

SAMA INSIDER

MAY 2023

**Addressing
health equity**

**Workplace safety
is paramount**



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Diane de Kock
Editor: *SAMA INSIDER*

Health equity

This month we focus on health equity, internationally and particularly in SA. Health equity is the state in which everyone has a fair and just opportunity to access healthcare.

Prof. Renata Schoeman, head of healthcare leadership at Stellenbosch Business School, says, "failure in providing a basic standard of care to the more than 84% of our population reliant on public health is intensifying," and makes six suggestions to address the issue (page 5).

Rwanda's universal health coverage initiative ensures adequate healthcare for almost 90% of its population, says Bada Pharasi, who feels that there are several learnings that SA can implement to ensure the success of its planned NHI (page 5).

Head of SAMA's Professional Affairs Department, Dr Claude Ndlovu, details 10 key points from SAMA engagements with the NHI directorate (page 6), and the WHO celebrates its 75th anniversary by calling for health equity in the face of unprecedented threats (page 7).

In the wake of recent attacks on doctors and healthcare professionals in the workplace, SAMA calls for urgent action from the Department of Health (page 8), and appeals to healthcare workers to remember poor and indigent patients who depend on public health facilities, when exercising their right to refuse to work.

The "Medicine and the Law" section of the magazine addresses: "May a nurse issue a medical certificate?" (page 13); "What the law requires after a procedure-related death" (page 13); "Advertising and the HPCSA Guidelines" (page 15); "Criminal charges for mistakes may have unintended consequences" (page 16); "Substance abuse" (page 17); "Proving a case of constructive dismissal" (page 18) and "A knee replacement goes to trial" (page 18).

In SA, we have a two-tiered and highly unequal healthcare system. The state-funded public sector caters to more than three-quarters of the population, and the private sector is largely funded through individual contributions to medical aid schemes or health insurance, and serves approximately 27% of the population. To address this issue, the government has tabled the NHI scheme.

The WHO says those people with the least coverage need to be prioritised before expanding access to others with more access to care.

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The AGM, welcome Prof. Boffard, violent protests, doctors survey, engaging with NDoH on NHI, uniting doctors

Dr Vusumuzi Nhlapho, SAMA CEO



SAMA recently conducted its annual general meeting (AGM) on 30 March 2023. This was arguably the most important meeting for the association this year. In the directors' report, SAMA reported on the activities that were conducted in the 2021 financial year, as well as the financial report for the period under review. The association has been saddled with the memorandum of incorporation of 2014 (MOI) that was not aligned with its undertakings. It was therefore compulsory that the SAMA board and management put forward a special resolution to amend the MOI to align with its undertakings.

This was a momentous task, because the Companies Intellectual Property Commission

(CIPC) compelled the association to abide by its MOI. The resolution passed by a landslide 72.16% of the votes cast (66% is required to pass, as per SAMA rules). The AGM recorded its highest interaction and voting figures at 843 votes, and its highest participation of 1 368 who accessed the voting platform. A total of 65% members were contacted telephonically, and 95% of our members were contacted via email and WhatsApp. SAMA is grateful for the confidence that members have entrusted in its leadership.

SAMA welcomes our new president, Dr Ken Boffard, who brings in a wealth of experience locally and globally. We are sadly saying farewell to our outgoing president, Prof. Risenga Chauke, who has steered this organisation through a difficult period in its history. We welcome new and re-elected board members – Prof. D Hagemester, Dr M Human, Dr S Harbor, Dr L Seymore and Dr S Maweya.

Medical doctors and other healthcare workers (HCWs) are essential workers. The recent violent protest action by the National Education, Health and Allied Workers' Union (NEHAWU) has been concerning to SAMA. The association opines that there is a right to protest by HCWs; however, that right does not supersede the right of patients to be treated. It is probably the first time in our history that a Minister of Health concedes that a protest action has directly resulted in the deaths of patients. This goes against the pledge that HCWs undertake – which is to first do no harm. The deplorable acts of intimidating and preventing our members from entering

and leaving workplaces does not belong in our healthcare institutions. Those responsible must be brought to book, as the evidence was shared across various media platforms.

SAMA has recently completed the unemployed doctors survey. The results show that there is a big problem in the National Department of Health (NDoH), which is currently sitting with a number of unfilled vacancies. SAMA will use this survey and sensitise the department to utilise the available resources to address the persistent shortage of medical doctors in this country.

SAMA recently engaged with the NDoH on the NHI. Dr Nicholas Crisp outlined the plans to have the bill tabled in Parliament in October 2023. The SAMA board and management raised concerns regarding some of the unresolved issues, such as contracting units for primary healthcare (CUPs) and the lack of communication to key stakeholders regarding this significant policy. Additionally, the state of readiness varies across the provinces, as does the effectiveness of the pilot work conducted. The department promised to engage more with key stakeholders such as SAMA, and utilise more platforms to communicate its plans.

SAMA recognises the importance of bringing the organisation together – bonded by our ethos of uniting doctors for the health of the nation. We are one SAMA, and our responsibilities are to preserve the profession by keeping the organisation focused on one vision. The leadership of SAMA will be embarking on a campaign of uniting us all for the health of our nation.

World Health Day – public health under pressure

SAMA Communications

With SA's healthcare system viewed, among others, as a reflection of the social issues the country is facing, on 7 April, World Health Day, Prof. Renata Schoeman, head of healthcare leadership at

Stellenbosch Business School, says there is not only one solution to addressing access to healthcare.

"Although efforts over the past almost three decades have to some degree improved

the quality of care, failure in providing a basic standard of care to the more than 84% of our population reliant on public health is intensifying. The deterioration of the healthcare system is especially evident in certain provinces

such as the Free State and Limpopo, where lack of resources, mismanagement of funds and declining infrastructure affect the poorer communities."

She says that the healthcare system in the country needs to be seen against the backdrop of rising poverty, unemployment and inequality, where the overburdened public health system struggles to accommodate the major challenges of meeting the increased demand for burden of diseases – communicable diseases such as HIV/AIDS, TB and non-communicable diseases such as diabetes, obesity, violence and injuries, and maternal, perinatal and nutritional conditions.

"SA's healthcare is chronically understaffed, and even though there is a worrying vacancy rate, the posts are not filled. Medical personnel and students are struggling to find employment due to posts not being made available to apply for, or frozen. We are losing a worrying number of medical professionals moving overseas to find employment due to the lack of positions and the uncertainty of what the future would hold for the private sector under the proposed NHI.

"The statistics of around 70% of doctors working in the private sector v. only 30%

available to service the public sector also do not provide a clear-cut picture. The trained professionals are there, however, there is a lack of positions to apply for, and this clearly points to healthcare in the country not having the budget, efficiency, or ability to fill these posts."

Prof. Schoeman says the unequal allocation of resources among the provinces is a worrying concern, in that the regions with the greatest health needs receive fewer resources.

"The Western Cape and Gauteng administrations are the two provinces that spend slightly more on healthcare than on education. This is in contrast to the other seven provinces, where education is the biggest expenditure item.

"In the 2019/2020 budget year, the Free State's budget spend was ZAR10.8 billion, compared to Gauteng's ZAR49 billion and the Western Cape's ZAR24 billion. The higher healthcare spending in these provinces is a result of new infrastructure and expanding services, creating an infrastructure deficit in poorer-resourced provinces such as the Free State and Limpopo. The provinces that manage their money efficiently, and allocate funds to infrastructure and resource development,

are strengthened with a larger portion of the national budget, leaving the rural areas and their people in poorer health."

Even though the healthcare system is not one-dimensional, with various other factors of socioeconomic inequalities playing a role, Prof. Schoeman suggests the following:

- efficiency of budget allocation per province
- stronger, qualified and ethical leadership to fight corruption and to manage budgets efficiently
- attracting and retaining medical professionals
- unfreezing posts to fill the shortage of medical professionals
- NHI, although proposed as a solution to address the healthcare needs of the country, is not likely to be implemented in the foreseeable future, and so not seeing it as the answer to the lack of care
- empowering healthcare users with lifestyle changes and the responsibility of caring for their own health to lower the increased burden of diseases such as diabetes – the focus should be on keeping the nation healthy to alleviate the pressure on medical care for non-communicable diseases.

Lessons learnt can bolster SA's public healthcare system

Bada Pharasi, CEO, Innovative Pharmaceutical Association South Africa (IPASA)



With Rwanda's universal health coverage (UHC) initiative ensuring adequate healthcare for almost 90% of its population, there are several learnings that SA can implement to ensure the long-term success of its planned NHI initiative.

While SA enjoys excellent private healthcare, its public healthcare system is

under constant scrutiny. This as the World Population Review's *Best Healthcare in the World 2023* study ranks SA's healthcare system 87th in the world, behind the likes of Vietnam, Botswana, the Philippines, Sri Lanka and Mongolia.

Although SA's public hospitals are often underfunded and understaffed, much of the system's scrutiny comes as a result of the country not having a universal healthcare system in place, and instead, two parallel systems that drive an ongoing divide between the country's low-, middle- and high-income socioeconomic groups.

The public healthcare system of SA is the backbone of its medical interventions, and serves as many as 80% of its almost 60 million citizens. Alarming, 80% of doctors operate in the private system, leaving the public system critically short of professional resources and invariably constrained.

Universal healthcare initiatives have proven effective in other countries in an attempt to

bridge this divide, and this is something that the Department of Health aims to emulate in SA with its proposed NHI initiative.

