

SAMA INSIDER

MARCH 2023

**SAMA CEO shares
his vision for 2023**

**Rolling power cuts
have a devastating
effect on healthcare
workers**



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MEDICAL ASSOCIATION**

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Diane de Kock
Editor: *SAMA INSIDER*

Challenges increase

The challenge of health is a global one, and rising to meet these challenges demands a functioning healthcare system that embraces all citizens. The stark reality of healthcare in SA is increasingly challenging, as reflected by many articles in this issue of *SAMA Insider*.

In his President's message (page 4), Prof. Chauke questions whether we are in a state of emptiness: "When dishonesty, lack of belief and mistrust and distrust exist, then there is organisational chaos."

Key to healthcare workers being able to do their jobs well is a functioning healthcare system. Rolling power cuts have had a devastating effect (page 8): "Complications range from non-functioning life-support machines to essential medications going bad and power surges causing expensive equipment to blow."

To compound these problems, Bernard Mutsago, SAMA health policy researcher reports (page 10) that the "high cost of living [has] impacted the following health-related factors: nutrition, access to health, mental health and social determinants of health".

A shortage of healthcare workers is a reality, particularly in the rural areas. "SA has 8 doctors for every 10 000 patients ... [but] in most districts in Limpopo, there's hardly one doctor for every 10 000 patients," report Mia Malan, Mohale Moloi and Linda Pretorius for Bhekisisa (page 11) in an interview with Nicholas Crisp, the health department's deputy director for SA's NHI on whether the NHI would solve the budgetary problems.

On page 16, vaccine hesitancy in SA is unpacked by the SAMRC's Bent Steenberg: "Curbing vaccine hesitancy is as much a matter of acknowledging its social, historical and cultural roots as it is of addressing its clinical dimensions." And on page 19, the importance of education is highlighted as critical when fighting diabetes in adults.

Young doctors continue to inspire and motivate; on page 15, we chat to Dr Dean Entres, the recipient of the SAMA Award for outstanding contribution to the medical students at the University of Pretoria, and on page 20 we introduce the WHO's new Youth Council.

As SAMA gears up to rise to the challenge of playing a pivotal role in creating a functioning healthcare system for all (page 6), may we continue to listen, support and communicate.

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Erasmuskloof Ext. 3, Pretoria
Email: publishing@samedical.org | www.samainsider.org.za | Tel. 012 481 2069

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Are we in a state of emptiness?



Prof. Risenga Chauke, SAMA president

"When there are rifts between superiors and subordinates, when generals and officers are disaffected with each other, and dissatisfaction has built up in the minds of the troops, this is called emptiness" Thomas Cleary, *The Art of War* (translated)

When dishonesty, lack of belief, and mistrust and distrust exist, then there is organisational chaos. When disorganisation is interwoven into the fabric of the organisation, everyone bears the brunt.

Every day, we wake up to negative news, and we have accustomed ourselves to being disappointed. There are few stories about the good happening in our country and being done by ordinary people. Are we, as a nation, in a state of emptiness? And is the perceived state of emptiness unique to our country? I leave this question for the reader to ponder.

As a sector, we have a responsibility towards the nation and future generations. Our energy levels are low. High levels of distrust within the health sector drain these energy levels, so we make less effort in accomplishing goals and

objectives, in clinical units, facilities, provinces and the nation.

Does emptiness create a platform for lack of accountability? Management feel that they are unaccountable to their teams, and some health professionals feel that they are unaccountable to their patients and society. This lack of accountability creates a vicious cycle of professionals thinking their efforts are worthless and feeling defeated by the system.

The same applies to trade unions and professional associations. The constituency feel that they are worthless, and association leaders may think that they need not be accountable to the same constituency that elected them to be in office.

This lack of accountability and appreciation plays into the hands of our legal professional colleagues, contributing to the high levels of medical litigation.

As individuals, we have a responsibility to be like-minded and to have the will and energy to work together for the good of our societies

How can this state of emptiness be brought to a halt?

Despite what is happening in the system, individuals can make decisions to brighten the corners they occupy. Each of us are given a stage to perform on, and those who are watching can emulate the good they witness. The ripple effects will go a long way towards bringing about a state of fullness. According to the *Art of*

War, "when the civilian leadership is intelligent, and the military leadership is good, when superiors and subordinates are of like mind, and will and energy operate together, this is called fullness". This highlights the value of leadership in crafting a vision and galvanising others to work on achieving objectives as a collective. As individuals, we have a responsibility to be like-minded and to have the will and energy to work together for the good of our societies.

Everyone deserves equal economic, political and social rights and opportunities

NHI may be the galvanising tool that leads the health sector to function as one, despite all its possible challenges. An insistence on making sure that NHI is implemented will go a long way towards bringing about social justice and protecting human rights.

Everyone deserves equal economic, political and social rights and opportunities. Everyone has an opportunity to participate in economic, political and social rights and opportunities if they are healthy.

SAMA has a big role to play in forging this cohesion.

History will judge us as SAMA, and I err on the side of being judged as having played our part in bringing fullness to the health of our nation.

We, as SAMA, are capable of bringing up leaders who shall eventually lead our nation. How fulfilling it would be if one day, one among ourselves can be that diligent, intelligent leader of our nation who can bring fullness to this nation that so earnestly seeks to be fulfilled.

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.





SAMA is gravely concerned that the State of the Nation (SONA) address is out of kilter with the reality of ordinary South Africans. The public hospitals and clinics are in a state of collapse, with no-one taking accountability for the loss of lives due to the delayed delivery of healthcare. Sadly, there was no mention of measures taken to address this sector.

During the SONA, the president did not see fit to address the healthcare system except to declare a national state of disaster over the energy crisis. Ordinary citizens and our members are still reeling from the trauma from the last declaration of a national state of disaster. During the COVID-19 pandemic, the procurement of personal protective equipment (PPE) resulted in a looting frenzy with little consequence management of those accused of corruption.

SAMA believes that this country and the healthcare system are already in a state of disaster, not just because of power outages. Our members are working in very tough conditions, without the proper infrastructure to do what they were trained to do – to administer quality health services to citizens.

SAMA strongly condemns the murder charge against Prof. Peter Beale. SAMA believes that medical doctors pledge to first do no harm. The association also believes that no doctor intentionally plans to commit murder. Prof. Beale voluntarily removed his name from the HPCSA register. His trial has dragged on unacceptably long despite a previous ruling that no further postponements would be tolerated.

The murder charge against Prof. Beale has created a dangerous precedent. This treatment of Prof. Beale by the National Prosecuting Authority is nothing but a case of ongoing victimisation. It will likely be 4 years before this case is finally heard. The association cannot remain silent as doctors are subjected to trial by media, while simultaneously being denied the chance to defend themselves in court due to endless delays in the justice system.

SAMA questions the appropriateness of a murder charge in any instance of alleged medical negligence and, even more so, in complex treatment situations where multiple causal factors come into play. This is all too frequently the situation in specialist medicine, and it is precisely due to this reason that inquests and HPCSA hearings call upon panels of experts to determine if any negligence exists.

Doctors should not be victimised due to failure of those systems. Our fears are that the current scenario will encourage the avoidance of any potentially high-risk patient management, exposing those patients to a possible treatment void. It will also discourage young people from entering medical practice, especially any of the high-risk specialties. This could further compound the severe shortage of medical doctors in SA.

SAMA believes in a mediated solution to issues of medical errors. Doctors are human and the association supports an alternative dispute resolution mechanism. SAMA recommends that a specialised medical court be established in which trained medical practitioners would be called upon to scrutinise decisions made by doctors.

SAMA regrets to report the temporary closure of the orthopaedics unit at Ngwelezana Hospital in KwaZulu-Natal (KZN) due to equipment breakdowns at the facility. This closure impacts on average 70 operations per week – such as trauma, spine, arthroplasty, deformity correction, sepsis and paediatric orthopaedics.

It is not only orthopaedic equipment that has broken down at Ngwelezana Hospital (a tertiary hospital). It is reported

that radiography equipment in theatre keeps breaking or has not been functioning since November 2022. The air conditioning in theatre is critical for many operations and it is reported that this is at most non-functional. The operating environment is dire, with flies landing on open arthroplasty wounds due to non-functioning theatre doors. Management have been consistently informed of equipment breakdowns and stock shortages, with no resolution from them. It is an abhorrent environment for our members to continue to operate in. Our members were informed that this temporary situation is estimated to last until March/April 2023. However, there is little hope that this will be the case.

SAMA has received reports that equipment breakdowns are happening in other hospitals in KZN and across the country. Elective surgery backlogs currently stand at 175 024 (<https://www.timeslive.co.za/news/south-africa/2022-09-28-sa-hospitals-have-a-backlog-of-175024-elective-surgeries/>). The breakdown by province is: Western Cape is ranked at number one with 77 139; Limpopo is at 45 690, followed by KZN at 17 903. The Free State has the lowest at 2 947, Mpumalanga has 3 005 and the Northern Cape 4 000.

The COVID-19 pandemic influence on the backlog is one of the primary reasons for such a high number. The contingency plans were to reschedule non-emergency operations, theatre services being provided over weekends and extended theatre hours. However, this is impossible if there are equipment breakdowns, maintenance issues and a general lack of infrastructure. Loadshedding adds another variable in that power surges are affecting medical equipment; some of the equipment does not have enough battery power to sustain operations during the higher stages of loadshedding.

The last Medium Term Budget Policy Statement did not seem to recognise the importance of prioritising healthcare funding. The lack of functional management at public healthcare facilities is robbing our people of a chance in life. It is SAMA's position that the public healthcare system must be declared a state of emergency so that people's lives can be saved.

Dr Nhlapho shares his vision for SAMA in 2023

SAMA Communications



Dr Vusumuzi Nhlapho

As SAMA moves into the last month of the first quarter of 2023, we took the opportunity to catch up with SAMA CEO Dr Vusumuzi Nhlapho to ask about his vision for the association, the implementation of the new strategy and the AGM to be held in March.

As we enter 2023, what is your vision for the association this year and what challenges do you foresee for SAMA and its members?

SAMA and the healthcare sector in general are battling the challenge of the preservation of the medical profession. Studying medicine and continuing to practise medicine are becoming more and more challenging. It is reported that there is a global shortage of health workers, and the WHO, which SA is signatory to, expects that the global deficit of health workers will reach 18 million in the next 8 years. The low- and medium-income countries, including SA, are experiencing the largest shortages.

The shortage of doctors at public hospitals in SA is at a critical stage where the ratio has widened to 0.8 doctors per 1 000 population. Albania, which has a similar GDP to SA, has a doctor: patient ratio of 1.88 doctors per 1 000 people. Peru and Thailand, also with similar GDPs to SA, have doctor: patient ratios of 1.35 and 0.95 per 1 000 people, respectively.

