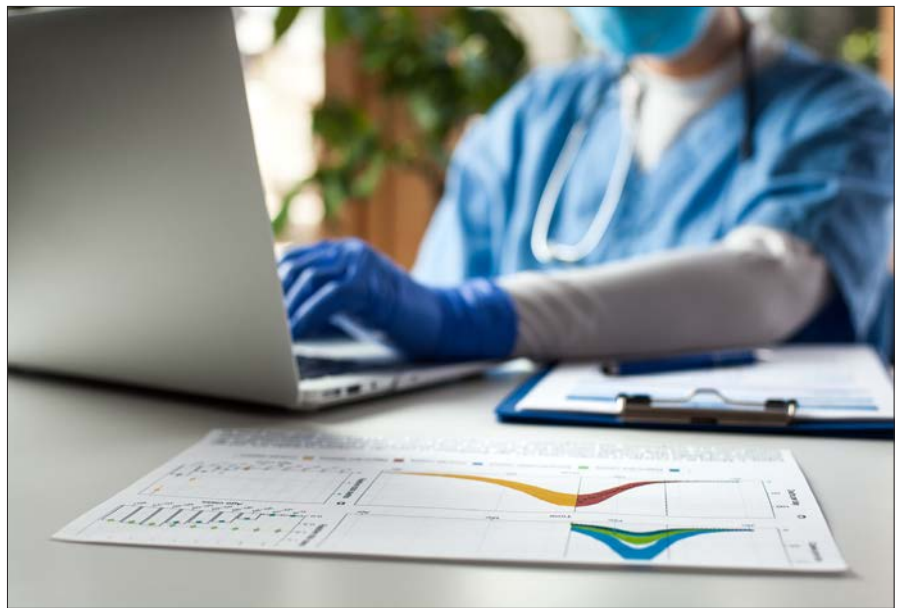
- senior doctors raising specific cases
- referral from other MM meetings.

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

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

Cases should be presented in verbal format in a de-identified fashion, describing only the facts of the case, including any confounding factors. The major issues should be identified during the presentation, with the chair providing further clarification if required. The chair should ensure that following the presentation, the key discussion points are agreed. These should always include:

- What went wrong (or right)?



- How did it go wrong (or right)?
- Why did it go wrong (or right)?
- What could we do differently in future?
- What are the key lessons for the organisation?

A consistent approach to problem-solving should be used to discuss the case. The chair should ensure that any discussion relates to the facts of the case and not to personal issues. This is not a meeting to attack or openly criticise individuals who have contributed to patient care – doing so impedes the development of a "just" culture.

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

At the completion of the discussion, action points should be agreed and prioritised by all present in the meeting. Responses to these issues should be presented at subsequent meetings. Minutes should be kept – patient and doctor details should be de-identified.

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

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

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

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

Letters to the Editor

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

Please note that letters:

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

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



A junior doctor's battle to keep death at bay for state patients

Bhekisisa Team

A junior doctor at a major state hospital in Johannesburg (who wishes to remain anonymous) recounts her journey to hell and back.

I spent half a decade working to get into medical school, then another 6 years training to become a doctor, but it took just 4 months in my dream job before I was completely flattened by it.

I'm now a junior doctor at a major state hospital in Johannesburg. I pushed hard to get a post at this facility because I knew I would get unmatched training.

This hospital's legacy of chaos is well known, and I realised the stress of working there would likely be worse than what people had warned me about.

But nothing could have prepared me for what lay ahead of me – and I wasn't ready.

I expected that I'll work long hours, that I'll have to deal with losing patients, that there would be unkind seniors and [absent colleagues](#). But I did not anticipate that I'd have to face all of it at once, all the time.

I was walking up to 20 000 steps (about 16 km) on a normal day and no matter what I did, the system failed the patients before they even arrived in my ward. I spent the hour's drive to and from work crying and eating, because there was no time for either on the job.

One day I arrived at the hospital to find a patient's bed drenched in blood; she had a rare blood condition and had bled all night. The nurses didn't notice because the night shift was understaffed.

On another occasion, I remember having had to resuscitate a patient for 15 minutes by myself because the nursing staff refused to help. By the time my colleagues arrived, the patient was dead.

But each day I would return, hoping to keep death at bay for my patients for as long as I could.

In May 2021, I cracked. I woke up every day, still tired, and dreading work. Life was a cycle of work, sleep and sobbing.

I didn't see it coming, even though I'd been working for 2 months with only 2 days off.

I was physically exhausted, and emotionally too. The job robs you of moments you can't get back: religious holidays, important family moments, weddings, funerals.



Every time I tried to figure out how I got to this place, I would retrace my steps only to find that it was all me. I made decisions and commitments that led me to this. For what? Dread, a deep hatred for my job and anger at the path I had chosen.

I felt unbearably alone, even though I knew I wasn't the only one. For every horrifying story I can tell, other doctors I've worked with can give 10 more.

I've spoken to colleagues all around the country and time after time health workers – from juniors to those who've been at it for years – all relay how they are brought to a standstill by the mental toll of this job.

The world's doctors are detached and dissatisfied

Looking back, I realise that I was close to burnout last year.

The WHO says people get to this point because of "[chronic workplace stress that has not been successfully managed](#)" and lists feeling exhausted, detached from your job and getting less and less satisfaction from it as [tell-tale signs](#) that someone's job has pushed them to their breaking point.

It's something many doctors experience, and although there aren't consistent figures

(because methods to measure burnout rates among health workers aren't standardised), research shows that the [signs of burnout are seen in more than 80% of physicians](#).

