

SAMA INSIDER

NOVEMBER 2022

**Mental health:
How are we doing?
What do we need to do?**

**Inside a Joburg
emergency room
during loadshedding**



**SOUTH AFRICAN
MEDICAL ASSOCIATION**

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WEBINAR | Three Years into COVID-19: Lessons, Challenges and Recommendations

Presented by the South African Medical Association and the South African Medical Research Council, a revered panel of experts will share their expertise as they reflect on the reality 'beyond COVID-19'.

Speakers

Prof Linda-Gail Bekker

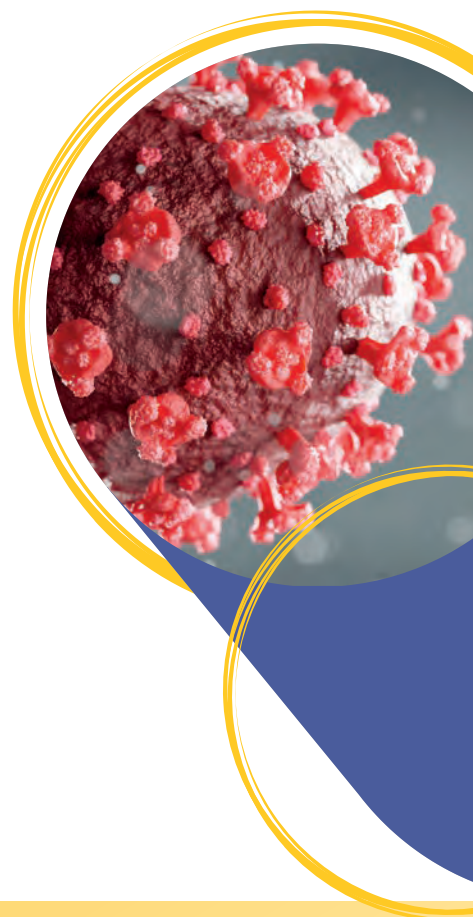
Physician-Scientist at the Desmond Tutu HIV Centre

Prof Ames Dhai

Chairperson of the UNESCO International Bioethics Committee

Dr Shirley Collie

Chief Health Analytics Actuary at Discovery Health



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CONTENTS

NOVEMBER 2022



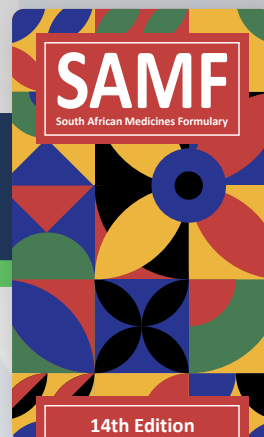
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- | | |
|--|---|
| <p>3 EDITOR'S NOTE
Time for change
Diane de Kock</p> <p>4 SAMA IN THE NEWS</p> <p>4 From the desk of the CEO
Dr Vusumuzi Nhlapho</p> <p>5 FROM THE PRESIDENT'S DESK
Thinking like a doctor, acting like a humanitarian
Prof. Risenga Chauke</p> <p>6 A torchlight tragedy: Inside a Joburg emergency room during loadshedding
Jesse Copelyn</p> <p>7 "Add human rights defender to your resume": How Tlaleng Mofokeng uses medicine to treat indignity
Dr Tlaleng Mofokeng</p> <p>8 Using outcome measuring and reporting to improve the SA health system
Bernard Mutsago</p> <p>9 Mental health: How are we doing? What do we need to do?
Prof. Lesley Robertson</p> <p>10 CPD certificates now available on HPCSA online portal
SAMA Communications</p> <p>11 COVID pandemic created immunisation gaps in Africa. Over half a million children are at risk
Edina Amponsah-Dacosta</p> <p>12 A 5-year-old osteosarcoma patient undergoes SA's first Van Nes rotationplasty procedure
SAMA Communications</p> | <p>14 Quality conscience: Doing the right thing
Brandon Ferlito</p> <p>14 Badmouthing colleagues unethical and risks healthcare reputational damage
Dr Yash Naidoo</p> <p>16 HIV treatment in SA: How to help people stay on ARVs when life gets in the way
Melanie Bisnauth</p> <p>17 Webinar: 3 years into COVID-19: Lessons, challenges, and recommendations
SAMA Communications</p> <p>18 ADHD brings creativity, focus, energy and neurodiversity to the workplace
SAMA Communications</p> <p>19 Rural Doctor of the Year: Craig Parker – the doctor-engineer who created a COVID lifeline for rural areas
Biënne Huisman</p> <p>20 Obesity costs South Africa billions. We did the sums
Micheal Boachie</p> <p>20 MEDICINE AND THE LAW
Caught by consent
Medical Protection Society</p> <p>22 BRANCH NEWS</p> <p>24 WELCOME TO SAMA</p> |
|--|---|

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Diane de Kock
Editor: *SAMA INSIDER*

Time for change

This month we celebrate reaching finality in the SAMA/SAMATU case (page 4), humanitarianism (page 5), challenging loadshedding in hospitals (page 6) and the importance of recognising human rights (page 7).

In her article, Dr Mofokeng appeals to healthcare workers to use the practice of medicine as “a powerful tool in the restoration of people’s dignity” and to “add human rights defender to your resume”. This appeal resonated recently when world-renowned cancer surgeon Prof. Carol-Ann Benn resigned from the Helen Joseph Hospital after 17 years’ dedicated service at the public health facility. “There was harassment and an obstructive workplace culture that made our daily working lives impossible,” said Benn, who is known as a doctor who puts her patients first.

Changing attitudes to mental health is paramount, as illustrated so tragically by Life Esidimeni. “Gross inhumanity towards people with mental illness occurs in our country at institutional and individual levels,” comments Prof. Lesley Robertson, adjunct professor in the Department of Psychiatry at Wits. In her article (page 9) she analyses how we are doing and what we need to do. “We need to have the right conversations, and a willingness to change.”

COVID-19 exposed fault lines in health systems and national routine immunisation programmes around the world, which resulted in the largest sustained decline in childhood vaccine coverage rates (page 11). “There is a need to intensify demand for vaccines and immunisation programmes. This is critical to build back public confidence and trust in vaccine immunisation services in a post-COVID world.”

Helping people stay on ARVs in SA is critical. “People living with HIV need to be on ART for their whole lives,” but sadly many interrupt treatment. In the article on page 16 the authors maintain “the needs and views of people with HIV must be heard and considered to protect and build on the health gains from the country’s antiretroviral programme.”

The SAMA/SAMRC webinar on 1 December will look at lessons, challenges and recommendations 3 years into COVID-19 (page 17) – “issues that have needed to be confronted since the onset of COVID-19, from the scientific, health and ethical aspects, in order to dissect the uncertainties we currently face and to consider what our trajectory going forward ought to be.” Register in advance for this webinar at https://us02web.zoom.us/join/register/WN_ZfDtcxbjRbCTuVtsPxjC8g. After registering, you will receive a confirmation email containing information about joining the webinar.

As we near the end of 2022, let’s open new conversations and be a catalyst for change.

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SA could face state of medical emergency over health worker shortage, warns SAMA

SAMA said that the country may soon find itself in a state of medical emergency over the shortage of healthcare workers.

The association said that more than 40% of doctors were looking at leaving SA because of the poor working conditions.

Adding to the list of problems were the extended bouts of power cuts.

The association's Dr Mark Human said that urgent intervention from the government was needed to address the critical staff shortages at hospitals.

"We want to help people, and if you are completely hamstrung in your ability to do so, you will move elsewhere, and that is why so many doctors are looking at moving elsewhere. It's got nothing to do with salaries," Human said.

Tamika Gounden: Eyewitness News, 7 October 2022.

Deep crisis for hospitals in SA

SA's critical private and public hospitals are facing an onslaught of challenges making it

harder to care for patients – with extended loadshedding exacerbating a skills shortage in the sector.

Speaking to [ENCA](#), chairman of SAMA Dr Mvuyisi Mzukwa said that there is a huge possibility that vulnerable people going into theatre, having a child at a hospital or in ICU could face serious complications because of loadshedding.

He has called on the government to take action and exempt all hospitals from blackouts: "It is important we do it as quickly as we can."

SA has experienced the worst loadshedding it has ever seen on record this past week, with stage 5 blackouts persisting for most of the week.

The national power utility on Sunday (25 September) [announced](#) that stage 3 loadshedding would continue to be implemented during the day between 00h00 and 16h00, escalating to stage 4 during the evening peaks between 16h00 and 00h00.

Mzukwa said that power surges have been ripping through medical equipment, and despite there being battery backups or generators in some hospitals, when

loadshedding reaches the higher stages, such as stage 5 or 6, they cannot sustain energy for long enough.

Backup systems also often don't kick in on time or at all due to poor maintenance – systems need to be able to supply the electricity in seconds as soon as a blackout occurs, said Mzukwa. SAMA has not been alone in calls for intervention, with the HPCSA echoing its sentiment.

In a statement by the council's president, Simon Nemutandani, loadshedding was said to be crushing hospitals across the country.

According to HPCSA, over 80% of the population relies on the public health system, with 420 state-run hospitals and 3 000 state-run clinics that often do not have backups.

The Department of Health's Phaahla said he was concerned about the situation but expected loadshedding to ease. He has now ordered that the director-general work with provincial heads and finalise an assessment.

He said the department is also looking at ways to exempt hospitals from loadshedding.

Extract from article: Business Tech, 27 September 2022.

From the desk of the CEO

Dr Vusumuzi Nhlapho, SAMA CEO

SAMA represents the interests of its members. The organisation is approaching the end of the year, with its eyes set on achieving its objectives and key results for the benefit of its members.

It is with excitement that we are reaching the finality of the SAMATU case. On 5 October 2022, SAMATU's application for leave to appeal was dismissed with costs. What this means is the following:

- SAMATU is interdicted and restrained from unlawfully and otherwise interfering with SAMA's business, by distributing communication, orally or in writing, addressed to the general public, to SAMA members, to SAMATU members, to the media, to government departments and/or government officials.
- SAMATU is restrained from interfering with the rights of SAMA.
- It further prohibits SAMATU from unlawfully competing with SAMA.
- Additionally, it restrains SAMATU from taking any steps whatsoever to encourage

SAMA members to cancel or not renew their membership with SAMA.

