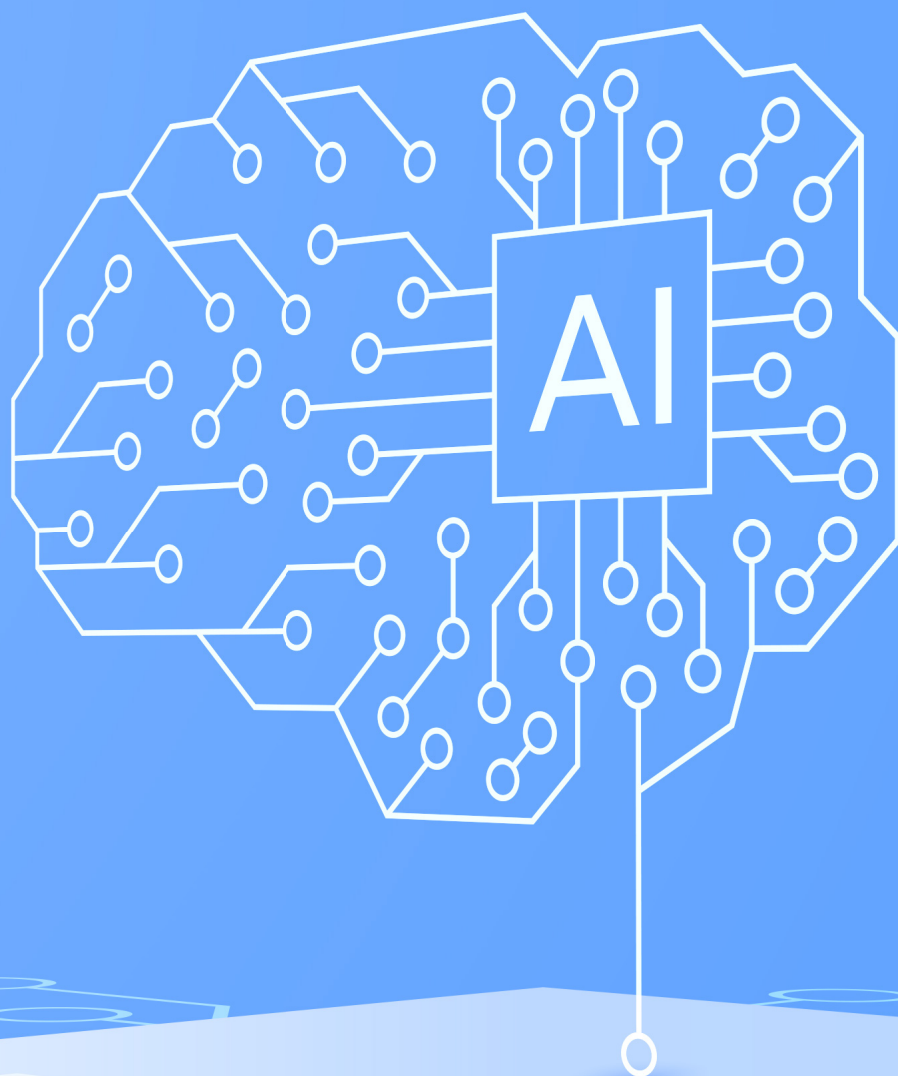


SAMA INSIDER

APRIL 2023

Focusing on ChatGPT

**GPs are essential to
keep the healthcare
system functional**



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Diane de Kock
Editor: *SAMA INSIDER*

ChatGPT – let's investigate

ChatGPT is changing the way information is created – is there a space for this new technology to improve healthcare? The jury is out, and vigorous debates are being held at all levels of use.

Prof. Jonathan Jansen, president of the Academy of Science of SA, says that every new technology over, say, the past 100 years has come with perceived threats. Human ingenuity has responded in ways that took the best of the invention and worked around its excesses in the process. "One thing is clear," says Dr Jaco du Toit, director at the Centre for Cyber Security at the University of Johannesburg, "we should investigate it. We should understand its limitations and impacts better. By understanding better, we can respond better." Peter Geldenhuys, futurist and director of the Institute for Technology, Strategy and Innovation comments: "AI will not replace people – but the person using AI might replace you."

In this issue of *SAMA Insider* we focus on ChatGPT, what this means for healthcare and medical research (page 5), and some words of wisdom from a discussion hosted by the Academy of Science of SA on "The implications of ChatGPT for assessment in higher education" (page 6). And bioethicist Brandon Ferlito unpacks the ethical implications for healthcare (page 7): "ChatGPT's ethical implications for medical practice are intricate and multidimensional, necessitating considerable thought and analysis on the parts of healthcare professionals, decision-makers and technology developers ... [it] needs to be thoroughly explored and addressed."

On page 10 SAMA's Dr Mhlengi Ncube analyses the 2023 Budget, focusing on the healthcare sector and highlighting some considerations for the Minister of Health. The often-extreme challenges of working in healthcare in SA are brought into focus in Husna Ismail and Olga Perovic's article (page 11) on how water cuts are hurting hospitals and clinics and increasing the risk of infections. Similarly, intensified power cuts have already overburdened the public health system (page 12), and fewer than 50% of hospitals identified for exemption from loadshedding have been spared.

We introduce a new regular column 'SAMA Legal Affairs' (page 9), to address frequently asked questions by members, and SAMA labour law advisers Simon Buthelezi and Phumzile Gwala unpack "vicarious liability" and the "early termination of a fixed-term contract".

Globally, the WHO reports that the world needs to reduce sodium use by 30% by 2025 (page 18), and WHO countries begin negotiations on a global agreement to protect the world from future pandemics (page 20).

Giving back to the community is a priority for SAMA branches, and this month Gauteng branch report on the recently initiated corporate social responsibility fund (page 25), which donated to six charities.

Your input and contributions are welcome. Please email Dianed@samedical.org.

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GPs are essential to keep the healthcare system functional



Prof. Risenga Chauke, SAMA president

GPs are an integral part of the health system. They are leaders, managers, collaborators and co-ordinators of care. They play a critical role in society and the healthcare system. The role of a GP is not only to treat diseases and ailments: GPs co-ordinate the healthcare system from top to bottom.

They are the frontliners, together with nursing practitioners, in attending to an individual with a health concern. They get to know their patient's partners and family members. This translates to them treating the whole community. They get to know more about the social aspects of their patients than might be expected, because the individual, family and community feel comfortable discussing issues with their GPs.

GPs become members of the community they serve. They are community leaders who are influential and respected. Their training enables them to engage with and to provide care to everyone, regardless of age, sexual orientation, nationality or culture.

In the not-so-distant past, GPs also provided home visits, a service that was stifled by the high level of crime in our society. But technology has enabled GPs to continue providing the necessary care over

the telephone or internet – what is called telemedicine.

Half of what is taught in medicine turns out to be wrong or at least irrelevant by the time the doctor retires from practice, but which half is wrong is not known, according to Prof. Edward Hundert, Dean for Medical Education at Harvard Medical School. For example, a few decades ago, sugar was purported to be the energy that your body required to keep it active, but today, it is known that sugar is the new cigarette, because of the damage that it does to your body.

It is thus imperative that GPs continuously learn to stay up to date.

GPs face rapidly changing technology, new treatment protocols and consumeristic patients, hence the requirement for them to be committed to lifelong learning, so that they can continuously educate communities. "Medicine is about learning how to learn medicine for a lifetime" (author unknown).

The health system that neglects GPs does so at its own peril

Even in the time of ChatGPT and Dr Google, the vast majority of people still need human touch, and someone to make sense and connect the dots when ill. Technological advancement should aim to support decision-making, improve quality of care and make the lives of doctors easier. Human input or involvement connects the understanding of the impact of social factors on health. GPs know when their patients experience psychosomatic symptoms, which might present as an acute abdomen requiring surgery.

Because GPs treat and deal with people on the ground, they are best suited to take people's healthcare needs to the authorities responsible for providing the necessary resources.

Equally so, the leaders and policy-makers in the health sector draft legislation and policies to govern practice and ensure that the healthcare needs of the people on the ground are met.

Communities are moving data, and GPs are data collectors

Implementation of those policies and legislation will not necessarily be done by artificial intelligence, but by the human work force. Who is better equipped to implement these policies and legislative frameworks than the GP? GPs can represent the government among the people, and clarify policies at granular level.

Hence my argument – do more to elevate the status of the GP as an integral part of the health system. The health system that neglects GPs does so at its own peril.

If we, as a country, need to implement and see the NHI working, then GPs (and nursing practitioners) need to be an integral part of the NHI system. The GP must be able to advocate for the patient, but at the same time, advocate for national health coverage.

Apart from providing clinical services, GPs are also important in research, as they generate data from the communities they are serving, data that can greatly assist in improving the health system. Communities are moving data, and GPs are data collectors. Ethical and consent issues should be clarified that will allow these data to be gathered.

GPs are also teachers of future healthcare professionals. Medical institutions can use GPs to expand their community teaching programmes to produce fit-for-purpose future healthcare providers, both undergraduates and postgraduates.

It is for these reasons that the GP should be highly regarded in the medical profession and in the healthcare system, in order to keep the system functional.

ChatGPT has many uses. Experts explore what this means for healthcare and medical research

Keymanthri Moodley, distinguished professor in the Department of Medicine, and Director, The Centre for Medical Ethics & Law, Stellenbosch University, **Stuart Rennie**, associate professor, University of North Carolina at Chapel Hill

The sanctity of the doctor-patient relationship is the cornerstone of the healthcare profession. This protected space is steeped in tradition – the Hippocratic oath, medical ethics, professional codes of conduct and legislation. But all of these are poised for disruption by digitisation, emerging technologies and “artificial” intelligence (AI).

Innovation, robotics, digital technology and improved diagnostics, prevention and therapeutics can change healthcare for the better. They also raise ethical, legal and social challenges.

Since the floodgates were opened on ChatGPT (Generative Pretrained Transformer) in 2022, bioethicists like us have been contemplating the role this new “chatbot” could play in healthcare and health research.

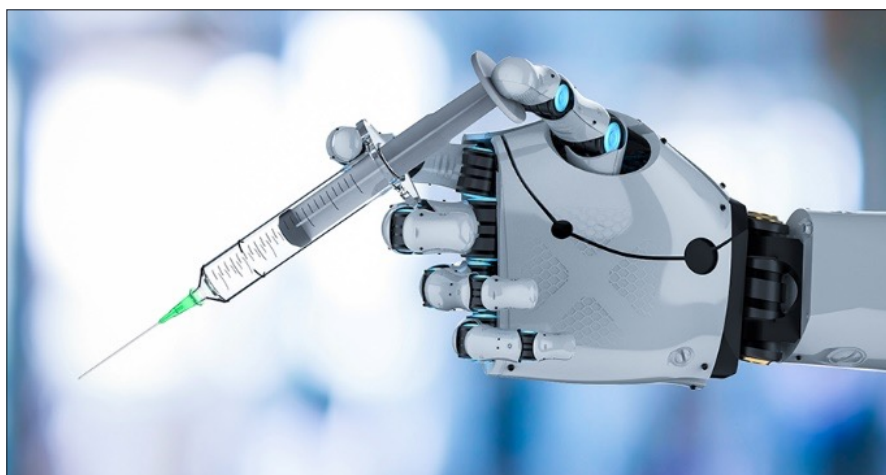
ChatGPT is a language model that has been trained on massive volumes of internet texts. It attempts to imitate human text and can perform various roles in healthcare and health research.

Early adopters have started using ChatGPT to assist with mundane tasks such as writing sick certificates, patient letters and letters asking medical insurers to pay for specific expensive medications for patients. In other words, it is like having a high-level personal assistant to speed up bureaucratic tasks and increase time for patient interaction.

But it could also assist in more serious medical activities such as triage (choosing which patients can get access to kidney dialysis or intensive care beds), which is critical in settings where resources are limited. And it could be used to enrol participants in clinical trials.

Incorporating this sophisticated chatbot in patient care and medical research raises a number of ethical concerns. Using it could lead to unintended and unwelcome consequences. These concerns relate to confidentiality, consent, quality of care, reliability and inequity.

It is too early to know all the ethical implications of the adoption of ChatGPT in healthcare and research. The more this technology is used, the clearer the



implications will get. But questions regarding potential risks and governance of ChatGPT in medicine will inevitably be part of future conversations, and we focus on these briefly below.