One such example is Rwanda's UHC initiative, which has seen almost 90% of Rwanda's population adequately covered for healthcare-related issues. The successful implementation of the initiative has even received praise from the WHO, which has noted that the country is performing exceptionally well in ensuring that its population meets goal 3 of the UN Sustainable Development Goals, which calls for good health and wellbeing. This includes ensuring that the population has access to the medical services that they require, irrespective of their circumstances and without the threat of impending financial ruin.

The country's commitment to achieving this is evidenced by its 15.6% increase in health expenditure during the 2019/2020 financial year, which surpassed the 15% required by the former Organisation of African Unity's Abuja

Declaration – the entity now more commonly referred to as the African Union (AU).

To achieve this, the Rwandan government has, over the past few decades, built its strategy through several evidence-based and population-centric approaches. This includes increasing its health budget and the number of healthcare facilities, as well as bolstering service delivery and broadening community-based health insurance schemes.

To this end, Rwanda increased its number of healthcare facilities from 1 036 in 2013 to 1 457 in 2020, which has greatly increased geographical accessibility and contributed to a reduction in the time spent to reach such a facility. Furthermore, broadening community-based insurance schemes has provided access to healthcare services to much of the population, and has reduced out-of-pocket costs – an expenditure that the majority of the poor and vulnerable simply cannot afford to incur.

At the same time, while Rwanda's UHC initiative may appear on track, and while it

seems that the country has achieved close to UHC, a notable achievement, conversations suggest that there are glaring gaps that require immediate attention should the country want to meet its goal of 100% UHC by 2030.

This includes implementing additional healthcare financing reforms, identifying policy options to expand coverage in remote and rural regions, and evidence-based policy reforms to ensure a clear course for service delivery.

As the backbone of Rwanda's UHC target, its community-based health insurance programme comes with additional challenges. These include a disproportionate risk equalisation in the social healthcare insurance contributory system, unit costs exceeding some individuals' income, cost escalations and flaws in funding mobilisation and recovery. Still, there is sufficient evidence to suggest that SA should not miss the opportunity to learn from Rwanda's unique community-based health insurance programme and geographical expansion of accessibility.

To achieve SA's NHI goal, the Department of Health will need to address the challenges presented by Rwanda's UHC initiative, while also acknowledging and taking action on several problem areas in its own public healthcare system.

Research suggests that to prepare SA hospitals for the NHI initiative, finances, professional resources and staff numbers must be increased, infrastructure upgraded, access to medicines and equipment enhanced and healthcare workers given adequate training, not only in their specific fields, but also on the intentions of the NHI.

Given that reports indicate that the additional ZAR23.7 billion set aside by finance minister Enoch Godongwana for health expenditure over the medium term is insufficient for future healthcare sector upgrades, there is crucial work to be done if SA wants its NHI initiative to be successful in the long term.

References available on request.

NHI update: 10 key points from SAMA engagements with the National Health Insurance directorate

Dr Claude Ndlovu, SAMA Head: Professional Affairs

SAMA periodically engages with the National Health Insurance (NHI) directorate in the National Department of Health (NDoH) on a variety of issues relating to the NHI. Below are some of the most important updates from our engagements:

- The NHI Bill has been in Parliament since 2019, and there have been public oral presentations followed by clause-by-clause deliberations, which were concluded in November 2022. The NDoH made recommendations for changes, and the Bill has been amended, also known as B Bill, which will be tabled in the National Assembly and voted on, most likely by April 2023.
- Two significant changes in the NHI Bill that are of particular interest to SAMA are: limiting the power delegated to the minister, and introducing contracting units for primary healthcare (CUPs) as part of the NHI Fund, away from just being provider organisations, but as funding mechanisms too.
- The NDoH is preparing for a fully integrated implementation of NHI in a phased manner

over several years. Some of the details that are being debated and explored include clinical governance frameworks in the primary healthcare space, contracting of private GPs, reimbursement models and how to implement them, strategic purchasing, and others.

- The NDoH is determining how particular aspects of the fund will be implemented, such as how the board will be appointed, human resources, standard operating procedures (SOPs), defining who is a user and establishing links with the Department of Home Affairs.
- The NHI directorate is currently a branch within the NDoH, and is anticipated to mature with time into the NHI governance structure. The branch's technical capacity is presently being built, and 44 positions have been advertised so far.
- 51% of all the money spent in the health system in 2022 was spent in the private sector to provide services to 14% of SA's population. The NHI directorate considers

the NHI to be the best available vehicle to drive equitable health expenditure.

- CUPs are being implemented at the subdistrict level. The CUPs are multidisciplinary teams that involve public and private providers, GPs, public clinics, community health workers, optometrists and other health practitioners.
- Systems and processes for developing standard treatment guidelines, benefit packages and other related considerations are in place. The various bodies and committees that the NHI Bill seeks to formalise into the benefits committee have been set up.
- The NDoH has been engaging with various stakeholders to get feedback on NHI implementation and ensure its success.
- The NDoH acknowledges that there will be constitutional and other legal challenges to the Bill, and there may still be further public consultations, if National Council of Provinces (NCOP) so chooses, before the Bill becomes an Act.

WHO celebrates 75th anniversary and calls for health equity in face of unprecedented threats

SAMA Communications

On 7 April 2023, the WHO marked its 75th anniversary, along with its 194 member states and other partners, by calling for a renewed drive for health equity.

Seventy-five years ago, in the aftermath of the deadliest and most destructive war in human history, the came into force: a treaty between the nations of the world, who recognised that health was not only a fundamental human right, but also fundamental to peace and security.

Over the past seven-and-a-half decades, there has been extraordinary progress in protecting people from diseases and destruction, including smallpox eradication, reducing the incidence of polio by 99%, saving millions of lives through childhood immunisation, declines in maternal mortality and improving health and wellbeing for millions more.

"The history of WHO demonstrates what is possible when nations come together for a common purpose," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "We have much to be proud of, but much work to do to realise our founding vision of the highest attainable standard of health for all people. We continue to face vast inequities in access to health services, major gaps in the world's defences against health emergencies, and threats from health-harming products and the climate crisis. We can only meet these global challenges with global co-operation."

To meet these challenges, the WHO is urging countries to take urgent action to protect, support and expand the health workforce as a strategic priority. Investments in education, skills and decent jobs for health need to be prioritised to meet the rapidly growing demand for health and avert a projected shortage of 10 million health workers by 2030, primarily in low- and middle-income countries.

A global education programme on basic emergency care targeting 25% of nurses and midwives from 25 low- and middle-income countries by the end of 2025 was also recently announced by the WHO. This 25x25x25 emergency care programme will provide nurses and midwives with the skills and competencies to make a major difference in saving lives and reducing disabilities.



The first World Health Assembly opened in the Palais des Nations, Geneva, on 24 June 1948, with 53 of the organisation's 55 member states represented, as well as 9 countries not yet members



After the earthquakes struck, WHO Director-General Tedros Ghebreyesus (centre) became the first top UN official to visit northwestern Syria since the start of its civil war over a decade ago

Looking forward to the next 75 years and close to the turn of the next century, a renewed commitment to health equity will be the key to addressing future health challenges. In the shadow of the COVID-19 pandemic, the WHO's roadmap to recovery includes an urgent paradigm shift towards promoting health and wellbeing and preventing disease by addressing the root causes and creating the conditions for health to thrive. The WHO is urging countries to provide health by prioritising primary healthcare as the foundation of universal health coverage.

The COVID-19 pandemic has shown that protecting health is fundamental to our economies, societies, security and stability. Learning from the worst pandemic in recent

history, the WHO stands ready to support the countries of the world as they negotiate a pandemic accord, the revision of the International Health Regulations and other financial, governance and operational initiatives to prepare the world for future pandemics.

Over the past 5 years, the WHO has invested in science and digital health, creating a Science Division led by the organisation's first Chief Scientist. This has come at a time when science is under sustained attack every day. Countries must protect the public from misinformation and disinformation. The future of health depends on how well we power health through science, research, innovation, data, digital technologies and partnerships.

Workplace safety is paramount

SAMA Communications

SAMA is a professional association for public and private sector medical practitioners, existing to serve the best interests and needs of its members in all healthcare-related matters.

SAMA once again raises our deep concern about the safety of doctors and healthcare professionals in the workplace. The recent armed robbery at Tshepong Hospital, North West Province, during an academic meeting, is unacceptable and indefensible.

Due to poor safety and security in hospitals and clinics, lives of doctors, nurses and other healthcare workers are frequently at risk. Assault, attempted rape and rape in health facilities are reported frequently. The association has been actively engaging health authorities and correctional services in each of the provinces on these acts of violence.

There is a lapse in the obligation of the Department of Health with regard to S 8(1) of the Occupational Health and Safety Act No. 85 of 1993, which clearly stipulates that the employer is duty-bound to provide and maintain a workplace that is safe and without risk to the health of their employees.

In a survey conducted by SAMA on some categories of healthcare workers, the nature and the extent of violence against healthcare workers, and an increase of such acts over the past decade (2012 - 2022), were recorded. These were mainly in the public sector.