We have entered the phase of nominations into SAMA committees. All member-driven committees are responsible for promoting health through their expertise and influence in the medical profession, influencing and advocating for SAMA policy with respect to issues pertaining to healthcare, protecting the integrity of the profession against unethical practices, fraud and preserve practices, and growing SAMA membership. These are the committees that opened for nominations from 10 October to 6 November 2022:

- South African Registrars Association (SARA)
- Specialist Practice Committee (SPC)
- General Practitioner Private Practice Committee (GPPPC)
- Academic Doctors Association of South Africa (ADASA)
- Junior Doctors Association of South Africa (JUDASA)

- Public Sector Advocacy Forum (PSAF)

On the international front, SAMA was represented at the WMA General Assembly in Berlin, where two important documents that have taken years to finalise were accepted. These were "Physicians Treating Relatives" and "Assisted Reproductive Technologies". The importance of this alignment was successfully sought from national medical associations represented from across the world. SAMA sits on two workgroups – Advocacy and Communications and Reproductive Technology and we are happy to report that these have progressed very well. SAMA also strengthened the relationship with the AMA on coding, and this is a unique offering that we are proud to offer to members. Furthermore, the recent assembly adopted the revised International Code of Medical Ethics. We will be embarking on unpacking these revisions in the next issue.

Thinking like a doctor, acting like a humanitarian



Prof. Risenga Chauke, SAMA president

The profession of being a medical doctor takes years to achieve. As a profession it is usually a humble one. In the not-so-distant past, training to be a doctor was like training for the military – follow the instructions and do as you are told, or you're out.

Recently, this militaristic type of training is slowly relenting, and trainees are much freer to engage their supervisors without needing to feel intimidated or scared. But it does still happen that the trainees or juniors feel intimidated by their elders.

What is it about the training of medical doctors that even necessitates this discussion? Doctors are trained in processes and algorithms for diagnosis of a particular disease, and eventually in treating the disease.

The medical thinking or way of processing things follows a particular set of standards in a dogmatic way. But this dogmatic thinking often deprives doctors of a humanitarian way of doing things.

The humanitarian way encompasses soft skills – while doctors' training may encourage their viewing patients as objects, the humanitarian approach promotes ethics and compassion.

Acting like a humanitarian that means that while you maintain a systemic way of thinking and doing things, humanitarian behaviour should take precedence.

The insurance companies that cover medical negligence have it on record that patients who are treated with dignity and respect are much less likely to sue or pursue a doctor legally, even if a medical mistake were to happen, than patients who were treated with disrespect.

COVID-19 has increased our humanitarian needs, which were already high before the pandemic. The world economic meltdown is also worsening the situation. Poverty levels are on the rise. We are dealing with climate change, wars, and rumours of wars among nations. All of these increase the necessity for humanitarian compassion.

Patients who come to be seen by doctors are in need of compassion. We as doctors can make their lives a little bit easier by caring a little bit more for them, rather than just thinking of them as processes.

We need to elevate a humanitarian way of doing things in our practices, be they private or public. In that way, we will help to lessen the burden of problems that our patients carry.

Humanitarianism has to do with a belief in improving people's lives and reducing suffering. In fact, as doctors, in our mission we should be motivated by humanitarianism.

This humanitarianism should not be limited to our interaction with patients in our practices, rooms or hospital wards. It should spread and encourage each of us to participate meaningfully in our communities.

This way of doing things could improve the outputs in our community engagements. My belief is that community involvement should not be limited to health-related matters. We should be actively involved in school projects, political projects, church projects and similar activities around our communities. In so doing, we will add meaning to the lives of those who look up to us.

The gains from such activities will not be limited only to those we interact with: we ourselves will gain, and reduce our work-related pressures – and therefore improve our mental wellbeing.

As doctors, we should not have an “us and them” – rather we should live by the mantra, “they are us, and we are them”

Doctors, as humanitarians, should work towards advancing the wellbeing of humanity as a whole. Humanitarianism is the antithesis of the “us versus them” mentality. As doctors, we should not have an “us and them” – rather we should live by the mantra, “they are us, and we are them.” We should acknowledge that we are members of the communities that made us, where we come from, where we live, before we are doctors.

We need to elevate a humanitarian way of doing things in our practices, be they private or public

The fundamental principle of humanitarianism is found in almost all religions: “Do unto others as would be done unto you.”

So, as doctors, in all the spaces we find ourselves in, let's embrace the concept of humanitarianism, while applying the particular way of doing things our training has taught us.

A torchlight tragedy: Inside a Joburg emergency room during loadshedding

Jesse Copelyn, for *Bhekisisa*

In the emergency room at Charlotte Maxeke Johannesburg Academic Hospital in July, a doctor was holding his patient's eyelids open with one hand and moving a pen light across the man's face with the other.

The patient, in his early 20s, was unconscious. Dried blood covered his hair and face.

He'd been rushed to the trauma unit after falling from a significant height and the doctor was trying to establish whether he was brain dead.

Both of his pupils constricted as the light passed over them.

It was a **sign that the man's brain was functioning**, at least partially.

There was potentially still time to operate and save him, says David Kerr,* a medical student who was on the young man's treatment team.

"We needed to act fast."

Kerr and his supervisor rushed to make a booking for the CT scanner, a **sophisticated X-ray machine** that could help the doctors to figure out exactly where the brain damage was, and whether it could be fixed in surgery.

This patient's situation was so urgent that he would likely be pushed to the front of the queue, Kerr remembers thinking.

But the administrator in charge of scheduling appointments for the CT scanner had bad news – loadshedding had kicked in.

The lights were still on because most of the hospital was supported by a series of generators.

But the CT scanner wasn't working. The machine uses an **enormous amount of energy**. To scan 7 904 patients over a 1 year period, it requires the same amount of power as **14 households in the Cape Town suburb of Delft**.

A confused back and forth ensued between Kerr's supervisor and the administrators: was there any way to switch the machine on?

But they warned him: "There's nothing we can do."

An additional senior source at Charlotte Maxeke confirmed that the hospital had been left without a CT scanner due to loadshedding in July. Although Kerr doesn't know why the generator wasn't able to support it, there are several potential explanations.

A radiologist at a different Johannesburg government health facility told *Bhekisisa* that CT scanners are often offline during loadshedding because they use so much power. Another common problem with these complex machines is that they can fail when their source of electricity changes from the Eskom grid to the backup power supply, says **Tony Behrman**, a Cape Town-based hospital management expert.

Helpless, Kerr and his supervisor returned to their unconscious patient. They would have to monitor him for hours until the power was back.

About an hour later, Kerr's supervisor repeated the torchlight test. This time, the patient's right pupil responded, but the left eye just stared back, blank and fixed.

"We all really wanted to help him," recalls Kerr, "but there was just nothing we could do, it was heartbreaking."

By the time the power came back on – 3 hours after the patient had been booked into the hospital – neither of the man's pupils moved.

But there was still a small chance that the hospital's brain surgeons could save him. So the doctors pushed the man into the scanner.

The machine revealed a brain bleed so severe that the neurosurgery department decided that if there had been a window to save him, it had now passed.

Soon thereafter, the patient was declared brain dead.

When the trauma specialist in charge of the emergency unit heard that hours had passed before the patient got a CT scan he was furious.

"You let this patient die," he screamed at the team. "You killed him."

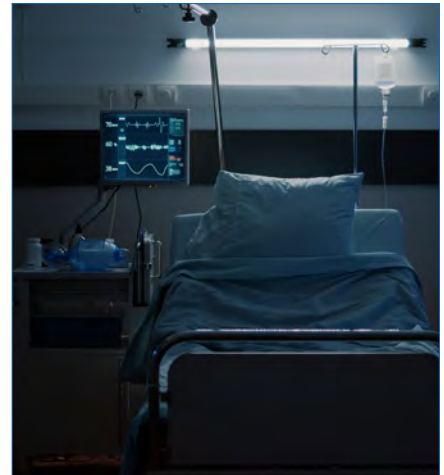
But his anger dissipated as soon as he heard the word "loadshedding". He apologised.

And that's the moment that stood out to Kerr, because if it had been the doctors' mistake that delayed treatment for the dying man, it would have been a serious offence.

The fact that it was the government's failure meant the incident was uncontroversial.

Kerr concludes: "We just carried on with the day."

**David Kerr is a pseudonym. The medical student requested anonymity out of fear that he would be victimised for speaking out. His identity is known to Bhekisisa.*



Source: Bhekisisa, 22 September 2022. <https://bhekisisa.org/health-news-south-africa/2022-09-22-a-torchlight-tragedy-inside-a-joburg-emergency-room-during-loadshedding/>.

SAMA comments

SAMA has demanded that all public health facilities be exempted from loadshedding, as the blackouts compromise the delivery of healthcare and can lead to unfortunate outcomes for patients. The association said it had noted with grave concern the conditions that healthcare professionals found themselves working under during loadshedding.

Eskom implemented stage 6 loadshedding in September, causing blackouts at more than 3 000 state-run clinics across the country that depend on the state-owned enterprise. SAMA said the blackouts were adding "salt to the wound", given the dreadful state of public hospitals.

Chairperson Dr Mvuyisi Mzukwa said they believed that the overall working environment challenged the ability of healthcare professionals to deliver the most basic healthcare. He said in general, the health system was collapsing and this was compounded by issues regarding uninterrupted electricity supply, clean, safe water and medical supplies. He added that loadshedding compromised essential emergency operations.

“Add human rights defender to your resume’’: How Tlaleng Mofokeng uses medicine to treat indignity

Dr Tlaleng Mofokeng



Before I was an activist and an [author](#), I was perhaps the most frustrated medical doctor in SA.

I grew up in Qwaqwa, a rural town in an apartheid-era bantustan, now called the Free State.

Because of the unjust conditions of the racist regime, I had no choice but to fight for survival; I didn't choose activism, activism chose me.

Today, I may be a rebellious Catholic, but when I was growing up I spent my school holidays at the monastery visiting the nuns.

At the convent, I could choose one of two activities. I could do the stations of the cross (a [14-step Catholic prayer practice which commemorates Jesus Christ's last day on Earth](#)) for hours each day. Or, I could do something which I still think was the best decision of my life — I could help the nuns take care of the elderly.

This experience made me want to be a doctor for as long as I could remember.

Women are people; not a collection of organs and ailments

At medical school, we were biomedically trained. In practice, the conditions we worked under meant we didn't have the time to consider the wide range of experiences

patients had and how those things impacted their health.

Often, you'll hear public health experts say that women need to know that early detection for breast or cervical cancer can save their lives.

But what does it take, practically, for a poor rural woman to make multiple visits to a clinic for a screening test? They may have to wait months for their results and even longer to be referred to a specialist should they need treatment.

Many women have to choose between competing needs for themselves and their families. Sometimes it's about making a decision between putting petrol in the car or buying food for the household.

I realised that we, as doctors, were being trained to see patients – especially women – as a collection of organs and ailments.

Women were no more than expectant mothers or future caregivers or potential cervical cancer cases.

At no time did we stop to consider that they were individuals with their own stories, desires and aspirations.

Safe abortion saves lives

These days, I see the practice of medicine as a powerful tool in the restoration of people's dignity.

That means understanding the ways in which racism, colonialism, imperialism, white supremacy, capitalism, ableism (discrimination in favour of able-bodied people) and transphobia have multiple and compounding effects.

These systems of power continue to determine who is seen as fully human.

