

SAMA INSIDER

JUNE 2023

**SAMA celebrates
25 years**

**Being a good doctor
requires empathy –
Prof. Makgoba**



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Diane de Kock
Editor: *SAMA INSIDER*

Celebrating inclusivity

Welcome to the June *SAMA Insider*, an issue celebrating inclusivity and empathy in healthcare.

SAMA celebrated its 25th year of existence in May. At the celebrations, Dr Percy Mahlathi delivered a keynote address (page 5): "Redefining the future: Celebrating 25 years of SAMA". On page 7, we look back at the role SAMA member Dr Hendrik Hanekom played in the amalgamation of doctors' groups to form SAMA. "It was an honour and privilege to have played a small part in unifying the medical profession and in that way contributing to an SA we all love," says Dr Hanekom.

A recent landmark ruling compels the Department of Health to grant free public health services to pregnant and lactating women, and children under the age of 6 years (page 8). "SAMA members and all healthcare workers have an ethical duty of care for the patients they manage."

A new, world-class biomedical research facility has been established by Stellenbosch University, which will not only benefit the people of SA, but the entire African continent. "The BMRI is not just a facility – it represents a new way of doing science on the African continent. It is a symbol of our commitment to using science to create a better future for all," said SU rector Prof. Wim de Villiers.

Dr Mhlengi Ncube, HOD, SAMA Health Policy and Research, unpacks the leadership of multidisciplinary teams for primary care in SA, looking at lessons from Australia, Indonesia, China and Qatar (page 11). "A multi-stakeholder forum is required in SA to define MDTs for primary care, how these MDTs could be implemented and how they could be regulated in the context of NHI."

Prof. Malegapuru Makgoba soon retires as the first health ombud in SA. *Spotlight* recently interviewed him about how he shaped SA health policy (page 15). "Being a good doctor requires empathy and a deep understanding that every single patient craves 100% care. Such empathy is not something that can be taught or learned from books ... it is something people are born with. It derives from a person's nature and values."

In our Medicine and the Law section (page 20) we address making sure that you pay your HPCSA annual fee, whether it is acceptable for a medical practitioner to treat family members and friends, salary deductions from employees' pay – what is allowed and what isn't – and the procedural fairness of a dismissal.

As SAMA moves into the next 25 years, let's take heed of Dr Percy Mahlathi's words: "In celebrating the 25 years, I would propose ... that this moment is celebrated by the broader medical profession, not just by SAMA members. After all, this is the only internationally recognised representative of SA medical doctors. Trust and honest collaboration lies at the heart of whatever endeavours we make."

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Email: publishing@samedical.org | www.samainsider.org.za | Tel. 012 481 2069

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Redefining the future: Celebrating 25 years of SAMA

A keynote address by Dr Percy Mahlathi, 21 May 2023

The programme director, chairperson, board of directors, branch chairpersons, chief executive and staff – I greet you all and thank you for inviting me to share in your joy at SAMA reaching this milestone. It is pleasing that you have taken the decision to celebrate this. In tackling the assignment, I decided to engage from a personal perspective, having been one of the leading team members in the establishment of this national asset.

Let me first talk about why SAMA was formed.

One Friday in July 1994, a few former leaders of NAMDA [the National Medical and Dental Association] were in Cape Town for some business or other. I was a general practitioner in Khayelitsha during those years. I took the liberty of engaging my former leaders to discuss the state of medical politics in our country. We had prematurely disbanded NAMDA in 1992 for reasons that I personally did not agree with.

That meeting helped me decide not to accept a post in the National Department of Health when I was later approached by the then health minister to join her department. The minister needed people who could help transform health services. But I felt the more urgent task for me was to contribute to the transformation of the state of medical politics. The Cape Town meeting with Dr Diliza Mji, Dr Mvuyo Tom, Dr Fazel Randera and Dr Ayanda Ntsaluba had ended with me being given the task of figuring out how the process would unfold. There had been previous attempts by other groups to engage the Medical Association of SA (MASA), but those attempts kept faltering.

So, when I started working on a draft position paper regarding unity, I had to bear in mind the possibility of other groups objecting to the entry of a defunct NAMDA. One cannot negotiate with formalised groups as unorganised individuals. It was therefore imperative that we reconstitute ourselves by forming the Progressive Doctors Group (PDG). Dr Zolile Mlisana and I became the key PDG co-ordinators. Dr Mlisana was a member of MASA's Federal Council. Many black doctors were MASA members even though they disagreed with the organisation's politics and its stance regarding apartheid health. My former



Dr Percy Mahlathi

surgery teacher Dr Edo Barker confirmed this during MASA's submission at the Truth and Reconciliation Commission's hearings in 1996.

Most black doctors were members for the purpose of accessing the *South African Medical Journal* (SAMJ). Dr Mlisana, a very dependable and honest colleague, had a good relationship with both Dr Hendrik Hanekom and Dr Bernard Mandel. This proved to be a strategically important relationship for organising and managing substantive negotiations towards establishing up a future united medical association. From a PDG perspective, influencing future health policy was sacrosanct, and as valuable as ensuring that SA doctors speak with one voice.