It's not surprising.

Studies, both from [SA](#) and elsewhere in the world, reveal that medical students experience a high mental health burden, with as [many as one in four students showing symptoms of depression](#), especially when they start working in a hospital. And in the midst of the COVID-19 pandemic, hospital health workers had to [deal with even more stress](#) because of relentless workloads, many patients dying and uncertainty. Young doctors, who already experience high stress levels, were particularly vulnerable to burnout, a [study](#) from the UK found.

Crawling back to health

I'm grateful that I had people around me when I reached breaking point: trusted colleagues I could turn to; family who tried very hard to understand even when they didn't; a therapist willing to see me after hours.

I managed to crawl out. But not everyone does.

And this can have devastating [consequences](#) – not only for doctors' own mental

wellbeing, but also for patient care and the broader health system.

Research shows that doctors who are burnt out, or close to it, make more mistakes. They also struggle to make decisions, lose compassion for their patients and may ultimately leave the system, which a public health sector that's [already buckling under the load can ill afford](#).

But there are things that can help health workers to [become more resilient](#), which may carry us through stormy times – perhaps not unscathed, but at least intact. And building these skills as students already may help young doctors to cope better when they start working.

Support programmes such as talking to a counsellor or practising [mindfulness](#) are some tools that can help, and a small [study](#) among medical students from the Western Cape showed that participating in a structured online programme significantly improved students' mental wellbeing and stress management.

Setting up a system where students can talk to peers can also be part of the solution. A study among medical students at a university in the USA revealed that [both the person offering support and the one seeking support benefit](#) from talking about their work-related stress. Similar programmes have popped up at many medical schools in several countries over the past 2 years, perhaps driven by the [increasing mental health burden brought on by the COVID-19 pandemic](#) – to such an extent that young doctors have called for peer support to be [incorporated into medical students' training](#).

Recovery without hope

I don't cry every day on my way to and from work anymore; I guess that's a type of recovery.

What I feel now is closer to hopelessness.

I don't know what I can do to improve things for my patients because I cannot imagine the public health system changing.

At the very least, though, my experience has taught me that having compassion for myself

will help me to keep treating my patients with care.

I've also learnt to look at my colleagues who lack empathy with kindness and my harsh seniors with some care, because I don't know where they are along the chain of brokenness. Everyone has a story and everyone carries around the burden of seeing how their job has whittled away their joy.

Changing the state health system's crises is complicated. It's something outside the scope of the doctors who show up for work every day. But perhaps the first step is acknowledging that doctors aren't heroes; they're humans trying to do a superhero's job.

The author of this opinion piece, a junior doctor, has requested anonymity to ensure they are not victimised; their identity is known to Bhekisisa.

Source: Bhekisisa, 2 August 2022. <https://bhekisisa.org/article/2022-08-02-a-junior-doctors-battle-to-keep-death-at-bay-for-state-patients>.

Reviewing clinical research protocol for ethics approval

Lisa Reid, SAMA CPD accreditation and research ethics officer

SAMAREC (SAMA Research Ethics Committee) follows the standards adopted by the latest version of the FDA and ICH Guidelines for Good Clinical Practice, and conforms to the guidelines laid down by the WMA, in particular, the latest version of the Declaration of Helsinki, the Belmont Report, the National Department of Health, the South African Health Products Regulatory Authority (SAHPRA) and other relevant statutory bodies involved in the healthcare sector.

A REC should consider the following issues when reviewing a proposal for a clinical study:

- the scientific relevance of the clinical study
- the suitability of the investigator(s) for the proposed study in terms of his/her availability, qualifications, experience, supporting staff and available facilities
- the relevance of the study rationale and the appropriateness of the inclusion/exclusion criteria to the SA context
- the suitability of the study application in relation to the objectives of the study, i.e. the potential for reaching sound conclusions

with the smallest possible exposure to risk of participants, and the justification of predictable risks and inconveniences weighed against the anticipated benefits for the participants and/or others

- the suitability of the study population, whether they constitute a vulnerable group, if so whether the research is justified and whether sufficient measures to protect their interests are in place
- whether the number of participants to be recruited is adequate to demonstrate the predicted effect
- risk-benefit analysis taking full cognisance of benefits and harms beyond the life of the study itself, particularly in relation to chronic life-threatening conditions
- if placebos are to be used, whether their use can be justified
- whether by their participation in a clinical study the participants are not denied timely access to medical personnel, investigations, equipment or procedures
- the means by which initial recruitment is to be conducted and by which full information

is to be given and how informed consent is to be obtained

- the adequacy and completeness of the written information to be given to the participants, their relatives, guardians and, if necessary, legal representatives – all written information for the participant and/or legal representative must be submitted in its final form
- whether the application allows the participants and/or their representatives adequate time to consider the patient information document before informed consent is sought
- the content of any advertisements or public notices that will be used to recruit participants to a study
- whether the study protects participants' rights to privacy and confidentiality according to the provisions of the Protection of Personal Information (POPI) Act No. 4 of 2013
- the provision of compensation/treatment in the case of injury or death of a participant if attributable to a clinical study, and the insurance or indemnity to cover the liability of the investigator and sponsor

- the extent to which investigator(s) and participants are to be compensated for participation in the study
- making specific recommendations regarding the continuation of treatments beyond the duration of the study, or mechanisms to ensure that participants' access to treatment are fairly protected and not unduly compromised
- the demographic information available to assess whether the patient population is adequate to support the study
- whether there is no cost to the participant, medical schemes or insurance for trial specific procedures
- whether the product will be made available to participants after the trial ends, and if so whether there is any cost to the participant to continue treatment post-trial
- whether any restrictions will be placed on the publication of results by the investigators after completion of the trial
- the adequacy of the statistical methods proposed to evaluate the data generated, and whether the study is advancing knowledge in the research field.