That is why in my capacity as the [United Nations special rapporteur on the right to health](#), I [submitted](#) an amicus (friend of the court) brief to the US Supreme Court, at the time it was considering overturning [Roe v Wade](#), a court ruling that ensured the right to an abortion in the USA for nearly 50 years.

I [wrote](#) to the court that abortion rights are human rights. When a pregnant person asks for a [safe abortion](#), they are asking for control over their own body and self-determination of their own future. They're

asking for the ability to continue their education or to earn a living.

As a proud abortion provider, I am telling you that [safe abortions save lives](#).

I'm worried that the US court's decision to [scrap the right to terminate a pregnancy in June](#) takes us back to a darker time. They are already hinting at a long list of rights that might be taken away too — [LGBTQIA+](#) and same-sex marriage rights, as well as the right to contraception.

The function of freedom is to free someone else

We are truly living in challenging times. I am tired.

But there is one thing that gives me hope: more and more people are practising their professions in service of human rights.

Elected leaders and those in positions of power may not be doing much, but we are a community of doers.

We, the goalkeepers, are leaders at this moment.

And so, I have one request: Add "human rights defender" to your resume.

The right to health is indivisible and it's key for gender equality and necessary for [sustainable development](#), peace and security.

As goalkeepers, we must ensure that people realise their rights and move from surviving to thriving.

As the late novelist Toni Morrison [said](#): "You are moving in the direction of freedom and the function of freedom is to free somebody else."

Tlaleng Mofokeng is a medical doctor and the United Nations special rapporteur on the right to health. She was speaking at the Bill & Melinda Gates Foundation's Goalkeepers meeting held in New York City on 20 and 21 September. This is an edited version of her speech – watch her full speech [here](#).

Source: Bhekisisa, 12 October 2022. <https://bhekisisa.org/opinion/2022-10-12-add-human-rights-defender-to-your-resume-how-tlaleng-mofokeng-uses-medicine-to-treat-indignity/>.

Using outcome measuring and reporting to improve the SA health system

Bernard Mutsago, *SAMA health policy researcher*

The recent Southern Africa Outcome Measuring and Reporting (OMR) conference, held virtually on 16 and 17 September 2022 in SA, showed that traditionally, health systems have rewarded volume over value, and this needs to change. SAMA joined a wide array of professionals concerned about better healthcare and outcomes, stakeholders committed to value-based healthcare and an expert panel to deliberate on how OMR can be improved in the SA health system.

The convening of this conference was driven by a confluence of factors in the SA health system, namely a fragmented approach to structural, process and outcome measurement; findings of the Health Market Inquiry (HMI); the recognition that National Health Insurance (NHI) is not a silver bullet; and the ongoing international push for clinical practitioners to influence OMR frameworks.

Conference delegates were reminded that the SA health system continues to be marred by bad indicators in the public and private sectors, while incomplete, sporadic and non-standardised information on provider performance and clinical outcomes persists. It was revealed that norms and standards exist mostly in the public health sector, although some standards have been piloted in the private sector and among GPs. The health system is currently characterised by an absence of standardised, reliable and readily accessible information on health outcomes. The health system has a diverse set of players involved in quality and outcomes processes, but operating in a siloed fashion, including health quality assessment, the Council for Medical Schemes, the Board of Healthcare Funders, the office of Health Standards Compliance, the Independent Practitioners Association Foundation and hospital groups. The capitation model also creates an unfavourable environment for better OMR, as it captures only volume, and price-quality considerations are not tightly integrated.

The meeting invoked the findings of the HMI report, which notes that the private sector is characterised by rising care costs without commensurate improvements in health outcomes. There is also market concentration, a regulatory void for practitioners and the



absence of value-based purchasing. The HMI highlighted the fact that outcome measuring is key, and recommended the establishment of a new and independent statutory body to perform this function, called the Outcome Measuring and Reporting Organisation.

One of the success factors for an OMR system is the vital participation of practitioners. Practitioners must own the dialogue about how OMR can improve our healthcare system. The HMI recommended that the establishment of the OMR system should be practitioner-driven. The physician community can actively engage in the OMR process through some of the following actions: advocating for and supporting an OMR system; documenting structural, process and outcome measures to track disease management; ensuring that effective national protocols are in place; assisting stakeholders to develop and design data collection tools and processes; and working with the Office of Health Standards Compliance, among other activities.

The goal of OMR must be improving patient care – hence the conference underscored patient-reported outcome measures, concomitant with a person-centred care model. Patient-reported outcome measures should be applied across the board, that is, should be used by all stakeholders.

To achieve effective OMR, value-based care should take centre stage. There are powerful global forces steering a course towards value-based care. According to the value-based care guru, Prof. Michael Porter,

patient value is defined as patient-relevant outcomes, divided by the costs per patient across the full cycle of care. The central tenet of value-based healthcare is maximising the value of care for patients and reducing the cost of healthcare. The fee-for-service system dominating private care in SA is antithetical to the philosophy of value-based care, with its overservicing, excessive costs and rewarding of volume over value. The fee-for-service model has repeatedly come under strong criticism for rewarding bad performance.

Delegates at the OMR conference were unanimous that OMR projects should start forthwith: further delays are unwarranted. There was agreement that OMR needs to be informed by national policy, protocols and care pathways. There was expressed preference for OMR to start with conditions that make good clinical and financial sense. Alignment should be ensured between the public and private sectors, and approaches need to be evidence-based and compliant with legislation such as the Protection of Personal Information Act No. 4 of 2013, as OMR involves processing individual health data. Another winning formula is the avoidance of politics and vested interests – OMR should not be a matter of control, but collaboration. Within a public health system, better OMR and quality care for patients will thrive in a highly decentralised decision-making set-up coupled with high localised accountability.

More details on OMR can be obtained from the website of the OMR Conference: <https://omrc.co.za/>.

Mental health: How are we doing? What do we need to do?

Prof. Lesley Robertson, *for Spotlight*

As a proud South African, I am always conscious of our resilience, our ingenuity and how we come together in adversity. But things are falling apart. Plagued by bereavement and job losses, betrayed by politicians and heads of institutions, and an ever-present fear of crime, trauma and violence, our centre cannot hold.

Mental health awareness fills our radio talk shows and magazines. However, ignorance, discrimination and outright abuse of people with mental illness prevail.

Think of the "Tembisa 10" story.

Only social development staff protected Ms Sithole's right to privacy and referred her for mental healthcare. Healthcare providers were seemingly unaware of her need. Nando's continues the abuse, with a mocking advert inferring she deliberately scammed others. That she has mental health issues is public knowledge. How lacking are we in insight and judgement?

Gross inhumanity towards people with mental illness occurs in our country at the institutional and individual levels. At institutional level, the most obvious is the Life Esidimeni tragedy. At the individual level, remember Jostina Sangweni, accused of witchcraft and brutally murdered earlier this year. Our mental health awareness clearly fails to protect people with psychosocial disability (psychosocial disability is used here to include people with mental and/or intellectual disability).

Population wellbeing and psychosocial disability

In 2020, SA ranked 103 out of 149 countries on the [happiness index](#), a measure of population wellbeing derived from six factors: GDP per capita, social support, healthy life expectancy, personal freedom, the good will of others and trust in government.

While demographic and other inequities are not reflected, it is likely that people with psychosocial disability fare the worst. Mental health conditions negatively impact wellbeing – they increase the risk of unemployment, social exclusion, poor physical health, shortened life expectancy, loss of autonomy and liberty, being a victim of violence and government neglect.

Globally, the COVID-19 pandemic has taken its toll on mental health, and the happiness



index of many countries worsened. High-risk groups are those with greater mental health problems, including women, youth and poorer people. While social cohesion is protective, people with pre-existing mental health conditions are the loneliest, and at highest risk for severe symptoms and poor recovery.

In their concluding [observations](#) on SA of 2018, the UN Committee on the Rights of Persons with Disabilities (UNCRPD) expressed grave concern regarding the rights of people with psychosocial disabilities. Our medical model of disability and mental health legislation were criticised. The needs of women and children were emphasised. We need to change the way we live so that people with psychosocial disability may also experience wellbeing.

Societal change

Every citizen contributes to an environment that enables others to flourish.

Mental health literacy is imperative, not only awareness of emotional pain, post-traumatic stress, anxiety and depression, but understanding the range of conditions. We need to comprehend what life is like for people with intellectual disability, autism, attention deficit hyperactivity disorder, bipolar and psychotic disorders. We need to learn about personality (as in how we perceive ourselves and the world around us) and intergenerational trauma. Our knowledge of substance use disorders is particularly poor;

people with harmful or dependent substance use are so often shunned, even as we advertise alcohol and some of us extol the virtues of cannabis.

Social cohesion strengthens psychological resilience. Conscious, positive social interactions with inclusion of those with psychosocial disability are needed. To mitigate stress, safety and security are fundamental. Trustworthy government is pivotal. Abusiveness, crime, illicit substance trade and violence thrive on the back of corruption and mismanagement. While we all suffer, those with psychosocial disabilities are often rendered helpless and homeless.

To prevent disability, early recognition of mental health conditions, support in accessing care and assistance in recovery are essential. Family, neighbours, employers, colleagues, educators, police, lawyers, prison wardens, religious groups, healthcare providers – everyone in contact with the person must play their part. For those with severe psychosocial disability, structured support is often required. Protected employment and supported living are two ways of enabling their participation in society.

Throughout all, kindness, empathy, compassion and altruism pervade. This does not mean self-pity is indulged or harmful behaviour excused. It means we stand by those who struggle as they experience the consequences of their choices and actions, practise prosocial behaviour and gain self-efficacy.

Health system change

While society supports the person with psychosocial disability in utilising healthcare, quality care must be accessible. Quality care implies that it impacts positively on the person's life. Accessible implies that the services are known to the user, acceptable, available, affordable and appropriate to their need.

Our current system is inaccessible, even in provinces that use more than 5% of public health expenditure on mental healthcare. Around 90% of people who need care do not access it. Of those who do receive care, most are male, many access it through involuntary admissions (a process at odds with the UNCRPD) and almost a quarter are re-hospitalised within 3 months of discharge, implying therapeutic failure. We have no idea how many are better off for accessing care.

What must we do? We need to see major shifts in mindset and structure at micro (individual), meso (system) and macro (national) levels. None of them are novel.

Items to consider

1. At micro-level: a shift from disorder- to person-centred mental healthcare, with:

- shared decision making in the therapeutic process
- patient satisfaction
- meaningful outcome measures which reflect improvement in social and occupational functioning, mental health symptoms and distress, physical health, and wellbeing.

2. At meso-level: a shift in treatment setting from psychiatric hospital to community, with:

- a focus on rehabilitation, recovery and prevention of disability – infrastructure at community level is needed to facilitate effective therapeutic assessment and process

- every healthcare practitioner, from lay health workers to subspecialists, understanding their patients' mental health and be able to intervene appropriately
- collaboration between mental health, general health, social care and non-health stakeholders – infrastructure that facilitates collaborative care is required, including internet and data availability, confidentiality agreements and the physical space for face-to-face group meetings at district or community level
- access to general hospital psychiatric care before symptoms or behaviour are unmanageable; hospitals to see themselves as serving the community.