Potential ethical risks

First of all, use of ChatGPT runs the risk of committing privacy breaches. Successful and efficient AI depends on machine learning. This requires that data are constantly fed back into the neural networks of chatbots. If identifiable patient information is fed into ChatGPT, it forms part of the information that the chatbot uses in future. In other words, sensitive information is “out there” and vulnerable to disclosure to third parties. The extent to which such information can be protected is not clear.

Confidentiality of patient information forms the basis of trust in the doctor-patient relationship. ChatGPT threatens this privacy – a risk that vulnerable patients may not fully understand. Consent to AI-assisted healthcare could be suboptimal. Patients might not understand what they are consenting to. Some may not even be asked for consent. Therefore medical practitioners and institutions may expose themselves to litigation.

Another bioethics concern relates to the provision of high-quality healthcare. This is traditionally based on robust scientific evidence. Using ChatGPT to generate

evidence has the potential to accelerate research and scientific publications. However, ChatGPT in its current format is static – there is an end date to its database. It does not provide the latest references in real time. At this stage, “human” researchers are doing a more accurate job of generating evidence. More worrying are reports that it fabricates references, compromising the integrity of the evidence-based approach to good healthcare. Inaccurate information could compromise the safety of healthcare.

The global south needs locally relevant conversations about ethical and legal implications

Good-quality evidence is the foundation of medical treatment and medical advice. In the era of democratised healthcare, providers and patients use various platforms to access information that guides their decision-making. But ChatGPT may not be adequately resourced or configured at this point in its development to provide accurate and unbiased information.

Technology that uses biased information based on under-represented data from people of colour, women and children is harmful. Inaccurate readings from some brands of pulse oximeters used to measure oxygen levels during the recent COVID-19 pandemic taught us this.

It is also worth thinking about what ChatGPT might mean for low- and middle-income countries. The issue of access is the most obvious. The benefits and risks of emerging technologies tend to be unevenly distributed between countries.

Currently, access to ChatGPT is free, but this will not last. Monetised access to

advanced versions of this language chatbot is a potential threat to resource-poor environments. It could entrench the digital divide and global health inequalities.

Governance of AI

Unequal access, potential for exploitation and possible harm-by-data underline the importance of having specific regulations to govern the health uses of ChatGPT in low- and middle-income countries.

Global guidelines are emerging to ensure governance in AI. But many low- and middle-income countries are yet to

adapt and contextualise these frameworks. Furthermore, many countries lack laws that apply specifically to AI.

The global south needs locally relevant conversations about the ethical and legal implications of adopting this new technology to ensure that its benefits are enjoyed and fairly distributed.

Source: The Conversation, 22 February 2023. <https://theconversation.com/chatgpt-has-many-uses-experts-explore-what-this-means-for-healthcare-and-medical-research-200283>.

ChatGPT – calm your inner Luddite, keep your inner sceptic

Karen MacGregor

"Calm your inner Luddite, hold on to your inner sceptic," is one of the messages for educators contemplating ChatGPT and other large language models, from Dr Roze Phillips, a futurist who straddles the worlds of work and academia. "Trying to outsmart AI [artificial intelligence] is not a viable strategy."

For example, trying to outsmart AI to ensure that students are not plagiarising. Rather, and importantly, many people are suggesting that educators make new technologies part of the learning process, Phillips told a discussion hosted by the Academy of Science of SA (ASSAf).

It is essential to have a "growth mindset", which means being able to ask excellent questions, change and grow from failure. That is just as important as getting the right answer.

"I'm in the world of work and in the world of education, where the job is to prepare students for the world of work. How does the world of work really work?" asked Phillips, who was a medical doctor and then a researcher for the SA Medical Research Council before moving into the corporate world, and then back into academia.

"Whether in medicine or law or finance, technologies are part of how people work. To deny our students these technologies – to hold that away from them in assessments – is not useful because we are not preparing students. The job of technologies is to help us be better at work."

On 22 February 2023, ASSAf hosted the 11th ASSAf Presidential Roundtable Discussion, titled "The implications of ChatGPT for assessment in higher education". It was moderated by Prof. Jonathan Jansen, ASSAf president and distinguished professor of education at Stellenbosch University.

Other panellists were Dr Franci Cronje, research associate at the design and marketing IIE Vega School in Cape Town, and Prof. Johannes Cronje, professor of digital teaching and learning at Cape Peninsula University of Technology.

Their enlightening presentations showed, to the 1 400 participants, many ingenious uses of ChatGPT and AI-assisted technology for academics and students in the arts and the sciences.

Humanising the inanimate object

It is important not to look only at ChatGPT but at large language models, AI and technology generally, and what these tell us about what we should and should not do, said Phillips, founder and CEO of Abundance at Work and adjunct faculty at the Centre for Business Ethics of GIBS Business School.

"I spend a lot of time on ChatGPT, to be honest, and I find that the conversations are quite enlightening. Obviously technologies are helping us to organise the world's information. But what technologies are also doing is starting to simulate being human." With ChatGPT,

"when you sit there and type in text, you are having a peer-to-peer conversation."

Conversing with ChatGPT also reminds Phillips that it is a master in the realm of language. "As educators we do not quite understand how complex language is and how language itself can manipulate." For instance, language can take a position: it can be optimistic, it can be cynical.

"As students and as members of society, being able to distinguish how we use language is going to be a fundamental skill that we are all going to have to have in the coming years." People need to think about prejudices, misinformation and how language is being used.

ChatGPT and other large language models organise the world's information the way the world has input that information. "It has the same biases that humans have. It gets things wrong as we humans do. It simulates being human. It's almost a childlike version of being human and it is learning exceptionally fast."

She recalled spending many months travelling around SA with a little robot called Romo, conversing with people about the impacts of technology on the world of work. "I realised that we spend a lot of time humanising inanimate objects while dehumanising ourselves."

"Our young people are doing exactly that. They are humanising the inanimate object. We as educators have to be very careful about how we also get taken in by technology."

Plagiarism and assessment

In education, the initial focus on ChatGPT has been on the plagiarism battle. "I am worried that we will take our eye off the student, and that we should never do. Is education about being as efficient as possible in assessing students? Or is it about the effectiveness of their learning?"

"ChatGPT can be a partner in learning and it can make the learning process as important, if not more important, than purely the assessment," Phillips said.

There is a need to lift the veil on assessment. Many students find ways to pass assessments but go through the year worrying about exams, focusing on the product rather than the learning.

In the USA, ChatGPT has learned to pass some of the questions in medical exams. Two things became clear.

First, ChatGPT can become more accurate as it looks at more data, because it is learning from databases. "It can become more consistent and it can perform better in terms of holding the integrity of its arguments. It's not as good as human beings are, but it's getting better."

More fascinating, Phillips said, is that being a generalist seems to make ChatGPT especially good at applying information. For instance, because ChatGPT draws on philosophy, biology, law and various other subjects, it is able to present strong arguments in, say, a legal or a medical case.

"When we teach students, are we teaching specialists or are we also teaching generalists? We are going to have to learn more about how the transdisciplinary nature of knowledge works."

A word to the wise

What are we learning about how we are learning? "This is the curse of knowledge. As



experts, it's becoming increasingly difficult for us to teach. For the world of work, students need to learn how to collaborate – students already know how to compete."

Tools like ChatGPT work well in conversation and can be used as a peer in education. "We can do learning in an asynchronous way, where people are not coming together but ChatGPT is the partner in learning. I argue that would be the best way of using large language models," said Phillips.

"The job of the educator is to hold the hand of the student as they go through the process of learning, and to remind them of what the integrity of the learning process requires. It's not about getting the answer, it's about the process of learning. And the job of the student is to learn how to learn – not just what to learn, but also how to learn."

Science and technology are great at telling people what is, and technologies are evolving to do almost anything. ChatGPT and other AI-assisted tools have

led Phillips to understand the importance of distinguishing between what is versus what ought to be.

A big problem – and an opportunity – for people is how to keep up with technology. "Our technologies are progressing faster than our wisdom." There must be a focus on lifting humanity's wisdom, said Phillips, and that is all about moral progress.

She urged educators to learn how language models work and to understand the complexities of language. Understand too the ethics involved in the use of technologies in education, and teach that to students. "If we can do that, then we will produce better humans, who figure out how things ought to be, and not just the way things are."

Source: University World, 2 March 2023. https://www.universityworldnews.com/post.php?story=20230302062634124&utm_source=newsletter&utm_medium=email&utm_campaign=AFNL0396.

The new Dr Google? ChatGPT and the ethical implications for healthcare

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

Chat Generative Pre-trained Transformer (ChatGPT), developed by OpenAI, was introduced in November 2022, and is powered by artificial intelligence (AI) technology to produce human-like texts in a conversational way. In addition to writing essays and responding to follow-up questions, ChatGPT is able to admit its errors and refute false assumptions thanks its dialogue format.

Despite the fact that it may be impressive from a technical perspective, the thought of depending on an AI-powered machine to have conversations and generate responses raises fundamental ethical concerns, especially for healthcare.

The use of digital health technologies and AI-powered machines (such as ChatGPT) is expanding across all healthcare settings, with

their usage and abilities seemingly endless. ChatGPT has the ability to perform various tasks in healthcare. Users of ChatGPT within the healthcare space have already started using it as a personal assistant by having the AI-powered machine produce sick notes, while patients are using the chatbot to seek out medical advice – in other words, ChatGPT may be the new Dr Google.

There are also several other ways in which ChatGPT can be used in healthcare, among them interacting with patients, helping with diagnosis and triage, integrating with electronic health records, delivering medical education and training and providing support for mental health. Although the use of ChatGPT may be “beneficial” and “useful”, there are some potential ethical concerns that the healthcare profession ought to be aware of.

Potential ethical concerns

There are various ethical issues raised by the usage of ChatGPT in healthcare that need to be taken into account. Some of these issues include:

- Privacy: ChatGPT’s application in healthcare may require the collection and storage of personal and sensitive health information.
- Algorithmic bias: there is a chance that ChatGPT will provide biased or misleading responses, leading to misdiagnoses or misguided therapies and treatments.
- Inequity: not all patients may be able to use ChatGPT, especially those who lack access to or are uncomfortable utilising technology.

Other potential ethical concerns that need to be taken into consideration include: accountability, autonomy, responsibility, trust, impact on the healthcare workforce and impact on patient-doctor relationships. Additionally, while ChatGPT in healthcare raises ethical concerns similar to those in other locations, specific difficulties in Africa must also be taken into account. These may include concerns about the societal acceptance of digital health technologies and the possible amplification of already existing health disparities due to unequal access to such



technologies. Moreover, ChatGPT might not be able to address some medical problems unique to Africa.

Furthermore, the potential use of AI technologies such as ChatGPT in end-of-life care and mental healthcare raises unique ethical implications. There may be substantial emotional, psychological and ethical repercussions for patients and their families if AI technology is used to anticipate a patient’s course of illness. If a chatbot is used to “support” or offer advice to a mental health patient, the ethical implications may be increased due to the patient’s heightened vulnerability. Recently, the use of ChatGPT by an online mental health company (Koko) to assist in user response in an experiment has once again raised ethical questions about healthcare and AI technology.

Potential mitigation strategies

Certain steps can be taken to mitigate the ethical implications of using ChatGPT in healthcare. Some of these steps include ensuring openness about

the technology’s function, obtaining informed consent from patients, ensuring its input and training data is diverse to avoid algorithmic bias, using ChatGPT to support and supplement rather than replace human interaction, prioritising patients’ right to make informed decisions and ensuring equitable and equal access to ChatGPT. Using ChatGPT in healthcare must also be done with consideration, compassion and respect for the patients.

Conclusion

ChatGPT’s ethical implications for medical practice are intricate and multidimensional, necessitating considerable thought and analysis on the parts of healthcare professionals, decision-makers and technology developers. To ensure that the application of ChatGPT is in accordance with the ethical principles of beneficence, non-maleficence, autonomy and justice in healthcare, the ethical implications of ChatGPT in healthcare need to be thoroughly explored and addressed.

References available on request.