Many doctors and medical staff are now fearful for their safety and find themselves in a situation of moral distress when it comes to

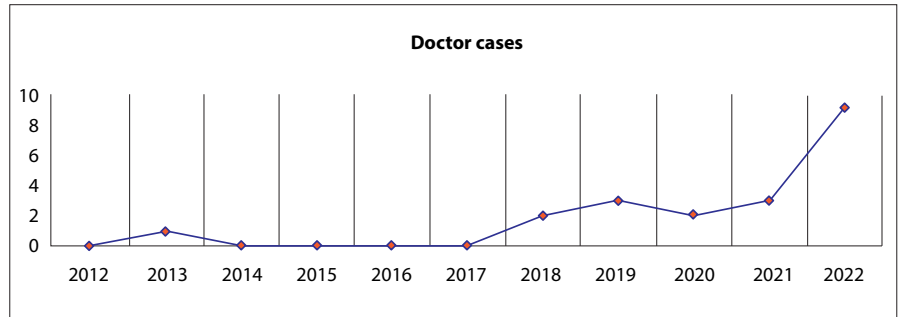


Fig. 1. Cases of violence against doctors over a 10-year period, SA.

providing care to patients under these adverse conditions. SAMA's safety guidelines for medical professionals advise on the doctor's right to refuse care when his or her life is in danger.

This situation cannot continue unabated and urgent action is needed to ensure the safety of our healthcare professionals. The Association urges the Department of Health to take immediate steps to address this issue, together with:

- Providing adequate security measures in and around healthcare facilities to ensure the safety of staff and patients;
- Providing a high security presence and strong visibility, CCTV surveillance, metal detectors, exit and entry check systems;
- Developing and implementing policies to address the root causes of violence against healthcare workers;
- Providing training and support for healthcare workers to assist them in identifying and



managing situations that may lead to violence; and

- Increasing public awareness of the importance of respecting healthcare workers and the critical role they play in the community.

SAMA believes that if healthcare workers would exercise their right to refuse to work due to safety and security risk factors, this would result in poor, and indigent patients who depend on public health facilities for health care, being disadvantaged even further than they currently are.

How to stay CPD compliant

Lisa Reid, SAMA CPD accreditation and clinical research ethics officer

Continuing professional development (CPD) is essential to maintain and enhance your skills, knowledge and expertise in your field. Here are some steps to help you stay CPD compliant:

- **Understand the requirements.** Check the requirements for HPCSA CPD compliance for your profession. Understand how

many CPD hours you need to complete annually or over a specific period, and the types of CPD activities that are acceptable.

- **Identify your learning needs.** Identify the areas where you need to develop or enhance your skills and knowledge. Consider your current role and future

career goals, and the changing needs of your practice.

- **Plan your CPD activities.** Develop a CPD plan that outlines the CPD activities you will undertake to meet your learning needs. Set goals for each activity, including the expected learning outcomes and the number of CPD hours.

- **Select relevant CPD activities.** Choose CPD activities that are relevant to your learning needs. Attend conferences, workshops, seminars, webinars and training courses, read relevant journals, and engage in professional discussions and networking.
- **Document your CPD activities.** Keep a record of all your CPD activities, including the name of the activity, date, duration and learning outcomes. You can find a record your activities on your HPCSA profile: <http://www.hpcs.co.za>.
- **Evaluate your CPD activities.** Evaluate the effectiveness of your CPD activities in meeting your learning needs and achieving your goals. Reflect on your learning outcomes and how you can apply them in your practice.
- **Review and update your CPD plan.** Review your CPD plan regularly to ensure

that it is up to date and aligned with your changing needs.

By following these steps, you can stay CPD compliant and enhance your professional skills, knowledge and expertise.

For further information on how to accredit CPD activities that you may be hosting, please email cpd@samedical.org.

Report reveals extent of damage caused to healthcare professionals during the COVID-19 pandemic

World Medical Association

A comprehensive report from the World Health Professions Alliance (WHPA) and the WHO has revealed the extent of the physical and psychological damage done to healthcare professionals during the COVID-19 pandemic because the health systems they worked in failed to protect them.

It pulls together evidence of the impact of the pandemic from the WHPA's five members, FDI World Dental Federation, the International Pharmaceutical Federation (FIP), the International Council of Nurses (ICN), World Physiotherapy and the WMA, which together represent 41 million healthcare professionals.

The report, "What the COVID-19 pandemic has exposed: The findings of five global health workforce professions", says that healthcare workers feared for their personal safety during the pandemic because of a lack of protective equipment, and that the absence of any systematic support and security left many feeling undervalued.

WMA president Dr Osahon Enabulele said: "Many physicians are exhausted and demoralised after taking risks and making sacrifices during the COVID pandemic. Junior doctors are disillusioned and experiencing increased physical and mental burnout.

"It is vital we prepare now for the next pandemic. That involves strengthening health services around the world and increasing support for physicians and other healthcare personnel."

WHPA chair Jonathon Kruger said, "By pooling the data from surveys of their

memberships conducted during the pandemic, the WHPA organisations have been able to put together a unique picture of what the pandemic looked like for health professionals on the ground. By identifying the challenges we have in common across the professions, we can work together to resolve them.

"It is vital we prepare now for the next pandemic"

"The WHPA is also pleased to see the publication of this report as one of the first concrete outcomes of the memorandum of understanding signed between its members and the WHO in November 2022, and looks forward to continuing the collaboration."

ICN chief executive officer Howard Catton, who is a co-author of the report, thanked fellow authors Hoi Shan Fokeladeh and Erin Downey, and said the report should be used by governments to influence their plans for the next global health emergency, and ensure that healthcare staff do not have to carry such a heavy and unfair burden in the future.

"Around the world, prior underinvestment in health systems meant that they failed the health professionals and multidisciplinary teams that are the lifeblood, the very essence of our healthcare services.

"We know what needs to be done: the challenge is making it happen. A vital first step

would be to have more health professionals in the most senior leadership positions to counter the current disconnect between decision-makers and healthcare professionals on the front line.

"We need governments to honour the contribution of nurses and others during the pandemic, elevate them to positions where they can more directly influence healthcare policies, and make sure that they never again have to face a deadly pandemic without the care, support and protection that they deserve."

The report says that vaccination information and training needs to be revised to address vaccination hesitancy and rejection. It also highlights the lack of mental health and psychosocial support experienced by professional staff, and the profound disruption that occurred to their education, with the closure of education centres, and postponement or cancellation of clinical placements.

It says concerted efforts are needed to protect healthcare workers from the chronic violence that exists in healthcare settings, and that they should have a greater say in high-level planning, strategy and decision-making about the policies that they are responsible for carrying out.

The report concludes that there needs to be a greater involvement of healthcare professionals in efforts to rebuild healthcare systems after the pandemic, as part of a whole-society response that will contribute to global preparedness and health security.

Prof. de Vries bags two global mental health awards

UCT News

The University of Cape Town (UCT)'s Prof. Petrus de Vries has received two prestigious international awards for his relentless research and capacity-building efforts in the field of child and adolescent psychiatry and mental health.

Prof. de Vries is the head of Child and Adolescent Psychiatry in UCT's Department of Psychiatry and Mental Health in the Faculty of Health Sciences. He recently received the Royal College of Psychiatrists (RCPsych)'s inaugural Psychiatric Global Health Contributor of the Year award for 2022. The RCPsych is a professional body in the UK, responsible for education, training and setting and raising standards in psychiatry.

Outstanding contribution

RCPsych president, Dr Adrian James, lauded de Vries for his outstanding contribution to the field and for leading several actions and initiatives in global health that have inspired many mental health and other professionals, as well as families and communities. De Vries received his award at the 2022 RCPsych award ceremony. The event honoured psychiatrists for their exceptional contribution to the field globally.

"I was very excited when I saw that RCPsych recognised the importance of global mental health by introducing this award. Needless to say, I was very surprised but delighted to be the first recipient," De Vries said.

"Awards are a powerful motivator"

Meanwhile, the International Association for Child and Adolescent Psychiatrists and Allied Professions (IACAPAP) also awarded de Vries with the IACAPAP medal for his outstanding contributions to the IACAPAP and to the international child and adolescent mental health community.

The award recognises de Vries's work as the IACAPAP treasurer from 2018 to 2022, as co-editor of the IACAPAP *Monograph* and for his decade-long stint as co-ordinator of the Helmut Remschmidt Research Seminars – an international research capacity-building programme aimed at early-career child and adolescent mental health professionals. The announcement was made at IACAPAP's annual conference held in Dubai in December 2022.



Prof. Petrus de Vries received awards for his outstanding contribution to the field of child and adolescent psychiatry and mental health

"None of us [do] what we do for awards. But the recognition helps us charge our own batteries and can be a very powerful motivator for others to make socially responsive contributions to their communities," he said.

Source: UCT News, 1 March 2023. <https://www.news.uct.ac.za/article/-2023-03-01-ucts-petrus-de-vries-bags-two-global-mental-health-awards>.

Conducting safe clinical trials as a principal investigator

Lisa Reid, CPD accreditation and clinical research officer

As a principal investigator (PI) conducting clinical trials, it is essential to prioritise the safety and wellbeing of trial participants. Here are some key considerations for conducting clinical trials safely:

- **Obtain proper training.** PIs should have appropriate training and experience in conducting clinical trials, including SA Good Clinical Practice guidelines, the trial protocol and the investigational product.
- **Follow the protocol.** PIs should strictly follow the protocol approved by the ethics committee. Any deviation from the protocol should be reported to the ethics committee.
- **Adequate patient selection.** PIs should select appropriate patients for the trial according to the eligibility criteria specified in the protocol. Screening for inclusion

and exclusion criteria should be done meticulously to ensure patient safety.