3. At macro-level: a shift towards prioritisation of mental health, with:

- a change in mindset in health system planners and funders to facilitate employment of specialists at district level, i.e. to allow for community psychiatry. While primary care practitioners must be trained and capacitated to provide primary mental healthcare to people with any mental health condition, there is no evidence that they can assess and effectively manage severe mental illness. Expecting them to do so will increase healthcare provider stress, as responsibility and patient need outweigh expertise
- recognition of psychosocial therapeutic interventions as health technologies. Health technology assessments of specific occupational therapy, psychotherapy, physiotherapy, counselling and social work interventions to allow incorporation into healthcare packages and insurance funding
- feasible, detailed implementation plans, with appropriate budgetary allocation to enable

equitable, accessible services at each level of care

- good governance, with transparent, rigorous monitoring and evaluation of the system, its financing, and its effectiveness in achieving wellbeing among people with mental health conditions.

Finally, our mental health policy needs updating, and the UNCRPD has recommended that our mental health legislation is repealed as it allows for substitute decision-making (when others decide on behalf of a person deemed to lack mental capacity, such as with involuntary or assisted hospital admissions). Legislation that endorses supported decision-making (whereby a person nominated by the individual with psychosocial disability supports them in coming to their own decision) is recommended by the UNCRPD. While this recommendation is controversial globally, we have not yet begun to discuss it in SA.

Nevertheless, our national mental health policy was not implemented, and our legislation has not resulted in accessible, person-centred care close to people's homes. The UNCRPD and the WHO have outlined a way forward, adaptable to local conditions. We need to have the right conversations, and a willingness to learn and change.

Prof. Lesley Robertson is an adjunct professor in the Department of Psychiatry, University of the Witwatersrand, and leads the Sedibeng District Specialist Mental Health Team in Gauteng. She writes in her personal capacity.

Source: Spotlight, 4 October 2022. <https://www.spotlightnsp.co.za/2021/10/04/mental-health-how-are-we-doing-what-do-we-need-to-do>.

CPD certificates now available on HPCSA online portal

SAMA Communications

Effective from February this year the HPCSA CPD certificates will no longer be issued to HPCSA professionals. A template will be completed after each activity by the service provider of the event/activity and sent through to the HPCSA for capturing on points.

The new process will automatically upload the accredited CPD event/activity

points to the HPCSA medical professionals' profile.

The new process alleviates the burden on professionals to keep track of certificates and allows automatic update of your CPD points directly to the HPCSA. It also places no administrative burden on the medical professional but rather

on the service provider providing the CPD activity.

Any discrepancies of point allocation can be discussed with the service provider of the event/activity.

For more information contact: cpd@samedical.org

COVID pandemic created immunisation gaps in Africa. Over half a million children are at risk

Edina Amponsah-Dacosta, *postdoctoral research fellow, Vaccines for Africa Initiative, University of Cape Town*

The COVID pandemic exposed the fault lines in health systems and national routine immunisation programmes around the world.

A recent WHO report showed that the pandemic fuelled the largest sustained decline in childhood vaccine coverage rates.

These declines threaten to undo the exceptional efforts made in preventing and controlling the devastating burden of vaccine-preventable diseases globally. Routine immunisation has prevented 2–3 million deaths yearly. Of the lives saved, 800 000 were in the Africa region. Routine immunisation has led to a drastic reduction in diseases like neonatal tetanus and measles. And bacterial meningitis (type A) and polio have virtually been eliminated across the continent.

The repercussions of the pandemic on routine immunisation programmes in the African region are yet to be fully realised. What we do know so far is that the pandemic has resulted in substantial disruptions to national routine immunisation programmes. As a result, the continent is seeing an increased number of outbreaks of vaccine preventable diseases.

African countries had nearly eliminated the deadly form of meningitis type A. But a 4-month-long meningitis outbreak was reported in the Democratic Republic of Congo in 2021. It accounted for 2 665 cases, claiming 205 lives. This resurgence has been linked with the suspension of meningitis vaccination campaigns at the height of the COVID pandemic. In February 2022, Malawi reported its first wild case of poliovirus type 1 in 30 years. A second case followed in Mozambique 3 months later. The outbreaks sparked mass polio vaccination campaigns across southern Africa.

UNICEF and the WHO have warned of the heightened risk for measles outbreaks, given widening immunisation gaps.

Currently, Zimbabwe is contending with a devastating measles outbreak. Within 5 months, there have been 6 551 confirmed measles cases and 704 related deaths.

These emerging outbreaks are a matter of great concern. They call for urgent and sustained public health interventions. Unless these are put in place, the compounding effects of the pandemic could derail regional progress towards the global immunisation targets that secure the health and wellbeing of infants and children.

The resurgence of deadly vaccine-preventable diseases underscores the importance of maintaining high vaccination coverage rates. Children everywhere must have access to all the recommended lifesaving vaccines they need. The disruptions observed during the COVID pandemic also highlight the importance of establishing resilient health systems. Systems must be able to withstand acute and prolonged shocks while delivering essential health services like immunisation programmes.

Immunisation before COVID

It is important to contextualise the performance of routine immunisation programmes within the African region. Even before the pandemic, the African region was already contending with a precarious situation.

For one, an estimated 30.7 million children under five continue to suffer from vaccine preventable diseases. These include rotavirus diarrhoea, pneumonia, pertussis and measles. Of these children, more than 520 000 die each year because of poor access to essential immunisation services.

The continent's health systems have to manage on average 150 cases of disease outbreaks and other public health emergencies every year. These range from armed conflicts to climate-related disasters (including flooding, drought and famine) and disease outbreaks. National routine immunisation programmes have had to function in this context.

The pandemic widened immunisation gaps

On the continent the pandemic has substantially disrupted national routine immunisation programmes. In many countries health systems were forced to divert limited resources to combat the pandemic. This often left immunisation services vulnerable.

At the height of the pandemic, several countries reported having to suspend vaccination services. There were disruptions to vaccine supply chains that led to stockouts. The number of people taking up immunisation services declined due to restrictions on public gathering. Many people also feared being exposed to the virus at health facilities.

A good measure of the COVID-related disruptions to immunisation programmes is the

coverage of the three doses of the diphtheria-tetanus-pertussis (DTP3) vaccine. The WHO uses the coverage of DTP3 to monitor access to immunisation services and measure the performance of broader health systems.

The WHO report shows that the COVID-19 pandemic contributed to a general decline in DTP3 coverage globally – irrespective of economic power or income level.

In Africa, national immunisation programmes in several countries maintained optimal performance, achieving DTP3 coverage rates above 90%. These included Algeria, Botswana, Burkina Faso, Burundi, Ghana, Kenya, Malawi, Mauritius, Namibia, Sierra Leone, Uganda and Zambia.

Of concern, however, are the 29 countries that recorded coverage of less than 90%, creating substantial immunisation gaps.

DTP vaccine coverage in many African countries was below the WHO's 90% threshold. The increased misinformation and disinformation during the pandemic also led to some decline in public trust and confidence in immunisation services. This has significantly affected vaccine demand.

Charting a way forward

The pandemic provides useful lessons on the importance of continuously strengthening health systems and "crisis-proofing" national routine immunisation programmes.

COVID-19 has been a catalyst for renewed political interest in immunisation programmes. But this must be followed up with regional solidarity to re-prioritise routine immunisation in the national and regional public health agendas.

National governments will have the responsibility to secure and sustain donor funding while increasing domestic financial commitments that will fill the funding gaps for national immunisation programmes. This is in line with the declarations they have endorsed.

But most importantly, there's a need to intensify demand for vaccines and immunisation programmes. This is critical to build back public confidence and trust in vaccines and immunisation services in a post-COVID world

Source: The Conversation, 21 September 2022. <https://theconversation.com/covid-pandemic-created-immunisation-gaps-in-africa-over-half-a-million-children-are-at-risk-190565>.

A 5-year-old osteosarcoma patient undergoes SA's first Van Nes rotationplasty procedure

SAMA Communications

A 5-year-old Angolan patient with osteosarcoma (bone cancer) in the right femur received a new lease on life after becoming the recipient of SA's first Van Nes rotationplasty procedure at the expert hands of Life Vincent Pallotti Hospital's super-specialised Life Orthopaedic Hospital team.

Van Nes rotationplasty is a surgical procedure used to treat bone cancer of the lower limb where standard limb-saving reconstructions are not possible. It consists of shortening of the leg with a rotation of 180° of the lower leg, which is adapted to the remaining upper leg bone (femur), changing the ankle function into a new knee joint.

"The procedure provides patients with more function than a traditional amputation would, as the patient's ankle acts as a substitute for the knee joint. It allows a prosthesis to fit more comfortably, providing better leg mobility and stability than patients who undergo a full high above knee amputation," says Dr Thomas Hilton, orthopaedic oncology and joint replacement surgeon at Life Orthopaedic Hospital at Life Vincent Pallotti Hospital in Cape Town.

Dr Hilton met the 5-year-old Angolan patient, who had bone cancer in the lower part of the thigh bone (femur), when he travelled to Namibia for an orthopaedic oncology outreach programme in the Windhoek Central state hospital. "Standard limb salvage procedures were not possible for the child due to the extent of the tumour, and a Van Nes rotationplasty was deemed to be the best surgery for her," added Dr Hilton.

Dr Hilton led the unique 6-hour *pro bono* procedure at Life Orthopaedic Hospital with support from Life Vincent Pallotti Hospital specialists and Dr Alma de Waal, an anaesthetist from Groote Schuur Hospital. "This is a great example of how public-private partnership can help patients," he said. Dr Hilton explained that standard methods use mega-prosthetics or healthy bone tissue transfers with titanium plating systems. In a Van Nes rotationplasty, the middle and lower section of the femur, including the knee, is removed along with the cancer, and the lower shin (tibia), ankle and foot are then rotated 180° and reattached to the remaining thigh or femur bone.

According to Dr Hilton, a rotationplasty is more common in young children because



Dr Thomas Hilton, the patient and parents

they have so much growth remaining in their skeleton that standard prosthetics would leave them with a limb that would be too short to be useful. Most children recover well from rotationplasty and are more likely to adapt to the prosthesis because they are young and learn much faster than adults. They can usually resume activities such as running, ballet, climbing trees or playing soccer.

"I am truly privileged to be able to work with bone and soft-tissue tumour/sarcoma patients. They are some of the bravest patients in the world.

"Bone tumours or bone sarcomas like osteosarcoma do not get enough airtime in the media and exposure to fundraising and research. Fortunately, they are rare cancers. This doesn't make it any less difficult for the patients who are diagnosed with them. They are usually young with their whole lives ahead of them and face gruelling chemotherapy and life-altering reconstructive surgery. In modern medicine we can perform limb salvage surgery in more than 90% of cases," explains Dr Hilton.