High school students nowadays do not find the profession as exciting a career option as it used to be in the past. There are tech-based career options that are far easier to enter and more enticing than medicine. Tech billionaires are created every day, further creating an

obsession with making your first million. In medicine our profession is more than just making money.

The journey to become a doctor has hardly changed over the years. The new generation – the Millennials and Generation Z – have neither the appetite nor the patience to stay the course of 6 years of study plus additional internship and community service work. What does this bode for the medical profession? The journey to medicine will continue to be a long one, and there are no shortcuts to becoming a medical professional. No one would like to be seen or operated on by a doctor who took shortcuts in their studies.

Therefore, our role as an association is to preserve the profession by opening up opportunities to young people to find their place in the sun in this fulfilling cause of helping to save people's lives.

Technology and the Fourth Industrial Revolution (4IR) can be of benefit to medicine. However, our medical doctors need to have a full understanding of medicine and surgery before looking into technologies such as artificial intelligence and robotics in medicine. These technologies are there to assist doctors and help leapfrog medicine into the 4IR.

SAMA is looking into factors that affect our members, such as the criminalisation of medical errors, as part of medicolegal and ethics matters. Our members are under siege, especially those working in the suboptimal public healthcare system. Additionally, when medical complications arise, doctor liability is a separate charge despite the fact the doctor was operating with inefficient infrastructure that could not guarantee quality health outcomes.

The NHI is reportedly planned for implementation in the near future despite our assertions as an association that there are many unanswered questions regarding its feasibility. The corporatisation of the medical profession is a strategic issue that is also coming to the fore, and we are working on policy influence that will assure independence of the medical profession.

Our strategic pillars – brand amplification, enhanced member value, strategic partnerships and membership growth – remain our focus in being able to deliver the vision and mission of the organisation. Our true north is being a core partner to our members as we unite for the health of the nation. To ensure alignment

between SAMA's key strategic pillars and staff performance, the organisation underwent an extensive process of reviewing its internal performance management process. This was followed by a detailed process of cascading the CEO's balance score card to all departments and in turn to individual employees. All employees signed their performance score cards and performance was assessed according to the signed performance contracts. The process as implemented was a success, and there is alignment between the association's overall strategy and individual staff performance. More work is being done to entrench this alignment with a view of also creating synergies between departments in SAMA.

A new strategy has been implemented for SAMA to address challenges and key initiatives affecting members. How is this progressing and what are your plans for the future?

As the four strategic pillars underpin all the work that drives the association, we aim to establish a new growth trajectory by reorienting our operating model for maximal effectiveness, and leveraging digital technology to deliver results with maximum efficiency.

Delivering transformative growth requires the whole organisation to act in concert, from the marketing and sales teams that drive member acquisition, to the product and service frontrunners who aim to deliver the ultimate member experience, to the member engagement staff who help ensure customer satisfaction, loyalty and retention. This also includes the back office teams who ensure that SAMA can deliver on the value promise to our members. As market conditions, competitive threats and customer sentiments often change, such growth will require a mixture of resolute persistence and nimble execution.

Our journey began with a carefully designed growth strategy, clear implementation plans, effective communication plans, a review of our progress and ongoing reorienting of the organisational goals. Phase I of our journey (quarter 4 2022) focused on intentional steps and dedicated action to develop the needed business capabilities and to embed high-level business processes in order to result in ultimate success. The key focus areas that we were able to put in place are the redefined

SAMA value proposition, an understanding of the new business directives that will be pursued, an embedded performance culture and effective governance operational structures.

Phases II and III, the next 6 months of 2023, will focus on acceleration (Q1 - Q2), and monitoring and stabilisation (Q3 - Q4), respectively. We are charged up to execute our strategic imperatives on this journey.

As we accelerate, we will ramp up work and ensure increased focus on attaining business performance targets. The aim is to break down major strategic goals into smaller, achievable chunks. This will help everyone in the organisation to understand departmental strategies at a micro level, and to see what goals need to be reached now to produce the desired results at year's end.

As we complete the second year of the cycle, we will ensure effective monitoring of critical aspects of the growth strategy: productivity, brand loyalty, membership growth, cost management and new revenue streams. One of the most difficult tasks will be ensuring we are all fully equipped, supported

and motivated to race to the finishing line. We will therefore focus our energies on regularly monitoring progress and seeking feedback from our internal and external stakeholders. We will use reporting cadences and check-ins to provide updates, re-establish due dates and milestones, and ensure all teams are aligned and delivering in line with key performance targets.

We must carefully steer the SAMA ship to calm and clear waters, stay the course and focus on our vision of a renewed organisation. We must remain committed to the promises we've made to our members as we deliver the reimagined value proposition, and deliver superior results by reconfiguring our operations for efficiency and effectiveness while capacitating the organisation through strategic talent management and optimisation. We will leverage digital technology to modernise our business processes and integrate our systems. Lastly, to succeed, we must embrace a culture of collaboration, teamwork and an unrelenting thirst for exceeding even our stretch targets.

The 2023 AGM is due to be held in March. Please outline important issues on the agenda?

The SAMA AGM is scheduled to be hosted virtually on 23 March 2023. However, it is anticipated that this meeting may not meet the quorum requirements, and a second meeting will proceed accordingly on 30 March 2023, also virtually, where the members present will form the quorum.

The meeting will open with a director's report presentation on the events of 2021 and the annual financial statements in relation to the financial year ended 31 December 2021.

The members at the AGM will vote on the election of directors, appointment of external auditors and the special resolution to approve the adoption of a new memorandum of incorporation.

Electronic log-in details and links will be shared with members via e-mail on 27 February 2023. The electronic platform allows members to ask questions verbally as well as in written format.

Voting will open a week prior to both meetings, and close before the meeting.

We look forward to maximum participation of members in this important engagement.

SAMA conference 2023: Designing health for the future

Monde Süssmann, SAMA HOD: Corporate Affairs

The SAMA conference will be held on 19 - 21 May 2023 at Sun City. It will be the first time the conference is held face-to-face since the COVID-19 pandemic. This conference therefore offers our members and key stakeholders an opportunity to establish strategic networks.

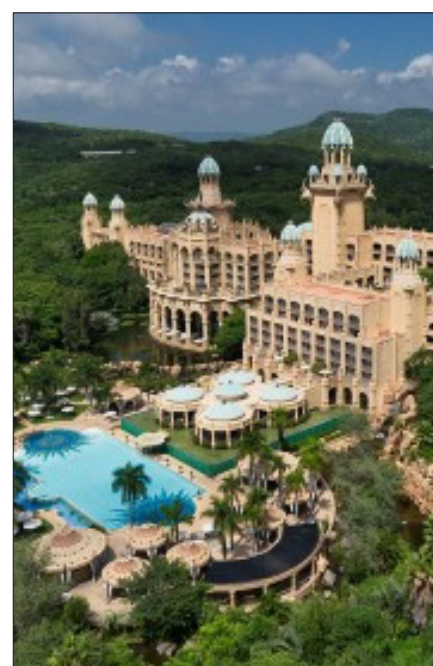
COVID-19 has taught us the importance of taking our destiny into our hands. The pandemic brought a lot of uncertainty into healthcare. That is why the theme of our conference is "Designing health for the future".

What does designing health for the future mean? This means taking back control of the healthcare system – in terms of forecasts and trends, and arming our members with the best defences in the fight against any outbreaks that can happen. It is also about looking at the current imperatives – influencing policy on issues such as universal health coverage represented by the impending NHI in SA. How will NHI changes affect both public and private practice?

Our doctors are persecuted in the courts. How can the medical profession and SAMA as an association design a future for our members that will ensure their safety, considering the complex factors in the medicolegal and ethics space?

How do we save the crumbling healthcare system and ensure that doctors in both the private and public sectors are capacitated to deliver quality health outcomes? Influencing policy and acting as thought leaders are SAMA mandates. This conference allows us to articulate these decisions through the involvement of our stakeholders.

SAMA's thought leadership comes to the fore when it comes to designing and dealing with bread-and-butter matters that our members face. While we are focused locally, this conference will also look at the global healthcare space to arm our members within the various clinical disciplines and drive this influence beyond the local healthcare system.



Rolling power cuts have a devastating effect on healthcare workers

SAMA Communications

On 25 January, *Medical Brief* reported that healthcare workers are continuing to take strain from rolling power blackouts, with complications ranging from non-functioning life support machines to essential medications going bad and power surges causing expensive equipment to blow.

"We had to just keep her there and watch her bleed," said Nicholas Brink, a distressed community service doctor formerly working at Tintswalo District Hospital in Mpumalanga. He was describing how in December 2022, without electricity, doctors were unable to properly assist a woman who had just miscarried, and was bleeding profusely.

"Without a light source, power for a small suction machine and basic sterilised equipment, we were running out of options. For her, just waiting for the power to come back on wasn't an option."

This was just one example cited by Brink in an emotional conversation, reports *Medical Brief*, about the impacts of rolling blackouts on health services. In urban areas it may be an inconvenience, but "for our patients it's a matter of life and death", he said.

Various healthcare workers told *Maverick Citizen* rolling blackouts were having a spiralling effect on their practices, people's health and access to healthcare services.

Stress and anxiety

They said a negative impact on individual health could come through stress and anxiety or through not being able to prepare food or water or store medicines safely.

Simultaneously, an impact on health services comes when clinics and hospitals cannot carry out core functions smoothly because of electricity cuts. On 16 January 2023, for example, the National Health Laboratory Service (NHLS) issued a memo to Gauteng hospitals advising them that rolling blackouts were affecting networks in labs: "We are trying our best to ensure the integrity of samples is maintained. Kindly note this has a negative effect on turnaround times."

At the trouble-stricken Helen Joseph Hospital in Johannesburg, doctors say during power outages, the "pumps can't pump water, so no water. Lights come back and surge and break equipment. We have

one-third of our dialysis machines out of commission."

Dr Nicholas Brink, former community service doctor, 2022, Tintswalo Hospital, Mpumalanga said:

"Loadshedding affects the whole continuum of health, from the vulnerable patient in the community, through to their efforts to access healthcare services and the quality of care they receive.

"Because of the fragility of rural communities and rural health facilities, a small knock can have disastrous effects. Although it is difficult to prove causality, power cuts' effect on the refrigeration of food and access to clean water increase the burden of infectious gastroenteritis, with diarrhoea being a leading cause of death in children under five.

"Things like home oxygen machines and CPAP [continuous positive airway pressure] devices, which are more common after COVID-19, stop working during power cuts – often leading to unnecessary complications. Insulin, a critical drug for managing diabetes, requires refrigeration. Power cuts pose a serious challenge to patients, often with disastrous complications.