- **Obtain informed consent.** PIs should obtain informed consent from patients or their legal representatives before enrolling them in the trial. Informed consent should be obtained in a language that the patient understands and should include a detailed explanation of the trial protocol, the potential benefits and the risks involved.
- **Monitor patients.** PIs should monitor patients closely during the trial for adverse events, and document them appropriately. Any serious adverse event should be reported to the ethics committee immediately.
- **Maintain accurate records.** PIs should maintain accurate and complete records of all aspects of the trial, including patient

data, drug accountability, adverse events and study visits.

- **Ensure drug accountability.** PIs should ensure that the investigational product is appropriately stored, dispensed and accounted for throughout the trial.
- **Ensure compliance with regulations.** PIs should comply with all local and international regulations and guidelines governing clinical trials.

In summary, conducting clinical trials safely requires careful planning, attention to detail and strict adherence to protocols and regulations. As a PI, it is essential to prioritise patient safety and to act with integrity and professionalism at all times.

For ethics approval, please contact samarec@samedical.org.

Global patient safety and wellbeing research initiative invites grant applications

SAMA Communications

The MPS Foundation, a global not-for-profit research initiative that aims to shape the future of patient safety, has launched its second grant programme.

The Medical Protection Society (MPS) launched the MPS Foundation last year, and its first research grant programme received over 150 expressions of interest. 10 applicants were successful in securing funding for their research.

The foundation is now inviting new research grant applications from both MPS members and non-members. It will invest in research and analysis, with a key focus on patient safety and the wellbeing of healthcare professionals and teams, both medical and dental, and applications will again be considered from the jurisdictions where MPS has members. These include SA, Singapore, New Zealand, Ireland, Hong Kong, Australia, the UK, Malaysia, the Caribbean and Bermuda.

Research projects supported by The MPS Foundation need to be academically robust and evidence-based. Available funding will range from ZAR112 231 to ZAR4 489 245 – the

equivalent to GBP5 000 to GBP200 000 (subject to currency fluctuations) – depending on the scale, focus and duration of the proposal.

The funding focuses on five main areas:

- the impact of human factors on patient safety, outcomes and risk
- the impact of processes and delivery models on patient safety, outcomes and risk
- the personal and professional wellbeing and development of clinicians
- the impact of digital integration and technology on patient safety, outcomes and risk
- the evaluation of the effectiveness of teaching and learning innovations and their impact on patient care, safety, outcomes and risk.

Dr Graham Stokes, MPS Foundation chair, said: "Patient safety and the wellbeing of healthcare professionals and teams are more vital today than ever. Until now, funding for research into both has been limited, but this is all set to change with access to research funding through the MPS Foundation. As a global not-for-profit research initiative, we aim to take

non-clinical research in a new direction and transform the future of patient safety.

"Our aim is simple: to create sustainable global change through ambitious research that can be used to develop a knowledge base that improves patient safety, enhances the wellbeing of healthcare teams and reduces risks.

"I am delighted with the progress the MPS Foundation has made, and to launch the second grant programme. Our first grant programme saw expressions of interest from all MPS jurisdictions, with 10 of those research projects awarded funding. These projects are exciting, diverse and carry great potential.

"All research projects must be academically robust and evidence based. While funding will be available up to GBP200 000, smaller grants from GBP5 000 will also be available, and I would strongly encourage healthcare professionals to consider applying for support whatever the scale of their proposal."

Healthcare professionals can register their interest by visiting and entering their details via the online grant portal. Calls for expressions of interest close on 5 May 2023.

Self-harm – teenagers hurting themselves to regulate emotions

SAMA Communications

Self-harm, the act of deliberately inflicting pain and damage to one's body by means of cutting, burning, scratching and self-poisoning through medication or substances in order to relieve emotional distress, is a growing concern among teenagers.

A 2021 UNICEF report found that more than 65% of SA young people have had some form of mental health issue, but did not seek help. More than a quarter of respondents did not think their mental health problem was serious enough to seek support, while 20% did not know where to access help and 18% were afraid of what people would think.

Dr Terri Henderson, child psychiatrist and member of the SA Society of Psychiatrists

(SASOP), says self-harm is a cry for help and should never be ignored or downplayed as attention-seeking behaviour or a means of "acting out".

"Contributory and co-occurring challenges for a teen such as depression, anxiety, post-traumatic stress disorder, ADHD and substance misuse often lead to self-harm as one of the methods teenagers engage in to cope with their undiagnosed and untreated mental health conditions.

"The age of onset is approximately 12 years, although there is stronger association with puberty rather than chronological age. The number of teens presenting with self-harm infliction is increasing significantly due

to heightened levels of anxiety, depression and stress experienced among teenagers, availability of medication, alcohol and drugs, and the social transmission of the behaviour via social media channels."

Dr Henderson says research shows that 50% of teens who self-harm will use self-harm repeatedly. She attributes the high rate to depression, ongoing physical, verbal and sexual abuse, continuing interpersonal negative experiences and dysfunctional support systems.

"Most young people who self-harm do not seek help for the behaviour, fearing the stigma associated with it, and the reaction of parents, peers and other adults. They fear

that others will judge them or they may be viewed as a burden to caregivers, and are often ashamed of their self-harming activities. When self-harm is used regularly as a coping mechanism, symptoms are often hidden to avoid the recognition of numerous and especially new scars. Eventually, self-harm is a behavioural pattern or coping mechanism that is difficult to break."

What triggers self-harm?

Dr Henderson says that there are numerous and variable predisposing factors that contribute to self-harm, such as:

- puberty: this is a neurodevelopmentally vulnerable time for teenagers, especially females, when there is an increase in emotional disorders and risk-taking behaviours
- child and family adversity
- emotional neglect
- maladaptive parenting (little time or attention is given to children/teens and families in which negative emotional displays by children are punished)
- disruptive, unsupportive home environments
- exposure to negative life events such as parental separation or divorce, loss of a parent, the experience of any form of abuse, past or current bullying and peer interpersonal challenges
- sexual abuse
- individual biological vulnerability in the form of emotional reactivity (high sensitivity to emotional stimuli) and emotional intensity (the tendency to have extreme reactions).

"Self-harm is often associated with perfectionism and self-criticism, creating a scenario where hurting oneself is used as a form of self-punishment, providing a behavioural model for vulnerable teens," says Dr Henderson.

"The combined set of invalidating home environments (where very few positive affirmations are given) and emotional vulnerability, interact to contribute towards self-harm by creating emotional dysregulation – the inability to calm yourself emotionally," she said.

"The home environment is fundamental in teaching children how to regulate emotions, manage emotional arousal and tolerate emotional distress. If the role models at home are not functional, children are ill-equipped in managing their emotions. This, coupled with childhood traumas of abuse and neglect, contributes to chronic



hyperarousal, increasing the risk for emotion dysregulation."

The rate of self-harm is six times greater among the LGBTQ+ teenage community due to an increased prevalence of mood disorders, substance misuse, victimisation, bullying and social stress.

"Low self-esteem, peer interaction difficulties or exposure to psychological bullying (social exclusion, cyberbullying, repeated rejection from peers and social isolation) are significant triggers. There is an association with smoking and alcohol use, where both are used as maladaptive coping mechanisms."

Why teens use self-harm to cope

Adolescents who self-harm externalise their pain in a physical and real form that makes it less abstract and easier to understand, in order to:

- relieve anxiety
- release anger
- relieve unpleasant thoughts or feelings
- release tension
- relieve feelings of guilt, loneliness, alienation, self-hatred and depression
- externalise emotional pain
- provide an escape from emotional pain
- provide a sense of security or control
- self-punish
- stop racing thoughts
- stop flashbacks
- facilitate relaxation.

Signs to look out for

Dr Henderson says that parents who discover that their teen is self-harming are inevitably going to be frightened, and filled with questions as to the underlying reasons for the behaviour.

"Parents may feel confused, angry and helpless when they see signs that their child or teen is engaging in self-harm. Clues that may lead one to detect that a teen is self-harming include behaviour in trying to hide scars, such as wearing long sleeves no matter the weather, or flinching in pain if their arm is touched. Other signs of mental distress are often present, such as depression, increasing isolation, withdrawal from activities, friendships, schooling and sports, decreased focus on self-care behaviours such as bathing, changes in sleeping and eating patterns, irritability or markedly erratic moods."

Dr Henderson says once self-harm has been identified and it appears to be minimal and limited to one or two incidents, a short-term intervention with a family doctor or psychologists will be adequate.

"More specialist support and intervention is required for severe or recurring cases, especially if there is concomitant suicidality. Group or individual dialectical behaviour therapy is an effective therapeutic intervention. Medication is not used to treat self-harm, but may be necessary to treat psychiatric disorders such as depression and anxiety co-occurring with the self-harm."

"As a parent, your role is to provide support and make changes that allow your teen to know that you support them 100%. You are not able to fix them, but walking with them through support and treatment is going to get you and your teen into a much better and healthier mental health space."

Contact the SA Anxiety and Depression Group on 0800 567 567 to speak to a counsellor if you are worried about a teen.

References available on request.



May a nurse issue a medical certificate?

Karlien Pienaar, administrator, SAMA Legal Department

When an employee has been absent from work for more than 2 consecutive days or for more than two occasions in an 8-week period, the employer may insist that the employee produces a medical certificate as evidence of the employee's illness, without which the employer could refuse to pay the employee for those absent days.

An employee might therefore approach a doctor requesting a medical certificate after the fact. It would then be permissible for a medical practitioner to back-date a medical certificate as long as the practitioner is of the opinion that the patient was unfit at the stipulated time, and also provided that the practitioner clearly indicates "whether the certificate is being issued as a result of personal observations by such practitioner during an examination, or as a result of information which has been received from the patient and which is based on acceptable medical grounds".