He added that in a small number of patients, limb saving is not possible, and amputation is necessary to provide local control of the tumour. Some amputations are morbid and do not leave the patient with a good function ability due to short amputation stumps. There

are also cultural and traditional fears and concerns that affect decision-making and acceptance of traditional amputation.

"Van Nes rotationplasty provides a good functional option for young patients where traditional methods of saving a limb are not possible. It is not an easily accepted reconstructive method due to its unusual cosmetic appearance. We hope that this brave patient and family will serve as ambassadors to help counsel future patients considering a Van Nes rotationplasty," concluded Dr Hilton.

"We are proud of the clinical accomplishments and milestones of our Life Orthopaedic Hospital team, and we are fortunate to have highly skilled super-specialised orthopaedic surgeons and nursing staff that offer our patients this level of care and clinical intervention, of course with the support of our complementary services and medical aid funders," said Gavin Pike, hospital manager at Life Vincent Pallotti Hospital.

The Life Orthopaedic Hospital at Life Vincent Pallotti Hospital has been providing over 13 years of super-specialised orthopaedic care to the community, and continues to strive to be at the forefront of orthopaedic patient care, treating patients with an array of orthopaedic conditions that require clinical intervention.

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Providing quality healthcare for over 80 years

Quality conscience: Doing the right thing

Brandon Ferlito, PhD student, Department of Philosophy and Moral Sciences, Ghent University, Belgium

On 8 November 2022, the world celebrates World Quality Day, which is listed on the SA Department of Health's health awareness calendar. World Quality Day, established by the UN in 1990, aims to increase public awareness of the value of professional performance of duties and tasks in organisations and across nations to support the advancement of innovation, growth and sustainability. The theme for this year's World Quality Day is "Quality conscience: Doing the right thing". The theme highlights the importance of the healthcare profession and government leaders to drastically change our mind-set on quality and to be conscious of our responsibility and unique role in ensuring that trust is earned and maintained.

In SA, providing quality healthcare is a Constitutional obligation. There have been significant changes over the two decades in health policy and regulations to ensure compliance in providing quality care, and the government has consequently implemented a number of improvements and programmes to improve healthcare, efficiency, safety and quality of delivery and access for all users. However, despite the government having set a number of admirable objectives for bettering the standard of service delivery in healthcare settings, reports in the media reveal that public healthcare institutions' services still fall short of basic standards of care and patient expectations. Due to the ongoing challenges, the SA healthcare system has been described as "ruined and in serious need of repair".

There have also been significant efforts to increase the standard of healthcare service in SA, yet users of healthcare continuously express concerns about a number of public institutions. There is seldom a day that goes by that we do not hear about quality failures and how they affect patients, employees and stakeholders. The following problems are just a few of many: extended wait times due to a lack of staff, adverse events, poor hygiene and inadequate infection control procedures, increased litigation due to preventable mistakes, a lack of resources for medicine and equipment, and poor record-keeping. In addition to the onslaught of challenges facing the country's healthcare system, the current ongoing energy crisis is making it harder to care for patients.

Despite the significant efforts over many years to reform the healthcare system and raise the standard of care provided to patients, many recipients of healthcare still experience avoidable harms every day. As a result, there is still much that needs to be done by the government and society as a whole to address the issues of poor service delivery. There have been several effective treatments and proposals to improve the standard of healthcare in SA. However, it appears that corruption and a lack of leadership abilities still cause significant delays in the delivery of high-quality healthcare.

Nevertheless, SA has the opportunity to use its knowledge of health disparities and the negative effects of past segregation to create high-quality healthcare service delivery that

will benefit all citizens. According to Meiring, the following methods can be used to address healthcare quality:

- keeping patients safe and limiting risks
- constantly delivering on promises to patients, clients and stakeholders
- leading continuous quality improvement initiatives
- identifying and integrating new evidence-based practices into our healthcare services
- monitoring and analysing existing and new processes and outcomes
- ensuring that regulatory requirements are achieved and maintained.

In addition, leaders in the healthcare and government sectors must help healthcare organisations set up effective procedures to guarantee that objectives are reached and that they keep their commitments to stakeholders, patients and clients. The cornerstones for creating, maintaining and enhancing the reputation and trust in the healthcare industry are systems of governance, assurance and improvement coupled with a culture of quality. The work done by custodians of quality in healthcare organisations has a significant role in improving outcomes, raising efficiency levels and cutting costs.

The theme of "Quality conscience: Do the right thing" is simple. Let World Quality Day 2022 serve as the catalyst for universal access to high-quality healthcare.

References available on request.

Badmouthing colleagues unethical and risks healthcare reputational damage

Dr Yash Naidoo, case manager, Medical Protection Society

As an organisation that has been working for SA doctors for 65 years, and which supports more than 31 000 members in the country, the Medical Protection Society (MPS) has insight into areas of medicolegal risk that many might not think about. Dr Yash Naidoo, case manager

at MPS, offers some timely advice on how interprofessional criticism can negatively affect your relationship with patients, and even increase your risk of complaints.

After 2 years of working from home, the working world is slowly starting to return to the office. With that comes the commute, and

for many, like me, the car radio. I tune in to one of Johannesburg's popular breakfast shows during my drive, and pay little attention to the chat segments between songs.

One morning, however, there was something different on the radio. The host – a well-known celebrity – said something

that immediately pricked up my ears: "I have a bone to pick with every single dentist in the country." Oh no, I thought. What have we done?

I was a dentist before becoming a practising lawyer. Those two professions are relevant in the context of this article. I no longer practise either profession, but instead my current role gives me the privilege of assisting doctors, dentists and other healthcare professionals when they find themselves in trouble with their regulator, among other things.

If the profession is brought into disrepute, then the public will lose faith in its professionals

Back to the radio show. It turns out that what had happened to the host was that she had consulted a new dentist and was pleasantly surprised to hear his positive comments about the dental work done by the previous dentist. "Every other dentist I've gone to ... the first thing they rush to do ... is to trash the dentist you went to before," the radio host proclaimed. Her colleagues in the background at the studio could be heard concurring. They all agreed that the practice of making disparaging comments about colleagues, in a particular profession or industry, annoyed them.

They then opened their phone lines to the public, asking people to call in and say which professions they believed were notorious for a lack of collegiality – specifically, which professionals don't compliment their colleagues. Dentists featured prominently. Lawyers too.

Interprofessional animosity was highlighted by a caller – between physiotherapists and chiropractors. Doctors were also mentioned – by more than one caller. One pointed a finger at GPs, while another was very specific in describing what she perceived to be a spat between ophthalmologists and optometrists. When questioned on which of the two professions she fell under, her reply was that she was neither, but that she had first-hand experience of disparaging remarks made by each professional about the other, when she was required to take her child to consult both.

Even sangomas (traditional healers or diviners) were not spared. The radio host

summed it up perfectly: "It actually doesn't serve the patient."

For me, this segment provided a fascinating insight into public sentiment and perceptions about various professions. Particularly the healthcare professions. And it reminded me about a specific rule of the HPCSA, and why the rule is so important.

The HPCSA rule

The HPCSA's ethical rule 12 says that "(a) practitioner shall not cast reflections on the probity, professional reputation or skill of another person registered under the (Health Professions) Act or any other Health Act."

Let's break that rule down and focus on some of the less straightforward terms.

"Shall" is archaic legalese. Put simply, it means "must". "Cast reflections" essentially means to look back on something, in this context, in a negative light. "Probity" is the quality of having strong moral principles, honesty, decency. The remainder of the rule needs no further dissection.

To put it simply, as healthcare practitioners registered with the HPCSA, we must not badmouth our colleagues.

Why does the rule exist?

That question is understandable. Does the HPCSA simply want us to sugarcoat our views and heap praise on our colleagues for the sake of it? No – the rule clearly does not say that. But what is its purpose?

The reason will perhaps become clearer when viewed in the context of the HPCSA's general ethical guidelines for healthcare professions.

The HPCSA says the primary professional duty of a healthcare practitioner should be concern for the patient's best interests and wellbeing. To fulfill this duty, they must, among other things, honour the trust of their patients and be mindful that they are in a position of power over their patients, and should avoid abusing this position.

The preamble to the general ethical guidelines starts with the first sentence: "Good clinical practice is based on a trust relationship between patients and healthcare professionals."

With this background, it should be clearer why the rule in question exists. It is there to ensure that the reputation of the profession is upheld. And not for the sake of the professions, but for the sake of the patient. If the profession is brought into disrepute, then the public will lose faith in its professionals, which in turn leads to a breakdown in trust and, inevitably, compromised clinical practice.

We are human

I appreciate that it is not always easy to keep tight-lipped. A slip of the tongue can happen, even innocently, as an observation in passing. Or a thought out loud. But we must remember the rule, the reason for it, and then ask ourselves – is the comment I am about to make going to benefit the patient in any way? If the answer is no, then it should not be said.

Reporting unprofessional, illegal or unethical conduct

With that said, it is not the case that you should always remain silent. That is where the HPCSA's rule 25 comes in. It says you must report any unprofessional, illegal or unethical conduct on the part of another colleague to the HPCSA. The circumstances under which this rule would be applicable are beyond the scope of this article, but it is mentioned here as a reminder that there are conflicting duties and rules in professional practice, and when faced with such conflicts, careful consideration is required before acting.

Without trust, clinical practice is compromised. And the best interests of the patient fall by the wayside

Conclusion

The healthcare profession is a noble profession. We have a duty to uphold its reputation. This reputation is important for the public's trust in the profession. Without trust, clinical practice is compromised. And the best interests of the patient fall by the wayside.

A negative comment about a colleague, said to a patient, can create a negative perception of the profession as a whole. Before making a comment about a colleague, ask yourself if it will benefit the patient in any way. If not, don't say it. And if you find yourself in a professional or ethical dilemma, remember to contact MPS to request assistance.

Source: Medical Brief, 12 October 2022. <https://www.medicalbrief.co.za/badmouthing-colleagues-unethical-and-risks-healthcare-reputational-damage>.

HIV treatment in SA: How to help people stay on ARVs when life gets in the way

Melanie Bisnauth, public health technical advisor, Anova Health Institute and doctoral researcher, School of Public Health, University of the Witwatersrand, Kate Rees, public health medicine specialist, University of the Witwatersrand, Cathrine Chinyandura, researcher, University of the Witwatersrand

Antiretroviral therapy (ART) has turned HIV into a manageable chronic condition. When ART is working effectively, HIV cannot be transmitted. This allows people with HIV to live fuller lives without the fear of infecting others. It's also led global HIV control efforts to focus on increasing ART coverage. The aim is to improve the health of people living with HIV, and to decrease and eventually halt the spread of the virus.