"The area served by Tintswalo Hospital is vast; people travel large distances at great cost and can't get the services they need when they arrive, impeding the screening and management of acute and chronic illnesses at a great cost to patient and state."

Life and death

"Access to cellphone signal is a matter of life and death, and in rural areas loadshedding often causes halts in the whole network. People can't call an ambulance. Doctors can't access the internet for critical information we've come to depend on, and can't seek advice from specialists, in a setting with none on site.

"Neonatal units rely on warming machines and CPAP machines. If the machines lose power momentarily, even in the few minutes it takes before they reboot, it can harm babies. Prolonged loss of power is a disaster. We can certainly attribute some deaths to this."

Brink said in late December 2022 there was no power for 10 hours after a transformer blew. "We had to take the kids off the warmers and CPAP and resort to pure oxygen and kangaroo



care – using the mothers' skin to keep the babies warm. Several babies needed to be transferred to other facilities, but only one was accepted, accompanied by a doctor in a basic ambulance. One, who was otherwise doing well, weighed less than 1 000 g and couldn't be transferred."

Prof. Rudo Mathivha, head of ICU, Chris Hani Baragwanath Hospital, Johannesburg, said:

"There are many people in the community who are affected: diabetics on insulin that is going off; children requiring home nebulisation from electricity-driven nebulisers; oxygen generators for oxygen-dependent people failing; infants having to be fed cold formula constituted from unsterilised unheated water; multitudes of citizens having food rot in their refrigerators and having to throw it out; fire hazards from having students/children study by candlelight.

"It's true that the majority of indigent people constantly live with the above amenities missing in their shacks, but we cannot afford to have the whole country reduced to that level before we even get a chance to uplift them."

Dr Hanneljie Ferreira, medical officer, Tshepong Hospital, said: "Two X-ray machines broke down over the weekend: one new machine at our 24-hour community health centre, and also at the Tshepong Orthopaedic Outpatient Department (OOPD). Monday at OOPD is the busiest day, so there are long queues at the X-ray dept."

Dr Sham Moodley, vice chair of the Independent Community Pharmacy Association, said: "At a pharmacy level, the stability of the fridge items is difficult to manage. The products on the dispensary shelf are also now

being subjected to extreme temperatures with no air-conditioning for long periods. We have to monitor temperature in the pharmacy for compliance several times daily. Small pharmacies cannot afford the high-end units to generate power to keep the aircons going. This affects medicine stability and patient care.

"The added cost of generators and inverters is not factored into the dispensing fee model of pharmacists – so there is a struggle to maintain the service levels v. costs related to loadshedding. The industry is very computer-dependent. The equipment is not coping with the unstable supply, and requires constant replacement."

Linda-Gail Becker, professor of medicine and Chief Operating Officer of the Desmond Tutu HIV Foundation (DTHF) said: "All of our research sites must have electricity 24/7, so they all have backup generators. Generator diesel costs have escalated – this makes clinical research precarious in terms of sustainability.

"The DTHF has three big trial centres outside hospitals where we must provide generator backup for possible electricity outages to ensure pharmacy temperatures and fridges are maintained for experimental and other drugs and vaccines. Normally these generators would kick in on the odd occasion. Now they run daily, many times a day. These all require diesel and maintenance.

"The cost just for this to our organisation was ZAR370 000 in 2022. At current loadshedding we predict the cost to go to ZAR425 000 in 2023 and ZAR445 000 in 2024.

"This will go through the roof if we need to rely on generators only. The possibility that a generator fails may result in a fridge of experimental vaccines having to be discarded."

A rural doctor in the Eastern Cape commented: "Our metro call centre doesn't have a functioning generator, which means during loadshedding we're unable to contact emergency medical services to book ambulances. Even when we can book (if we know a cell number of someone well positioned), the dispatcher is unable to contact the ambulance drivers/paramedics as cellphone signal is also reliant on Eskom. I currently have an 11-year old girl with an acute abdomen needing transfer to Mthatha but can't facilitate this."

From surgeries being delayed to equipment malfunctioning, the list is endless.

Western Cape Health Department spokesperson Maret Lesch said emergency surgeries were being performed, but "elective surgeries are postponed, resulting in backlogs".

Clinic services affected by prolonged outages involved electronic systems, test

SAMA comments

"The constant on/off with massive uncontrolled power surges creates a wear component on most appliances that you cannot even calculate! Anything with a compressor (think fridges/aircons etc) will have a much higher failure rate," says Dr Mark Human, Gauteng chair/chair of SAMA's Human Rights Law and Ethics committee.

SAMA spokesperson Nomonde Sussmann said GPs struggled to process electronic medical aid claims, online authorisations and bookings, to obtain laboratory data, and power surges also damaged their equipment.

"Increased costs of alternative power sources such as diesel, inverter and battery systems have escalated for all businesses, including private practices. Fridge line medications kept overnight in practices affect the efficacy of these medicines, resulting in doctors having to dispose and incur the cost of replacement."

Sussmann warned this would ultimately push up the cost of medical care or force some GPs to close their doors.

Sussmann said more loadshedding could see hospital admissions increase as people using alternative sources of power such as candles and paraffin were injured in accidents. There has also been a spike of gastrointestinal infections due to poor water quality, worsened by power outages.

results, radiology, patient referrals and transfers, pharmacy scripts and dispensing medication.

"Many of our staff have to work extra hours to capture patient data and catch up on administrative tasks when the electricity is restored," Lesch said.

Private hospital group Life Healthcare had an "unprecedented level of electricity outages", with 1 300 hours of them from January to September 2022.

"This was almost double the total hours of outages during the 2021 financial year," CEO Adam Pyle said. "Our diesel consumption for the 2022 financial year was close to 1.3 m litres compared with the almost 365 000 litres used in the 2021 financial year. That's an almost 3.5-times increase."

Pyle said prolonged use of generators pushed up costs, including maintenance.

"The energy crisis affects the public and private healthcare sectors ... We are absorbing the costs, but if loadshedding stays at these unprecedented levels these costs will ultimately result in the cost of healthcare, both private and public, increasing," he said.

University of Cape Town public health specialist Prof. Leslie London said "maintaining a cold chain for vaccines and other medicines is always a priority, and with longer power outages, it will become more difficult to ensure that vaccines do not become ineffective".

London said clinics, the backbone of the proposed NHI, were a concern. "Preventive measures are not the mainstream of big hospital services, so it will be primary care and prevention that is hit most. It's clear that power outages of the scale we are experiencing now

will make maintenance of such services very difficult," he said.

National Health Department spokesperson Foster Mohale said the health ministry had not received reports from provinces indicating a huge loadshedding impact: "That's simply because we have committed to provide health facilities with resources to fuel and maintain alternative sources of energy."

Meanwhile, for patients battling the curse of blackouts from their homes, the situation is just as dire. Every time loadshedding is ramped up, Steven Williams and his ailing brother Deon, who depends on oxygen to survive, feel a sense of panic.

The Johannesburg father has been caring for Deon since he was diagnosed with chronic obstructive pulmonary disease.

An inverter and three batteries to ensure an uninterrupted oxygen supply at home can no longer cope with the outages. Three weeks ago, the 57-year-old was admitted to hospital after experiencing breathing difficulty.

"Because of the short breaks in-between load shedding the batteries don't charge enough ... if we have a 4-hour loadshedding my brother often has to use the manual oxygen cylinder," said Steven.

"Since loadshedding intensified, he has spent more time in hospital as he often struggles to breathe at home. We are always on the edge ... not knowing what might happen next. I sleep with one eye open to ensure the batteries don't run flat"

Source: Medical Brief, 25 January 2023. <https://www.medicalbrief.co.za/healthcare-workers-tell-of-the-devastating-toll-of-rolling-power-cuts/>.

The rising cost of living as a determinant of health in SA

Bernard Mutsago, health policy researcher, SAMA Health Policy and Research Unit



The cost of living has increased substantially in recent times, especially over the COVID-19 pandemic. This has threatened the health of SA individuals, families and communities. Despite some relief measures by the SA government, such as the social relief of distress grant, additional funding for health and an increase in the social grant amount, the high cost of living impacted the following health-related factors: nutrition, access to health, mental health and social determinants of health.

Poverty, unemployment and inequality have been chronic challenges in SA post-apartheid. The country's National Development Plan (NDP) 2030 seeks to address these three intertwined challenges, which have remained high over the decades. The NDP proposes some interventions to reverse these challenges and to raise the standard of living for South Africans.

While poverty, unemployment, inequality and high cost of living have persistently impacted the country since the dawn of democracy, they have been exacerbated by an immediately preceding decade of low economic growth and the onset of COVID-19. SA's economy was already ailing before COVID arrived, and had experienced a decline over the past 10 years. The pandemic itself induced a GDP contraction of 6.4% in 2020.

Close to 2 million jobs were lost during COVID-19, pushing the unemployment rate to 35%, and youth unemployment to over 50%. The country's annual inflation rate soared to a 13-year high of 7.8% in 2022. The price of food and non-alcoholic beverages

went up by 9.7%. Electricity tariffs increased by 512% from 2007 to 2020. Petrol prices more than doubled in 5 years, from ZAR12.86 per litre for petrol 95 at inland prices in July 2017, to ZAR26.74 per litre in July 2022. Rising fuel prices have triggered a chain reaction of escalating costs of transport and production costs, leading to rising costs of food and other basic necessities.

There is strong evidence that large income differences have damaging health and social consequences. Inequality is one of the underlying challenges in SA, which is recognised by the World Bank as the most economically unequal country in the world. Only about 16% of South Africans has private medical aid cover. Medical aid premiums continue to rise faster than inflation. A significant proportion of the country's population (28%) accesses private healthcare through-of-pocket payments.

Therefore, as a result of mounting economic pressure and hardship, SA has experienced growing civil unrest and a series of cost-of-living protests.

Impact on access to health

Economic and physical access to health can become constrained in a high cost-of-living environment. For example, in 2022, on average, both medical aid services and medical insurance increased by 4.3%. In the past 12 months, doctors increased their fees by 3.2%, while dentists increased their fees by 4.3%. And the cost of visiting a hospital has increased by 3.2% since February 2020. Further, there was a rise in the costs of over-the-counter medicines and other medical essentials, leading to catastrophic expenditure for many individuals and households. Rising costs of public and personal transport to go to healthcare facilities added another layer of expenditure.

Impact on nutrition

Good nutrition is an essential part of a person's overall health and wellbeing. Poverty, low income and job losses, which are all linked to the COVID-19 pandemic, impact the ability to afford a nutritious diet, thus adversely affecting health outcomes. The levels of malnutrition rose in the COVID-

19 era: in 2021, 10 million South Africans, including 3 million children, lived in a household affected by hunger.