SAMAREC reviews health research involving human participants prior to initiation of such research, and focuses on the ethical implications relating to the clinical research. Ensuring protection of the rights and welfare of the participants is the committee's primary concern. Based on the above-mentioned standards and guidelines, SAMAREC will advise and make suggestions to study doctors and applicants.

For further information please contact samarec@samedical.org.

Migrants in SA have access to healthcare: Why it's kicking up a storm

Kudakwashe Vanyoro, postdoctoral researcher at the African Centre for Migration and Society, University of the Witwatersrand

A political storm has erupted in SA after a [video went viral](#) showing the health minister for Limpopo Province – which borders Zimbabwe – berating a Zimbabwean woman who was seeking healthcare. Responses have been divided. Some have called for Phophi Ramathuba to [step down](#) on the grounds that verbally abusing a patient was out of order. Others have supported her, saying she reflects the sentiments of South Africans living in the area. *The Conversation Africa* spoke to Kudakwashe Vanyoro, who has done research on the treatment of migrants in SA's healthcare sector, to unpack the issue.

What does the law say about treating non-South Africans?

According to SA's [National Health Act No. 61 of 2003](#), primary healthcare facilities run by the state must provide free care to everyone, except for people covered by private medical aid schemes.

The country's [Refugee Act No. 130 of 1998](#) stipulates that refugees are entitled to the same access to treatment and "basic healthcare services" as citizens in public healthcare facilities. This also applies to undocumented migrants who are citizens of any country in the [Southern Africa Development Community](#). For higher levels of care, refugees and migrants must pass a means test. In some situations, irregular migrants must pay the whole cost of medical services.

These laws reflect the country's Constitution. [Section 27](#) states that healthcare is a right that should be afforded to everyone.

In this context, medical xenophobia is a term that scholars use to describe negative attitudes, perceptions and practices of healthcare providers towards non-national patients on the basis of their national origin. Providers include frontline staff like nurses, doctors, clerks and security personnel.

The main idea that informs this discrimination is that the patient is an outsider and therefore "undeserving" of care in a public facility. The thinking is that non-nationals are overburdening the public healthcare system by using resources that are already scarce.

In my view, medical xenophobia is sustained by unfounded myths such as the myth that non-nationals come to SA in buses to give birth or to get access to HIV treatment. These attitudes and perceptions translate into exclusionary practices such as denial of treatment or delay in accessing services.

In most instances, language, documentation and referral systems are used as vehicles of this discrimination. Healthcare providers scapegoat non-nationals for being unable to speak the local language, lacking referral letters or being undocumented.

How serious is the problem in SA?

It's a very serious problem. But the experiences of non-nationals aren't all the same.

They differ according to geographical context, identity and the kind of treatment a person is seeking.

Take geographical context. Discrimination may be more widespread in metropolitan

spaces like Johannesburg where there's increased political scapegoating of migrants. In this context health simply becomes an extended site for these tensions.

But it's different where undocumented non-national patients seek to use primary healthcare services in towns on the border of neighbouring countries. Take Musina, the northernmost town in SA, just a few kilometres away from the border of Zimbabwe. Here non-nationals access healthcare services with relative ease, partly because of cross-border, intergenerational kinship. This lends a different political meaning to the issue of migration.

The kind of treatment people are seeking also affects the response. Non-nationals with different health conditions have different experiences and outcomes.

This points to the need to avoid generalisations. It's important to break down where the pressure points are and how healthcare providers respond. My [research](#) shows that not all SA health providers are hostile to all African migrants.

Is the current response from South Africans misplaced?

SA's public healthcare system is [overburdened](#). But this is not because of non-nationals. According to the most reliable statistics, they constitute no more than [8% of the total population](#).

The challenges within the public healthcare system relate to the general

shortages of medical personnel, state facilities lacking beds, staff facing high workloads and low morale among nurses in public facilities.

Providing primary healthcare has undoubtedly been complicated by the post-apartheid era's shortcomings in the governance of the health system, mismanagement of funds and state resources, corruption and underfunding. A [report](#) by civil society group Corruption Watch highlights how corruption prevents a vast section of the population from accessing their right to decent healthcare.

The blame on migrants is therefore misplaced as these are health system management and governance issues. This should not be a debate about individuals in a country that continues to feel the effects of health inequalities embedded by apartheid.

How much pressure do foreign nationals put on the system?

A higher concentration of non-nationals is likely in areas of high mobility and transit, like border towns and metropolitan cities.

But this is not significant enough to mount pressure on the public healthcare system. For example, most people who move to SA from within the region are moving for work. This suggests there's no relation between high mobility and seeking health services. Even if there were reported cases of women crossing the border to give birth, the public healthcare system is guided by the [Uniform Patient Fee Schedule](#), which sets out who must pay for certain services at any SA health facility.

And, where there are pressures, these can be buffered if the proper systems are put in place to respond to challenges related to documentation, language and poor referral systems.

What should be done?

The WHO has highlighted the importance of public healthcare systems needing to be responsive to the needs of migrant populations. In a [2019 report](#) it notes countries should accommodate sudden spikes in demand brought on by the arrival of new populations.

The results of poor governance should not be blamed on poor migrants who are simply in need of services. Healthcare providers should desist from being political gatekeepers and instead use notions of morality, ethics and public service in their decision-making.