UNAIDS set 90-90-90 targets to measure global progress by 2020: 90% of people with HIV know their status, 90% of those with a known status are on treatment, and 90% of those on treatment are virally suppressed (a blood test result that means ART is working effectively). These targets have now been increased to 95-95-95, to be reached by 2030.

SA has [achieved](#) the first 90 target but it [falls short](#) on the second 90. Despite having more than [5.5 million people](#) on treatment, only 75% of those with a known status are on ART.

Poor retention in health services is one of the most important reasons for this. People living with HIV need to be on ART for their whole lives. This is a tough ask, and although the pills are available free of charge in public health institutions, many people [interrupt treatment](#). Modelling and programme [data suggest](#) that the number of people re-initiating ART is as high as, or higher than, the number of people starting treatment for the first time.

Interrupting treatment is a problem for two reasons. First, people who aren't on treatment are likely to become sick and die. Second, without consistent treatment HIV can be transmitted, leading to additional infections.

At [Anova Health Institute](#) we support the Department of Health in providing HIV services in five districts of SA. In a [recent study](#), we wanted to know more about why people with HIV interrupt and return to treatment, and how we can support them to stay in care.

Reasons for stopping treatment

We surveyed 562 and interviewed 30 people returning to care after interrupting ART in three provinces in SA. We also explored



service provider challenges in providing treatment and care.

Our [analysis](#) showed that retention in care is influenced by multiple factors. These include individual, family, societal and healthcare service barriers.

Mobility or relocation was the most common reason for treatment interruption, reported by close to a third of respondents. It was followed by ART-related factors, including side-effects, and feeling too sick to continue ART (15% of respondents), and time limitations due to work (10%). Participants who move around a lot said managing their ART was difficult because of administrative hurdles.

[Health service barriers](#) included negative service provider attitudes and providers insisting on transfer letters, which led to interruption of treatment and care. Feedback sessions conducted with 99 healthcare providers revealed that people returning to care were sometimes sent to the back of the queue or turned away if they did not have transfer letters. Both these practices are discouraged in national guidelines. Most providers [reported](#) they had seen or heard other providers act poorly towards recipients of care after interrupting ART. The poor behaviours and attitudes of providers were partly attributed to limited resources and work overload.

On the other hand, we [found](#) that clinics that had flexible and extended-hours services

were better able to keep people in care. This shows that health services need to be more responsive to different life circumstances.

What must be done

Health systems should be set up to allow people to change where they pick up their drugs. [Movement between provinces](#) is common in SA. Health services need to be more responsive to people moving within and between districts and provinces, as well as outside SA. A functional health information system is needed to link medical records and allow movement between clinics or drug pick-up points anywhere in the country. Healthcare providers should not insist on transfer letters. [The official policy](#) requires people to be assisted without a transfer letter, but in practice many are turned away. Improved treatment literacy would also empower people to understand their own treatment and demand access to care.

ART and other services relating to HIV and other chronic diseases can be provided in [many ways](#) inside and outside [health facilities](#). In SA, ART and chronic medication can be provided through the [Dablapmeds programme](#). This allows people to collect 3 months' medication at pick-up points closer to home or work. Models like this should be supported and strengthened.

People with HIV [told the Department of Health](#) they wanted prescriptions for 12 months,

and ART refills of 3 - 6 months. A 12-month prescription was used during COVID-19 as an emergency measure, and Anova's programmes reported no decrease in viral suppression. This policy should be expanded.

Healthcare providers need improved working conditions and support to improve their ability to provide empathetic, quality services. Overall, the country needs more patient-centred and responsive health services to improve retention on ART.

People on ART need [comprehensive support](#) that covers medication-related issues,

psychosocial support and socioeconomic support. Proactive strategies could include check-in phone calls or messages, appointment reminders and pop-up sites to collect treatment in remote communities, and after-hours facilities. Task shifting allows different forms of treatment support to be offered, and can promote [ART adherence](#).

Why this matters

Supporting people living with HIV to stay on treatment is the biggest challenge currently facing SA HIV services.

The needs and views of people with HIV must be heard and considered to protect and build on the health gains from the country's antiretroviral programme.

Services that are flexible and take into account people's changing life circumstances will improve health and decrease HIV transmission.

Source: The Conversation, 26 September 2022. <https://theconversation.com/hiv-treatment-in-south-africa-how-to-help-people-stay-on-arvs-when-life-gets-in-the-way-190684>.

Webinar: 3 years into COVID-19: Lessons, challenges, and recommendations

SAMA Communications

Since the 16th century, at least three pandemics have re-occurred at 10- to 50-year intervals, with varying levels of morbidity and mortality. Infectious disease outbreaks, such as Ebola, influenza, AIDS, SARS and MERS, have featured prominently at an international level over the last few decades, with data suggesting that these catastrophes are increasing in frequency.

The COVID-19 pandemic has resulted in an unprecedented burden on human health, significant disruptions in healthcare systems, and grave social and economic consequences. It has affected large parts of the world population, and its effects will last for several years. All countries and regions were unprepared for the COVID-19 pandemic, with no country or region in the world having adequate public health structures to manage the situation. The virus spread quickly, even in some of the best-resourced regions. Inequitable access to preventative and treatment modalities has been the experience globally. Also concerning has been the political response, with a lack of consistent messaging and, at times, irrational decision-making. Pandemic corruption, including in the procurement of urgent personal protective equipment (PPE) and medical supplies, has been rife in some areas. On the social front, simple preventive measures have been ineffective without clear guidelines. Unjust vaccine nationalism, and in some parts of the world, queue-jumping to gain early access to vaccines outside national priority guidelines, were also seen. On the other hand, low and waning vaccine confidence and a loud anti-vax

voice have also adversely impacted efforts to contain the infection. That there may be another outbreak, which could be more dangerous than the COVID-19 pandemic, is an inevitable reality. We must utilise the lessons learned during this pandemic to be prepared for such an eventuality.

A good understanding of the scientific and technical aspects of this outbreak is critical to inform acceptable and comprehensive ethical deliberations and analysis around different aspects of the pandemic. Since the beginning of the outbreak there has been a huge bulk of scientific literature resulting in an "infodemic" or even a "panicdemic". One of the greatest scientific achievements has been the remarkable speed at which vaccines were made available to the public. Vaccines have reduced the infection rate as well as the number of severely infected people, and deaths, especially in vulnerable people. Most of the vaccines available today require two doses to be effective. However, over time the protection wanes, and booster shots have been advocated especially for the vulnerable.

As we move into the third year of the pandemic, we witness a decline in the numbers becoming infected, an easing of restrictions, a further waning of vaccine uptake, pandemic fatigue and in some quarters, increasing efforts to understand the lessons learned, ranging from the social through to economic and ethical aspects.

However, similar to the dawn of COVID-19, we remain steeped in uncertainty as we approach its dusk. Are we truly in the tail end? When will the pandemic be declared to be over? And will

SAVE THE DATE

Date: 1 December 2022

Time: 18.30 - 20.30

CPD: 2 clinical points

Register in advance for this webinar:

https://us02web.zoom.us/join/register/WN_ZfDtcxjbRbCTuVtsPxC8g

After registering, you will receive a confirmation email containing information about joining the webinar.

it transition to endemic status? Are the vaccines still of value? Should we continue encouraging unvaccinated people to take the vaccine? And what about the boosters? How many doses do we need? Going forward, will we require one or two shots annually against SARS-CoV-2? These are just some of the questions we grapple with currently.

On 1 December 2022, SAMA, in collaboration with the SA Medical Research Council (SAMRC), will host a webinar with authorities in the field to explore issues that have needed to be confronted since the onset of COVID-19, from the scientific, health and ethical aspects, to dissect the uncertainties we currently face and to consider what our trajectory going forward ought to be. Prof. Linda-Gail Bekker, physician-scientist at the Desmond Tutu HIV Centre, Prof. Ames Dhai, chairperson of the UNESCO International Bioethics Committee, and Dr Shirley Collie, chief health analytics actuary, Discovery Health, will share their expertise as the "beyond COVID-19" reality is being reflected on.

ADHD brings creativity, focus, energy and neurodiversity to the workplace

SAMA Communications

More than 1 million SA adults with attention deficit hyperactivity disorder (ADHD) represent an “untapped opportunity” for businesses to enhance inclusion, advance workforce diversity and improve their performance and competitive advantage.

Employees with ADHD might need some adaptations in the workplace for how they think and work differently, but in exchange, they bring positive qualities of innovative problem-solving, out-of-the-box thinking, high energy levels, focus under pressure and an entrepreneurial mindset, says Prof. Renata Schoeman, head of the MBA in Healthcare Leadership programme at Stellenbosch Business School.

September 14 was National ADHD Awareness Day, highlighting a condition that often affects not only children but continues into adulthood and, if not properly treated, impacts the ability to find and keep work.

“However, adults with ADHD can be highly intelligent, creative and out-of-the-box thinkers, with high energy levels, and the ability to hyper-focus when under pressure or really interested in and engaged with a task,” she said.

Employers who show understanding and are willing to make simple, non-costly accommodations can reap the benefits of “brains that are wired differently” to foster diversity of thinking and different approaches to work, enhancing collaboration, creativity and innovation in solving business challenges.

“Research has shown that ADHD has low treatment rates, which can come at a cost in productivity losses, reduced quality of work output and increased sick leave. However, studies have also shown that companies that purposely hire a neurodivergent workforce and, most importantly, support them, outperform their peers on the bottom line,” Prof. Schoeman said.

Most children with ADHD will carry it through to adulthood, but the symptoms in adults differ, she said.

Childhood hyperactivity shifts in adults to being disorganised, easily distracted and impulsive. Adults with ADHD tend to have poor time management and are often running late; they are forgetful and lack attention to detail; have poor listening skills and struggle to focus and concentrate, for example in long meetings.

“Although they have the potential to be highly productive, adults with ADHD can

be sabotaged by their own behavioural tendencies. Paralysing procrastination, poor time management, being disorganised and poor financial management may be evident. Their constant activity and talkativeness can also cause interpersonal tension.

“They are often described as good starters, but bad finishers,” Prof. Schoeman said.

She said that ADHD in adults has low rates of diagnosis and treatment, resulting in reduced work performance and increasing the risk of developing other mental health conditions such as depression.

Depression may also be the result of the struggle to cope with ADHD symptoms and not understanding the underlying cause of failure, while some adults with ADHD develop negative coping mechanism such as substance abuse.

Adults with ADHD may be workaholics, tending to overschedule themselves, which in turn leads to feelings of being overwhelmed, and depression or mood symptoms.

“ADHD is not a disease that can be cured. But treatment with medication, various forms of behavioural therapy and training in skills such as time management can help employees to function optimally in their social settings and at work.

“Untreated ADHD is costly, with a significant impact on the adult’s quality of life, family and ability to stay in employment, as well as costly for the employer. Encouraging a person to seek diagnosis and treatment can change their life journey in a positive direction.”