Impact on mental health

SA has an existing mental health crisis that is worsening in contemporary times, and has been accelerated by the COVID pandemic and the associated economic meltdown. Evidence demonstrates an association between mental health and socioeconomic status. The 2021 Mental State of the World report has identified SA as the lowest-ranked country based on mental wellbeing, which was associated with the country's economic slowdown and high unemployment. It is reported that heightened poverty, unemployment and food insecurity, against the backdrop of the COVID pandemic, have worsened mental health in SA. Other factors that worsened mental health include the lockdown and associated effects of confinement, domestic violence, strained relationships, job losses, grieving and loneliness.

Impact through social determinants of health

Social determinants of health are defined as the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These conditions include income and social protection, education, unemployment and job insecurity, working life conditions, food insecurity, housing, basic amenities and the environment, early childhood development, social inclusion and non-discrimination, structural conflict and access to affordable health services of decent quality. The conditions in which people live and die are, in turn, shaped by political, social and economic forces. A harsh economic climate and shrinking disposable incomes in South Africa make it extremely difficult to secure day-to-day conditions and goods to sustain good health and wellbeing, such as decent accommodation, basic amenities, adequate nutrition, safety and security, among others.

References available on request.

These doctors want to work in SA's rural hospitals. But there's no money to hire them

Mia Malan, Mohale Moloi and Linda Pretorius, for *Bhekisisa*

SA has 8 doctors for every 10 000 people in the country, 2019 World Health Organization data show. Although this figure is higher than in most other African countries, it's much lower than in other middle-income regions. In Latin America and the Caribbean, for instance, there are about 30 doctors per 10 000 people (when high-income countries in the region are excluded).

Public hospitals in rural areas are particularly badly hit. A 2017 study showed that in most districts in Limpopo, there's hardly one doctor for every 10 000 patients. An analysis of the health department found that less than 3% of medical graduates in SA end up working in rural areas 10 - 20 years after graduating.

The Umthombo Youth Development Foundation addresses this by helping learners from rural areas to become health workers, who are then expected to work at the hospitals in (or near) the towns or villages they grew up in after graduating, for the same number of years that the foundation supported them.

Umthombo has produced 500 such health workers since 1999.

But they now face a problem: provincial health departments don't have enough money to employ all the graduates.

Mia Malan asked Nicholas Crisp, the health department's deputy director for SA's National Health Insurance (NHI), if the NHI would solve the budgetary problems – or not?

Mia Malan (MM): We don't have enough rural health workers. The Umthombo Youth Development Foundation addresses this by training and mentoring rural health workers, but now provincial health departments don't have the money to employ all of them. How did we end up in this mess?

Nicholas Crisp (NC): Government spends out of the fiscus. In other words, of the tax monies that we pay, around 15% of government expenditure goes toward the health sector. It's appropriated in parliament, and the bulk of the health budget, around 85%, goes into the provincial equitable



shares and is allocated by the provincial legislatures to health. Provinces must make do with that budget to run their services. The cost of employment (COE) is included in those budgets, and provinces are not allowed to exceed the COE ceiling. Because the budgets are being decreased every year – in health it's about a 1.1% per annum decrease – and the unit cost of employing a person is going up, because salaries, allowances and overtime go up, it means that there are fewer posts that can be filled to employ people into that space.

MM: If budgets are decreasing every year and we have fewer and fewer positions for health workers, how are we ever going to improve the health system?

NC: This brings us to the NHI. Up until now the country generally, and even we in government, looked at the health system as the public health system. The public health system has only 49% of the expenditure on

health in the country; 51% is spent in the private sector. Private health sector money is spent on somewhere between 15% and 20% of the population. So because the money is there, the resources are there.

Less than 3% of medical graduates in SA end up working in rural areas 10 - 20 years after graduating

Medical schemes' premiums [generally] go up 8.5 - 10% per annum, so there's more money getting into the private sector, while there's less money going into the public sector. So, we are only seeing about 8.6 million lives covered out of a total of 60 million people [with private sector resources].

With the NHI, the intention is that we pool the resources. I'm not saying it will happen overnight; it won't. But over time, we will create a central pool where the two halves – in other words, 8.5% of our gross domestic product (GDP) [the combined public and private health sector proportion of GDP spent on health] – becomes available for buying services for everybody.

The purchaser [of health services], the NHI Fund, will buy from all health providers [both public and private sector], not just the public sector or the private sector. So a person who lives next door to a private hospital but doesn't have a medical scheme will be able to get their services purchased under the NHI from that facility or that provider. Over time, the Fund will build up knowledge of where services are not provided, and make plans through [strategic purchasing models](#), to make sure that we buy services for those people.

MM: You're saying that the NHI will help because it'll have more funds than what provincial health departments currently have, as you'll pull in the private sector money that the government doesn't have access to right now. Will you then be able to provide doctors to underserved areas?

NC: At the moment, the [public sector spends \[about\] ZAR5 500](#) per person per annum. [That is] around R265 billion a year [for 80% of the population]. The private sector spends about [ZAR277 billion a year](#) [for 20% of the population]. Now, if we had the full [estimated] ZAR550 billion for 60 million people, we have just over R9 100 per capita to look after healthcare. That would almost double the amount of resources available for people in the public sector and it would reduce, dramatically, the amount per capita for those in the private sector.

The size of the difference is five to one – we're currently spending five times as much on a person in the private sector as in the public sector, and they're not necessarily getting better healthcare. We're all trained in the same space. [Private sector patients might get healthcare] quicker and in a better environment, with less struggle to travel, but they're not necessarily getting better healthcare. They might be getting more healthcare.

What happens under an NHI is that funds, over time, become available to purchase services elsewhere.

In a rural setting, you may have people living in a small community in [the] rural Eastern Cape, where there's no general practitioner. No healthcare worker is going to open a practice there because there aren't enough people with money to pay for services to make it viable. Over time, the government is the only solution to put medical officers in such areas. [Under the NHI](#), if the fund is buying a service for a population, general practitioners are guaranteed an income.

MM: That sounds great in theory, but we often see provincial health departments not using their full budgets, because they don't have the administrative capacity to do so. What systems will the NHI have that provincial health departments don't have?

NC: Instead of the money being given directly to a provincial government, [it will come to the Fund and the Fund will purchase services](#). The incentive is now on the management and the staff at that hospital, if they want to keep their jobs, to deliver a service and produce the outcomes that are worth paying for. Otherwise, the NHI is not going to pay for the services and they won't get the revenue.

That is what we call a purchaser-provider split.

It removes the responsibility of the provincial administrations, and specifically the provincial departments of health, to be the provider of the services. They will behave more like a private company does, where the managers will not get paid unless they deliver the service. [Provincial health departments] are still going to have to buy the medicines, employ the staff and do whatever else is required to deliver a service, but they're not going to be guaranteed the money for their budget; they're going to have to earn the money and be paid for the services that they provide.

MM: South Africans would be concerned about corruption when there's such a large pool of money. How are you going to safeguard corruption in such a large fund?

NC: Every government department is required to have a risk management plan.

We are identifying where the risks are. They are perverse incentives and there are opportunities for people to collude. We know when we talk to our colleagues in the private sector, they also have [big problems with managing fraud and corruption](#). So it's a societal issue. It's not purely a government issue.

For the NHI, it's important to design out the incentive to steal

For the NHI, it's important to design out the incentive to steal. There are ways to do that, by simplifying the system and making it very transparent, so that the public can see everything that's going on, and can see where transactions are taking place, who's getting accredited and how they're getting accredited. That way, it will be far more difficult to defraud the system.

If we see a [pattern](#), as we know is the case at the moment in the private sector (where certain practitioners will [for example] be doing large numbers of tonsillectomies that are not necessary), there's no mechanism in the private sector to do anything about it now. Under the NHI we will definitely do something about it. We will investigate why those people are behaving in the way they are, [meaning that they are] not sticking to standard treatment guidelines or [are] deviating from what we expect.

We then need to do something about it; there need to be consequences. Those are all provided for in the [Bill](#). There are ways to deregister accredited providers who behave badly. There are ways to remove people from various committees if they don't act in the correct manner. There are ways in which we will deal with quality and defrauding within a hospital system by just not paying them if they can't prove that they've done the work they say they've done.

Source: *Bhekisisa*, 17 January 2023. <https://bhekisisa.org/multimedia/2023-01-17-these-doctors-want-to-work-in-sas-rural-hospitals/>.

Mental health in general health practice

Prof. Melvyn Freeman

What do health professions understand by “health”, and how does this affect their practice? Surely a facile question, not worthy of space in *Insider*. But when one looks at the WHO definition, it seems that many practitioners may not practise proper health or healthcare. If health is indeed a state of physical, mental and social wellbeing and not merely the absence of disease or infirmity, how many practitioners can truly claim to practise “health” care? In this article, I will focus only on the part of the definition that alludes to health including both physical and mental health, and what this may mean for professional practice.

Firstly, if a person is experiencing an emotional, behavioural or cognitive difficulty, should they be visiting their primary healthcare provider? Should this care and treatment be to a similar level and standard to that which they would get if they presented with a physical health problem? If not, why not? We need to answer such questions in the light of research that shows that around 90% of people with a mental health condition in SA do not get treatment for their condition.

The reality is that for many primary care practitioners, mental health is an uncomfortable space and they immediately refer upwards, or push the person out. And where primary care practitioners do treat the person, they tend to do this in the comfort of the medical model that they are familiar with. This may be good for some patients, but for many more, supportive counselling may be indicated, preferred and effective.

Secondly, do GPs look to find mental health problems as they do physical health problems? There are many instruments used routinely to assess if a person has high blood pressure, diabetes, ear problems, eye problems, TB, HIV and so on. But with mental health, most practitioners are not aware that



there are easy-to-administer and validated screening instruments. But many would in fact probably rather not diagnose a mental health condition, as they don't know how to deal with it if they do make a diagnosis.

The fact is, though, that a significant number of people seen in general practice do have mental health conditions. If we assume that the percentage of patients coming into a practice or clinic is about the same as the population prevalence, then in SA, around 16.5% of people attending a primary care facility have a mental health condition. In reality, a minute percentage of these are identified and treated.

Many patients who are already being seen and treated in clinics will have a mental health condition, because people with chronic conditions are more likely to also have a mental health condition. People living with heart disease are more than twice as likely as others to also have depression or anxiety. Diabetes is significantly linked with depression and other conditions. Depression is particularly prevalent in people with cancer. Mental health conditions are more prevalent among people living with HIV/AIDS and TB

than among the general population, and so on.

If a person with comorbid conditions is not seen by a single practitioner in primary care, we get the absurd situation of treating conditions rather than people, and splitting people's body from their mind. This where there is abundant evidence that most mental health conditions can be treated effectively in primary care. If it is decided that only the physical condition will be dealt with, the problem is that recovery is so often directly tied to dealing effectively with the mental health problem that the approach is wasteful of resources, and thus the attainment of physical health is undermined.