Unpacking vicarious liability

Simon Buthelezi, labour law advisor, SAMA Legal Department

Vicarious liability, also called imputed liability, simply put, means indirect liability for the actions of another person. In the case of employers, it is liability for the unlawful actions of their employees, and this happens mainly in the cases of harassment or discrimination in the workplace.

This can be taken further to include negligence of an employee when operating equipment or machinery, resulting in personal injury or damages to property. A good example would be if a cleaner working on a

surgery floor does not display a sign indicating that the floor is wet, and an incoming patient slips and injures him/herself, or a case of a loose ceiling board falling and damaging a client’s cellphone.

Employers are responsible because they are considered to have the ability to avoid vicarious liability, as they are able to prevent and limit any harmful acts by their employees by proactively exercising reasonable care to prevent employees’ negligent behaviour through training and guidance.

Disputes dealing with vicarious liability

In the Supreme Court of Appeal (SCA) in the matter of *Stallion Security (Pty) Limited v van Staden* (526/2018) [2019] ZASCA 127, an employee, Mr Khumalo, had been appointed by Stallion as a site supervisor in relation to certain security services provided by Stallion, in terms of a contract with a Bidvest entity. Mr Khumalo, as site manager, was provided with a bypass or override key in relation to Bidvest’s biometric system, to enable him to

perform his duties. As a result, he came to know of the Bidvest premises and gained access to the office area, and forced an employee of Bidvest, Mr van Staden, to transfer money to his personal bank account, and then shot and killed him.

Mr van Staden's family pursued a claim for delictual damages against Stallion, founded on vicarious liability for the wrong committed by Mr Khumalo. Even though the intentional wrongs of Mr Khumalo were committed entirely for his own purposes, the question to be determined was whether a sufficiently close link existed between the wrongful act

of the employee, on the one hand, and the business or enterprise of the employer on the other.

The court held that Stallion had furnished Mr Khumalo with much more than a "mere opportunity" to commit the wrongs in question, as he was able to enter and exit from the office area without detection, and was afforded intimate knowledge of the layout and the security services at the premises. Also, it was by virtue of his employment with Stallion that he was in possession of the override key to the office area, and it was that special position that created a material

risk that enabled Mr Khumalo to abuse his powers.

Conclusion

However, in addition, the SCA concluded that SA law should be further developed to recognise that the creation of risk of harm by an employer may constitute or show a close link between the harm caused by the employee and the business of the employer. Whether the employer had created the risk of the harm that materialised must be determined objectively.

References available on request.

SAMA LEGAL AFFAIRS



Should practitioners treat immediate family members?

Karlien Pienaar, administrator, SAMA Legal Affairs Department

A query was recently received on whether a practitioner may consult with and treat an immediate family member, and while it makes sense to diagnose and prescribe medications for a spouse or children, the practitioner should be mindful of the following aspects.

When treating immediate family members for simple illnesses and ailments such as flu, things might seem straightforward. However, in cases where judgement calls are required for more serious circumstances, matters can become more complicated. Consideration should be given to allowing a colleague to treat an immediate family member. Therefore, while it is not strictly forbidden by the HPCSA, it is advisable to refrain from treating them yourself.

In terms of previous resolutions that were taken by the executive committee of the Medical and Dental Professions Board (MDPB) of the HPCSA, it was indicated that

in order for a practitioner to avoid being suspected of unfair financial gain or of abusing their rights with medical schemes, it was not permissible to render an account for the services rendered.

The only costs that may be reimbursed to the practitioner would be the actual expenses incurred, in other words, laboratory fees or any material that was used to treat the family member. This would include the dispensing of pharmaceuticals.

The aforementioned query was received from an anaesthesiologist, and it was argued that where anaesthetics were administered, there would always be evidence of the procedure through hospital records and surgeon claims, and that it would not be possible for an anaesthesiologist to unfairly gain financially from the medical scheme, nor to abuse their rights in this regard. The legal opinion, therefore, concluded that the practitioner could submit a claim to the

medical scheme as it would "not rise to the level of unethical practice".

The same basic principles apply when it comes to self-prescribing, which appears to be commonly practised among medical practitioners. It is not advisable for a practitioner to self-prescribe in the case of serious illness, and a colleague should be approached for an independent and adequate diagnosis, and appropriate treatment and/or medication. This is even more relevant when considering habit-forming scheduled medicines that should not be self-prescribed at all.

Any further queries or comments in this regard are welcome and may be forwarded to the administrator in the Legal Services Department, Karlien Pienaar, on karlienp@samedical.org.

Sources: HPCSA's MDPB Resolutions; WMA Statement on Physicians Treating Relatives.

SA 2023 Budget review: Focusing on the health sector and considerations for the Minister of Health

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



The 2023 Budget is premised on 2.5% economic growth based on the 2022 Mid-Term Budget Policy Statement. This growth is an upward revision from the projected 1.9% growth for the same period. The Minister of Finance allocated ZAR259.2 billion to the healthcare sector. What does this budget mean for the health sector in SA, and what could be included in the health budget?

Human resources for health

'The Department of Health, together with its provincial counterparts, should ensure that the estimated 28 000 vacancies are filled, where funding is available, to address staff shortages in areas where sufficient health workers are required to be at an appropriate level of care.'

Hospitals across the country are understaffed, state medical doctors are overwhelmed by patient volumes and backlogs while some doctors remain unemployed due to budgetary constraints. There is a dire need to move the patient-doctor ratio in SA from the current less than 0.79 doctors per 1 000 to more than 1 doctor per 100 population. This improvement could be achieved, in part, by allocating funds toward the employment of more doctors. Indeed, careful consideration needs to be made to employ the correct proportions per 1 000 population of allied healthcare workers so that doctors do not become burdened by tasks being shifted from a low allied health staff complement to doctors.

The Minister of Health, in this address to the 24th Association of Medical Councils of Africa (AMCOA) international conference under the theme 'The health workforce of the future and its regulation' in 2022, spoke about the

human resources for health crisis. He indicated that some healthcare workers are leaving SA for better salaries and working conditions in developed countries. In the 2023 health budget, the Minister of Health could elaborate on how he will allocate the budget to filling the different categories of vacancies in the state healthcare services.

National Health Insurance

The Minister of Health did not mention the NHI in his budget speech. This is after the advertisement of 44 NHI positions in September 2022. The mandate of these roles or their relevance in the 2023 financial year has not been elaborated. Since the NHI remains central to healthcare reforms in the country, there is an expectation that the Minister of Health will provide further information on how the government will spend on the different elements of the NHI in the 2023 financial year. The Minister of Finance, however, in his report to parliament, mentions the NHI when detailing that: "Funds totalling ZAR349.7 million in 2023/24, ZAR432.3 million in 2024/25 and ZAR568.6 million in 2025/26 are allocated to the National Health Insurance indirect grant to enable construction of the Limpopo Central Hospital in Polokwane.'

The Limpopo Central Hospital will have 488 beds and will commence in March.

Backlogs in medical interventions

"In the health sector, ZAR23.5 billion is added over the medium term. This funding will be used for antiretroviral therapy and to address backlogs in tuberculosis and other healthcare services, mitigate wage pressures, and fund laboratory services, medicine and other goods and medical supplies. In 2023/24, ZAR7.5 billion is allocated, followed by ZAR7.8 billion in 2024/25 and ZAR8.1 billion in 2025/26."

The Minister of Finance recognises the negative impact of the COVID-19 pandemic on the progress achieved by the HIV/AIDS, STIs and TB (HAST) programmes, and that poor health-seeking behavior has resulted in massive backlogs for specialist services in healthcare services in an already strained healthcare system. Wage pressures have increased as more human resources are required to clear

backlogs without causing burnout in medical doctors and allied health professionals. Stronger partnerships with institutions such as the Global Fund and US President's Emergency Plan for AIDS Relief (PEPFAR) are required to support HAST programmes so that more funds could be available to address backlogs in other health services through adequate staffing, and the availability of medical resources such as medicines and diagnostic capabilities. Sessional work to clear backlogs could help to sustain the private healthcare sector in the short to medium term to recover from the effects of job losses that happened as a result of the COVID-19 pandemic. The Minister of Health could in his budget review detail the economic impact that optimisation of operations and funding with health development partners could have on improving the cost-effectiveness of strategies to clear the backlogs. The Minister of Health could lay out plans on how to plug the wage gap and associated challenges such as staff morale and retention that are critical to sustaining the health system.

Revitalisation of healthcare facilities in the Eastern Cape and KwaZulu-Natal

"While the National Treasury, together with the Department of Health, continue to find ways to improve grant expenditure trends, the committee urges both departments to make more funds available in the 2023 budget for the Health Facility Revitalisation Grant to repair the health facilities destroyed in KwaZulu-Natal and the Eastern Cape during the April 2022 floods. A progress report should be provided in this regard in the next budget cycle."

Extensive damage to all forms of infrastructure, due to floods, was experienced in several areas in the Eastern Cape and KwaZulu-Natal in 2023. This caused long periods of disruption to healthcare services as buildings and equipment were lost, and the loss of bridges made some of the facilities difficult to access. An interdepartmental systems approach could improve the cost-benefit of the Health Facility Revitalisation Grant. Opportunities for infrastructure improvement also exist where modifications to facilities could be made to improve facility operations, working conditions for healthcare workers and patient outcomes.

Water cuts in SA are hurting hospitals and clinics – there's an increased risk of infections

Husna Ismail, epidemiologist, National Institute for Communicable Diseases, Olga Perovic, principal pathologist, National Institute for Communicable Diseases

SA is a water-scarce country. Changing rainfall patterns and the escalating electricity crisis are making the situation worse. Treating and distributing water requires electricity. Some of the country's biggest cities have had to impose water restrictions, and residents in other parts have gone months without regular water supply. Unfortunately, health facilities have not been spared. There have been numerous media reports of hospitals and clinics around the country being hit by water shortages. The Conversation Africa's Ina Skosana spoke to epidemiologist Husna Ismail about the dangers of clinics and hospitals running out of water.

How common are hospital-acquired infections?

The WHO defines healthcare-associated infections, or "hospital" infections, as those affecting patients admitted to a healthcare facility. These are infections not present at the time of admission. They also include infections that appear shortly after discharge. Healthcare-associated infections are a significant cause of illness and death in hospitals.

In low- and middle-income countries such as SA, the WHO estimates that 15 out of every 100 patients in hospitals will get an infection. In high-income countries, the estimate is 7 patients out of 100.

Which are the major infections?

Common types of healthcare-associated infections include bloodstream, cerebrospinal fluid, respiratory system, surgical sites, skin and soft tissue and urinary tract infections. Intravenous and other devices are likely sources of infections in hospital settings.

Micro-organisms such as bacteria, viruses, fungi and parasites cause infections. The most common bacterial agents are *Staphylococcus aureus*, *Klebsiella pneumoniae*, *Acinetobacter baumannii*, *Pseudomonas aeruginosa* and enterococci.

Patients are at higher risk of getting infections if they have underlying conditions.



These include but are not limited to diabetes, renal failure and malignancies. Long stays in hospital, surgical or invasive procedures, insertion of medical devices, intravenous tubing and artificial joints replacement also pose a risk. Patients may develop infection caused by micro-organism with emerging antimicrobial resistance while on antimicrobial treatment, or when they have been treated a few months to a year before. This makes individuals with antimicrobial resistance less able to fight infection.

Which infections are related to the availability of water?

Delivery of quality healthcare should take place in a hygienically clean and safe environment. This environment must have an adequate supply of clean running water and good sanitation for both patients and staff. The cornerstone of all infection prevention and control programmes is hand hygiene. Hand wash stations with water, soap, clean towels or alcohol-based hand rub should be available in key areas such as toilets and at the points of care. Standards for water quality, sanitation and environmental health should be met. Hand sanitisers must have at least 70% alcohol by volume.

Pathogens such as *Legionella* and non-tuberculous mycobacteria can contaminate the deep infrastructure such as pipes and drains or outlets of hospital water distribution systems. Other bacteria and moulds tend to adhere to surfaces at or near taps and sinks. Hospital management teams should have

systems to address water, sanitation and hygiene (WASH) malfunction or other related issues such as infrastructure.

Infection prevention and control programmes in healthcare facilities are important approaches to help protect vulnerable patients, as well as staff and visitors.

How can hospitals maintain infection control – even during water cuts?