Accommodating or adapting the workplace for an employee with ADHD asks employers firstly to equip themselves with knowledge and understanding of the condition, with information from reliable sources (www.additudemag.com is recommended).

Employers seeking to engage a more neurodiverse workforce should rethink recruitment and hiring practices, she said – including casting the net wider, adapting screening criteria and processes, and adapting interview methods to take into account the needs of people with conditions such as ADHD.

A conducive work environment that respects individual differences needs to be created, with a culture that accepts flexibility, and a mentor, “buddy” or coaching support can also help the adult with ADHD to adapt and cope with work challenges.

Physical changes to the work environment for the employee who is easily distracted or struggles to concentrate could include a separate office or noise-cancelling headset, allowing for the employee to have time offline or reroute phone calls and allowing for flexi-time or telecommuting.

Assistance with poor time management, disorganisation and memory could include providing written notes, visual or electronic reminders, breaking down goals and targets, providing regular supervision and feedback, and rewards or incentives for completed tasks.

Prof. Schoeman recommends a visual reminder of coping strategies for both the employee and their manager, called “the Rear Disc Brake” or RDB:

- R: Realistic goals. Rewards. Relax.
- D: Declutter. De-distract. Delegate.
- B: Book it (scheduling/note-making). Buddy up. Breaks.

Sometimes, no matter how hard they try, adults with ADHD may find that a change in career is the only answer, but this does not have to mean resignation if the employer is willing to find alternative placement within the organisation, with the assistance of a professional such as a coach, occupational therapist or psychologist.

“Find out what the person’s interests are. Focus on the individual’s skills (mental, interpersonal and physical). Understand their aptitude and personality. Tap into their strengths and consider the lesser-developed aspects as developmental opportunities, not weaknesses.”

Allowing employees to play to their strengths includes considering tailored career journeys or customised opportunities for career development, as well as customised performance management systems.

“ADHD is not a disability, and with the right treatment it should not be. Nonetheless, employers should be guided by the Code of Good Practice on Employment of People with Disabilities in creating equal opportunities and ensuring fair treatment for all differently abled people. It would be sensible and ethical for employers to support employees with ADHD and make reasonable accommodations not only for them to perform the essential functions of a job, but to perform optimally,” Prof. Schoeman said.

Rural Doctor of the Year: Craig Parker – the doctor-engineer who created a COVID lifeline for rural areas

Biënne Huisman for *Spotlight*

Dr Craig Parker's oxygen device – the OxERA – saved hundreds of lives during COVID-19, particularly around the rural Eastern Cape. Now, the device has earned a global nod as it was listed in the WHO's 2022 compendium under "innovative health technologies for low-resource settings".

A brochure describes OxERA as an "all-in-one device using an oxygen accumulator bag, an anaesthetic mask and an adjustable mechanical peep valve (a spring-loaded valve which the patient exhales against) that is cost-effective and oxygen efficient". The device requires an oxygen source, but uses less oxygen than traditional ventilators and is simpler to operate.

With a background spanning both mechanical engineering and medicine, Parker pioneered the idea for OxERA in March 2020.

Building solutions

In the throes of lockdown that year – with up to 50 COVID patients being admitted to Frere Hospital daily – Parker and his colleagues successfully used the device, preventing lung collapse and saving lives. Up the coast at Madwaleni District Hospital, overlooking the Xhora river – where oxygen had to be ferried in by bakkie over 2 hours via rutted roads from Mthatha – desperate doctors welcomed the device too.

"It was challenging," says Parker. "The device was still a prototype we were testing, but healthcare workers were desperate and finding them useful and they were saving lives. So we were just making them and donating them to those who asked."

Their most exciting feedback was from Zimbabwe.

"Zimbabwe compared to SA was so much worse," says Parker. "Really, if you were anything beyond mildly ill there, it was a death sentence. They had no hope of big bulk oxygen supplies that could support high-flow nasal oxygen solutions. They didn't have equipment or the skills to ventilate patients. And so they used OxERA devices a lot, through an NGO there called Kufema."

Democratising healthcare technology

In December 2020, SAHPRA approved the OxERA device for emergency use. It is being



Dr Craig Parker was awarded RuDASA's Rural Doctor of the Year award

manufactured and distributed by Gabler Medical in Cape Town, through a "social enterprise model" company called Umoya, which sees all profit ploughed back into the project.

Parker says they want to set a precedent in democratising healthcare technology. "So our original plan was to create a design that was open-source so that anyone could [3D] print their own unit. But that's not how the medical device world works. We realised that there is regulation for a reason. So we set up and registered a company called Umoya, a social enterprise. Now, this is not something that is well known in SA yet. What it means is that your business is not set up for a traditional capitalist objective, but a social objective."

"Usually, companies exist to create shareholder value. [With] our product, the profits go straight back into the company. We think this is a new, sustainable model for medical devices in the developing world because of the massively growing gap between fancy new stuff that's revolutionising healthcare, but which is completely out of reach for the majority of people who need it."

"Rural Doctor of the Year"

Earlier this month at the Rural Health Conference in Oudtshoorn, Parker received the Rural Doctor of the Year Award for 2022, a title bestowed annually by the Rural Doctors Association of Southern Africa (RuDASA).



The OxERA device

RuDASA said in a statement: "Dr Parker's leadership, knowledge and understanding of engineering, clinical and social fields were instrumental in the development of the OxERA product. He continues to provide leadership at Umoya, as they have been asked to assist with a number of other innovations to improve healthcare, specifically in resource-constrained environments."

During the interview, Parker's sentences have a self-deprecating bent. "Perhaps I am an average engineer, and an average doctor," he says. "But this combination of skills is quite unique, and they were hugely beneficial during COVID."

This is an edited version of the original article, which appeared in Spotlight, 26 September 2022. <https://www.spotlightnsp.co.za/2022/09/26/rural-doctor-of-the-year-craig-parker-the-doctor-engineer-who-created-a-covid-lifeline-for-rural-areas>.

Obesity costs South Africa billions. We did the sums

Micheal Boachie, senior researcher: SAMRC Centre for Health Economics and Decision Science, PRICELESS SA, University of the Witwatersrand

Globally, it is widely [acknowledged](#) that obesity-related conditions and their complications add hugely to healthcare costs and productivity losses. In turn, this adds a large burden on individuals, their families and governments.

One estimate suggests that of the total health expenditure on the continent, [9% is attributed](#) to dealing with people who are overweight and obese.

We conducted [research](#) to calculate the cost of obesity to SA's health system. Our aim was to estimate the direct healthcare costs associated with the treatment of weight-related conditions based on public-sector tariffs.

Based on our calculations, overweight and obesity are costing SA's health system ZAR33 billion (USD1.9 billion) a year. This represents 15.38% of government health expenditure and is equivalent to 0.67% of GDP. Annual per person cost of overweight and obesity is ZAR2 769.

Among the most expensive conditions to manage were diabetes and cardiovascular diseases.

Our analysis shows that overweight and obesity impose a huge financial burden on the public healthcare system in SA. It suggests an urgent need for preventive, population-level interventions to reduce overweight and obesity rates. The reduction will lower the incidence, prevalence and healthcare spending on non-communicable diseases.

Quantifying the financial costs of overweight and obesity also gives national policy-makers a sense of the scale of the cost to the state, of managing their diseases, and the costs to the community.

Scale of the problem

Half of all adults in SA are overweight (23%) or obese (27%). And the World Obesity Federation anticipates an additional 10% increase (37%) [in obesity among adults by 2030](#). Overweight and obesity hugely increase the risk of non-communicable diseases. This burden contributes to the country's high prevalence of diabetes, for example. An estimated 11% of people older than 15 had diabetes in 2021. This is much higher than Nigeria's prevalence of [4%](#).

Around 12 million people suffer from weight-related diseases for which they receive treatment in the public sector. These include

diabetes, hypertension, cardiovascular disease, arthritis and some cancers.

This does not include the numerous undiagnosed people with diabetes and hypertension who are not on treatment. Nor does it include people being treated in the private sector.

These non-communicable diseases cause life-altering illness, disabilities and premature death.

What we found

Our research calculated the cost of obesity starting at age 15. In doing our calculations we looked at the following: cancers, cardiovascular diseases, diabetes, musculoskeletal disorders, respiratory diseases and digestive diseases.

We costed each in detail and used the prevalence of those diseases to measure the cost to the system, taking account of healthcare use patterns.

In SA, the biggest share of the ZAR33 billion (USD1.9 billion) annual cost comes from treating diabetes (ZAR19.86 billion). Cardiovascular disease (ZAR8.87 billion) had the second-biggest share. These costs are, in turn, mainly driven by the cost of medication and hospitalisation. Diabetes and hypertension-related conditions are among SA's top-10 causes of death. Digestive diseases, such as gallstones and diseases of the gallbladder, contribute the least (ZAR395 million).

Diabetes (95%) and arthritis (58%) are the diseases that are mostly caused by overweight and obesity.

Overall, 53% of total healthcare costs of managing and treating these diseases in the public sector was attributable to the overweight and obesity problem. SA shares this dubious distinction with other high- and middle-income countries such as Brazil, South Korea, Thailand and Colombia. [Our results are similar to the World Obesity Federation's estimate of ZAR36 billion.](#)

We also warn that the ZAR33 billion is an underestimation of the economic cost. We used public-sector tariffs, which we calculated as 60% of private sector costs. We also excluded costs such as clinical screening and the treatment of comorbidities such as amputations, as well as potential costs for the undiagnosed.

And our findings don't include the indirect costs of productivity losses resulting from absenteeism. We also didn't consider



premature death as a result of overweight- and obesity-related diseases.

Next steps

Putting a health problem in monetary terms may create a sense of urgency to find ways to reduce future expenditure on the direct costs of healthcare, and to reduce future losses to the state from the consequences of illness and premature death, including the knock-on effects of worsening poverty as a result.

This is particularly problem in a setting such as SA, which already has a drastically under-resourced public-health system, [shockingly high unemployment](#) and [both under- and overnutrition crises that are aggravated by obesogenic environments](#) and poverty-driven food choices.

Until now, no detailed country-specific information on the economic cost of overweight and obesity in sub-Saharan Africa has existed. Based on our research, SA's burden is even higher than the African or global averages: [15.38%](#) of overall government health budget, which equates to [0.67%](#) of GDP.

Unless rapid steps are taken to decrease obesity and overweight, the health system will buckle under this strain, and the planned National Health Insurance scheme will not succeed in producing equity in health services.

The opportunity costs of overweight and obesity – and the diseases they often bring with them – are both personal and national. It is difficult to quantify the personal disability in monetary terms – the benefits of vastly improved quality of life are priceless.

Source: *The Conversation*, 13 September 2022. <https://theconversation.com/obesity-costs-south-africa-billions-we-did-the-sums-188768>.

Caught by consent

The Medical Protection Society shares a case report from their files

Mrs P, a 40-year-old nurse, attended her GP complaining of back pain, and was prescribed simple analgesia. After a month, the pain was no better, so she consulted a private neurosurgeon, Dr S, who advised conservative measures.