The dictum that there is no health without mental health has become common, certainly within the global public health community, but making the care and treatment of both physical and mental health within primary care an accepted part of general practice seems still some way off. For true health, the WHO definition must translate from good words into the practice of every health worker.

References available on request.

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Department of Labour inspections in the workplace

Ruan Vlok, *Head of Unit: Employment Law, SAMA Legal Affairs department*

The Department of Labour recently announced that they will gear up for more inspections in workplaces in all sectors throughout the country. Medical practitioners, in their capacity as the employer within their private practice, could expect a yearly labour inspection from the Department of Labour through their employment and labour inspectors. The purpose of this article is to provide insight on these unexpected visits, and the basics aspects to comply with, to ensure compliance with all requirements in line with the Basic Conditions of Employment Act No. 75 of 1997 (BCEA).

Basic aspects which will be subjected to these inspections are:

- Section 29 of the BCEA requires that the employer supply the employee with the following particulars in writing:
 - full name/address of the employer
 - name and occupation of the employee
 - place of work

- employment date
- the ordinary hours of work
- the employee's wage or the rate
- the rate for overtime work
- any other cash payments the employee will be entitled to
- any payment in kind
- how frequently remuneration will be paid
- any deductions made from remuneration
- the leave to which the employee is entitled
- notice period to terminate employment
- any period of employment with a previous employer that counts towards the employee's period of employment
- list of any other documents that form part of the written particulars.

- Registration with the Compensation Fund and Unemployment Insurance Fund: Employers are required to register with the Compensation Fund and the Unemployment Insurance Fund. During

these visits, employers will be required to provide proof of such registration and proof that payments to the funds are up to date.

- Relevant posters: The display of certain legal posters in the workplace is required by labour legislation. These posters are a summary of prescribed legislation, and should be posted in an area accessible to all employees. These posters include:
 - Basic Conditions of Employment Act No. 75 of 1997
 - Employment Equity Act No. 55 of 1998
 - Occupational Health and Safety Act No. 85 of 1993.
- Attendance registers: These registers could either be a hard copy or an electronic version.
- Information pertaining to remuneration: Employers will have to provide copies of payslips to enable the inspectors to track compliance with payment rates and leave entitlements.

SAMA responds to the 2023 Budget Speech

SAMA Communications

SAMA is concerned that the Budget Speech presented by the Minister of Finance, Mr Enoch Godongwana, on 22 February 2023 was focused primarily on bailing out ailing state-owned enterprises, with little attention paid to basic services such as education and health, thereby further eroding Section 27 Constitutional rights for all in the country. Regarding the health sector, the following was pronounced:

- Budget allocation: ZAR23 billion will be allocated to health, to cover the shortfall in compensation budgets and to improve services, which include hiring new staff, retaining health workers appointed during the pandemic and clearing the backlog.
- Revenue division: these allocations minimally alleviate the financial pressures in health, where the costs of providing services continue to increase.

SAMA expected some specific pronouncements on the following:

- **Safety and security of medical professionals:** investment into the safety of healthcare workers due to the rise in crimes targeting healthcare workers countrywide was not addressed.

Many facilities are on their knees because of lack of medical equipment, and lack of maintenance of medical equipment

- **Compensation of medical professionals:** though the budget includes the hiring of new staff and compensation adjustments, SAMA waits to see how that will translate into reimbursing of our public service doctors.
- **Loadshedding impact and green energy proposals:** only 77 out of 400 hospitals are exempted from loadshedding, and many clinics are not exempted at all. Coupled with cable theft in some hospitals, the public healthcare system is in a state of disaster when it comes to the provision of electricity. Our members are not able to practise where operations are delayed or postponed. Poor and indigent patients who visit public health facilities are the most disadvantaged in this context. The ministry has yet to present proposals to invest in renewable energy in the public health facilities, bar the Centre for Science

and Industrial Research feasibility study that was started in 2022.

- **Infrastructure development of health facilities:** SAMA notes that the Limpopo approved project is welcomed, but it is only a drop in the ocean. There are many facilities

that are on their knees because of lack of medical equipment, lack of maintenance of medical equipment and other infrastructure support systems.

- **Recruitment of medical professionals:** SAMA welcomes the additional budget to

retain staff who were brought in during the pandemic. However, more needs to be done to address unemployed medical professionals and placement of interns, community service doctors and those doctors who have completed their community service.

A name to remember: Dr Dean Entres

Nileen Gale, *SAMA marketing and communications specialist*

Born and raised in Pretoria, Dr Dean Entres completed his MB ChB degree at the University of Pretoria in 2022. He is currently completing his internship at Tygerberg Hospital. As the recipient of the SAMA Award for outstanding contribution to the medical students at the University of Pretoria's 2022 graduation, we reached out to Dr Entres to find out more about this ambitious medical intern.

Why medicine? I have an interest in the basic sciences and mental health and I want to help improve the quality of people's lives. Getting into medical school and training to be a doctor is a challenge and at the time that was also appealing.

Put the same amount of effort and thought into your wellbeing as you put into achieving your academic goals

What does it mean to you to have won the SAMA award? I am deeply honoured that my class decided that I should be the one to receive the award. I know I invested a lot of time throughout the years to resolve the issues and improve the education of our class. There were, however, a lot of people that were critical of most of these successes; students notified me of problems, advised on potential fixes and aggregated relevant information, and staff assisted with finding and implementing solutions.

Where do you see yourself in the next 5 - 10 years? This is a question I am currently thinking about. During my years in the

medical field I have noticed just how big an impact non-health factors have on health outcomes. I need to figure out how I want to divide my time between clinical and non-clinical work, and in what position I will have the largest impact for the least amount of time. If I do decide to specialise it will likely be in a field like psychiatry, public health or family medicine.

What advice do you have for youngsters who would like to become doctors one day? Medicine can be a rewarding profession and most of my friends are finding internship to be "a lot, but enjoyable". Do not choose this profession because it is prestigious or because you did well in school and can perform at a high level. Understand that this profession will take up most of your time each week for a number of years, especially if you decide to specialise.

A number of students have told me about using medication to cope with the stress and anxiety. There have been stories of crying, having breakdowns, migraines with aura temporarily causing partial blindness and mutism due to sleep deprivation and stress. If you do decide to enroll in medical school, focus on learning clinically relevant information and skills, and not on getting the best marks. Put the same amount of effort and thought into your wellbeing as you put into achieving your academic goals.

In your opinion, what do you feel is a major challenge in the health sector and how do you propose to overcome it? I suspect doctors spend 50 - 70% of their time doing administrative work instead of treating and supporting patients. An integrated electronic system that focuses on having minimal typed input from physicians could cut down on this number considerably. As a practical example, doctors (interns) type discharge summaries, and depending on the case, this can take



Dr Dean Entres

over 30 minutes to do. The demographics, diagnosis, examination and test results, course of treatment and discharge plan form the main parts of a discharge. With an integrated electronic system all this information can be obtained elsewhere and prewritten in a defined format with the doctor only reviewing it and writing the discharge plan. The idea can go further into best medical practice with medication being ordered online and the system suggesting medication and dosage based on available stock, blood culture findings and society guidelines.

This idea likely exists in multiple forms already and if it were implemented, I think doctors would experience less burnout and be able to see more patients.

We are confident that Dr Entres has a bright future ahead of him, and wish him all the best!

Vaccine hesitancy in SA: COVID experience highlights conspiracies, mistrust and the role of the media

Bent Steenberg, *medical anthropologist, Vaccines and Infectious Diseases Analytics Research Unit, South African Medical Research Council*

In recent weeks, China has reported a spike in new cases of COVID and related deaths. Some countries have imposed travel restrictions as a result. But most – including SA – have not.

Instead, the SA government's approach is to increase testing, boost surveillance and, most importantly, breathe new life into its COVID vaccination campaign.

SA first introduced COVID vaccines in February 2021. It set an ambitious target of fully vaccinating 67% of the population (40 million people) by the end of that year. By mid-January 2023, almost 2 years down the road, only 35% (21 million people) had been fully vaccinated.

One area that's seen a troublingly low turnout is Soweto. The area is a massive cluster of some 30 townships – underdeveloped, racially segregated urban areas – in the south of Johannesburg. Soweto has about 1.7 million inhabitants; most are black. Only about 20% have gone to a vaccine site to finish their inoculation.

This vaccination rate is in stark contrast to what Sowetans told us as part of a study we undertook back in August 2020, before vaccines became available nationwide. The study was done at Chris Hani Baragwanath Academic Hospital in Soweto – Africa's largest hospital. More than half of everyone we interviewed said they would accept a vaccine. This was still much lower than national surveys at the time, which estimated a hypothetical acceptance rate of about 75% on average.

This clearly shows that hypothetical intent to vaccinate cannot be used to predict uptake. To plan an effective rollout, it's paramount to understand the social underpinnings of vaccine hesitancy in Soweto. Such insights would likely be transferable to places with similar demographics and socioeconomic profiles throughout South Africa.

What drives hesitancy?

There is always a certain "field of suspicion" in perceptions and attitudes towards illness and inoculation. People may have uncertainties and doubts concerning, for

instance, adverse side-effects, symptoms, or outcomes of disease. This is especially true in the case of a novel, rapidly spreading and potentially deadly virus like COVID-19.

In Soweto, we identified a host of factors amplifying this field of suspicion.

The haphazard way in which the media reported on the disease was one such factor. There were conflicting messages coming from health and government authorities. Wild speculation, rumours, "fake news" and whispers about COVID-19's nature and true origins spread via local social media networks and in some parts of the press. Some concepts weren't explained in a way non-expert audiences could engage with (or in languages that the vast majority of people in Soweto speak).

Mistrust of the institutions involved was another factor. Suspicion and uncertainty opens a space in society for stubborn false or incorrect claims and conspiracy theories. Some people were saying that COVID-19 fatalities had been deliberately exaggerated and that it was a scheme concocted by "Big Pharma". Some believed that the virus did not exist. Others claimed that Bill Gates had put a microchip in the vaccine to "control" the masses, or that the 5G network was somehow causing it.

In Soweto, various Africanised counter-factual claims circulated. For instance, some warned that COVID-19 was a man-made virus purposefully created to destroy black African populations. Or, in a contradictory version, black people were immune and COVID-19 only infected white people.

When such misinformation flourishes, people become even more anxious, doubtful and hesitant about getting vaccinated.

Structural, social, economic and political factors together decrease uptake in immunisation programmes. This is particularly evident in townships such as Soweto because of histories of colonisation, marginalisation and racism. For instance, during apartheid, the white government displaced thousands of people and decreased funding for social services such

as education and healthcare for non-whites. This resulted in a lack of medical coverage for and discrimination against black people, both economically and in terms of healthcare. These historical and structural health disparities continue to have an impact on the broader healthcare picture in SA even today.