Municipal water supplies to hospitals and communities must be pathogen-free and regularly monitored. Municipalities should have water quality assurance systems in place to ensure clean water. Contaminated municipal water can cause outbreaks that affect community and healthcare settings.

Hospital management should have a risk assessment plan for water shortages. They should communicate with municipalities about the provision of an alternative supply of clean water to the affected areas. Possible solutions could include a permanent (quality-assured borehole water) or temporary (watertanks) backup water supply. Those solutions must also be maintained properly to avoid contamination and subsequent infection of patients.

Source: The Conversation, 16 February 2023. <https://theconversation.com/water-cuts-in-south-africa-are-hurting-hospitals-and-clinics-theres-an-increased-risk-of-infections-199425>.

Hospitals to be exempt from loadshedding – but not soon

SAMA Communications

Hospitals are among the entities to be exempted from loadshedding under the national State of Disaster regulations promulgated at the beginning of March by Co-operative Governance and Traditional Affairs Minister Nkosazana Dlamini-Zuma.

MedicalBrief reports that it may take a while before conditions are met for all hospitals to be spared power cuts. Eskom has warned that it is technically impossible to isolate and exclude most institutions from loadshedding, given how embedded they are in Eskom's transmission and distribution networks. It has also been revealed that dozens of hospitals lack the necessary infrastructure for cable installations and other measures.

The regulations allow government departments to use emergency procurement procedures to add new energy sources and perform maintenance work on existing electricity infrastructure, reports the *Mail & Guardian*, but accounting officers will have to report on emergency expenditure to both the auditor-general and parliament, aimed at preventing a repeat of the COVID-19 emergency funding looting that took place during 2020 and 2021.

Ministers will also now have the power to exempt facilities from loadshedding "where technically feasible" – and only if it would not increase the risk of higher loadshedding stages, reports *News24*.

Dlamini-Zuma said Eskom could now import power from neighbouring countries under the new regulations, while the "wheeling" of electricity to allow third-party networks to provide power would also be introduced.

Former Eskom CEO André de Ruyter had warned that trying to halt loadshedding at all hospitals and other services could trigger a national blackout. In an affidavit after an urgent court bid launched by the United Democratic Movement, Inkatha Freedom Party, Action SA, the National Union of Metalworkers and other organisations, he warned that it would put "immense strain" on the system.

Eskom also flagged concerns that hospitals and other institutions that qualify



for exemption from loadshedding share distribution lines with thousands of other customers.

Health minister Joe Phaahla said that 46 government hospitals buckling under the weight of loadshedding would have cables installed to exempt them from rolling blackouts – at a cost of ZAR350 million – while solar power and alternative energy sources were also on the drawing board, reports *BusinessLIVE*.

Intensified power cuts have devastated the already overburdened public health system, including water supply challenges because of non-functioning pumps, and while some progress had been made to ensure hospitals are freed from loadshedding, and even with the exemption relief from the new regulations, investigations had revealed that dozens lacked the necessary infrastructure.

"Both Eskom and various municipalities, which are electricity distributors, have said certain infrastructure is needed for cables to bypass where the health facility's supply is linked with the local supply of residential and business areas," said Phaala. "They've given us a number of hospitals we see as a priority."

He had acknowledged that fewer than half of the hospitals identified for exemption from loadshedding had yet to be spared from blackouts, reports *LegalBrief*, and said the National Department of Health had originally given Eskom a total of 213 hospitals to be

considered for possible exclusion. About 67% are supplied by municipalities, while Eskom supplies about 33% of the rest.

The minister said that in the next financial year, "we are looking at using our own infrastructure fund to work with electricity distribution agencies, whether it be Eskom or the local municipalities, to procure the necessary additional cables from our infrastructure grant".

Intensified power cuts have devastated the already overburdened public health system

The health department said 46 hospitals countrywide needed cable installation. So far, 76 hospitals have been exempted, and the ministry said the remainder would receive budget support for generator fuel and maintenance.

In the current financial year, about ZAR260 billion is allocated to funding healthcare, 23% being for the national health department. Of this, 85% is transferred to the provinces to fund health system priorities via grants.

The Treasury has apportioned another ZAR23.7 billion to cover the shortfall in compensation budgets and to improve public health services, but critics have said the extra funds barely scratch the surface of the provinces' pressure as budgets shrink.

Water pumps

Power outages affect not only life-saving machinery, electronics and lights in hospitals, but also hamper water pumps during extended periods of blackouts, particularly in Gauteng, and Phaahla said while all hospitals had reservoirs, they can only last for a limited period if water pumps do not function during loadshedding.

In the year ahead, he said, the health sector infrastructure grant would be utilised to ensure that where possible, underground

water could be used to supplement municipal supplies.

"Clinics and community health centres are going to be covered within the solar energy roll-out programme. The National Department of Health in partnership with Council for Scientific and Industrial Research is conducting a due diligence exercise into how best to provide additional power from independent power producers, and the installation of batteries and solar at health facilities," he said.

Included in the new regulations were:

- Exemptions or expedited approvals for land to be used for energy generation must be granted. Also, it allows for access to servitudes on public and private land for Eskom and Eskom group companies to expand the national transmission work.
- Cellphone operators and broadcasters must

issue public service announcements on the national State of Disaster at no cost to users.

- Recruitment must be expedited of skilled personnel, and the appointment of original equipment manufacturers by Eskom.
- Water boards and municipalities must revise the minimum operation levels for reservoirs, and increase water treatment and reservoir storage capacity and water treatment schedules to maximise water treatment while electricity is available.
- Water boards (or municipalities that are water service authorities) will be exempt from penalties for exceeding the notified maximum demand during periods of loadshedding.

Source: MedicalBrief, 1 March 2023. <https://www.medicalbrief.co.za/hospitals-to-be-exempt-from-load-shedding-but-it-wont-happen-overnight>.

SA's mental health needs better funding

SAMA Communications

In the face of a mental health pandemic in SA, the share of the national public health budget allocated to mental healthcare is not only woefully inadequate but could be better invested in prevention and care at primary healthcare and community level.

Responding to finance minister Enoch Godongwana's 2023 Budget tabled yesterday (22 February), the SA Society of Psychiatrists (SASOP) said it was concerning that mental healthcare continued to be underfunded while common mental health conditions, including anxiety and depression, were on the rise.

"Mental healthcare continues to be allocated only 5% of the national public health budget, and since the health budget itself is declining in real terms, the mental health portion is actually declining in monetary terms," SASOP public sector national convenor Dr Kagisho Maaroganye said.

One in three South Africans suffers from mental illness, with 75% unable to access treatment, while Dr Maaroganye said mental healthcare professionals had seen a significant increase in common mental health problems "after COVID-19 ran through the country and caused both documented and untold misery for all citizens".

Common and treatable mental health disorders have overtaken physical illnesses



and injuries as the leading cause of medical disability claims in SA.

However, the focus of the mental healthcare system is skewed towards more severe mental health conditions that affect less than 1% of the population, he said.

The latest Mental State of the World report rated South Africans' mental wellbeing the lowest in the world, with the country's "mental health quotient" (MHQ) at 46/100, a decline of 3% from 2020. SA also had the highest percentage (36%) of people experiencing emotional distress or struggling with mental health, an increase of 8% from 2020.

"The combined effects of the COVID-19 pandemic – social isolation, job losses, illness and threats to people's physical health, deaths of family members – have caused widespread emotional distress and mental illness.

"Treatment rates fell due to lack of access to mental healthcare facilities during lockdowns and patients may have had relapses, while those who did not previously experience mental health problems now find themselves with anxiety, depression and sleep disorders," Dr Maaroganye said.

Meanwhile, he said, underfunding of mental healthcare hampered prevention and diagnosis of mental illness, and limited access to treatment.

"Shortages of mental health clinicians, a lack of experienced practitioners and insufficient resources to follow up and ensure compliance with treatment all contribute to a persistent treatment gap.

"In addition to the factors that put the general population at risk of mental illness, there are specific populations that are particularly vulnerable to mental illness, specifically the maternal population and children and adolescents," he said.

Insufficient attention to the mental health needs of expectant and new mothers, and of children and adolescents, suggests that the prevalence of mental illness is likely higher than indicated in surveys.

"SA's mental healthcare budget, as a percentage of the overall health budget, is at the lower end of international recommendations for mental health spending, but it is also misdirected. Budget allocations are hospital-centric and reactive, with 86% of the budget allocated to inpatient care, and almost half that on specialised psychiatric hospitals.

"The focus is on treating the most severe conditions, which have a prevalence of less than 1%, rather than preventing or providing early intervention and treatment for widespread and common mental health conditions of anxiety and depression before they escalate into more serious mental illness.

"Almost 20% of the mental healthcare budget is spent on hospital re-admissions. This 'revolving door syndrome' is a costly reflection

of a highly inefficient system with an inability to optimise care at primary and community level," he said.

While only 8% of the mental healthcare budget is allocated to primary healthcare, SASOP argues that it is at this level that community psychiatry can work to prevent mental illness and ensure early treatment that prevents mental health conditions becoming disabilities.

Dr Maaroganye said that community psychiatry offers the best prospects of optimal care for a stabilised mental healthcare patient in the community, and preventing the costly "revolving door" of repeated hospital admissions.

"While specialised psychiatric hospitals, and psychiatric wards in general hospitals, do serve a purpose, the success of a healthcare system ultimately depends on the extent to which we can prevent illness, and on treating illness effectively to prevent relapse. The aim is to improve quality of life by enabling persons with mental illness to maintain their dignity, obtain or re-obtain independence, and return to being productive members of society," Dr Maaroganye said.

Within the budget limitations for mental healthcare, SASOP has called on the government to focus investment in mental healthcare at the community psychiatry level.

The organisation proposes the following as more appropriate investments in mental healthcare:

- development of IT systems that hold and distribute psychiatric information between

community-based psychiatric facilities and psychiatric units/hospitals to facilitate continuity of care and better understanding of care outcomes, and inform service planning

- strengthening child and adolescent mental healthcare through establishment of more community-based mental health facilities and provision of treatment and rehabilitation for children and adolescents
- expansion of the substance abuse helpline set up in Gauteng, which gives substance use help-seekers access to human and physical resources to manage their substance-use disorders
- improving mental healthcare for expectant and new mothers by investing in the mental healthcare education of all primary care nurses and healthcare workers, not only antenatal care nurses and midwives, to bolster early detection and treatment of depression and other psychiatric conditions that have a high prevalence in SA during pregnancy and after childbirth
- increasing expenditure on community psychiatry through (i) hiring of psychiatrists, psychiatric medical officers, mental health nurses and allied professionals with interest and expertise in mental health; (ii) renovating or expanding primary healthcare clinics to accommodate mental health clinics; and (iii) facilitating the training of generalist clinical staff to manage patients' mental illness independently or with support from psychiatric clinicians.

Early termination of a fixed-term contract – what's your recourse?

Phumzile Gwala, *labour law advisor, SAMA Legal Affairs Department*

When an employer and employee enter into a fixed-term contract, both parties agree at the conclusion of the contract that the contract will endure until its agreed term expires. At common law, the contract may not be terminated before that time. If either party terminates before the expiry, this amounts to breach of contract.

What is the recourse for the aggrieved party (employee)?

A member can contact SAMA Legal Affairs Department immediately, and forward the contract of employment to the labour law

advisors so that they can peruse the document to ascertain the terms and conditions that are stipulated on the binding document. The labour law advisor will then assist the member with the following:

- they will call on the employer to adhere to the terms of the contract until the expiry of the agreed term. This is a call that the employer make "specific performance" of the contract; or
- they will cancel the contract because of the breach and sue for damages arising from the breach. The amount of damages that could be claimed would place the

employee in the position (s)he would have been in if the contract had not been breached, subject to the claimant being required to attempt to mitigate the loss. Typically, this would require the employee to seek alternative employment, and not to sit back and require the employer to pay for the unexpired portion of the contract.

Important point to remember: The employer may dismiss an employee at any time during the term of a fixed-term contract on the basis of misconduct or incapacity, provided that a fair procedure is followed.

NEHAWU protest action – SAMA responds

SAMA Communications

SAMA is aware of and sympathises with the plight of public service workers with regard to remuneration and poor incentives as the reasons for the mass action embarked on by the National Education, Health and Allied Workers' Union (NEHAWU).