Source: The Conversation, 30 August 2022. <https://theconversation.com/migrants-in-south-africa-have-access-to-healthcare-why-its-kicking-up-a-storm-189574>.

WHO: Hepatitis outbreak in children

Vismata Gupta-Smith, for the World Health Organization

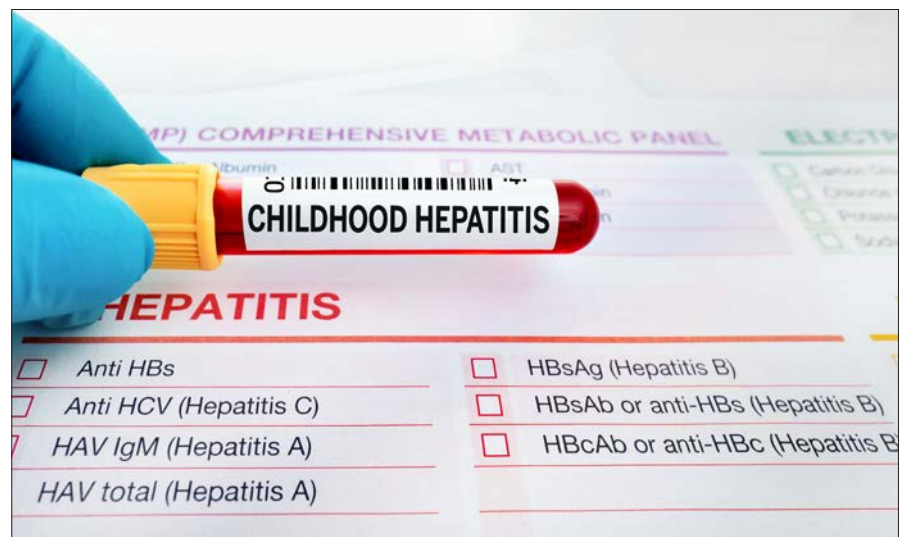
We are talking about a hepatitis outbreak in 35 countries, which is largely impacting children under five. Here I discuss the possible causes and the signs that parents, caregivers and countries should be looking for, with Dr Philippa Easterbrook.

Where are we right now in this outbreak?

Well, the first cases of severe acute hepatitis, which means inflammation of the liver in previously healthy young children, were reported from Scotland in early April this year.

And from that time, over the last 4 months, more than 1 000 cases have been reported from 35 countries worldwide. The majority of these cases are in young children aged less than 5 years old, and most present with the typical symptoms of acute gastroenteritis, so abdominal pain, nausea and vomiting. But then with rapid progression to jaundice indicating liver damage. That's shown by pale stools, dark urine and yellowing of the skin or the eyes. A distinctive feature of this event has been the rapid progression and the severity of the liver disease in previously healthy children.

Around a third have required intensive care support, and 48 – that's around 5% – needed an urgent liver transplant for acute liver failure. And that's a life-changing event. 18 children, that's around 2.5%, died.



But overall, although this is a very serious event, the cases remain rare. Philippa, what do we know about the causes of this outbreak so far?

Well, what was unusual about this event is that we didn't know the underlying cause. So one of the first priorities for the WHO was to work with countries and partners to establish a cause. And early on some of these underlying causes were excluded through investigations of the affected children.

First, that none of the children were infected

with the viruses that commonly cause hepatitis, so – hepatitis A, hepatitis B, C or E.

Secondly, that there was no evidence for a common exposure to foods or water, or to medications or other household members.

And thirdly, and importantly, there was no evidence for a link to COVID vaccination, since almost none of the affected children had been vaccinated. But there was an early clue that a common virus called adenovirus may have a role, either acting alone or as a co-infection

with another virus such as either past or current COVID infection.

So we now have a much better picture and understanding. Around half to three quarters of all the affected children in those who had blood tests or blood samples available and who were tested were positive for adenovirus.

Do we know why a common virus like adenovirus caused such severe disease? And what are the signs that parents, caregivers and countries should be looking for?

We don't know for certain, but there are two likely explanations. First, that the young children had become more susceptible and sensitive to adenovirus. And this might be because over the 2 years that there had been

public health measures for COVID in place, such as mask wearing or closures of schools, there had been much less exposure among these children to many infections, including adenovirus. When these measures were lifted, that's in early this year, there was then an increase of the circulation and transmission of these infections.

A second possible explanation is a role for previous COVID infection. And we know that this was very common in the children. Around 70% had evidence of past COVID infection. And it could be that in some of these children who were then exposed to adenovirus, they had a hyper-reactive immune response that led to liver inflammation and the hepatitis.

But it was also noted that only 10% of the affected children had current active COVID infection. So we don't think that active COVID infection plays a part or is a cause. But there is reassuring news going forward in that the number of cases have declined and these cases remain rare, and the majority of children recover. But it's important that countries remain alert to the possibility of further cases. And that they have in place referral pathways, and facilities to provide appropriate care. And for parents to remain aware that if their child were to develop symptoms of gastroenteritis, which were to worsen, or to develop jaundice, they would seek medical care promptly.

UCT awarded two new SAMRC extramural units

Helen Swinger, for UCT News

Two of four newly launched South African Medical Research Council (SAMRC) extramural research units (EMUs) to develop critical health research have been awarded to the University of Cape Town (UCT). The units, led by top African researchers, will strengthen the country's health systems and counter diseases and pandemics such as COVID-19.