Another factor was related and, in some ways, similar to the issue of mistrust. The pandemic triggered a social mechanism that medical anthropologists refer to as "othering", just as it did and still does in the ongoing HIV pandemic. This time, othering presented in its more sinister form – racialisation.

Othering can be viewed as scapegoating and stigmatisation – believing, for instance, that the virus affects only the rich, white people or foreigners.

Othering and racialisation also reinforce false divisions: the *mkhukhu* (shack) dweller against the wealthy, black people against white people, those who are pro-vaccination against those who mistrust vaccines. All of these tensions combined can destabilise the authorities' credibility as they try to roll out immunisation programmes.

Way forward

It remains paramount during vaccination rollouts to explore and address factors that influence vaccine confidence and selectivity.

Appropriate media coverage of vaccination and debunking of wrong "information" is crucial in driving forward immunisation.

Curbing vaccine hesitancy is as much a matter of acknowledging its social, historical and cultural roots as it is of addressing its clinical dimensions. These are lessons best remembered for future outbreaks – and they are even more important to unravel now as SA's government encourages more people to line up for the COVID-19 jabs.

Source: The Conversation, 26 January 2023. <https://theconversation.com/vaccine-hesitancy-in-south-africa-covid-experience-highlights-conspiracies-mistrust-and-the-role-of-the-media-198002>.

The budget and salary reimbursement model and corporatisation of healthcare

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



Dr Mhlengi Ncube

Reimbursement models are methods used by medical administrators, the public healthcare sector and other healthcare service providers to determine the amount of money they will pay for healthcare services. These models significantly influence healthcare service delivery models and the cost of healthcare provision. There are several different reimbursement models, and therefore it is important for policy-makers to ensure that the reimbursement models they use are suitable to achieve the goals of the health system in which the models are employed, and within the available budget.

Governments and health development agencies, when making health financing policy decisions, use the budget and salary model (BSM) to pay doctors and allied health professionals for the provision of clinical care as well as to fund operational costs. The aim of these entities is often to ensure the best quality of healthcare services to the largest number of people possible. The BSM facilitates the ability of government and development-funded healthcare establishments to achieve the predictability that is required for healthcare services to be provided within a predefined budget. With predictability comes the additional advantage of cost control. Cost control is important to improve access to

healthcare, especially in low- and middle-income countries (LMICs), where access to healthcare services is often influenced by the socioeconomic conditions of households. This method also has room for doctors and allied health professionals to be paid fairly based on multi-criteria salary-determining methods. The downside of this model is the potential for underfunding. Many public healthcare service systems in LMICs suffer from resource constraints and understaffing due to budget constraints. Innovative healthcare financing, supply chain optimisation and improved human resources strategies for health are some of the solutions to addressing the potential underfunding challenges that come with the BSM.

In some countries, government and non-profit healthcare services are placed in the same category as other state-owned enterprises, and have been privatised administratively or in ownership. This kind of transformation of healthcare services is referred to as the corporatisation of healthcare. The corporatised healthcare services in some of these countries have continued. In countries where government doctors are poorly remunerated, the opportunity to earn more could become attractive to some doctors. Such an arrangement could potentially improve the work-life balance of doctors who work in understaffed hospitals. Theoretically, a combination of work satisfaction and resource availability should help the BSM to improve the quality of care. The reality, though, is likely to be the opposite. This is because cost of clinical care in a for-profit arrangement can mostly be controlled by controlling clinical management options. The protocolisation of clinical management by process-engineering methods such as Lean Six Sigma can potentially reduce medical errors and reduce process flow, but generally do not reduce the cost of clinical care.

Protocolisation of clinical management could improve the quality of care, especially where clinicians can define the circumstances of the patient but are not clear on the clinical management course to take. Protocols, however, are not foolproof, as they can be misleading. In addition, when the clinician is

clear on the management decision to take, protocols could be limiting to innovation and not in the best interest of the patient. When the BSM is used in for-profit settings, protocols become the most viable tool to cut operational costs and increase profits, often at the expense of clinical outcomes and to the frustration of the patient and the clinician. This is because while doctors are often motivated by seeing a patient recover, while they achieve a target income, they would be meeting profit targets.

The BSM must not be used to reimburse doctors for services in private hospitals or similar establishments

When protocolisation is stretched to its extremes, executive decisions creep into doctors' scope of practice. For example, doctors could be forced to use a specific brand of medical technology purely because of financial interests, such as strategic partnerships between the manufacturer and the hospital group, rather than the patient's best interests. In some instances, protocols could dictate the use of simple high-profit clinical management plans in place of the required level of comprehensive care. Such activities could drive profits and increase the pay of doctors at the expense of clinical outcomes and job satisfaction for doctors when the BSM is used in for-profit medical settings.

The use of the BSM in for-profit healthcare services essentially commodifies healthcare. Job dissatisfaction in doctors when profit is prioritised over healthcare outcomes is a reflection of the nobility of healthcare practice, and the moral hazards of commodifying healthcare. The global economy is characterised by economic inequality at micro and macro levels. SA

has one of the highest Gini coefficients in the world, at 0.63 before the COVID-19 pandemic, and probably worse since then. The Gini coefficient is used to measure inequality using a scale of 0 - 1, where 0 is total equality and 1 is total inequality. Inequality impacts the welfare of those who are at the bottom of income distribution.

Commodifying healthcare in unequal societies is bound to promote inadequate healthcare for the economically disadvantaged. The need to not commodify healthcare is made clear in UN Strategic Development Goal (SDG) 3, in which the UN member states commit to ensuring health to all people (not only those who can afford it). The WHO seeks to address the health inequities that are promoted by the commodification of healthcare through the universal healthcare coverage (UHC) policy. The objective of UHC is to ensure that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship.

Healthcare practice regulators such as the HPCSA, in WHO member states, being signatories of the UHC policy, have the moral obligation to ensure that ethical rules

Commodifying healthcare in unequal societies is bound to promote inadequate healthcare for the economically disadvantaged

of practice in their respective countries are designed to ensure the success of UHC. Such rules must ensure that healthcare systems in unequal economies must not be commodified or corporatised. The clinical

decision autonomy of medical practitioners must be protected for the sake of continuous improvement in the quality of care and access to healthcare for all people. It is recommended that the HPCSA ethical rules must not at any point in the foreseeable future be amended to allow the use of the the BSM to pay doctors in private healthcare establishments, or any global payment model that has the effect of commodifying healthcare.

In conclusion, the BSM is suitable for reimbursement of doctors in healthcare settings such as public and non-profit healthcare services because these entities often aim to preserve the highest quality of care while serving the highest population coverage that can be achieved within a restricted budget. The BSM, however, must not be used to reimburse doctors for services in private hospitals or similar establishments. The HPCSA must also guard against the introduction of amendments to ethical rules that have the effect of commodifying healthcare and promoting healthcare service inequality in the country.

Derivative misconduct and employee rights

Simon Buthelezi, labour law advisor, SAMA Legal Department

Derivative misconduct is not a common occurrence in the workplace, especially in the public sector. As a result, employees are often unsure about their rights, as the terrain is mostly uncharted.

Derivative misconduct is unacceptable or improper behaviour by a group of employees by failing to disclose information that may enable the employer to accurately identify the wrongdoer who committed misconduct in their presence, thus hindering the employer from carrying out a proper investigation and correctly managing the situation.

Origins of doctrine of derivative misconduct

The concept of derivative misconduct was hinted to in an obiter dictum by Nugent J in *Food & Allied Workers Union v Amalgamated Beverage Industries Ltd* [1994] ZALAC 1;1994 (15) ILJ 1057 (LAC) (FAWU) at 1063, in which he stated the following: "In the field of industrial relations, it may be that policy considerations

require more of an employee than that he merely remained passive in circumstances like the present, and that his failure to assist in an investigation of this sort may itself justify disciplinary action."

The above statement, although non-binding, makes an inference that as the employees failed to disclose which employee assaulted the non-striking employee, all employees on strike who were present when the incident took place did commit the assault.

Derivative misconduct through case law

The concept of derivative misconduct is mainly applied in misconduct committed during strike action. This is because, during this time, employees are always in groups, as seen in *Food and Allied Workers Union case above*. This concept was also confirmed in *Dunlop Mixing and Technical Services (Pty) Ltd and others v National Union of Metalworkers of South Africa obo Nganezi*

and others [2016]10 BLLR 1024. In this matter, the Labour Court held that an employee is implicitly bound by the duty of good faith to the employer, and it is a breach of that duty should an employee remain silent about the knowledge the employee possesses about the business interest of the employer being improperly undermined.

When properly conducted, the collective disciplinary hearing will reveal two most important features: firstly, that the employee has acted collectively and associated themselves with misconduct; and secondly, whether the employee witnessed the misconduct, even if (s)he did not participate but failed to disclose the information when approached to do so.

Conclusion

Collective inquiries are very complicated, and members are advised to seek advice when charged collectively.

References available on request.

Over 12% of South African adults have diabetes – education is critical to achieve good outcomes

Patrick Ngassa Piotie, project manager, University of Pretoria Diabetes Research Centre, University of Pretoria

Over 12% of adults in SA have diabetes. Since 2019, researchers at the University of Pretoria have been working on the [Tshwane Insulin Project](#). The project consists of delivering training workshops on comprehensive diabetes and hypertension management in primary care. The researchers also provide technical assistance to healthcare professionals to improve diabetes care. *The Conversation Africa* spoke to project manager Dr Patrick Ngassa Piotie about what diabetes is and why it's so difficult to manage.

What is diabetes?

Diabetes mellitus, or [diabetes](#), refers to a group of conditions that affect how the body uses blood glucose (sugar). Diabetes occurs when the pancreas is no longer [able to make insulin](#), or when the body cannot make good use of the insulin it produces. This leads to elevated glucose levels in the blood. Over time, high blood glucose levels cause damage to the body and the failure of various organs.

There are different types of diabetes. Type 2 is the most common. It accounts for 90% of all cases. With type 2, the body is still able to produce insulin but can't use it correctly. Type 2 diabetes mostly affects adults of a certain age, who are overweight, don't exercise and have a family history of diabetes.

Type 1 diabetes can develop at any age, but it occurs most frequently in children and adolescents. With type 1 diabetes, the pancreas produces very little to no insulin. This means people who have type 1 diabetes need insulin daily to maintain blood glucose levels.

Lastly, there's diabetes that occurs during pregnancy – gestational diabetes. It affects both mother and child, but usually disappears after pregnancy.