SAMA respects the rights of public service workers to protest. However, the association condemns the reports of arson, intimidation and blockages of healthcare facilities that ensued from 6 March 2023. SAMA received reports of these blockages at a number of facilities in several provinces, including Gauteng, KwaZulu-Natal and the Eastern Cape, preventing access of its members and the public to the hospital facilities, including access to specialist services. The lack of ethical leadership by NEHAWU members actively engaging in the protest is of concern. SAMA believes that protests can be carried out effectively and safely, while equally not putting the lives of healthcare professionals and the public at risk. There is no place for intimidation, violence and arson of any kind, at any facility, let alone a healthcare facility. The association affirms that healthcare facilities are not places of protest – instead, these are institutions for quality care of the country's most vulnerable patients.

There is no place for intimidation, violence and arson of any kind

SAMA attributes this protest, and all the resultant effects, to the government for their lack of recognition of the critical importance of the public healthcare system, their lack of focus on capacitating an already dwindling healthcare workforce and the lack of remuneration progression despite the rising costs of living. This reflects the poverty in thought and care by government in all its structures towards healthcare workers. The strikingly poor response from government structures at all levels highlights the deficiency of leadership, from hospital management to the health ministry.

It is demoralising for our members to be working in parlous conditions, from the poor



Dr Mvuyisi Mzukwa, SAMA chairperson, comments

10 March was the fifth day of the strike by workers affiliated to NEHAWU, which has seen disruptions to services at various healthcare facilities and departments across SA. The strike is over a wage dispute for the 2022/23 financial year, in which the employer implemented a 3% salary increase and a ZAR1 000 cash gratuity payment.

SAMA chairperson, Dr Mvuyisi Mzukwa, said that while SAMA sympathised with plight of the striking workers, they did not agree with "the way they are conducting themselves".

"Not everyone belongs to NEHAWU, so you cannot expect that just because one union is on strike, then everybody else is expected to comply," he said.

Mzukwa also spoke on the deaths of four patients announced by health minister Joe Phaahla, saying that these were just the tip of the iceberg as there might be other patients the department or public did not know about.

"There are stories of babies in the paediatric wards who have gone without food for a long period of time ... that's how cruel the strike, in terms of patient care, has been.

"We are going to see a lot of patients dying from this," he said, commenting that the strike would also worsen the backlog workers were trying to clear from the COVID-19 pandemic era and affect critical services to patients. Mzukwa said the strike would have a psychological impact on doctors because of the fearful conditions they are being forced to work under.

"The burnout, psychologically and physically, because ... examining a patient is tiring on its own, and now if you've got other added things that you do for the survival of that patient, nursing the patient, feeding, cooking for the patient, that is beyond what I can describe," he said.

Both SAMA and the Democratic Nursing Organisation of SA (DENOSA) slammed the government for its poor handling of the situation, with SAMA calling out the state for failing to have adequate police protection to maintain order.

infrastructure, the lack of medical supplies and the rapidly escalating shortage of staff at these facilities, to the failed promises of remuneration and incentives. This, especially following a health pandemic where healthcare workers across the country valiantly led the people through tumultuous, violent waters, losing

their own lives, the lives of their colleagues and their loved ones along the way.

Source: TimesLIVE, 10 March 2023. <http://www.timeslive.co.za/news/south-africa/2023-03-10-watch-doctor-manhandled-by-striking-workers-call-for-soldiers-intervention/>.

Antibiotics are being inappropriately prescribed for COVID, increasing the threat of antimicrobial resistance – research

Fidelma Fitzpatrick, consultant microbiologist, Beaumont Hospital, Dublin, Ireland, and Professor and Head of Department, Clinical Microbiology, RCSI University of Medicine and Health Sciences, Deidre Fitzpatrick Hughes, senior lecturer, Clinical Microbiology, RCSI University of Medicine and Health Sciences

Antibiotics are drugs designed to treat infections caused by bacteria (for example, skin infections). They don't work on infections caused by other microbes such as viruses (including COVID and flu) or fungi (for example, thrush).

Beyond treating bacterial infections, antibiotics also have other important uses, like preventing infection during major surgery.

Bacteria have existed for [billions of years](#) and are adept at survival. Since the early 20th century, when antibiotics were introduced as medicines to fight infections, bacteria have worked out several ways to protect themselves and avoid being killed.

When antibiotics are misused or overused, more opportunities arise for bacteria to develop and improve these protective tools. This contributes to a problem called antibiotic or [antimicrobial resistance](#), where bacteria evolve over time so that antibiotics no longer work against them. This makes infections more difficult to treat as doctors have fewer antibiotics to choose from, in turn increasing the risk of serious illness and death.

But how has the COVID pandemic affected antibiotic use, and the problem of antibiotic resistance? A recent study that analysed pharmaceutical sales data from 71 countries suggests that as COVID cases went up, so did antibiotics sales.

The researchers examined sales of four antibiotic families commonly prescribed in respiratory infections (cephalosporins, penicillins, macrolides and tetracyclines) from March 2020 to May 2022.

They sourced monthly sales data for these antibiotics per 1 000 people, and from a separate database also gathered data on COVID infections. For comparison, the researchers used global antibiotic sales trends from 2018.

Not surprisingly, they found antibiotics sales fell sharply over April and May 2020. This drop was likely a result of fewer infections spreading while people were under strict

lockdown measures, and perhaps some people [avoiding healthcare](#).

However, antibiotic sales gradually increased thereafter. The resurgence of non-COVID respiratory viral infections with the [easing of lockdowns](#) may have contributed to increased antibiotics sales from 2021 onward. By May 2022, sales had returned to just below pre-pandemic levels.

Using statistical models, the researchers found an association between increasing COVID rates and higher antibiotic sales.

COVID and antibiotics

Research has previously identified seasonal spikes in antibiotic use correlating with the winter virus season. This is concerning because antibiotics are designed to target bacteria, and have no effect on viruses such as those that cause colds or flu.

Many antibiotic prescriptions in these cases are [inappropriate](#). However, distinguishing viral from bacterial infection can be difficult clinically, especially in the initial stages of infection. This may explain why patients are sometimes started on antibiotics while waiting for laboratory test results.

In certain situations, antibiotics are appropriate. For example, viral lung infections can damage airways and compromise the normal [protective immune responses](#). This can allow bacteria to attach to airway cells and invade, causing a secondary bacterial infection.

Early in the COVID pandemic, antibiotic prescribing was probably based on previous experience with flu, where rates of secondary bacterial infection had been reported to be as high as 65%. But as the pandemic progressed, data indicated bacterial co-infection in COVID was [less than 10%](#). Specific antibiotic prescribing guidelines for patients with COVID were published.

Yet despite increasing evidence that bacterial co-infection in COVID is low, research has shown antibiotic prescribing among COVID patients has remained high.

This latest study provides further evidence that antibiotics are commonly prescribed to COVID patients.

Some limitations

Similar to other large studies on antibiotic consumption, this study uses antibiotic sales data as a proxy for antibiotic use. The sales data are already captured in databases from a number of countries, and more readily accessible than data on antibiotic prescriptions in many countries, which may not be captured electronically. But because of the nature of the data, we can't draw any conclusions as to how many of the antibiotics purchased were appropriately prescribed.

Further, data on non-COVID infections, which can impact antibiotic prescribing and rates of resistance, were not included. The pausing of routine childhood vaccination programmes during the pandemic probably increased bacterial infection risk in some countries, necessitating increased antibiotic prescriptions. This may have contributed to the trends seen.

When interpreting these findings, it's also important to note that not all continents were represented equally. Some large countries, such as Bangladesh, were excluded.

Finally, testing protocols vary between countries, so there may have been some inconsistencies in the COVID case data. And access to antibiotics is inconsistent globally, especially in low- and middle-income countries, which likely impacted some countries' sales rates.

The challenge of antibiotic resistance

Antibiotic resistance is a global threat to public health, impacting humans, animals and the environment.

Inappropriate antibiotic prescribing in COVID could be contributing to the problem. To address this, we need to see more alignment in guidelines and protocols for clinicians, especially linking diagnosis of viral respiratory infections with antibiotic

prescribing guidelines. Support for the development of rapid diagnostics to confirm or rule out co-infection would also give clinicians confidence to avoid antibiotics in some patients.

More broadly, tackling the issue of antibiotic resistance requires increased public awareness of the issue, enhanced

global surveillance of antibiotic use and resistance, improved infection control policies and better sanitation.

This rests on a co-ordinated “One Health” approach – a joint global effort across a range of sectors to provide solutions for human, animal and environmental health. This strategy should address health inequalities and will

require bespoke interventions, especially in low- and middle-income countries.

Source: The Conversation, 15 February 2023. <https://theconversation.com/antibiotics-are-being-inappropriately-prescribed-for-covid-increasing-the-threat-of-antimicrobial-resistance-research-199480>.

Obesity should be treated as urgent “gateway” medical condition, say experts

SAMA Communications

With more than half of South Africans now overweight or obese, experts are calling for the “gateway condition” to be treated as a medical problem and for urgent interventions to be put in place to address it, writes *MedicalBrief*.

Data from the WHO show that the Saudi Arabian population has the highest percentage of the world’s obese or overweight adults (70%), followed by the USA (68%), New Zealand (66%), Australia (65%), the UK (64%), Argentina (63%) and SA (54%).

The WHO estimates that 39% of adults are overweight, and 13% are obese – 68% are women, 31% are men and children make up a concerning 13% of this category, reports *Health-e News*.

Wits University clinical endocrinologist Dr Sundeep Ruder said the reason why more women are prone to being overweight or obese is not well researched, but could be explained through biological characteristics.

Women carry more fat for natural and hormonal health, and during certain periods, like pregnancy and menopause, there is always a change in weight as a part of the natural process. In an obesity environment, these processes are amplified in women.

Ruder said hormonal changes can have a direct and indirect effect on a person’s weight. One of these ways is how the body responds to stress, “mental agitation due to unfulfilled or interrupted desires” – a condition that ends the body into a “fight or flight” mode.

“When this happens, hormones are being chronically released, being activated more through mental thoughts. Hormones that you need when you are stressed become overworked and activated because they are constantly used. When you stress, you

self-soothe and this affects your eating behaviour.”

Another leading specialist endocrinologist has also warned that obesity is the “gateway” to more than 220 other health conditions, and is not getting the medical attention it needs in SA, reports *TimesLIVE*.

Obesity is the “gateway” to more than 220 other health conditions, and is not getting the medical attention it needs in SA

Too many people “simply can’t lose weight despite all the hard work of exercising and changing diets” due to various underlying issues including genetics, and environmental, psychological or neurological factors.

Dr Sindeep Bhana, from the Centre of Advanced Medicine, and head of diabetes, endocrinology and metabolism at Chris Hani Baragwanath Hospital’s internal medicine department, said despite obesity being a public health crisis, it was mostly regarded as a non-medical issue, even by doctors.

“It’s a huge problem and whether we admit it or not, it’s a medical problem because it leads to all other diseases. Obesity means more diabetes, more blood pressure, more cholesterol problems, more heart attacks, strokes and kidney

failure. All of these conditions are costly to the patient, the patient’s family, the society and, of course, to the government coffers as well.”

Bhana said not treating obesity as a “lifelong disease needing scientific insight and comprehensive lifelong healthcare treatment” was not only problematic in SA, as even in high-income countries, “only a very small percentage of people who have been recognised as being overweight and obese have been offered any form of treatment.”

“It’s a worldwide problem. Some countries are moving ahead, like Canada and the UK, where the management of this condition is better, but in SA being obese is blamed on patients, and the responsibility of losing weight is put squarely on their shoulders. No one says, when diet and exercise is failing, let’s consider pharmacotherapy ... like we do with other chronic diseases such as diabetes and hypertension.”

The African Centre for Obesity Prevention (Action) estimates that about 3.91 million SA schoolchildren will be overweight or obese by 2025.

Paediatrician Dr Zakira Mukuddem-Sablay from the Red Cross Children’s Hospital in Cape Town said the medical fraternity should engage families about the rise in childhood obesity and address barriers to a healthy lifestyle. “Every effort should be made to correct misconceptions and to end stigmas within communities as another life-saving strategy to prevent and treat childhood obesity.”