UCT's Prof. Ntobeko Ntusi is the director of the SAMRC/UCT Intersection of Noncommunicable Diseases and Infectious Diseases Unit. Colleague Prof. Collet Dandara is the director of the SAMRC/UCT Platform for Pharmacogenomics Research and Translation Unit.

Unit directorships were also awarded to Prof. Refilwe Nancy Phaswana-Mafuya of the University of Johannesburg (UJ) and Prof. Pascal Bessong of the University of Venda (UNIVEN). Prof. Phaswana-Mafuya heads the SAMRC/UJ Pan African Centre for Epidemics Unit and Prof. Bessong heads the SAMRC/UNIVEN Antimicrobial Resistance and Global Health Research Unit.

Research and development crucial

The four new units extend the SAMRC's many interventions in key areas of health, expanding and complementing the SAMRC's existing 24 EMUs (established within

universities) and the 11 intramural research units (established within the SAMRC).

Speaking at the launch in Johannesburg on 22 August, SAMRC president and chief executive officer Prof. Glenda Gray said the deadly COVID-19 pandemic had highlighted the crucial role of research and development in the health sector.

"When we looked at our choices for extramural units, we wanted to look forward to what the world's going to look like in the next 10 - 20 years and position the SAMRC to not only respond to the diseases of the past and present, but to pivot to the future ... to be prepared for future pandemics and work towards making SA resilient."

Each of the four new unit directors is a recognised black African researcher who has made outstanding scientific contributions to advancing science and building the knowledge base in their disciplines, Prof. Gray said.

The launch comes at a critical point of the SAMRC's Strategic Plan 2021/21 - 2024/25 implementation, Gray added. Importantly, the units will also support the Department of Health's outcome 2 of the Negotiated Service Delivery Agreement, "A long and healthy life for all South Africans".

The launch was also attended by high-level representatives of the medical research community and government health department.



SAMRC president and CEO Prof. Glenda Gray announced the launch of four new Extramural Research Units to respond to the diseases of the past and present, but also to "pivot to the future" (photo: SAMRC)

Nexus of non-communicable diseases and infections

Prof. Ntusi's SAMRC/UCT Intersection of Non-communicable Diseases and Infectious Diseases Unit will enhance the understanding and management of the interaction between endemic infections such as SARS-CoV-2, HIV and tuberculosis, and non-communicable diseases such as



The keynote speaker, Prof. Kelly Chibale, director of H3D, UCT's drug discovery and development centre and the SAMRC/UCT Drug Discovery and Development Research Unit

heart failure, hypertension, diabetes mellitus, obesity, cancer and mental health.

“We wanted to look forward to what the world’s going to look like in the next 10 - 20 years”

Speaking at the launch, Ntusi, who is the head of the [Department of Medicine](#) at UCT and Groote Schuur Hospital, said that non-communicable diseases and infections often co-exist in individuals and manifest in intricate ways. An example is heart failure and hypertension in those with COVID-19.

“To improve our understanding of the management of that intersection of infections and NCDs we must have a systematic approach.”

However, the approach to understanding the managing of this complex nexus has been siloed, he said. This has limited opportunities to study the interaction of non-communicable diseases and infections and siloed approaches to research and clinical practices.

“We must have a systematic approach,” said Ntusi. “This will allow us not only

to better understand mechanisms of disease but will ultimately lead to better management of individuals that suffer from both, particularly those in low- and middle-income countries.”

He added, “The EMU will drive a new area of scholarship, generate new knowledge and a new generation of scientists and associations that will improve the health of those who suffer from these significant public health conditions.”

The new initiative will also bring together scientists from fields as diverse as imaging, basic science, immunology, public health and clinical disciplines.

“My hope is that this will give us the ability to leverage all this expertise to create much greater impact in terms of the work we do.”

In his thanks, Ntusi also paid tribute to the “outstanding contributions” of students, collaborations with staff in the unit, and “extraordinary support” from the research office executives, deputy vice-chancellor for research and internationalisation Prof. Sue Harrison and executive director Dr Linda Mtwisha, as well as the Faculty of Health Sciences.

Pharmacogenomics and precision medicine

Prof. Dandara’s SAMRC/UCT Platform for Pharmacogenomics Research and Translation Unit will identify inherited genetic variations, epigenetic changes and the microbial profiles associated with interindividual differences in the ways patients respond to therapeutic treatment. This includes herbal medicine.

The effects of pharmacogenomics, the intersection of genetics and pharmacology, play a large role in therapeutics, Dandara said at the launch. Dandara heads up the UCT Pharmacogenomics and Drug Metabolism Research Group (PharmGx).

Patients may present the same conditions and symptoms, but underlying genetic data means they show differential responses to the same treatment. This means that a drug produced in one part of the world does not work in the same way in another part of the world. Drug studies on African populations and those of non-African origin in Europe, for example, had demonstrated this.

“We are interested in screening the specific genomes that affect drug responses. We must study this to prevent toxic effects

and drug inefficacy in certain populations,” Dandara said.

“What we are interested in is screening the specific genomes that affect drug responses.”

Dandara said that pharmacogenomics could be used to tailor medications for specific populations. In the future, pre-emptive, one-off testing could become routine among patients. This could dramatically reduce their chances of adverse reactions to prescribed medications.

For this to become a reality, however, many more pharmacogenes in African populations must be characterised. Here capacity building is key, he said.

At UJ, Phaswana-Mafuya’s unit will focus on better understanding current pandemics through cutting-edge pan-African and global research, and epidemiological and public health studies among marginalised populations in diverse, low-resource settings in SA, sub-Saharan Africa and globally.