Doctors should not be bullied into providing medical certificates where they do not feel comfortable doing so. According to an article published on the website of Kontak Recruitment Agency, the Commission for Conciliation, Mediation and Arbitration

(CCMA) previously ruled that a medical certificate obtained under false circumstances could be deemed invalid and could lead to the dismissal of the employee. Subsequently, there could also be unwanted consequences for the practitioner if a complaint of unethical behaviour is submitted with the regulator.

A template of a medical certificate may be requested from the author of this article.

A recent query requested confirmation on whether a nurse may issue a medical certificate, and the following should be noted:

- According to the Basic Conditions of Employment Act No. 75 of 1997 (BCEA) 23(2), "the medical certificate must be issued and signed by a medical practitioner or any other person who is certified to diagnose and treat patients and who is registered with a professional council established by an Act of Parliament."
- According to a statement from the SA Nursing Council (SANC) dated 22 October 2020, it is indicated that the SANC recognises the provisions of section 23(2) of the BCEA, and is of the view that a person such as a professional nurse who holds an additional qualification in clinical nursing science, health assessment, treatment and

care would constitute a professional person who is certified to diagnose and treat patients.

Furthermore, in terms of the statement, "this nurse is capable of providing direct patient care of all types of illnesses and ailments, offering the first level of nursing care that patients receive, and is competent to independently render appropriate and skilled primary care service."

The SANC also indicates that such a professional nurse may recommend a maximum period of sick leave of 2 days, and that a patient be referred to consult with a medical practitioner if there has been no improvement in that time. Any further treatment would be acting outside of their scope of practice.

Lastly, any professional nurses who are not in possession of the additional qualification as indicated above, may only issue a certificate of attendance.

Any comments or queries are welcome and may be forwarded to Karlien Pienaar via email: karlienp@samedical.org.

References available on request.

What the law requires after procedure-related deaths

Dr Graham Howarth, head of medical services, Medical Protection Society

The nuances of procedure-related deaths, and the knowledge and application of the law linked to these, is poor in SA, says Dr Graham Howarth, head of Medical Services – Africa, Medical Protection Society, who clarifies some of the blurred areas and definitions.

Imagine, as a healthcare practitioner, attending the funeral of an elderly family

friend, and being somewhat uncomfortable at what you have heard regarding the death.

She had undergone hip surgery several weeks ago, and due to a combination of her age and the pain, had been immobilised.

A week after hospital discharge, a deep vein thrombosis was diagnosed, and 2 days later she was found dead in her bed.

Apparently, her GP considered cause of death to have been a pulmonary embolism.

Given the proximity of the funeral to her death, it must have been classified as due to natural causes.

You know that, given the history, a pulmonary embolism was not an unreasonable call, but you have a nagging concern that,

considering the recent procedure, death was probably procedure-related, and should have been classified as of unnatural causes, and been further investigated.

Are you right, and what are your obligations as a healthcare practitioner?

When a patient dies, the Births and Deaths Registration Act No. 51 of 1992 places an obligation upon the practitioner to classify the cause as either natural or unnatural. The decision may be made either by a practitioner who attended the patient before death or one who examined the deceased afterwards.

This examination cannot be cursory; the whole body needs to be examined, as a practitioner must be satisfied that death was due to natural causes – according to the Act.

Deaths from unnatural causes misclassified as of natural causes evade the scrutiny of investigation, while deaths due to natural causes misclassified as unnatural causes congest the already resource-constrained Forensic Pathology Service.

Clearly, it is important that practitioners know what causes are considered to be unnatural.

The regulations of the National Health Act No. 61 of 2003 consider deaths from the following causes to be due to unnatural causes if:

- they result from a physical or chemical influence, direct or indirect, and/or are related to complications
- any death, including those that would normally be considered to be from natural causes, which in the opinion of the medical practitioner is the result of an act or omission that may be criminal in nature
- any procedure-related (including anaesthesia-related) death, as contemplated in section 48 of the Health Professions Amendment Act No. 29 of 2007
- the death is sudden and unexpected, or unexplained, or where the cause is not apparent.

While it is important for perioperative practitioners to understand the nuances of procedure-related deaths, the knowledge and application of the law related to these is poor in SA.

In 2007, the Health Professions Act was amended to broaden the concept of anaesthesia-related deaths to procedure-related deaths – a term that clearly extends beyond the former. A death is considered to be procedure-related according to the following:

“The death of a person undergoing, or as the result of, a procedure of a therapeutic,

diagnostic or palliative nature, or of which any aspect of such has been a contributory cause, shall not be deemed to be a death from natural causes as contemplated by the Inquest Act, 1959 (Act 58 of 1959), or the Births and Deaths Registration Act, 1992 (Act 51 of 1992).”

The Act does not qualify the procedures, nor when a procedure is deemed to have started or ended. It has been suggested that a surgical procedure begins when the anaesthetist starts the placement of the anaesthetic paraphernalia, and ends when the patient is transferred from the recovery room.

Does this mean one only includes deaths that occur in theatre or the recovery room? Given the inclusion of the subclause – “or of which any aspect of such a procedure has been a contributory cause” – the answer is a resounding no.

It would be prudent to strongly reflect upon any death related to a surgical procedure where the patient dies before hospital discharge as a procedure-related death. Obviously, any death related to an acknowledged complication of the procedure, either before or after discharge, also fulfils the criteria of a procedure-related death.

So a post-discharge pulmonary embolism, despite prophylactic anticoagulation, would qualify to be included as a procedure-related death.

It is important to remember that a maternal death associated with a caesarean section constitutes not only an unnatural death but also a notifiable medical condition.

The reason for including procedure-related deaths in deaths whose cause is considered to be unnatural is so that they can be fully investigated and open to independent review of the care given.

Prudence dictates that any death related to a procedure be considered a procedure-related death, particularly if the person dies while still an inpatient.

One does not want an allegation that a death was misclassified in an attempt to circumvent scrutiny. If there is uncertainty, the advice is to contact the local Forensic Pathology Service and contemporaneously document the conversation – particularly if they advise against classifying it as being procedure related.

Unless there is a belief that the case has or will be reported to the police, the Inquest Act places an obligation to report a death considered to be unnatural to the police as



soon as possible. The responsibilities of those at the health facility include:

- reporting the death to SAPS;
- ensuring that the body is not removed by an undertaker;
- handing the body over as it was when the patient died, so medical paraphernalia (drips/lines/catheters/drains etc) should not be removed;
- providing the deceased person's full medical records, including special investigation results;
- not completing a Death Notification Form (DHA-1663); and
- completion of the GW7/24 form – Report of a Person Whose Death is Associated with the Administration of an Anaesthetic or Diagnostic or Therapeutic Procedure by the responsible clinician(s). The form makes provision for both the individual who performed the procedure as well as the anaesthesiologist (if anaesthesia was administered).

Once all of the relevant information is available, a magistrate will decide whether to hold a formal or informal inquest. The former involves a prosecutor and witnesses, and is rare in SA, while in the latter, the magistrate reviews the death based on the documents available.

Given the importance of the topic and the statutory nature of the obligations, it should come as no surprise that failure to comply with one's obligations is punishable. Were it determined that a practitioner made a false statement, particularly knowingly, punishment could include a criminal record, the possibility

of a fine and even imprisonment. Likewise, registered professionals, if in violation of their obligations, may be investigated, prosecuted and, if found guilty, disciplinary steps taken by their regulator.

So to return to you at the funeral – it could be argued that, despite the patient having

been discharged, the procedure could have been a contributory cause to her death. That being the case, the death should not have been deemed to be from natural causes as contemplated by the Inquest Act.

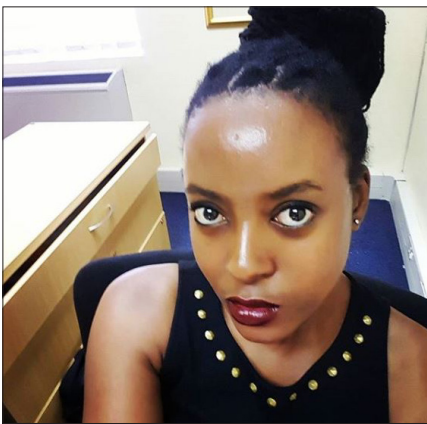
So you are now aware of a death that was probably not from natural causes and

the Inquest Act places obligations on you to report such deaths to the police – somewhat of a dilemma.

Source: Medical Brief, 22 March 2023. <https://www.medicalbrief.co.za/what-the-law-requires-after-procedure-related-deaths>.

Advertising and the HPCSA Guidelines

Wendy Massangaie, medicolegal advisor, SAMA Legal Affairs Department



The HPCSA recognises that healthcare practitioners must advertise their services, as most businesses do, to attract patients. Rule 3 of the Ethical and Professional Rules of the Health Professions Council of South Africa (booklet 2) sets out the way healthcare practitioners should engage with potential and current patients when advertising. This is designed to ensure that advertising is ethical and does not mislead or deceive the public.

What is acceptable as advertising?

Rule 3 of the ethical rules provides as follows: "Advertising and canvassing or touting: – 3.(1) A practitioner shall be allowed to advertise his or her services or permit, sanction or acquiesce to such advertisement: Provided that the advertisement is not unprofessional, untruthful, deceptive or misleading or causes consumers unwarranted anxiety that they may be suffering from any health condition. (2) A practitioner shall not canvass or tout or allow canvassing or touting to be done for patients on his or her behalf."