Prof. Shingai Mutambirwa, urology department head at the Sefako Makgatho Health Sciences University, said it’s “not too late to turn the tide on obesity.”

“The issue needs to be a discussion for everybody in the country, including medical

practitioners, the government and patients, so that we all recognise obesity is a medical condition that needs to be addressed.”

Meanwhile, the third “ObeCity” index has found that Cape Town’s residents again topped the charts for maintaining a healthy weight and being the healthiest food shoppers – Durban is the unhealthiest – while Johannesburg boasts the fittest population, doing the most exercise.

Its 2017 index also put Cape Town on top and Gqeberha at the bottom.

Discovery Health Medical Scheme said data show that obese members are more likely to have a chronic condition: 6.5 times more likely to have type 2 diabetes, 4.3 times more likely to have hypertension and three times more likely to have heart disease.

Vitality wellness head Mosima Mabunda said the obesity epidemic was driven by biological and socioeconomic factors leading people to consume more calories than needed, with the proliferation of cheap, energy-dense food, oversized portions, displays of unhealthy food

in shops and misleading food labelling as some of the ways consumers are increasing their unhealthy eating.

Challenges faced by Discovery members when trying to lose weight include lack of support (26%), lack of time to exercise or cook (23%), the cost of healthy food (17%) and lack of cooking skills of healthy food (6%).

Source: MedicalBrief, 8 March 2023. <https://www.medicalbrief.co.za/obesity-should-be-treated-as-urgent-gateway-medical-condition-say-experts>.

Massive efforts needed to reduce salt intake

World Health Organization

A first-of-its-kind WHO “Global report on sodium intake reduction” shows that the world is off track to achieve its global target of reducing sodium intake by 30% by 2025.

Sodium, an essential nutrient, increases the risk of heart disease, stroke and premature death when eaten in excess. The main source of sodium is table salt (sodium chloride), but it is also contained in other condiments such as sodium glutamate. The report shows that only 5% of WHO member states are protected by mandatory and comprehensive sodium reduction policies, and 73% of WHO member states lack full range of implementation of such policies.

Implementing highly cost-effective sodium reduction policies could save an estimated 7 million lives globally by 2030. It is an important component of action to achieve the Sustainable Development Goal target of reducing deaths from non-communicable diseases. But today, only nine countries (Brazil, Chile, Czech Republic, Lithuania, Malaysia, Mexico, Saudi Arabia, Spain and Uruguay) have a comprehensive package of recommended policies to reduce sodium intake.

“Unhealthy diets are a leading cause of death and disease globally, and excessive sodium intake is one of the main culprits,” said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. “This report shows that most countries are yet to adopt any mandatory sodium reduction policies, leaving their people at risk of heart attack, stroke and other health problems. The

WHO calls on all countries to implement the ‘best buys’ for sodium reduction, and on manufacturers to implement the WHO benchmarks for sodium content in food.”

A comprehensive approach to sodium reduction includes adopting mandatory policies and the WHO’s four “best buy” interventions related to sodium, which greatly contribute to preventing non-communicable diseases. These include:

- reformulating foods to contain less salt, and setting targets for the amount of sodium in foods and meals
- establishing public food procurement policies to limit salt or sodium-rich foods in public institutions such as hospitals, schools, workplaces and nursing homes
- front-of-package labelling that helps consumers select products lower in sodium
- behaviour change communication and mass media campaigns to reduce salt/sodium consumption.

Countries are encouraged to establish sodium content targets for processed foods in line with the WHO Global Sodium Benchmarks, and enforce them through these policies.

Mandatory sodium reduction policies are more effective, as they achieve broader coverage and safeguard against commercial interests, while providing a level playing field for food manufacturers. As part of the report, the WHO developed a [sodium country score card](#) for member states based on the type and number of sodium reduction policies they have in place.

“This important report demonstrates that countries must work urgently to implement ambitious, mandatory, government-led sodium reduction policies to meet the global target of reducing salt consumption by 2025,” said Dr Tom Frieden, president and CEO of Resolve to Save Lives, a not-for-profit organisation working with countries to prevent 100 million deaths from cardiovascular disease over 30 years. “There are proven measures that governments can implement, and important innovations, such as low sodium salts. The world needs action, and now, or many more people will experience disabling or deadly – but preventable – heart attacks and strokes.”

The global average salt intake is estimated to be 10.8 grams per day, more than double the WHO recommendation of less than 5 grams of salt per day (one teaspoon). Eating too much salt makes it the top risk factor for diet and nutrition-related deaths. More evidence is emerging documenting links between high sodium intake and increased risk of other health conditions such as gastric cancer, obesity, osteoporosis and kidney disease.

The WHO calls on member states to implement sodium intake reduction policies without delay, and to mitigate the harmful effects of excessive salt consumption. The WHO also calls on food manufacturers to set ambitious sodium reduction targets in their products.

To read the report, visit: <https://www.who.int/publications/i/item/9789240069985>.

What is burnout and how to prevent it in the workplace – insights from a clinical psychologist

Shahieda Jansen, *clinical psychologist and acting regional director, University of South Africa*

As the year begins, managing our stress levels is one thing we should all keep in mind as we move forward.

The definition of stress is the bodily, psychological and social-spiritual reaction to a demand or stressor. The stressor could be a deficiency (like unemployment), a danger to one's physical or mental health, or a deadline at work. A certain amount of stress is necessary for performance and is even pleasurable at times, according to Hans Selye, the "father" of stress research.

As social beings at our core, humans rely on others to organise both our internal and external environments. Although we cannot survive without interpersonal relationships, engaging with others in high-stress situations (such as lengthy patient care) can be emotionally draining and lead to the onset of stress symptoms. As with everything human, too much stress or the wrong kind of stress can suppress the immune system, leading to illness and discomfort.

Burnout is a vague term and can be communicated in a variety of ways, usually as being more complicated and harmful than stress. The scientific literature defines it as a combination of emotional weariness, depersonalisation and reduced functioning.

Depersonalisation is the state of feeling disconnected from oneself, as though one were viewing oneself from the outside. Cynicism, a loss of empathy, as well as harsh and insensitive behaviour, may occur due to this.

There is little doubt that stress and burnout are related experiences. But it's crucial to focus on the distinctions between them. Stress is tied to pressures that people face on a daily basis, and may also be beneficial. Burnout and stress begin to overlap when stress becomes protracted and chronic, causing distress and negative effects. But burnout distinguishes itself from stress in significant ways.

In a work context, some of the clear warning signs that someone may be close to or experiencing burnout – or a level of distress that is beyond that of stress – is when they begin to doubt their self-competence. Despite being capable, a burnout staff member may progressively feel inadequate or ineffective. The fatigue reported may be described as an inner



depletion or of being completely worn out and overextended. Furthermore, this usually caring and considerate person may display a lack of concern towards others, or an out of character "I don't care" attitude.

It should come as no surprise that employees in human services – including those in healthcare, mental health and correctional services – frequently experience burnout. Exhaustion, a lack of empathy, and doubting one's self-competence are just a few symptoms that can result from long-term, unrelieved exposure to other people's problems and toxic, unfavourable work settings.

The effects of burnout can have an impact on the person who experiences it as well as others in their environment. Consider instances in which there are acts of frustration, where a door gets slammed shut or kicked. Burnout may be accompanied by unhealthy interpersonal relationships at work and at home.

Stress, burnout and the meaning of life

Although it is typically thought of as a psychological process, burnout is more complex than that. Despite the fact that some people experience higher levels of stress than others, their stress is less likely to lead to burnout because they are more frequently connected with what is significant in their lives.

Some opinions on burnout neglect the primal human quest for significance in life. A meaningful existence involves having strong social ties, positive pride in our complicated identities rooted in "where we are from," feeling purposeful, and the conviction of living a life that matters.

One of the major issues facing modern civilisation right now is loneliness and isolation, which naturally frustrates desires for authentic connection and meaning. Belonging and interpersonal connections are key components of meaning both inside and outside of the workplace.

In modern times, people frequently transfer their desire for significance and purpose into their professional lives. Some people may yearn to see that their labour has significance beyond its purely economic usefulness. How their service or product "fits" with societal needs and wants is something they are interested in. Employees may be motivated by knowing that someone depends on and benefits from their contributions at work. According to research, even in situations of extreme professional stress, the perceived meaning of the work may prevent burnout.

Preventing burnout

There are a variety of self-help and community tools, as well as advice, available for the

prevention of burnout. I recall the stress management workshops I used to facilitate. Understanding how the body-mind is constructed to withstand stress and being able to manage stress is enlightening, and crucial to mental healthcare.

For instance, parental burnout – where a new parent feels unable to continue carrying out basic tasks like bathing small children or doing the dishes – can happen. And so, aiding a stressed-out mother in obtaining social support will allow her to take the required “me-time” and break from the constant demands for nurturing. This will protect both the mother’s sanity and the children’s wellbeing.

In my practice as a psychologist, over and above the application of stress reduction techniques, I deem it important that time is set aside to consider and take action on systemic and personal alignment with purpose and values. Contemplating whether our personal and work lives are worth living is itself a stress reduction exercise.

Regular intimacy with our higher values is nurturing, boosts our vitality and makes us feel part of some interwoven meaning frame. Alternately, creating a home or work environment where modest acts of kindness, generosity and helpfulness are frequently displayed might prevent the build up of chronic stress and anxiety.

Burnout may be accompanied by unhealthy interpersonal relationships at work and at home

Therefore, unless actions are taken to make work a place where employees can engage meaningfully with their

duties, even the best workplace stress management programmes won’t be able to lower the risks of burnout. Employers may need to understand the advantages of attempting to create a strong network of secure interactions among employees in the company.

For employees to feel heard, recognised and valued, it would be necessary to foster a genuine sense of belonging through the deliberate nurturing of social cohesion, and the strategic advancement of the paradoxes of sameness, unity and diversity. Creativity at work thrives in a setting of socio-spiritual visibility and safety. A tranquil and secure work or home environment is the cornerstone for the prevention and control of stress and burnout.

Source: The Conversation, 11 January 2023. <https://theconversation.com/what-is-burnout-and-how-to-prevent-it-in-the-workplace-insights-from-a-clinical-psychologist-196578>.

Countries begin negotiations on global agreement to protect world from future pandemic emergencies

World Health Organization

Countries of the WHO have begun negotiations on a global accord on pandemic prevention, preparedness and response, using the “zero draft” as a basis for negotiating an agreement to protect nations and communities from future pandemic emergencies.

Ending Friday, discussions on the draft pandemic accord took place during the week-long fourth meeting of the [Intergovernmental Negotiating Body \(INB\)](#), which includes the WHO’s 194 countries. Negotiations on the draft will continue over the next year according to a timetable laid out by the World Health Assembly.

Mr Roland Drieste, co-chair of the INB Bureau, from the Netherlands, said: “the start of discussions of concrete language for the WHO pandemic accord sends a clear signal that countries of the world want to work together for a safer, healthier future where we are better prepared for, and able to prevent future pandemic threats, and respond to them effectively and equitably.”

Fellow INB Bureau co-chair, Ms Precious Matsoso of SA, said: “The efforts this week, by countries from around the world, were a critical step in ensuring we do not repeat the mistakes of the COVID-19 pandemic response, including in sharing life-saving vaccines, provision of information and development of local capacities.”

Ms Matsoso added: “That we have been able to move forward so decisively is testimony to the global consensus that exists on the need to work together and to strengthen WHO’s and the international community’s ability to protect the world from pandemic threats.”

WHO member states will continue negotiations of the zero draft of the pandemic accord at the INB’s next meeting, to be held over 3 - 6 April, with a view to collecting all inputs necessary to develop the first draft.

According to the process agreed by governments at a special session of the World Health Assembly in late 2021, negotiations on the draft pandemic accord will aim to produce a final draft for consideration by the 77th World Health Assembly in 2024.

During the week, the senior diplomats from Israel and Morocco, who are serving as co-facilitators of the UN General Assembly High-Level Meeting on Pandemic Prevention, Preparedness, and Response, briefed the INB on their preparations for the 20 September meeting, in order to ensure collaboration between the processes.