And at UNIVEN, Bessong’s unit will conduct research on microbial, human and environmental determinants of the acquisition and transmission of antimicrobial resistance. The unit collaborates with communities and policy-makers to enhance our understanding of the dynamics of antimicrobial resistance for improved antimicrobial resistance stewardship.

Build skills, capacity

Preceding the launch, keynote speaker Prof. Kelly Chibale said that the new EMUs would empower and promote high-level research in SA. Essential to this are capacity building and skills.

Prof. Chibale is the Neville Isdell Chair in African-centric Drug Discovery and Development at UCT, the director of [H3D](#), UCT’s drug discovery and development centre, and the director of the SAMRC/UCT Drug Discovery and Development Research Unit.

Citing his own experiences in developing research in drug discovery and development, Chibale said it is critical to identify, develop, train and retain talent and skills in the leaders that will advance science.

Here, job creation is essential.

“Science is not always about just delivering products. It’s also about using science for development to create jobs, and providing hope and inspiration to young people.”

The “genetic link” requirement for surrogacy in South Africa

Thato Molefe, *MacRobert Attorneys*

In SA, as opposed to many other countries, surrogacy is strictly regulated. SA legislation only recognises altruistic surrogacy, while commercial surrogacy is illegal, carrying criminal sanctions if practised. SA formally recognised altruistic surrogacy upon the coming into operation of Chapter 19 of the Children's Act, 2005 in April 2010.

Chapter 19 sets out the requirements for legal surrogacy in SA, and provides for the consequences of such an agreement. Prior to this, the usual practice was for parties to enter into a surrogate motherhood agreement, and upon the birth of the child, approach the Children's Court to apply for adoption. This was necessary because SA law automatically assumed that the birth mother of a child was also the biological mother. However, the legislator recognised the problems that resulted from this unregulated approach, resulting in an extensive mandate to formalise the legality of surrogacy agreements.

Although the sections in chapter 19 are relatively straightforward, it has been challenged on constitutional grounds. In particular, section 294 was challenged in the case of *AB v Minister of Social Development* 2015 (10) BCLR 1228 (2016 (2) SA 27) (GP).

Section 294 reads as follows:

“No surrogate motherhood agreement is valid unless the conception of the child contemplated in the agreement is to be effected by the use of the gametes of both commissioning parents or, if that is not possible due to biological, medical or other valid reasons, the gamete of at least one of the commissioning parents or, where the commissioning parent is a single person, the gamete of that person.”

The commissioning parent is a person who enters into a surrogate motherhood agreement with a surrogate mother, and a gamete is either one of the two generative cells essential for human reproduction.

Therefore, the essence of section 294 is that there should be a genetic link between at least one of the commissioning parents and the child to be conceived.

In the case of *AB v Minister of Social Development*, first heard in the High Court,

the applicant was a single female who was unable to have children. She had undergone a substantial number of unsuccessful IVF attempts, using the gametes of herself and her former husband, a donor egg and her husband's gametes and finally, a donor egg and donor sperm (double-donor). Given these unsuccessful attempts, she thought she could make use of surrogacy. The result of such a surrogacy arrangement would be for a donor sperm and a donor egg to be inseminated into the surrogate mother, who would then carry the resultant pregnancy to term.

At least one commissioning parent needs to have a genetic bond to the child

However, the applicant was informed that section 294 of the Children's Act made it impossible for her engage a surrogate, because she did not have her own gametes (eggs) to use. Section 294 effectively excludes single persons who have a permanent or irreversible condition that does not allow them to produce effective gametes from any surrogacy arrangement. AB therefore decided to challenge the constitutionality of section 294.

The respondent, the Minister of Social Development, argued, *inter alia*, that it was not in the public's best interests to allow a single, infertile person to create a “designer” child with no genetic link to him/herself, and that the adoption process catered for the need of a single parent in AB's position to have a child. The Minister also argued that section 294 was designed to protect the best interests of children and to prevent their commodification. The High Court disagreed with the Minister's submission and ruled that section 294 was unconstitutional, as it infringed a person's right to equality and human dignity (insofar as those who are fertile are able to conclude

a surrogate motherhood agreement, even when they are single, and those who are infertile cannot do so).

The judgment passed by the High Court was a victory for the applicant. However, the declaration of unconstitutionality required confirmation by the Constitutional Court.

The Constitutional Court (AB and another v Minister of Social Development (Centre for Child Law as *amicus curiae*) 2017 (3) BCLR 267 (CC) was faced with the task of either confirming the High Court's finding that section 294 was unconstitutional, or finding that this was in fact not the position. The judgment passed by the Constitutional Court contained both a majority and minority judgment, which meant that the judges were not in agreement on the legal question. The majority of the court found there were legitimate reasons for the inclusion of section 294 of the Children's Act, and it was therefore deemed not to be unconstitutional.

The majority judgment, which to date has not been challenged and remains the current authority regarding the “genetic link” requirement, provided its rationale as to why section 294 was correct and constitutional. After a full ventilation of the various legal questions, the majority were of the view that section 294 was not discriminatory because it was not this section that caused AB (and others in a similar position) to feel socially isolated, marginalised or discriminated against, but in fact an existing medical condition. They ruled that no right to surrogacy *per se* exists in our law, but other options exist that could be used by a person who did not meet the requirements stipulated in chapter 19 (and more specifically, section 294). In other words, a single infertile person wishing to become a parent through surrogacy has the choice to enter into a permanent relationship with a fertile partner and thereby qualify for surrogacy. If the person elects not to do so, then such person must live with the consequences of his or her choice, or alternatively, explore the adoption process. It was the majority opinion that the requirement of donor gametes from a commissioning parent served a rational

purpose by creating a bond between the child and the commissioning parent(s) – which was ultimately in the best interests of the child.