In simple terms, advertisements must be truthful and not misleading, meaning that healthcare practitioners must not make claims that cannot be supported by evidence, and

should not exaggerate their services, nor exploit the vulnerability of patients or the public. This means that the advertisements cannot be seen as inferring fear, guilt or emotional manipulation to promote the services on offer, be it in the form of texts, imagery or language.

The ethical rules describe canvassing as "conduct which draws attention, either verbally or by means of printed or electronic media, to one's personal qualities, superior knowledge, quality of service, professional guarantees or best practice." In addition, touting is defined as "conduct which draws attention, either verbally or by means of printed or electronic media, to one's offers, guarantees or material benefits that do not fall in the categories of professional services or items, but are linked to the rendering of a professional service or designed to entice the public to the professional practice".

Canvassing and touting are thus closely associated with the practice of advertising, and are prohibited under ethical rule 3, as they refer to soliciting patients through the use of aggressive or unethical advertising. An example of this would be approaching patients outside of other healthcare facilities and offering them discounts or free consultations in exchange for them choosing a healthcare practitioner's services or making baseless claims as to the treatments or therapies on offer.

The importance of the rule

Healthcare practitioners are held in high regard by the public, and as such, the public places trust in the word of the healthcare practitioner, in that their best interests and autonomy will be respected. Advertisements are a way for healthcare practitioners to communicate with the public, which allows the public to make an informed decision about who they seek medical services from. It is for this reason that healthcare practitioners should not engage in any advertising that undermines the public's trust in the healthcare profession,

such as creating false expectations and making unrealistic promises. They cannot make false or misleading statements about their qualifications, experience, services, treatments or therapies that are known to be ineffective or may harm patients.

There are instances where healthcare practitioners find themselves in breach of ethical rule 3, with the public lodging formal complaints with the HPCSA for the unethical and unprofessional conduct of healthcare practitioners, based solely on the advertisement used by the healthcare practitioner. This is viewed as a breach of trust and confidence in the healthcare profession, and a breakdown of the relationship between the public and healthcare practitioner. The HPCSA is tasked with sanctioning healthcare practitioners who are found guilty of contravening the ethical rules, ranging from the imposition of fines to suspension of registration.

Conclusion

In light of the above, healthcare practitioners have a duty and responsibility to their patients and public to adhere to the ethical rules, as they are geared towards safeguarding patient care. It is common cause that healthcare practitioners are held in high regard, and advertisements must be ethical, truthful, informative and responsible. The public must be given accurate and honest information about their care. Therefore, healthcare practitioners are expected to always behave in a professional and ethical manner, and advertising is no exception. The importance of this rule cannot be overstated, as it is vital in protecting the public and in maintaining the integrity of the healthcare profession. Healthcare practitioners are urged to familiarise themselves with the rules concerning advertising, to ensure that they do not fall short of their duties and responsibilities towards the public and the profession.

South African doctors are bound by many rules. Criminal charges for mistakes may have unintended consequences

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

Claims for financial compensation for medical mistakes in SA have been on the rise since 2007. Recently, however, criminal charges for medical errors have also become more prevalent. One such case is that of Dr Danie van der Walt, who was ultimately acquitted on a charge of negligently causing the death of a child. Another example is the case of Dr Peter Beale, who was charged with, but not yet tried for, causing the death of a 10-year-old. Yet another is the ongoing case and charge of murder brought against Dr Avindra Dayanand for the death of a 35-year-old patient.

These cases have raised questions about how the medical profession is regulated in SA. Is the regulation effective in preventing harm? How are medical practitioners held accountable for harm suffered? What are the consequences of the regulatory environment? The Conversation Africa's Ina Skosana spoke to Larisse Prinsen, a medical law specialist, about what's in place.

How is the medical profession in SA regulated?

SA has a comprehensive framework for the regulation of the healthcare environment.

Healthcare in SA is overseen by the National Department of Health along with its provincial departments. The medical profession is regulated by numerous authorities and pieces of legislation.

Practitioners, depending on their branch of medical practice, are regulated by certain bodies that have been created by legislation. These statutory authorities provide field-specific regulation.

They include the Health Professions Council of South Africa, which is perhaps the primary regulator of the medical profession. The council has professional boards that are responsible for various aspects of the profession. For example, the boards determine standards of education and training for practitioners, and set and maintain standards of ethical professional practice as empowered by the Health Professions Act of 1974. The professional boards, such as the Professional Board for Emergency Care Practitioners, also

license practitioners and keep registers of them.

Health products are regulated by the South African Health Products Regulatory Authority. And medical research is overseen by the Medical Research Council.

These statutory bodies and professional boards also have the power to establish disciplinary committees and disciplinary appeals committees.

Which laws are in place?

Healthcare in SA is also regulated by the Constitution, medicolegal codes of conduct, the common law and precedents set by case law.

In addition, numerous Acts of Parliament exist that represent binding regulatory instruments. The Allied Health Professions Act of 1982, Dental Technicians Act of 1979, Health Professions Act, Medicines and Related Substances Act of 1965 and its 2002 amendment, Nursing Act of 2005, Pharmacy Act 53 of 1974 and South African Medical Research Council Act of 1991 regulate medicine and the medical profession.

Some of the most prominent pieces of legislation regulating the practice of medicine are the Choice on Termination of Pregnancy Act of 1996, Inquests Act of 1959, International Health Regulations Act of 1974, Mental Health Care Act of 2002 and its 2014 amendment, National Health Act of 2003 and the 2013 amendment and Traditional Health Practitioners Act of 2004.

In theory, SA has a sound healthcare regulatory framework. However, as is often the case, its efficacy can be undermined by human factors. These may include ignorance of the law, poor implementation, lack of resources, breaking of the law or even the wrongful assumption of being above the law. All these factors may contribute to the rise in criminal charges now being brought against medical practitioners, as well as the shock and pushback this has generated in the medical profession.

This is not only a SA trend but an international one. For example, in the UK, Dr Bawa-Garba was convicted of culpable

homicide over the death of a 6-year-old patient. However, countries such as New Zealand, Australia and England require gross negligence when prosecuting doctors in negligence cases.

How are medical practitioners held accountable?

Healthcare practitioners may be held accountable through internal disciplinary action, civil claims or criminal charges.

The HPCSA, and other bodies and professional boards, have the power to establish disciplinary committees. These committees most often deal with instances of "unprofessional conduct" or conduct that is "improper or disgraceful or dishonourable or untrustworthy".

An example of this type of conduct would be persuading patients to invest in a distressed company of which the medical practitioner is a director. These were the facts of a case involving Dr David Grieve. The doctor tried and failed to appeal a decision by the health professions council.

This means that medical practitioners may be held accountable by way of internal procedures. These may lead to fines, suspensions or the loss of their licences. The precise number of instances where doctors have been struck off is unknown since the majority of these matters are dealt with behind closed doors.

Civil or criminal processes may be based on malpractice or negligence. For a civil claim of negligence, it must be shown that the healthcare practitioner owed a duty of care to the patient, that this duty of care was breached, and that the breach was responsible for the harm suffered. If this is shown on the balance of probabilities, the patient is entitled to compensation. The test applied here asks if a reasonable medical practitioner in the same position would have foreseen the possibility of harm and have taken steps to guard against it. If so, negligence is shown.

For criminal cases of negligently causing the death of another person – culpable

homicide – the same requirements are used. But it must be proven beyond reasonable doubt. This is a [higher burden of proof](#).

Criminal charges should be carefully considered. Medical practitioners should not be held liable for mere [errors in judgment](#). In SA law, you are either negligent or you are not. There are no degrees of negligence. The distinction between acceptable errors in judgement or punishable negligence will

have to be decided case by case, taking all the facts into consideration.

Criminalisation of medical judgment may interfere with [appropriate medical decision-making](#). It may discourage doctors from specialising in higher-risk, yet much-needed, fields already suffering from skills shortages – such as obstetrics or neurosurgery. It may also lead to the practice of [defensive medicine](#) – recommending diagnostic testing or

treatment paths that are not necessarily the best available option but primarily serve to protect doctors against potential litigation or criminal charges.

Source: The Conversation, 11 April 2023. <https://theconversation.com/south-african-doctors-are-bound-by-many-rules-criminal-charges-for-mistakes-may-have-unintended-consequences-201898>.

Substance abuse: Misconduct or incapacity?

Phumzile Gwala, labour law advisor, SAMA Legal Affairs Department

Substance abuse refers to the use of illegal drugs or the use of prescription or over-the-counter drugs or alcohol for purposes other than those for which they are meant to be used, or in excessive amounts. Substance abuse may lead to social, physical, emotional and job-related problems. In a workplace setup, if an employee regularly drinks and/or uses drugs at work, or regularly arrives at work under the influence and is unable to control him- or herself, the conduct becomes one of incapacity rather than misconduct. On the contrary, if an employee who can control him- or herself and fails to do so, such conduct becomes misconduct.

Section 8(1) of the Occupational Health and Safety Act No. 85 of 1993 (OHSA) places a duty on employers to provide and maintain a safe and health working environment. In addition to that, regulation 2A of the OHSA provides that “any employer or user, as the case may be, shall not permit any person who is, or who appears to be under the influence of intoxicating liquor or drugs, to enter or to remain at a workplace.” Furthermore, “no person at a workplace shall be under the influence of or offer any other person intoxicating liquor or drugs.” Intoxication is not only a safety concern (for the employee him- or herself, but also for the other employees and patients) – it also has the potential to cause reputational damage.