One month later, Mrs P phoned Dr S to tell him her back pain had not improved and that she now had left-sided sciatica. This was confirmed by her GP, who arranged an MRI scan, which showed the disc bulge responsible for it. Overall, her condition was worse and she had been off work for over a month.

As Mrs P now had sciatica, Dr S felt that a microdiscectomy was a reasonable approach. He discussed the options with her over the phone, and explained the operation and its pros and cons. Dr S did record the phone call in the medical records, but did not state exactly what was discussed. Mrs P was happy to proceed, and so the operation was arranged. Dr S wrote a letter to the GP informing him of the plan.

Dr S next saw Mrs P on the day of the operation as she was brought in to be anaesthetised. He had a brief conversation with her, confirming that she was happy to go ahead and that she had no questions. She then signed the consent form, which listed none of the pros and cons of the operation.

Doctors must take reasonable steps to ensure that patients are aware of any risks

The operation was straightforward and there were no observed complications. However, 2 months after the operation, Mrs P felt that her pain was worse, and she had genital numbness and urinary symptoms. Her urodynamic investigations were normal, but she was numb in the S3 dermatome.

Mrs P brought a claim against Dr S, alleging that he had taken inadequate consent and had not informed her that the operation



Learning points

- Doctors must take reasonable steps to ensure that patients are aware of any risks that are material to them, and of any reasonable alternative or variant treatments.
- In deciding whether a risk is material, doctors should consider whether a reasonable person in the patient's position would be likely to attach significance to the risk.
- It is important to make a record of the consent discussion in the patient's notes.
- More information can be found about consent on the Medical Protection Society's website: www.medicalprotection.org/southafrica/casebook-and-resources/factsheets/factsheets/sa-consent-the-basics.
- Doctors are also encouraged to reacquaint themselves with the relevant provisions of the National Health Act No. 61 of 2003 in relation to consent, particularly section 6, which is the cornerstone of informed consent in SA: www.saflii.org/za/legis/consol_act/nha2003147/.
- If in doubt, Medical Protection Society members can contact us for advice.

could make her pain worse. She also alleged that the operation had been negligently performed, damaging the left L5 root and the S2 and S3 roots bilaterally.

Expert opinion

The Medical Protection Society sought expert opinion from a specialist neurosurgeon. The expert advised that although the consent form was inadequate, the overall consenting process, including the phone consultation and the brief discussion on the day of the operation, was just about acceptable.

The expert also opined that it was very unlikely that an experienced neurosurgeon such as Dr S would have damaged the

nerves without noticing and recording it. He noted that there was no suggestion of nerve damage in the immediate postoperative period, and suggested that deterioration occurring 2 months after the operation was more suggestive of a chronic pain syndrome.

The case was deemed defensible and taken to trial. The judge concluded that there had been no negligence during the operation, but that Dr S had taken inadequate consent. The ruling stated that Mrs P had not been warned of a 5% risk that the surgery could make her back pain worse and, if she had been, she would not have gone ahead. Mrs P was awarded a moderate sum.

Border Coastal and Transkei host internship orientation

SAMA Border Coastal branch (BCB) hosted its first final-year students Road to Internship Orientation with Walter Sisulu University students on the 8 October 2022 at the St Dominic's Conference Room in East London, in conjunction with SAMA Transkei.

Dr Mzu Theo Nodidika (National Council, BCB Council and former BCB Chairman) welcomed the students and Dr M P Dotye (Transkei SAMA) explained the purpose of the day to the students. Dr Madeleine Muller gave students a motivational talk outlining the journey from a newly qualified clinician to becoming an extraordinary doctor (<https://youtu.be/y-NhdQ-036w>) and Dr M Mlitywa, from the Transkei branch, explained the advantages of being a member of SAMA to the students.

Snacks, refreshments, gifts, information brochures and booklets were provided for the students. The presentation was well received by the approximately 20 students who attended. Thanks go to senior branch administrators Jasmin Obaray (BCB) and Nomgcobo Faku (Transkei), who organised the successful event.



Dr Mzu Theo Nodidika (BCB) welcomed the students



Dr Madeleine Muller outlines the journey from newly qualified clinician to becoming an extraordinary doctor



Branch administrators Jasmin Obaray (BCB) and Nomgcobo Faku (Transkei)

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.



Free State host successful registrars' function

Free State branch hosted a very successful and well-attended registrars' event at the Faculty of Health Sciences, University of the Free State in Bloemfontein on 29 September 2022.

Prof. Steven Matshidza, Free State branch chairman, opened and welcomed everyone, and delivered a talk on SAMA member benefits and spoke about the importance of joining SAMA. Dr Chantelle van der Bijl, Free State branch vice-chairperson, enacted the toast to the registrar doctors in celebration of their achievement. Angie Vorster, clinical psychologist, delivered a presentation on mental health.

The dinner was a good social encounter for the registrars to meet and indulge in sharing memories.



Lizaan Spangenberg (practice manager, Capitaux), Wiann van Zyl (certified financial planner and director of Capitaux), Dr Chantelle van der Bijl (SAMA FSB vice-chairperson), Angie Vorster (clinical psychologist, UFS) and Prof. Steven Matshidza (SAMA FSB chairperson)

Attending UFS health science research forum

SAMA Free State branch participated in the University of the Free States (UFS) Faculty of Health Sciences' research forum, which took place on 26 August 2022.

Various organisations exhibited at the event, which proved very successful for SAMA as 14 doctors signed up as members.



Medical students Kuhle Hloma, Konwaba Putsu and Angela Mathibe at the UFS health science research forum



Chenienne Gericke (branch administrator, CWB) and Charmalin Comalie (Publishing) from SAMA Cape Western branch set up a SAMA stall at the USANA Conference held from 8 to 11 September 2022 at Century City CTICC



Mandy Hattingh, branch administrator at KZN Midlands, proudly displays the new SAMA noticeboard at Grey's Hospital theatre complex. Replacing the old MASA noticeboard on 10 September, the new upgraded SAMA noticeboard will display all SAMA-related news to hospital staff. The old board will be donated to the SAMA Museum at SAMA head office in Pretoria.



Welcome to SAMA

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

Cape Western branch

Caitlyn Cordeiro
Bianca Londt
Ilham Adams
Ruschca Jacobs
Zahrah Ganief
Carmen Victor
Zara Ebrahim
Salaamah Davids
Cj Fortuin
Sadieka Kenny
Fadwa Fakier
Faye Bure
Bronte Moodie-Collison
Sergei Linkov
Angelica le Roux
Makhanani Patience Maphophe
Kealeboga Dorcas Mabuthile
Ciriski Andrews
Justin Carlse
Ahmed Dhansay
Nausheenah Parker
Mohini Anand
Angelica Panieri

Eastern Highveld branch

Siphamandla Nkosingiphile
Ncongwane
Marcus Semetsi
Lungelo Mngandi
Martez Nina Meyer

Free State branch

Imraan Khan
Vutlhari Matototo
Puseletso Shilia Moloi
Tebogo Godfrey Modimoeng
Kayra Massyn
Michaela Swepersad

Gauteng branch

Mehjabeen Khan

Gauteng North branch

Sandile Goodenough Mhlono
Wilson Sphiwe Mntambo
Sanjula Govender
Philissa Reyneke
Mulalo Noxolo Maphangwa
Mieke Landman
Omphile Senokwane

Griqualand West branch

Khanyisile Njovu

KZN Coastal branch

Ebrahim Ismail Haffeejee
Pooja Aashan Singh
Yanga Mbele
Philani Mbhele
Reece Govender
Fundiswa Mbele
Nothando Madondo
Luyolo Jevu
Sandiso Ntsele
Nokwanda Mahlobo
Ayanda Nkosi
Sinethemba Mgolombane
Luyanda Mthabiseng Mbuthuma
Ahmed Khan Fathima
Sibusile Yvette Mthuli
Fathima Bibi Jeewa
Zamane Nkululeko Khumalo
Mabushe Island Leokana
Neebo Sibanisewe Nkosi
Ntando Cebolenkosi Dlamini
Simphele Nhloso Zulu
Tenneh Chinyere Okafor
Phiko Mthimde

Bongisani Sonkosi
Malibongwe Gracious Xulu
Kwakhanya Sibabalwe Maholwana
Nothando Precious Mthethwa
Rethabile Mothapo
Nazo Nothando Nxumalo
Siyabonga Shongwe
Fanele Erick Gina
Sibongakonke Khoza
Siyabonga Jabulani Mbongwa
Florence Tinyiko Hlongwani
Phubokuhle Blessing Malinga
Siyanda Mahaye
Avela Fihla
Thubelihle Gwamanda
Thabisa Zamavananda Truth Ndebele
Simphele Luyanda Steven Sibiya
Zanele Sophie Marilela
Sibahle Yonela Tiya
Xolani Mexico Ndlovu
Wandiso Lungelo Nyandeni
Lethukuthula Minenhle Langa
Sifiso Macdonald Makhubu
Aphile Madikizela
Thando Praise Gumede
Nomvelo Vuyiswa Ndlala
Nombuso Thandiwe Shange
Jabulani Mjulo
Asandile Nondumiso Kwandiswe
Sikhakhane
Sibusisiwe Valentine Mdlalose
Ntala Mayimele
Sibonelo Majola
Zandile Melinda Sethole
Kubobonke Ntokozo Falcude
Romal Naidoo
Limuwani Budeli
Siyethembo Sonto Fisokuhle Zwane
Xabiso Honono

Saiyuri Naidoo
Jessica Reabetswe Mashego
Bongani Sanele Mafuleka
Taslimah Rawat
Philile Sinethemba Phakathi
Siyasanda Valentine Mkhize

KZN Midlands branch

Muhammed Uzair Charfaray
Nondalo Ngcobo
Zwelethu Khali
Aphelele Milisi
Zwakele Nzimande
Alicia Sivnarain
Banothile Sweetness Nxumalo

KZN Northern branch

Lisha Singh
Nonhlazeko Ndlovu

Limpopo branch

Morongwa Jacqueline Mashiane
Mahlatse Makgotso Chidi
Johannes Matsobane Molomo
Unarine Ratshilumela
Muelelwa Netshipise
Sanele Priscillia Mathibela

Transkei branch

Zamambo Maboza
Busisiwe Lilian Mohale
Someleze Zangqa
Asanda Marawu

Tygerberg Boland branch

Regan Fancensie
Maserame Prudence Mokoena
Genevieve Borrageiro
Tiffany Kirstie Sprout



CPD

For further information
please contact the
CPD Officer on

012 481 2000 

cpd@samedical.org 

WHAT ARE WE ABOUT

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

SERVICES AVAILABLE

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



SAMAREC

The South African Medical Association Research Ethics Committee (SAMAREC) has been a well-established Research Ethics Committee (REC) in South Africa since 1992.

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