In brief, the majority judgment of Nkabinde J emphasised that the best interests of the child were paramount, both in terms of the Children's Act and in terms

of section 28(2) of the Constitution, while Khampepe J, writing for the minority, also considered the interests of the infertile person wanting to become a parent.

In conclusion, in some respects the provisions of chapter 19 of the Children's Act relating to surrogacy have improved the previous position, where commissioning

parents had to adopt their own biological child following the birth of such child to a surrogate. But our Constitutional Court has upheld the constitutionality of section 294, and so confirmed that at least one of the commissioning parents needs to have a genetic bond to the child to be born in terms of a surrogacy agreement.

Good records in a worst-case scenario

The Medical Protection Society shares a case report from their files

A claim against a hospital and consultant psychiatrist goes to trial, after a patient commits suicide. The Medical Protection Society (MPS) also provides assistance with the inquest and hospital inquiry.

Mrs Q was a 29-year-old new mother of a 2-month-old baby daughter. She had an established history from the age of 21 of recurrent depressive disorder without psychotic symptoms. The management of two previous episodes had been shared between her specialist psychiatrist and her GP. Her last episode, which had occurred 3 years previously after a miscarriage, was associated with fleeting suicidal ideation, and she was briefly admitted as a voluntary patient. Between episodes she made a good functional recovery and had a successful career as a legal secretary. Unfortunately, her relationship with her husband was strained. While the new baby was welcomed, it further highlighted the difficulties around the husband working away from home during the week. Mrs Q's family lived locally and she had a supportive relationship with her elder sister, who was a housewife.

Late one Wednesday evening, she was brought to the emergency department by her sister, in whom she had confided that she was experiencing intrusive, upsetting thoughts of killing herself by jumping from a motorway bridge. She felt extremely guilty towards her baby whom she loved. She had been feeling low ever since the birth, but in the last 3 weeks she had felt this way all day and nothing brought her any pleasure at all. She was admitted to an acute psychiatric ward for 21 days. She agreed she

needed to be somewhere safe and came in voluntarily. Her GP had recently started a selective serotonin reuptake inhibitor (SSRI) antidepressant, and this was continued, along with a long-acting benzodiazepine for agitation, which she was given on a few occasions. Her rapport with staff was good and her mental state was recorded frequently by medical and nursing staff. She had regular 1:1 sessions with her named nurse, which she reported as being helpful.

After a couple of days she disclosed no further suicidal ideation, but persistent biological symptoms including insomnia and anergia impaired her ability to function independently, so her psychiatrist applied for extra funding from her medical aid scheme, and her admission continued for another 7 days. During this time her baby was being cared for by her sister, to the satisfaction of Mrs Q, who didn't want her daughter brought into hospital. As Mrs Q's energy returned, she went on increasing periods of unescorted leave to her sister's house. Careful recordings of her mental state with appropriate risk assessments were made before and after each leave, and Mrs Q always returned at the agreed time. She was not suffering any side-effects from the pharmacological treatment given to her. The ward social worker contacted her sister, who confirmed that the leave periods were going well and, in her view, her sister was getting better.

In the third week, Mrs Q went on a fourth period of leave, but failed to return. Ward staff called her sister, who said she had left her house hours earlier at the appointed time. Later that day, Mrs Q jumped to her death from a multistorey building.

Learning points

- As with any other mental disorder, multi-disciplinary interventions are required to provide appropriate management of patients with depression, as was provided in this case.
- Risks can never be eradicated even with best practice, only reduced. Good record keeping helps to maintain best practice with clear communication between professionals, and demonstrates that best practice has taken place.
- Appropriate record-keeping is recognised as an important component of professional standards, and assists healthcare professions to give a logical account when their decision-making is called into question.

Subsequently, there was an HPCSA complaint and inquest, and an internal hospital inquiry, all of which received considerable media attention. MPS was able to provide medicolegal support to our members at each stage. The high quality of the medical records was invaluable – demonstrating the level of care that had been given.

However, Mrs Q's husband made a claim against the hospital and the consultant psychiatrist for failing to provide good care and not preventing her suicide. The case was defended based on the quality of the healthcare record, where every step was reflected upon and every decision explained. The case duly went to trial and the judge found in favour of the defendants.

Griqualand West hosts informative CPD meeting

The Griqualand West branch hosted a CPD meeting on Thursday, 25 August 2022 at the Flamingo Casino in Kimberley. The topics discussed at the meeting, which was presented by Dr Esme Olivier and Dr Mbesi Joseph Ngundu, were "Alcohol and the law" and "Drunk but never touched alcohol. What could it be?"

Dr Esme Olivier qualified as a doctor at the University of the Free State, and is currently a full-time senior clinical manager of the operating theatre and clinical forensic medicine services in the public sector in SA. She is the chairperson of the Clinical Complaints Review Committee.

Alongside a number of colleagues, she is a member of the Health Technology Committee, as well as a member of the Risk Management and Provincial Medico-legal Task Team. Her clinical interests include forensic pathology.

Dr Mbesi Joseph Ngundu graduated from the University of Kinshasa in the Democratic Republic of Congo in 1989 as a medical doctor (MD), and has the following additional qualifications:

- diploma in public health from MEDUNSA (SA)
- certificate in HIV management from FPD (SA)
- certificate in advanced course in diabetes care for health professionals from CDE (Centre for Diabetes and Endocrinology), SA
- MPH from MEDUNSA (SA)
- MMed Fam Med from University of Pretoria (UP).