Case law

In *Transnet Freight Rail v Transnet Bargaining Council & others* (2011) JOL 2699(LC), the Labour Court held that “the requirement to assist such employees by providing them



with treatment has been widely accepted.” However, when an employee who is not an alcoholic and does not claim to be one reports for duty under the influence of alcohol, (s)he will be guilty of misconduct. The distinction between incapacity and misconduct is a direct result of the fact that in scientific and medical circles, alcoholism is a disease, and it should be treated as such. In this case, the Labour Court went further to say that “where an employee is suffering under incapacity as a result of their alcoholism, the employer is under an obligation to counsel and assist the employee in accessing treatment for their disease.” The purpose of placing such a duty on an employer is based on the current medical understanding of alcoholism – that it is a diagnosable and treatable disease, which results in the incapacity of the

employee. The distinguishing feature in such cases of alcoholism appears to be, as with all instances of incapacity, that the employee is not at fault for their behaviour – the employee cannot be blamed for their disease and its impact on their behaviour, and such discipline would be inappropriate in the circumstances.

Take-home note for the employer

It is always wise for employers to differentiate between instances of misconduct and incapacity relating to substance use in the workplace to ensure compliance with the Code of Good Practice.

SAMA Legal Affairs is only a phone call away and always ready to give support and advice to members.

Proving a case of constructive dismissal

Laetitia Wolfswinkel, labour law advisor, SAMA Legal Affairs Department

The Labour Relations Act No. 66 of 1995 at section 186(1)(e) provides for the employee to terminate “a contract of employment with or without notice because the employer made continued employment intolerable for the employee”. This form of termination of employment is better known as constructive dismissal.

In the matter of *Gold One Limited v Madalani and Others* (JR 1109/15) [2020] ZALCJHB 180, the Labour Court confirmed that the following well-established three requirements must be proven in order to prove a case of constructive dismissal:

- the employee must have terminated the contract of employment
- the reason for the termination of the contract must be that continued employment has become intolerable
- it must have been the employee's employer

who made the continued employment intolerable.

In the case of *Johnson v Rajah NO and Others* (JR33/15) [2017] ZALCJHB 25, the Labour Court dealt with each of the above requirements, and on the first requirement held that the employee need not establish that he had no choice but to resign: the test is whether a reasonable alternative to resignation existed. With regard to the second requirement, the Labour Court stated that the word “intolerable” means that there is a heavy burden on the employee, who is required to show that continued employment was objectively unbearable. It was stressed that intolerability is not established by the employee's say-so, perception or state of mind, and what is relevant is the conduct of the employer viewed in an objective sense.

On considering the third requirement, the court referred to the matter of *Murray v Minister of Defence* (383/2006) [2008] ZASCA 44, where the Supreme Court of Appeal held that the employer must be culpably responsible for the intolerable conditions, saying that “even if the employer is responsible for the intolerable circumstances, it may not be to blame. There are many things an employer may fairly and reasonably do that make an employee's position intolerable. More is needed: the employer must be culpably responsible in some way for the intolerable conditions – the conduct must have lacked ‘reasonable and proper cause.’”

Constructive dismissal is clearly not an easy application to pursue. Members are advised to seek advice before resigning with the view of claiming constructive dismissal.

Knee replacement claim goes to trial

The Medical Protection Society shares a case report from their files

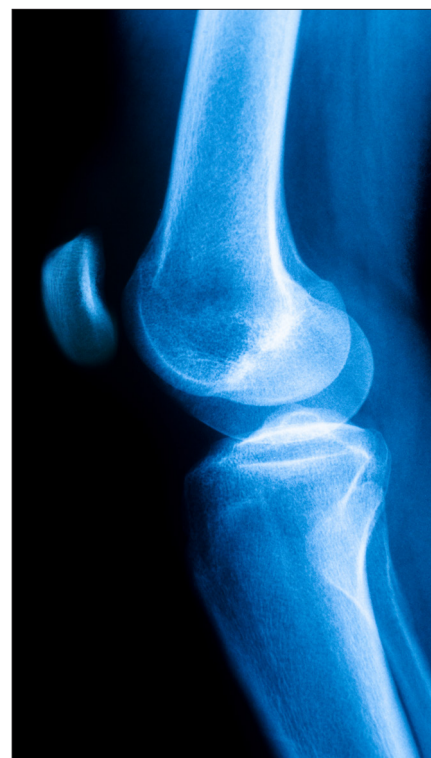
Specialist orthopaedic surgeon Dr W received a claim following a total knee replacement, which progressed to a trial. Suzanne Tate, litigation solicitor at the Medical Protection Society (MPS), explains how the judge dismissed the claim on the third day due to careful consideration and preparation with the right experts and legal team.

Mrs Q was referred to specialist orthopaedic surgeon, Dr W, as an adult patient with cerebral palsy (CP), by a leading rehabilitation consultant. Having been previously independently mobile but with a longstanding high-tone gait, her mobility had been deteriorating with increasing knee pain. Steroid injections into the knee joint had only provided short-lived relief.

Mrs Q's left knee had patella alta (high riding), 15 degrees of valgus, 25 degrees of fixed flexion and advanced osteoarthritis. Dr W agreed to perform a left total knee replacement as a pain-relieving procedure, with any improvement in mobility being a bonus. The surgery went well, and Dr W was able to correct the valgus and straighten the fixed flexion to 10 degrees.

Mrs Q remained an inpatient for 1 week, receiving intensive physiotherapy twice daily. However, she had a failed discharge to her home, where she struggled to cope with stairs, and she was readmitted for a further 12 days. During this time she continued to receive twice-daily physiotherapy. She was seen by the consultant in rehabilitation and received Botox injections into her hamstring. Mrs Q was later discharged to another hospital for further rehabilitation under the care of the consultant in rehabilitation. When Dr W saw Mrs Q as an outpatient 4 months after surgery, it became clear she had not been receiving any physiotherapy, and she had 40 degrees of flexion in the left knee. Dr W arranged for physiotherapy and Mrs Q's gait and flexion improved.

Over time, Mrs Q's left knee and mobility deteriorated, and significant fixed flexion deformity led to the need for revision surgery 6 years later. The revision surgery was performed by a second surgeon and it was a much more invasive procedure, using a hinged implant.



Allegations

Mrs Q made a clinical negligence claim against Dr W, alleging that she woke after Dr W's surgery with very considerable flexion deformity that never resolved. As a patient with CP, this complication was entirely foreseeable, and Dr W's surgery should have been planned with specific postoperative management to address the complication. It was alleged that Dr W was negligent in failing to provide continued postoperative epidural to prevent pain and spasm and permit effective physiotherapy, and a failure to provide postoperative muscle relaxants, splintage and use of a continuous passive motion machine, intensive physiotherapy and if necessary manipulation under anaesthesia (MUA). It was alleged that Dr W gave postoperative instructions for a normal total knee replacement regime, and ought to have referred Mrs Q to an alternative surgeon if he was not adequately experienced. This left Mrs Q wheelchair bound 5 years earlier than she would have otherwise required, and necessitated revision surgery.

We never accepted that Mrs Q woke from surgery with considerable fixed flexion that never resolved. Her detailed physiotherapy notes clearly demonstrated she was able to independently mobilise with elbow crutches and a flat left foot to the floor up to 6 months postoperatively. Mrs Q did not pursue a claim against the hospital or the consultant in rehabilitation for her postoperative rehabilitation post-discharge, and eventually accepted that Dr W had no control or responsibility over her physiotherapy provision or her postoperative rehabilitation after her discharge 3 weeks after surgery. Dr W's direction for a normal knee replacement regime in his operation note referred only to the management of the drain, her wound and the usual postoperative blood tests and X-rays. In every other respect, Dr W was patently aware of her CP and the likely complications, having performed a technically challenging surgery that took twice as long as a normal knee replacement, and having arranged intensive physiotherapy over the course of a 3-week period as an inpatient, when patients are usually discharged after a period of 2 - 3 days postoperatively.

It was eventually accepted that Dr W had sufficient experience to perform the surgery, having been specifically referred by a leading rehabilitation consultant, and as a surgeon specialising in knee replacements for patients with other neurological disorders and having performed other surgeries for adult patients



with CP. It was accepted there was not any other surgeon in the country with greater experience.

Dr W accepted that Mrs Q suffered from muscle spasms periodically, when her pain flared. However, he did not accept that a continued postoperative epidural, muscle relaxants or splintage or MUA could have avoided the permanent fixed flexion that eventually returned. All of the postoperative measures Mrs Q alleged should have been provided are only temporary in nature, and once they stop, the muscle spasms can return eventually, leading to the fixed flexion deformity. It is not possible to keep a patient on an epidural or use muscle relaxants with a continuous passive motion machine indefinitely. MUA would only have taken Mrs Q back to the position achieved immediately after surgery, after which muscle spasms would again occur. The fixed flexion deformity was a slow and inevitable deterioration of her underlying CP.

This highlights the risk any clinician faces when acting as an expert – they must insist on seeing all the records

Mrs Q did not accept she ever received effective physiotherapy while she was an inpatient. Her considerable fixed flexion prevented this, and the physiotherapists simply left her in her bed as they were unable to perform any exercises.