Pre-diabetes is a reversible condition. It happens when blood glucose levels are higher than normal, but [not high enough to be called diabetes](#). It can lead to diabetes unless measures such as lifestyle modifications are taken to prevent it.

The symptoms of diabetes are linked to the high levels of sugar in the blood. They include feeling tired and weak, feeling more thirsty than usual, urinating often, or losing weight without trying. Other symptoms such as blurry vision, recurring infections or slow-healing sores are signs of an advanced stage of the disease.

How is it managed?

This depends on the type of diabetes. For example, people with type 1 diabetes need daily insulin injections. The management of type 2 diabetes consists of adopting a healthy lifestyle including increased physical activity and healthy diet. However, type 2 diabetes is a progressive disease. This means that, as the condition progresses, people with type 2 diabetes will need oral drugs and/or insulin to keep their blood glucose levels under control.

Managing diabetes is not just about keeping the blood glucose levels within normal ranges. Often, people with diabetes and healthcare professionals must control the blood pressure and cholesterol levels as well. In addition, a key aspect of managing diabetes is to prevent complications by protecting target organs such as the kidneys and the heart, or the feet.

At the [University of Pretoria Diabetes Research Centre](#), we have developed an acronym that summarises our approach to good diabetes care: the [four "Bs" and four "Cs"](#) or 4Bs 4Cs.

The 4Bs are critical elements to control diabetes:

- blood pressure control
- blood glucose control
- blood cholesterol control
- breathe air, don't smoke.

The 4Cs are important tests that people with diabetes should receive every year:

- check eyes, with a diabetic eye screening – a specific test to check for eye problems caused by diabetes
- check mouth, by going to the dentist
- check kidneys, with a laboratory test
- check feet, with a simple easy-to-do foot exam.

To manage diabetes, healthcare professionals need the full participation of people with diabetes, and their families. That is why it's important that people with diabetes and their families receive [diabetes education](#). People with diabetes must be [equipped](#) with the skills to navigate self-management decisions and activities.

What are the main challenges in managing the condition?

In SA, most people with diabetes rely on the public health system for care. This system



is overburdened, overstretched and under-resourced. These systemic challenges have an impact on the delivery of diabetes care, despite the availability of diabetes medication – including insulin – free of charge at primary care clinics.

Healthcare professionals often don't have time for diabetes education because of long queues and congested health facilities. As a result, people with diabetes [don't receive the education they need](#). This, in turn, means people don't have a good understanding of their condition, which affects their ability to adopt appropriate self-management behaviours, and to adhere to their medication.

Research conducted in SA has consistently shown that healthcare workers [don't comply with diabetes management guidelines](#). They also fail to implement the recommended processes of care such as measurements of body mass index, waist circumference or weight.

Having paper-based medical records instead of electronic medical records is an additional barrier. The medical records are often lost or misplaced. In a context where healthcare professionals rotate often between departments, it becomes difficult to preserve patient history and to ensure continuity of care. A paper-based system makes it difficult to implement structured diabetes care.

SA [studies](#) have found that screening for diabetes-related complications is lacking. For example, healthcare professionals are [not able to screen patients for eye problems](#) caused by diabetes. Diabetic eye screening requires a specific camera that is not available in most clinics and community health centres.

How can these be addressed?

Diabetes care should be structured, evidence-based and facilitated by a multidisciplinary team trained in diabetes management.

SA's health system should be strengthened. Investments are needed to improve the delivery of diabetes care. There is a pressing need for the continuous training of healthcare professionals in diabetes management.

Because of the heavy workload on primary care nurses and doctors, allied healthcare workers, community health workers and health promoters should be trained to carry out non-clinical duties such as diabetes education and support.

The recognition and integration of diabetes educators within the public healthcare system should be a priority. This will ensure that diabetes

education becomes systematic and consistent. It should be repeated at regular intervals. Families of people living with diabetes should also be involved and receive diabetes education because their support is crucial.

Technology, digital health solutions and telehealth can improve the delivery of quality diabetes care. Clinical information systems such as electronic medical records and electronic patient registries can have a positive impact on evidence-based diabetes care. Those systems should be introduced as a matter of urgency.

What are some of the key lessons from the Tshwane Insulin Project so far?

The use of digital health, enhancing the role played by community health workers and

following patients proactively are some of the innovations that were introduced.

Most healthcare professionals were eager to embrace change and new knowledge. And people with diabetes and their families were appreciative of the education they were receiving. They qualified it as life-changing.

Improving diabetes care and outcomes in SA will require a strong will and unwavering support from the health authorities, the introduction of clinical information systems, the use of technology and digital solutions, advocacy and accountability.

Source: The Conversation, 14 November 2022. <https://theconversation.com/over-12-of-south-african-adults-have-diabetes-education-is-critical-to-achieve-good-outcomes-194502>.

WHO holds inaugural meeting of Youth Council

World Health Organization

The WHO hosted the inaugural meeting of the WHO Youth Council from 27 to 30 January in Geneva, bringing together representatives from 22 diverse youth organisations from health and non-health backgrounds.

The WHO Youth Council is a dynamic network aimed at amplifying the voices and experiences of young people and leveraging their expertise, energy and ideas to promote public health. They will be working with youth and youth organisations worldwide to create a youth movement for health.

"The Youth Council is the central element of WHO's commitment to engage with young people, by supporting their leadership, promoting partnerships and advocating for their recognition and visibility," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "Your voices and your insights can make a real difference to realising WHO's vision of Health for All."

The Youth Council will provide advice on health and development issues affecting young people, actively engaging the WHO Director-General and senior WHO leadership. It will serve as a platform for designing and incubating new initiatives as well as expanding WHO's existing youth engagement activities. Through the Youth Council, WHO will develop an inclusive Youth



The WHO Youth Council

Engagement Strategy across all levels of the organisation.

During the four day meeting, the Youth Council members discussed key priorities and work plans to accelerate progress on universal health coverage, noncommunicable diseases, mental health and youth leading for health. They interacted with the WHO Director-General, chair of the WHO Executive Board, Dr Kerstin Vesna Petrič, and other senior WHO leaders to brainstorm on concrete initiatives.

Several key outcomes of the meeting include:

- agreeing on mechanisms for making partnership opportunities accessible to young people across the globe through

the networks represented by the Youth Council members and beyond

- identifying avenues to establish channels for the Youth Council to showcase their work during key WHO meetings and collaborative events
- exploring gaps in the availability of data on health inequity issues of young people and identifying WHO technical support to report these gaps
- developing a proposal to engage with WHO member states. As a first step, the Youth Council identified opportunities for the inclusion of youth delegates as part of delegations from member states and developing mechanisms to integrate youth delegate programmes with support from WHO leadership.

Professionalism is not a dress code

Dr Yash Naidoo, case manager at Medical Protection Society

A would-be patient in a small town in SA sought the services of a psychologist. In this particular town, there was only one to choose from. She visited the practice, but the first impression she got, before even consulting with the psychologist, led to her absconding on the pretence that she had to step outside to make a quick phone call. She thereafter lodged a complaint with the HPCSA against the psychologist.

In her complaint, she made the following remarks: "The entrance of the practice looked like a scene from the *Jungle Book*." She also said the psychologist had a loud voice and the physical appearance of a motorcyclist, such that she believed he was a patient rather than the practitioner. His jeans were worn out, torn up and loose, she alleged. He had visible tattoos. He wore a sleeveless vest. The complainant even went as far as to rebuke the psychologist's grey chest and arm hair, and the chain around his neck.

The complainant summed it up by saying that while she was not one to name and shame, her view was that the above needed to be investigated and rectified.

How did Medical Protection assist?

The psychologist, as a member of the Medical Protection Society, asked for assistance after receiving notification of the complaint from the HPCSA. In doing so, he prepared a written report regarding the allegations, which he sent to MPS for our professional views and advice.

We acted swiftly to appoint a firm from our panel of expert attorneys, to assist the member in preparing a formal written response to the complaint. The attorneys then formally went on record for the member; that is, they notified the HPCSA that they acted for the member on the instructions of MPS.

Unfortunately, unbeknownst to MPS and the appointed attorneys at the time, the member had also sent his initial letter (in which he sought assistance and advice from MPS), directly to the HPCSA. The HPCSA quickly reverted directly to the member, asking him to send them a picture of his practice and a picture of himself in a short-sleeved shirt. The member duly obliged, and sent photos of the practice, and a photo of



himself wearing a biker's vest, directly to the HPCSA. From a procedural standpoint, all correspondence, including letters and photos, ought to have been settled and sent to the HPCSA via the attorneys appointed by MPS. Unfortunately, that could not happen because the attorneys were only belatedly advised of these developments, and the member had acted before taking advice.

Despite the attorneys raising an objection regarding the admissibility of the member's letter and photos for consideration by the HPCSA's Preliminary Committee of Inquiry (the PCI), and despite assurances from officials at the HPCSA that these were removed from the agenda of the meeting of the PCI, to be postponed pending a formal letter of explanation submitted on the member's behalf by the attorneys, the matter was nonetheless considered by the PCI, who made their decision based on the photos and letter submitted directly by the member to the HPCSA.

Outcome

Thankfully, despite the procedural irregularities, the HPCSA resolved to accept the member's letter of explanation, concluding that there was no evidence of unprofessional conduct.

Learning points

If you receive notification of a complaint from the HPCSA, the first thing you should

do is note the deadline for submission of your letter of explanation and contact MPS. It is strongly recommended that you avoid responding directly and personally to the regulator, but that you take professional independent advice before proceeding. There is no harm in simply acknowledging receipt of the HPCSA's correspondence and undertaking to respond in due course.

Due to the subjective nature of physical appearances, it is no surprise that the HPCSA's rules are silent on dress codes

With that said, you are at liberty to prepare your response personally and send it directly to the HPCSA – there is nothing in law precluding you from doing so – but this is strongly discouraged. Firstly, you may be in breach of the terms of your contract of insurance (if you are indemnified by an insurer, which MPS is not). Secondly, it is often difficult to prepare an objective, dispassionate

letter when one is dealing with allegations of unprofessionalism against oneself. Having an objective set of hands assist in the preparation of the letter of explanation is recommended. With the oversight of a professional case manager or medicolegal consultant from MPS, in collaboration with a qualified attorney, an objective, professional and well-thought-out response can be prepared.

In the above case, the outcome was favourable for the member. What we can read into the outcome is that the HPCSA committee that reviewed the matter did not hold the view that a dress code equates to professionalism or non-professionalism. This is a progressive decision and should be lauded. Perceptions of physical appearances are very subjective. In the matter in question, the practitioner had intentionally designed his practice to be rustic, and to represent an

oasis in the desert, incorporating features of nature to create a feeling of tranquility, creativity and relaxation. He had in the past received many compliments from patients who described the practice as "homely", "artistic" and "calming".