After completing his medical degree, Dr Ngundu worked in the following countries: Democratic Republic of Congo, Zambia, the Kingdom of Lesotho, Botswana and currently SA. He has accumulated a lot of experience in rural medicine over the years.

He is currently the head of clinical unit in family medicine in Frances Baard Health District in the district clinical specialist team, with special emphasis on government priority programmes (maternal and child health, TB/HIV and non-communicable diseases).

Dr Ngundu has particular interest in research, diabetes management, HIV/AIDS and drug-resistant tuberculosis. He is a member of the PHREC (Provincial Health Research and Ethics Committee) and PCR (Provincial Clinical Review) committee dealing with drug-resistant tuberculosis and HIV complicated cases. Dr Ngundu is also a master trainer in ESMOE (Essential Steps in the Management of Obstetric Emergencies) and CPR for professionals under RCSA (Resuscitation Council of Southern Africa).

He is also the current chairperson of the SAMA Griqualand West branch since 2017, and he was the co-principal investigator in published research on "Factors contributing to the emergence of drug-resistant tuberculosis in the Northern Cape".

Dr Ngundu runs dedicated diabetes clinics in the Frances Baard Health District in Connie Vorster Memorial District Hospital, Jan Kemp



From left to right (back row): Tarryn Erasmus (Pharma Dynamics), Dr Esme Olivier (head of clinical forensics, NCDoh), Dr Mbesi Joseph Ngundu (SAMA Griqualand West branch chairperson and specialist family physician), Dr Jimmy Amsini (SAMA Griqualand West branch vice-chairperson). Front row: Ms Leanette Bitzi (business development manager, Rhythm Financial)

Dorp CHC and Ritchie Clinic, hence his interest in discussing diabetes management in resource-limited settings.

The meeting was well attended, and the presentations excellent and very informative.

Limpopo branch attends DoH gala dinner

On Saturday 20 August, SAMA's Limpopo branch was invited to attend the Department of Health's gala dinner, held at the Euphoria golf club. The theme for the evening was "Rural health matters".

Branch administrator Emma Fhulufhelo Netshiongolwe set up a SAMA table and banner at the event, handing out pens, masks and membership forms, which were very well received by all who attended. The dinner aimed to thank all the volunteer doctors, including some who had travelled to Limpopo to assist in the rural areas.

Newly elected branch chairperson Dr Daniel Mokumo handed out certificates in recognition of the volunteer doctors' work. He is also the clinical manager at Mokopane Hospital in Limpopo.



Dr Muthweiwana Dombo, deputy director general, healthcare services, Limpopo DoH, with volunteers Dr Kendall Brouard and Dr Paulus Blaauwhof



Branch administrator Emma Fhulufhelo Netshiongolwe represented SAMA at the event

Free State's membership recruitment

On 8 September 2022, the Free State branch held a membership recruitment drive at Botshabelo Hospital and JS Moroka Hospital in Thaba Nchu, Free State.

SAMA and non-SAMA members were welcomed with open arms. Information was exchanged by handing out a branch information pack and SAMA-branded items to the doctors as a token of appreciation.

Dr Benjamin de Bruin, Free State branch executive secretary, delivered a presentation on SAMA member benefits and spoke about the importance of joining SAMA.

The members checked and confirmed their membership status and details, and 10 doctors signed up as SAMA members.



Dr Timothy Masenya (acting clinical medical manager of JS Moroka Hospital) and Dr Benjamin de Bruin (SAMA FSB secretary)



Welcome to SAMA

SAMA welcomes the following new members who joined our association in August.

Cape Western branch

Salaheddin Omran Eknewir

Eastern Highveld branch

Tiisetso Mailula

Moratuwa Palesa Mosia

Eastern Province branch

Trust Kholwane Ngwenya

Free State branch

Zanele Noxolo Buthelezi

Kuhle Hloma

Relebohile Makhallima

Thandile Mazibuko

Erwain Thysie Meyer

Vuyolwethu Mkhwanazi

Philile Mncube

Gomoco Moroenyane

Sibongakonke Manelisi Ngobese

Bulumko Nuxolo Ranelo

Yothando Sikuza

Jacques-Robin Steyn

Christiaan Leon Vosloo

Gauteng branch

Avishbar Gurunand

Ngoie Saddat Kitengie

Angelina Nqobile Msomi

Uhone Netsianda

Azwifarwi Tshifhango

Gauteng North branch

Lerato Ellen Baloyi

Muponisi Ezekiel Chabalala

Tumelo Mabidikama

Pfuzo Masindi

Lehlohonolo Mokgobo Segale

Goldfields branch

Serialong Angeline Mkatsane

Griqualand West branch

Munyaradzi Madhombiro

Tshepo Donarvin Peloele

KZN Coastal branch

Abdul Kader Essop Ismail

Amanda Suprise Mqadi

Bulunga Ndumiso Mpumelelo

KZN Midlands branch

Nabeel Mahomed

Thembeke Ngubane

Limpopo branch

Ompha Mulaudzi

Vongani Shilumane

Lowveld branch

Patrick Madunyana Hawkins Maduna

Africa Rodney Manzini

Casandra Mbazima

Irshaad Saley

North West branch

Mpho Patricia Baloyi

Jamie Louise Colloty

Transkei branch

Samuel Yao Alomatu

Nthabiseng Thaba Dila

Thembokuhle Mgadi

Sinengomso Xuma



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**
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 - Excellent Service
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