In parallel with the pandemic accord negotiations, governments are also discussing more than 300 amendments to the International Health Regulations (IHR; 2005) in an effort to make the world safer from communicable diseases and ensure greater equity in the global response to public health emergencies.

Governments have been working to ensure consistency and alignment across the INB and IHR processes. The proposed IHR amendments will also be presented to the World Health Assembly in 2024, and would together with a future pandemic accord provide a comprehensive, complementary and synergistic set of global health agreements.

Obituary: John Terblanche, 1935 - 2023

Emeritus Prof. Jake Krige

The Health Sciences Faculty is deeply saddened to announce the passing on Monday 6 March 2023, aged 87, of Prof. John Terblanche, a previous head of the Department of Surgery at the University of Cape Town (UCT) and Groote Schuur Hospital from 1981 to 2000.

Prof. Terblanche, internationally recognised as one of the world's leading researchers in the treatment of portal hypertension, graduated from UCT in 1958, and qualified as a surgeon in 1964 when he was awarded the Douglas gold medal as the best graduate of the year. His first research experience was in the laboratory with Prof. Chris Barnard, investigating profound hypothermia using extracorporeal circulation, for which he was awarded a ChM degree in 1964. This initial research experience was continued in Bristol where he developed a life-long interest in surgical diseases of the liver. There he was an early pioneer of experimental liver storage and transplantation, an interest he brought back to Cape Town, where it flourished under his guidance. He became co-founder of the MRC Liver Research Centre in 1973 with Prof. Stuart Saunders, a position he shared later with Prof. Ralph Kirsch, resulting in a highly productive and collaborative research partnership that lasted almost 30 years, and which produced key findings and highly cited international publications.

Prof. Terblanche was appointed head of the department of surgery at UCT at the relatively young age of 45 years. Larger than life and a force of nature, he was highly regarded as a clinician, researcher, and educator, but perhaps his biggest contribution was the visionary and pioneering leadership he brought to the endoscopic treatment of oesophageal varices at an international level. Leading by example, he transformed an excellent department inherited from his predecessor, the legendary Prof. Jannie Louw, into an outstanding one, equal to the finest in the world. His abiding interest in surgical aspects of liver disease led to the establishment of a robust and sophisticated experimental and clinical surgical research programme that became a mecca for hepatobiliary training and attracted international Fellows and visitors to Cape Town, to return home later, spreading the gospel according to Terblanche. Many visiting Fellows in turn become independent



His significant contribution to SAMA

Prof. Mark Sonderup

John made a significant contribution to the medical association at seminal moments. He participated in the old "MASA", but was importantly part of the MASA group actively pursuing and driving the formation of a new medical association, especially post 1994. He was elected as the vice-chairperson of the Board and National Council during the 2000 to 2002 triennium. He remained an active member of the Cape Western Branch and was the honorary branch president in 2001. Following his contribution to the association at senior leadership level, he remained on the board of directors and served on and as chair of the Health Policy Committee from 2003 to 2012. His work here was legendary. The Health Policy Committee did an enormous amount of work that John drove almost surgically and as only he could. His inputs and outputs were incisive, and SAMA's productivity during this period from a health policy perspective was remarkable. This was at a time of a myriad of new policies being introduced, notably by government. John allocated everyone on the committee work, and if one did not deliver, you would know about it. He was the national honorary SAMA President in 2005.

Prof. Terblanche's contribution to the formation, growth and development of the new SAMA was significant. He had gravitas and contributed to debate and discussion in a measured manner. Many bricks formed the foundation of the new SAMA. John was one of those cornerstone bricks.

researchers, leaders and mentors in their own right, willingly passing on the Terblanche legacy. The prodigious output from his strong and stable research team elevated the importance of the unit's work to an international audience.

John Terblanche was the editor of four books, 109 invited chapters and over 260 highly cited peer-reviewed publications. He was an ardent ambassador for SA and a popular and much-in-demand speaker at international meetings for over two decades.

He was a consistent and eloquent advocate for the continued support of surgical research and the promotion of academic surgery. Many benefited from his wise counsel, and he took great pride in the successes of his protégés. His personal qualities included boundless energy and enthusiasm, positive thought and determination in solving problems, the clarity with which he could see through and articulate issues, the meticulous incorporation of new knowledge and insights into his prolific and lucid writing, and his caring

clinical practice. The national and international esteem in which he was held is reflected by the award of 10 honorary Fellowships from each of the 10 English-speaking colleges and surgical associations in the world.

Many bricks formed the foundation of the new SAMA. John was one of those cornerstone bricks

He was a significant office bearer in numerous distinguished societies, and president of various international bodies, including the International Federation of Surgical Colleges (1997 - 2000), the International Association for the Study of the Liver (1996 - 1998) and the Pan African Association of Surgeons (PAAS) (2000 - 2002). In SA, he was president of the College of Medicine (1989 - 1992), the Association of Surgeons of SA (1992 - 1995), the Surgical Research Society of Southern Africa (1986 - 1988), the Southern African Transplant Society (1979 - 1981) and the Pan African Association for the Study of the Liver (1982 - 1984). He was an active vice-chairman of SAMA from 1989 to 2000.

John Terblanche will be long remembered by many as the consummate clinician-researcher-academician, but also as a kind and generous teacher and mentor. His legacy is set



Prof. Terblanche (second left) at the protest March in 2004

to endure, and we remain indebted to him for his vision, his values, his vigorous leadership, his innovative scientific contributions and the standards of excellence he practised and demanded. Isaac Newton's words could not be more apt, as those who worked with him could see further because they stood on the shoulders of an academic giant. His influence was immense and will last beyond his physical presence.

His continued love for his family was a cornerstone in his life. Anne, John's loving wife for more than 60 years, was a constant supporter of his career and a gracious hostess to the innumerable visitors, ranging from distinguished international guests to junior trainees, invited to dine at the Terblanche home. Our thoughts and sympathies go to Anne, his children James, Michelle, Michael and Christopher, their spouses and grandchildren.

Letters to the Editor

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

Please note that letters:

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

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



A student's potential criminal charge

Dr Graham Howarth, *Head of Medical Services (Southern Africa), Medical Protection Society*

This case outlines how we used the power of discretionary indemnity to assist a student member, where other providers may not have. The case itself may be well known to many junior medical staff and senior medical students working in SA state hospitals.

Students and junior doctors soon learn that an integral part of their daily job is to draw blood from patients and ensure that special investigations are performed. Almost simultaneously, they learn that when in the ward it is not unusual to lack a syringe, a needle, the necessary tube or other paraphernalia associated with drawing blood.

Some wards always seem to be well equipped while others are not, but even the former occasionally run out. The only certainty is that you never know what you will need and when you will struggle to obtain equipment.

Spot the bumbag

Experienced and well-organised students and junior doctors are soon identified by the carrying of a small bumbag with syringes, needles, swabs and laboratory tubes so one is always ready, and you have all the equipment available when you need to draw blood. When news spreads that a rare syringe size, butterfly set or needle becomes available in a particular ward, that ward is oversubscribed by the well prepared, who ensure that their supplies are replenished. Sadly, the habits of the efficient do nothing to relieve the problems of shortages on the wards.

So it is something that we all recognise and accept as being part and parcel of working in a less than efficient system.

The case

The problem occurred when prudent practice bumped up against policy. A hard-working student and well-respected bumbag aficionado, W, was running late one day. Normally at the end of a call the bumbag was stored in W's locker. On the day in question, W was running late and had an important meeting, so rather than go to her locker she dropped it on the front seat of her car – in full view of all and sundry, so no intention to conceal it. As fate would

have it, just prior to leaving, she had had the opportunity to restock her bag, so although it was small, it was full.

The problem came as she left the hospital premises and was stopped at the exit gate for a random security check. She thought nothing of it – she had nothing to hide and it was not the first time she had been stopped. Initially all was well, and the security guard did a cursory check all in good humour. He saw the bumbag, picked it up and looked inside, and that is when the atmosphere changed. When he saw the syringes, needles and swabs he knew things were amiss. He looked at W and asked her if she knew how serious it was to steal things from the hospital. She tried to explain, but to no avail. Within minutes a supervisor was there, and the supervisor was even more officious. Other students stopped and tried to intervene but that merely seemed to exacerbate the situation.

Once it was established who W was and how she could be contacted and followed up, she was allowed to leave – without the incriminating evidence. The next day she was called in by the hospital security and warned that they were inclined to pursue her for stealing the equipment, and report her to the SAPS. Given that as a student, she was registered with the HPCSA, they were also minded to report her to them. Other students and the university tried to intervene, but sadly to no avail.

That evening, W was contacted by a senior member of the hospital's staff and also a prominent academic, who was extremely supportive, and having spoken to her it was agreed that she would not attend at the hospital the next day. The academic also asked her to contact the Medical Protection Society (MPS).

How we assisted

W phoned us for advice. Clearly there was an element of personal conduct here, given that W stood accused of robbery, but there was a strong clinical element in the genesis of the predicament in which W found herself. Fortunately, MPS was able to exercise discretion to help W.

We contacted our local solicitors, who in turn contacted the hospital authorities. They were informed that the matter was



receiving the hospital management's urgent attention. Our solicitors also contacted the supportive academic, who collaborated W's explanation concerning students carrying provisions in the hospital. It was decided that a brief factual explanation would be provided to hospital management, as well as a confirmatory letter of the state of affairs from the supportive academic.

W decided she would not attend at the hospital for the rest of the week as per the agreement. She did inform us that she had heard that several fellow students had also contacted hospital management to inform management of the necessary practice in the hospital. Understandably W was worried, and made use of the MPS counselling service, which is available as a benefit of MPS membership.

Fortunately, common sense prevailed, and the hospital informed us that they accepted W's explanation. Hospital management informed us that their security could not turn a blind eye to the removal of hospital stock, and they suggested that in future students would be well advised not to remove equipment from the hospital. Management also promised to improve the provision of stock in the wards. When we subsequently spoke to W a couple of months later, she informed us that sadly, despite management's promises, bumbags remained an essential requirement for diligent students.

When can an anaesthetist leave the operating theatre while a patient is anaesthetised?

Neelu Ramcharan, *senior associate, MacRobert Attorneys*

The role of an anaesthetist is often stressful. They work in an unpredictable and dynamic environment where even minor errors can lead to significant patient harm.

Because anaesthetists are human beings, being in theatre constantly for a procedure lasting a number of hours might not always be possible. This article focuses on the situation when an anaesthetist leaves theatre while a patient is under anaesthetic.

Medical negligence

Medical negligence occurs when practitioners fail to exercise the standard of skill and care expected of reasonably competent practitioners in their branch of the profession.

Essentially, if an anaesthetist is negligent in managing a patient, that patient can sue the anaesthetist. The onus is on the patient to prove the negligence.

The following is a practical example from a case a few years ago.

An 11-year-old female was a pedestrian victim of a motor vehicle accident. She was discharged with external fixators *in situ*. She was re-admitted for the removal of the external fixators 4 months later. The patient was known to the anaesthetist, who had anaesthetised her previously. The patient entered theatre at 11h26 and anaesthesia commenced. The surgery commenced at 11h40. At some time between 11h45 and 11h50, the anaesthetist left the patient under the observation of a nursing sister to get a drink of water in the theatre tearoom. The anaesthetist was summoned back between 11h55 and 12h00 as the patient was developing a significant bradycardia and there was no oxygen saturation reading. The anaesthetist commenced resuscitation immediately.

The patient's parents issued summons against the anaesthetist. An expert on the case determined that the patient sustained a severe cerebral ischaemic hypoxic injury following a cardiac arrest during her surgery on 2 June 2017. It appeared likely that the cardiac arrest was caused by a massive pulmonary embolus occurring during surgery, possibly related to lower limb manipulation for contractures. The cardiac arrest was unexpected. There was a delay, due to the anaesthetist's absence, in the response to changes in some monitored

parameters – namely ST segment analysis, end-tidal carbon dioxide (ETCO₂) and an increasing tachycardia. An expert on behalf of the anaesthetist determined that it was doubtful whether these meaningfully delayed the onset of cardiopulmonary resuscitation (CPR), as it was instituted on development of the bradycardia prior to cardiac electrical arrest, or the outcome thereof. If the anaesthetist had been in theatre at the time of the early monitoring changes at 11h50 - 11h55, it is likely that he would have started to work through the possible causes, but he would in all likelihood only have commenced CPR when blood pressure readings and saturation tracing failed and a bradycardia occurred – i.e. at 11h55 - 12h00. Because of the nature of the pulmonary embolism, the CPR would still have taken 10 - 20 minutes to generate a cardiac output, even if commenced 5 minutes earlier. The conduct of the pre- and post-arrest phases of the resuscitation was according to standard of care and could not be criticised. The matter is still proceeding, and the parents are obtaining instructions to withdraw the action against the anaesthetist.