Due to the subjective nature of physical appearances, it is perhaps no surprise that the HPCSA's rules are silent on dress codes. Being professional is not a matter of simply conforming to a dress code. Professionalism entails, among other things, upholding your duties to patients, which include: acting in patients' best interests, respecting patients, getting informed consent before treating patients, respecting their confidentiality, allowing patients to participate in their own healthcare, being impartial towards patients and providing access to healthcare. Although the practitioner in question did not have any

tattoos, it is clear to see that a tattoo does not necessarily have any bearing on one's duties to patients. If a tattoo has the potential to disrespect a patient, then it probably should be covered up.

Professionalism is intertwined with community norms and standards. The latter change over time. For example, in the past, one might find doctors exclusively dressed in white coats. In recent times, one is more likely to find them in scrubs.

So, while dress codes may change with the times, what remains constant are one's professional and ethical duties towards patients as healthcare practitioners. If you uphold your duties as set out in the HPCSA's rules and regulations, you are unlikely to be found wanting by your professional regulator. On the other hand, dressing smartly will not cover up unprofessional behaviour.

Free State host successful intern and CPD function

SAMA Free State branch hosted a very successful and well-attended intern and CPD function at Dihlabeng Hospital in Bethlehem on 20 January 2023.

Dr Benjamin de Bruin, Free State honorary secretary, delivered a pre-recorded presentation on SAMA member benefits and spoke about the importance of joining SAMA and strengthening JUDASA representation in the Free State. Prof. Dirk Hagemester, Free State branch treasurer and specialist family physician, enlightened the intern doctors and medical officers on an ethical topic: "Consent in healthcare".

Prof. Hagemester qualified as a medical practitioner at the Universität Ulm in Germany and went on to specialise in family medicine. He completed Master's degrees in public health and in bioethics, a Doctor of Medicine as well as a PhD in health professions education. He also holds the following qualifications: emergency medicine (Germany), sports medicine and diving medicine (Germany), diploma in HIV management (SA), diploma in anaesthetics (SA), postgraduate diploma in internal research ethics and a Bachelor of Arts degree in history.

Prof. Hagemester has worked previously in Germany and the UK, and for the past 15 years in SA. Over the years, he has accumulated a wealth of experience in such diverse areas as primary healthcare, occupational health, diving and aviation medicine and district hospital inpatient care.

He works full time in the public health sector in Bloemfontein, as head of clinical unit in family medicine at the National District Hospital. Here he is involved in government priority programmes such as maternal and child health and HIV and TB care. He teaches as associate professor in a joint appointment at the University of the Free State.

His research interests focus on emergency care training. He is a master trainer in ESMOE (essential steps in the management of obstetric emergencies) and instructor trainer for basic and advanced cardiovascular life support (BLS & ACLS) under the RCSA (Resuscitation Council of Southern Africa).

His hobbies include family life, swimming, jogging, scuba diving, reading, travelling, languages and cooking.



Dr William Selfridge (Eastern FSB councillor and SEDASA representative) and Prof. Dirk Hagemester (Free State branch treasurer)

More than 80% of the intern doctors and medical doctors present joined SAMA.

Chatting to students at the University of Limpopo

On 4 February 2023, the SAMA Limpopo branch visited the University of Limpopo to chat to the medical students. Dr Felix Masinge, former Limpopo branch chairperson, branch council member and anaesthesiologist at Polokwane and Mankweng Hospital and lecturer at the University of Limpopo addressed the students and outlined the advantages of joining SAMA.

Dr Matsobane Johannes Molomo, medical practitioner at Mokopane Hospital, branch council member and a leader of JUDASA in the province, also presented to the students. The successful visit was well attended.



Medical student leader, Thabiso Nyambe with Dr Felix Masinge and Dr Matsobane Molomo at the University of Limpopo



Students wearing SAMA T-shirts

EP branch welcome Intern Representative Council

The SAMA EP branch hosted a welcome function for the Intern Representative Council on Thursday 26 January at the Beach Hotel. The event was well attended by intern representatives and various head of clinical departments.

Dr Farhaad Khan, SAMA EP branch representative, opened the meeting by highlighting the advantages of belonging to an association compared to a trade union.

The main speaker, Dr Konrad von Hagen, ex-Springbok rugby team doctor and current Cricket Protea team doctor, entertained the audience with many inside stories of the national team setup. One lucky intern won a Nespresso coffee machine in a lucky draw.

The branch also held an intern orientation at Livingstone Hospital at the end of last year, which was attended by 80 interns. Twenty interns joined SAMA.



Dr Farhaad Khan (SAMA EP Branch), Sybel Swanepoel (Investec Bank) and Dr Sarel Kritzinger (intern) who won a Nespresso coffee machine sponsored by SAMA EP branch



Dr L Pretorius (intern) with Sybel Swanepoel (Investec Bank) and Dr Farhaad Khan (SAMA EP branch) – Dr Pretorius won the lucky draw sponsored by Investec Bank



Dr Konrad von Hagen, ex-Springbok rugby team doctor, entertaining the audience



Welcome to SAMA

SAMA welcomes the following new members who joined our association in January and February 2023.

Border Coastal branch

Wilhelmina Johanna Kruger
Dane Rampini
Lubabalo Advocate Moshekile
Kadecia Michelle Lottering
Luvuyiso Gladman Xakayi

Cape Western branch

Zingisa Malusi
Elmien Vos
Lucas du Toit
Ammarah Kagee
Lufuno Muthivhi
Marizanne Bothma
Tamsyn Gaynor
Yusrah Solomon
Daniel Jared Adams
Brad Africa
Jason Galt
Timothy Jack de Wet
Rivkah Leah Bank
Alisha Buisman
Bianca Solange Costa-Tre
Earl-rae Husselmann
Mohamed Shakeel Razvi Ahmed

Eastern Highveld branch

Azile Mawisa
Nikita Jugmohan
Lungelo Sidingo Seluleko Ntuli
Thayosni Ponnen

Eastern Province branch

Nikita Heneke
Nontle Saul Mpisi
Brightite Brand
Jodie Batya Sher
Cara Jacobs
Juliet Lisa Horak

Free State branch

Busisiwe Dorcas Maphanga
Mustaffa Noor Zakhura
Lebogang Sylvia Mofokeng
Petra-marie Acho
Motebang Moeti
Jason Jawellen Vaaltyn

Sifiso Treasure Gama
Reitumetse Mmasetjhaba
Mmabatho Mahlaba
Cameron Albert Joseph
Sharnu Hendri Snijman
Thandokazi Sondishe
Retshidisitswe Connie Mohapi
Francis Maruping
Ndivhuho Sannah Ndlovu
Thapelo Ishmael Mokati
Keamogetse Desiree Beleng
Manqoba Comfort
Ndlangamandla
Neo Kananelo Motsumi

Gauteng branch

Michel le Grange
Jonathan Chan King
Shainal Desai
Timothy Nicholas Atcheson
Sameera Bhyat
Shezaad Atcha
Gontse Portia Mawela

Gauteng North branch

Rowan John Glanvill
Jithin George Thomas
Brendan Moonsamy
Nomvula Nncy Mahlangu
Lara Greyling
Thato Huma
Oreratile Rrammutla Ntsoko
Sahlako Saney Nchabeleng
Rosyn Lindiwe Mailula
Barend de Bruyn Botha
Oratile Rorisang Sookane
Nhlakanipho Zwakele Lubisi
Marianne Louise Schwellnus
Buhle Tobela Mathabela
Thamsanqa Samukelo Righteous Mbatha

Ntsamai Lydia Molebatsi
Jacobs Muhammad
Nicolette de Kock

Griqualand West branch

Andile Sibahle Nzimande

Relebohile Rearabetswe
Tshepang Rathaba

KZN Coastal branch

Sashin Juddhoo
Mvumeleni Menzi Khonzinkosi
Mathenjwa
Quraisha Ameer Saib
Sherisha Koomcaran
Priyashthan Naidoo
Laivan Pillay
Balungile Dzingwe
Prenolan Aiden Pillay
Phumzile Florence Carries
Abdullah Seedat
Mayesperi Kanniappen
Lona Mpepo
Lenthuri Naidoo
Aston Heeralal
Jolaine Anthony
Patrick Makaise
Sabathile Ntombikayise Dube
Lethokuhle Refuge Dangazela
Sesethu Mjoki
Nduduzo Wandile Mhlongo
Saraah Bee Bee Hassan
Bongani Dzanibe
Urekha Ballasur
Mpilenhle Pearl Ngcamu
Ezra Moodley
Celine Naidoo
Sithembile Pinky Khumalo
Masego Paul Mashatila
Sudhir Maharaj
Lungelo Thandeka Nxumalo
Athini Duba
Akona Ndisile
Mikar Singh
Yavani Choudree
Kharwa Mohammed

KZN Midlands branch

Lindiwe Patricia Khumalo-
Mugabi
Alexandra Bench
Zikhona Fundama
Nida Ozra Bhat

Yanga Mpuma
Asiphe Aviwe Mbizeni
Nomvelo Nondumiso Madondo
Nonkanyiso Fortunate
Cebekhulu

KZN Northern Branch

Nompumelelo Sithabiso Vilakazi
Simeon van der Merwe

Limpopo branch

Tiiso Philemon Dikobo
Nonhlanhla Fortunate Andiswa
Kaul
Zethembiso Busisiwe Pride
Nxumalo

Lowveld branch

Bhekinkhosi Samuel Lubisi
Tebogo Rayneck Moyana
Natalie Hlulani Mnisi
Thembeke Melinda Mthombeni

Outeniqua Branch

Stanley William Brighton

Transkei branch

Bandile Majali
Gcobisa Mpikashie

Tygerberg Boland branch

Liesel Irene Petersen
Karla Anna Talbot
Simone Nicole Booysen
Julia Josephs
Wonderful Choga

West Rand branch

Mark Andrew Nicolaou
Mittah Zungu

Unattached

Rashmika Deeplal
Tristan Brandon John Sam
Ruusa Tonata Ndilmeka Shivute



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The ethical practice of health professionals require consistent and ongoing commitment to lifelong learning by all health practitioners, through a process of Continuous Professional Development (CPD).

CPD assists health professionals to **update and develop the knowledge, skills and ethical attitudes that underpin competent practice**. This perspective protects the public interest and promotes the health of all members of South Africa.

Any health practitioner who registers for the first time as a health care professional after 1st January of a particular year will commence with his or her CPD programme immediately.

When health practitioners who are actively practising in South Africa attend a professional or academic activity abroad, it will be recognised for CPD purposes.

An Accreditor in South Africa should accredit/convert the activity attended internationally.

**The SAMA CPD Office will convert all CPD relevant activities attended by our members internationally free of charge.
For further information please contact cpd@samedical.org**