It was clear from the outset that Mrs Q's recollection of events was not in keeping with the significant number of physiotherapy

notes, which demonstrated she did not wake from surgery with fixed flexion deformity and effective physiotherapy was in fact performed. After serving a defence, we directed Mrs Q and her representatives to all of the physiotherapy notes, which undermined her case, and asked her to accept she did receive intensive and effective physiotherapy and that she did not receive the normal knee replacement postoperative regime. This step – taken early in the proceedings – ought to have been a red flag to her representatives that the contemporaneous notes were repeatedly at odds with Mrs Q's account.

The claim goes to trial

Despite this, Mrs Q pursued her claim to a trial. Liability remained fully denied. The trial judge eventually dismissed the claim on the third day of a five-day trial. The MPS legal team was able to methodically pick apart all of Mrs Q's assertions with the contemporaneous records. By the end of the third day, Mrs Q's expert accepted that he had not even seen all of her records, and he could not maintain any of his criticisms nor his opinion that Dr W was negligent. There was no case to answer. In particular, this highlights the risk any clinician faces when acting as an expert – they must insist on seeing all the records.

Commentary

It is a shame that Mrs Q and her representatives did not undertake a forensic review of all of her records with her expert before trial, or even before deciding to pursue a claim. Dr W had a claim hanging over him for 5 years, with all of the stress and worry that litigation entails, including the arduous process of a lengthy cross-examination by Mrs Q's team at trial. However, he was delighted with the outcome, and the claim demonstrated that careful consideration and preparation with the right experts and legal team throughout the lengthy litigation process can eventually result in the right outcome for our members.

Goldfields branch builds relationships

Dr Chantelle Liebenberg, Goldfields chairperson, recently introduced SAMA Goldfields branch to more than 50 interns at Bongani Regional Hospital, assisting some doctors with much-needed guidance and advice. The *Intern 101* booklets were handed out to the interns and were very well received, with other attendees asking for copies of the e-book.

"The hospital CEO, Dr Mkatsane, who is a SAMA member, had high praise for SAMA and invited us back to join them every Friday morning for their meetings," says Michelle duToit, Goldfields branch administrator. "He asked us to be more present in his hospital so that we have a closer working relationship.

"We are currently assisting some members with queries and advice, which I believe sets the tone for the interns to see what SAMA can and will offer them, should they decide to join us."



Griqualand West join Lenmed CPD symposium

The Griqualand West Branch attended the Lenmed CPD Symposium at the Lenmed Hospital in Kimberley on 25 and 26 March 2023.

Dr Lesego Diphatse, Griqualand West branch treasurer, delivered a presentation on SAMA member benefits, and spoke about the importance of joining SAMA. Prof. Dirk Hagemeister, Free State branch treasurer and family physician specialist, presented and enlightened the doctors and medical professionals on an ethical topic: "Consent in healthcare".

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



Dr Lesego Diphatse (SAMA Griqualand West branch treasurer), Prof. Dirk Hagemeister (SAMA Free State branch treasurer) and Annalize Keyser (stakeholder relationship manager at Lenmed Hospital)



Cape Western branch (CWB) donated blankets, knitted by SAMA staff with wool and needles donated by head office, to Mowbray Maternity Hospital. Chenienne Gericke, CWB administrator and Gertrude Fani, Publishing, dropped off the blankets

Free State meet and greet local doctors

In March, the Free State and Northern Division branch held a successful "Meet and greet" session at Boitumelo Hospital in Koonstad, Free State.

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

Prof. Steven Matshidza, Free State branch chairperson, delivered a presentation and spoke about the importance of joining SAMA and uniting public and private sector doctors. He suggested that having sessions both ways, whereby public sector doctors could locum at GP practices and GPs in private practice could do sessional work at the public hospital, to form a companionship, would assist this process.

Dr Coenraad Brink, Free State Northern Division Koonstad chairperson, delivered a presentation and also spoke about the



Dr Kabelo Mahasa (clinical manager at Boitumelo Hospital, Koonstad), Dr Celia Coetzer (GP, Koonstad), Prof. Steven Matshidza (SAMA Free State branch chairperson), Dr Coenraad Brink (SAMA Free State Northern Division Koonstad branch chairperson) and Dr Anastasia Barnard (SAMA Free State Northern Division Koonstad branch secretary)

importance of uniting the public and private sector doctors for the health of the nation.

Dr Anastasia Barnard, Free State Northern Division Koonstad honorary secretary, spoke about the upcoming CPD event to take place

in April 2023, and invited the public sector doctors to the function.

The members checked and confirmed their membership status and details, and 12 doctors signed up as SAMA members.



Welcome to SAMA

SAMA welcomes the following new members who joined the association in March and April 2023.

Border Coastal branch

Marcia Jojo
Pelokazi Kawe

Cape Western branch

Mark Royden Smith
Monya Bianca Pelsa

Aiden Beelders
Jessica Strong

Eastern Highveld branch

Margharetha du Plessis
Yav Ruwe
Siyabonga Bembe

Eastern Province branch

Darshan Chetty

Free State branch

Hendrik Kenfil le Grange
Tebogo Ephraim Keaeletsa
Kabelo Michael Mahasa

Caro Louw
Lynette Fouche
Mabonang Edith Rametse
Mayanda Tshisulu
Rethabile Mercy Molelekeng
Raadiyah Safiya Clarke
Sehrish Gite
Boingotlo Charles Gaserotse
Rethabile Bogatsu
Jana van Niekerk
Frederick Rapudi
Lefu Edward Seeta

Gauteng branch

Lolita Maria Mostert
Michael John Savage-Reid
Zizo Piti
Joshua Boanerges Lusamba Kiluba
Lealon Daniel Forbay
Nepo Ketso
Kealeboha Lepadima
Marianne Holm
Santhisha Vandayar
Nkululeko Mapossa
Njabulo Lydia Mbali Khama
Lethabo Hope Makgoba
Joshua de Klerk
Neo Mkhabela

Gauteng North branch

Monyepao Francis Sebetseba
Igantius Nkosinati Mabuza
Kinki Lucas Magana
Stephina Mncani Sithole
Akhil Neren Mahabir
Nqubeko Hlatshwayo
Kagiso Ratshefola
Radingwana Mamphotleng
Rhulani Ntokozo Maringe
Kagiso Seneng Mokgadi
Nhlamulo Amon Mukeri
Ambrose Lekalakala
Modidi Rocky Fachie
Kamogelo Ramatja
Lauri-anne Potgieter
Rendani Nelly Sathuma

Fumani Maphanga
Mochabo Tshibisho Phokwane
Tshifhiwa Ndou
Dakalo Mantshumuli
Mmathabo Mmakganyane Phasha
Nothile Zandile Gcwalise Ngema
Kurisani Bila
Mmathapelo Serakwana
Nyeleti Shaleen Munisi
Ntshabiseng Makoena Mokgokong
Thapelo Pretty Raseruthe
Mokgadi Adatair Mahafa
Marumo Moyagabo Chokoe
Mokgadi Precious Makoro
Mpago Kagiso Mampholo
Matshidisho Catherine Letsoalo
Mphuting Leaghn Serope
Komane Joel Malaka
Priscilla Phasha
Ndalamo Rambau
Maphuti Basetsana Mothata
Melissa Coetzer
Dyuksha Singh
Tlodipjane Letsoalo
Nondumiso Sheryl Mazibuko
Zizipho Mapeyi
Hassinah Mohammed
Sithabile Zuziwe Magubane
Zandile Nompumelelo Dube
Bredget Mdaka
Lekgetho Lekgetho

Goldfields branch

Musawenkosi Nkanyiso Mthembu

Griqualand West branch

Charles Obakeng Molusi
Mubashria Bibi Anjum
Usama Anjum

KZN Coastal branch

Zohra Bibi Banoo
Adila Omar
Ashley Wetherill
Xoliswa Shangase
Aliyaah Kalicharan

Devaksha Dookhi
Kiara Kiren Ramauthar
Amina Bibi Moosa
Nompumelelo Happyness Lembethe
Ndimiso Siphelele Hlengwa
Alka Asrai
Poonam Jairaj Dookan
Kureesha Naidoo
Clinton Sean Govender
Asthira Ramsakkan
Syed Kamram Ali Shah
Keshav Moethilalh

KZN Midlands branch

Luné Smith
Chante Alana Dove

KZN Northern branch

Sanele Mphakamiseni Magagula
Maxine Lechelle Willis

Limpopo branch

Lehutjo Lebolai Tjebane
Martha Lebepa Mamikie Mamabolo
Marie Stella Molope
Tokyo Nchabeleng

Lowveld branch

Sabatha Lindokuhle Nyawose
Success Kgodiso Shabangu

North West branch

Tshireletso Masilabele
Tasmina Shah
Samantha Anie

Transkei branch

Petrus Jacobus Claassen
Tivanya Pillay

Tygerberg Boland branch

Nompumelelo Angela Masango

Unattached

Palesa Nyakallo Mohale
Kial Parmanand

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.





CPD FOR HEALTH PROFESSIONALS ABROAD

A SAMA Member Benefit:

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



SAMAREC

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

As a registered REC with the National Health Research Ethics Council (NHREC), the Council reviews biomedical research proposals done in the Private Sector. Ethics review is done on any type of biomedical research, including full-scale clinical trials, observational and device studies, surveys and registers. If you are planning to publish your study or ensure that you comply with good clinical practice – SAMAREC will ensure your trial meets all the requirements. We offer a complete electronic submission process, and guarantee a quick turnaround time. SAMAREC has a designated Officer to keep you up to date with the progress of your application

For more information, please contact the
SAMAREC Officer | 012 481 2082 or samarec@samedical.org