SASA guidelines 2022

SASA (the SA Society of Anaesthesiologists) is the national professional body representing the interests of all anaesthesia practitioners and their patients. Their anaesthesia practice guidelines aim to set the same standard for the practice of safe anaesthesia at all levels in the SA context.

Specific guidelines on an anaesthetist leaving theatre

Chapter 5 of the guidelines discuss the appropriate management of a patient during the anaesthetic period.

The anaesthetist's primary responsibility is to the patient under his/her care. It is emphasised that the anaesthetist should remain with the patient throughout the conduct of all general anaesthesia.

If the attending anaesthetist leaves the operating room temporarily, care of the patient must be delegated to another anaesthetist.

The anaesthetist should notify the surgeon that (s)he is going to leave theatre for a few minutes, and provide the reason for doing so.

Anaesthetists may briefly delegate routine care of a stable patient to a competent person who is not a trained anaesthesia provider (untrained physician, nurse, technician, etc.) only under the most exceptional circumstances, for example to provide lifesaving emergency care to another patient. That person's only responsibility will be to monitor the patient during the anaesthetist's absence and to keep the anaesthetist informed until (s)he returns to theatre. In this situation, the anaesthetist remains responsible for the patient's care, and must inform the operating room team that (s) he is leaving theatre.

Before delegating the patient's care to an anaesthesia assistant, the anaesthetist must ensure that the patient's condition is stable, and that the anaesthesia assistant is competent, experienced and familiar with the operative procedure and the operating room environment and equipment.

The attending anaesthetist must remain immediately available when care is delegated to an anaesthesia assistant.

An intra-operative handover of care between two anaesthetists should be documented in the anaesthesia record and follow a structured protocol.

It is unacceptable for an anaesthetist to simultaneously administer general anaesthesia on more than one patient.

Legal responsibilities

From research, the following should be noted:

Following such an incident, there will probably be an investigation by the hospital management.

An anaesthetist must ensure that there is contemporaneous detailed record-keeping in all circumstances, as this is vital in the event of a civil action against him/her.

Anaesthetists must be familiar with the various legislation that regulates their practice.

Conclusion

If a serious incident occurs unexpectedly, make immediate contact with your professional indemnity liaison officer. If you are a member of the Medical Protection Society (MPS), you can contact MPS directly at CaseManagement@medicalprotection.org.za.

Gauteng branch gives back to the community

Last year, the SAMA Gauteng branch council members made a decision to give back to the community more actively, and initiated the corporate social responsibility fund. In August 2022, the branch wrote to all branch members and asked them to nominate a charity of their choice to be recipients of the fund.

The specifics of the fund were:

- The nominated charity of choice should be in the Johannesburg area, ideally within the boundaries of the branch.
- The branch council would allocate a percentage of the branch surplus funds to the corporate social responsibility fund.
- The chosen nominated charity would receive a portion of the funds.
- Ideally, the nominated charities would operate in the healthcare domain and/or positively influence one or more of the social determinants of health.

In total, six charities were nominated, and the branch council decided to donate to all six. The available funds were divided equally between the charities, giving each a sum of ZAR15 000.00.

Over the course of the end of 2022 and the beginning of 2023, the branch visited five of the charities and presented the donations.

Centurion Hospice

Centurion Hospice was established in 1997, when four philanthropists signed the first constitution and built a hospital on land donated by the City of Tshwane.

Today 26 years later, Centurion Hospice provides home-based and hospital care for patients over 16 years of age who have been diagnosed with a terminal and/or life-limiting illness. Some patients who require advanced illness care are not necessarily terminal, but rather bedbound.

Centurion Hospice reopened its 15-bed inpatient unit in October 2020 in the midst of the COVID lockdown, in response to the dire need for quality care.

Their holistic services include patients and their loved ones facing the rigours associated with life-limiting illness, through to the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual.



Dr Trevor Frankish and Shannon from Door of Hope



Loné Lourens (Woodside Sanctuary) and Dr Vee Wilson

Woodside Sanctuary

Woodside Sanctuary is a registered public benefit organisation and non-profit organisation that was established in 1955, over 64 years ago, by Vernon and Norah Veale following the birth of their son Barry Robin. Vernon and Norah were part of a group of concerned parents looking for a "home from home" environment for their children with special care needs. These parents could not bear the thought of placing their children in an institution, and wanted a residential care home that could offer their children a healthy and happy alternative to institutional life.

Today, Woodside provides full-time residential care to 83 people with severe/profound intellectual disability. Their



Dr Trevor Frankish presents a cheque to Lindiwe Dube (Kids Haven)



Tanya Schonwald from the SA Guide-Dogs Association

approach continues to be holistic in nature and incorporates 24-hour day nursing care, various forms of therapy, residential care (full-time and respite) as well as rehabilitation and stimulation programmes.

Residents are drawn from all over SA. All persons who are referred to Woodside by their medical practitioner, or Department of Health or Social Services, are assessed prior to being admitted as residents.

SA Guide-Dogs Association

SA Guide-Dogs Association for the Blind provides services to you if you have visual, physical or developmental needs through training guide dogs, service dogs, and autism support dogs, or orientation and mobility.

Through their services, they have immeasurably improved the lives of many people and given them the freedom of independence, mobility and companionship.

Door of Hope

Door of Hope is a faith-based organisation that primarily provides for destitute children. It has been operating for 23 years, and in that time has helped 1 848 babies, facilitated 841 adoptions and received 259 babies through the baby boxes. Today, Door of Hope cares for 61 babies in-house.

Kids Haven

Kids Haven was started by Moira Simpson, a qualified social worker, in October 1992 as a response to increasing numbers of children on the streets, and the violent deaths of two street children. Before she formally

established the centre, Moira had been feeding and counselling children on the streets, but she knew that they needed to get off the streets before real healing could begin.

The mission is to reach children in need, especially those without parental care, in providing shelter, protection, education, training and therapy. This encouragement results in positive inclusion for discarded, neglected and abused children. Kids Haven is dedicated to the care and protection of vulnerable children, including those with street connections, to support meaningful inclusion in society.

There are three pillars of care at Kids Haven. Pre-care aims to prevent family breakdown and to strengthen communities to support their own children and families, and extends to outreach on the streets, a soup kitchen

and the community preschool. In-care is the full 24/7/365 care and protection of up to 172 children and youth who live at Kids Haven. Children attend school and participate in many activities. While they live at the Haven they try to reconnect families with their children under supervision. "Our intention is to reunite families." After-care is the ongoing care to children now reunified with their families, or youth living independently in their communities.

Kids Haven relies on donor funding to meet the real costs of caring for children and providing everything that they need while in care. Donor funding is essential for pre-care and after-care.

We would like to thank all the branch members who nominated a charity. The branch hopes to continue with this project in 2023.

Griqualand West branch host intern and CPD function in Kimberley

The Griqualand West branch (GWB) hosted a beneficial CPD and intern function at the Robert Mangaliso Sobukwe Hospital (RMSH) in Kimberley on 11 February 2023.

Dr Elrico Oliphant, Griqualand West JUDASA representative, delivered a presentation on SAMA member benefits and spoke about the importance of joining JUDASA. The topics discussed at the event, which was presented by Dr Esme Olivier (acting CEO of RMSH and clinical manager of the Operating Theatre and Clinical Forensic Medicine Services), Dr Arun Nair (intern curator and acting Head of Unit of Family Medicine at RMSH) and Dr Eugene Elliott (medical microbiologist pathologist at the National Health Laboratory Service (NHLS)) were "Medical records and consent", "Child sexual abuse - the role of the hymen and the law", "2021: A few basics of the Handbook of Internship Training" and "Sensible pathology".

Dr Esme Olivier qualified as a doctor at the University of the Free State (UFS). She is currently in full-time senior clinical manager of the Operating Theatre and Clinical Forensic Medicine Services public sector in SA at the Kimberley Hospital Complex.

Dr Olivier is the chairperson of the Clinical Complaints Review Committee. Alongside



Dr Mbese Ngundu (SAMA GWB chairman) and Dr Arun Nair (intern curator and specialist family physician)

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

Dr Arun Nair qualified as a specialist family physician with a MMed FAM Med from UFS



Dr Mbese Ngundu (SAMA GWB chairman) and Dr Eugene Elliott (medical microbiologist pathologist at NHLS)

and FCFP (SA) from the College of Medicine of SA, and is currently working full time in the public health sector in Kimberley. He is acting head and consultant specialist in the department of Family Medicine at RMSH

and an affiliate lecturer with the Department of Family Medicine at UFS.

Dr Nair is an assistant editor for the *South African Family Practice Journal* and his clinical and research interests include healthcare-associated infections, primary healthcare, strategies for wound management in primary care, chronic care models, health education, teaching and training.

Dr Elliott qualified as a medical doctor in 1986 after training at the UFS. She then moved to rural KwaZulu-Natal where she worked for 10 years in general practice, doing district surgeon duties and mission hospital practice. Dr Elliott specialised in medical microbiology at the University of Pretoria in 2001, and worked in pathology in Gauteng, the Eastern Cape and the Free State for both the private sector and the NHLS. She was the HOD for microbiology at UFS before moving to InterSystems as part of the clinical group. Before COVID, she worked

as a medical advisor for MSD in the infectious diseases and vaccine portfolios.

In July 2020 she joined the NHLS in Kimberley where she supervised the set-up of the molecular lab to test for COVID in the Northern Cape.

In her career she has worked at most levels of the health system and has first-hand experience in the challenges facing the service delivery mandate. Her focus has been on improving service delivery to provide clinically relevant results to clinicians. Her MBA project was on reducing turnaround time for urine culture results, and she demonstrated significant savings with improved service.

Her interests are lean management and system improvement for clinical benefit by working smarter, and utilisation of information technology to improve data collection for better decision-making to optimise patient care.



Dr Esme Olivier (Acting CEO of Robert Mangaliso Sobukwe Hospital) and Dr Mbesi Ngundu (SAMA GWB chairman)



Welcome to SAMA

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

Border Coastal branch

Pelokazi Kawe

Cape Western branch

Jessica Strong

Eastern Highveld branch

Margharetha du Plessis

Free State branch

Hendrik Kenfil le Grange
Lynette Fouche

Gauteng branch

Michael John Savage-Reid
Zizo Piti
Lealon Daniel Forbay
Kealeboha Lepadima
Marianne Holm

Santhisha Vandayar

Nkululeko Mapossa
Njabulo Lydia Mbali Khama
Lethabo Hope Makgoba
Joshua de Klerk

Gauteng North branch

Stephina Mncani Sithole
Akhil Neren Mahabir
Nqubeko Hlatshwayo
Kagiso Ratshefola
Radingwana Mamphotleng
Rhulani Ntokozi Maringe
Kagiso Seneng Mokgadi
Nhlamulo Amon Mukeri
Ambrose Lekalakala
Modidi Rockey Fachie
Kamogelo Ramatja
Lauri-Anne Potgieter

KZN Coastal branch

Zohra Bibi Banoo
Adila Omar
Ashley Wetherill
Aliyaah Kalicharan
Devaksha Dookhi
Kiara Kiren Ramauthar
Amina Bibi Moosa
Nompumelelo Happyness
Lembethe
Ndimiso Sipehelele Hlengwa
Alka Asrai
Poonam Jairaj Dookan
Kureesha Naidoo

KZN Midlands branch

Chante Alana Dove

KZN Northern Branch

Maxine Lechelle Willis

Limpopo branch

Martha Lebepa Mamikie Mamabolo

Lowveld branch

Sabatha Lindokuhle Nyawose

North West branch

Tshireletso Masilabele

Transkei branch

Petrus Jacobus Claassen

Tygerberg Boland branch

Nompumelelo Angela Masango

Unattached

Kial Parmanand



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





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**