So, working on the first draft of what ultimately became SAMA's seminal policy document called the Ideal Professional Association, I knew that the profession was on the verge of truly navigating through the choppy waters of decades of racial divisions – divisions that permeated various aspects of our professional lives from training to practice, including academia. The profession had to heal itself and then

position itself as a valuable societal asset. This position paper, subsequently published as an editorial in the *SAMJ* (1996;86(10)) advanced several key principles.

On the role of the association, it proposed that the future association (SAMA) represent doctors with authority and credibility in all matters concerning their interests in the healthcare environment. It further directed the future association to promote the integrity and image of the medical profession, highlighting its intended role and values in a changed society. On governance, it declared that to guide and direct the association successfully, a strong, representative, inclusive and united governance structure would be needed, and that the association would need to speak on behalf of doctors with a clear, unified voice, be credible and be reliable in the eyes of the public.

So, the stage was set for hard negotiations. However, for any negotiation to succeed, trust must be built between parties. This was tricky because of the overt mistrust between leaders of the various groups. What I found in engaging closely with the MASA leadership was the presence of two leadership streams – those who were sold on creating a future



Celebrating 25 years. Standing, from left: Prof. S Matshidza, Dr J Mphatswe, Dr S Nzama, Dr M Nodikida, Dr MJ Ngundu, Dr D Sithole, Dr L Bayeni. Seated: Prof. D Hagemeister, Prof. R Chauke, Prof. A Dhai, Dr V Nhlapho, Dr RE Ngwenya, Dr M Mzukwa, Dr P Mahlathi, Dr A Hussain, Dr S Maweya, Dr M Human

united medical profession and those who were sceptical. Dr Mandel and Dr Hanekom were key proponents of unity, and were chairman and CEO respectively. They had international exposure to global medical politics in terms of their participation in the World Medical Association.

The medical profession certainly needs to safeguard the institutional legacy of SAMA and use it appropriately

There were other leaders who, if not taken into confidence, could easily sway most of the MASA membership away from unity. Two of these leaders stood out for me – Dr Richard Tuft and the late Dr Ivan McCusker. Upon individual invitations from them, I visited them at their homes. We shared our commitment and concern

for the medical profession, but cordially differed on how its future could be secured. Those two lengthy house meetings avoided unnecessary deadlocks at the negotiation table. Despite major differences that kept cropping up over the years post the formation, I maintained my respect for their honesty. When engaging with them, you knew exactly where they stood.

The road to launching SAMA was fraught with problems, walkouts during discussions and mutual suspicions, especially within the partner organisation block. Strategically, it was necessary that the PDG forge ahead and keep MASA at the negotiation table. They had the numbers, but the PDG had the political capital. Unity was not only for the sake of the medical profession, but also for the country's fledgling health system. So we soldiered on despite occasional rough words hurled at us. I remember being called a sellout, a communist and other unpalatable names. I guess that Hendrik may have had similar encounters from some sections of MASA. Despite all that, unification was key, and whatever we experienced, unity could not be compromised to protect our individual feelings.

It was later surprising to see some of those who were opposed to unification competing head-over-heels for its leadership positions. Launching SAMA in June 1998 did not mean all was well. Things later came to a head at SAMA National Council held in September 2001. This was a watershed moment, with those who had fought hard to bring about the birth of SAMA being booted out of its governance structures. On 28 December 2001 I exited SAMA, and maintained only my ordinary membership. I fully understood that sometimes those who bring about change may not necessarily be the best custodians of the future.

I have covered only a small fraction regarding the short history of SAMA. There is a lot more that I could say. But let me pause here and provide the reason why I have given this short account. It is all about the lessons we must learn from our past to inform the future. I believe that as a medical profession (and SAMA), we partially failed to grasp golden opportunities to entrench our influence on society and the state. The perpetual divisions, focus on mutual suspicions and fights, distrust in leadership ranks and failure to present a truly united voice

of the profession led to our reduced standing in society. We focused a lot on past divisions (with clear destructive racial undertones), defending ourselves to a point that, over time, we lost sight of the strategic goal of unity. Instead of harnessing our collective power of influence on what was an amenable government at that time, we found ourselves later seeking refuge at COSATU, expecting that its then labour might/power would help the cause of medical doctors. What a fallacy that was!

While I am a strong advocate of a very close relationship between medical doctors and nurses, I firmly believe that the SAMA-DENOSA [Democratic Nursing Organisation of SA] relationship could have been and still can be better structured. It should not have been limited to doctors being represented by DENOSA at the bargaining council. There should have been better structural relations based on professional grounds and mutual duty to our country, e.g. influence on national health policy, leadership development, professional regulation and other matters. Thus, health trade unionism would have a different meaning, defined by us –the two key professions in any health system. DENOSA previously had the DENOSA Professional Institute, which was dedicated to nurse leadership development. I strongly supported it in whatever manner I could during my first stint at the National Department of Health.

I would propose and urge that the board ensures that this moment is celebrated by the broader medical profession, not just by SAMA members

I had earlier hoped that SAMA would establish a formidable health policy unit and a leadership development programme, having marvelled what similar associations such as the Canadian and British Medical Associations were able to do. Unfortunately, not all dreams can be achieved when one has limited time in leadership. A leadership programme would enable us to produce grounded leaders for many aspects such as academia, practice,



SAMA management celebrating the 25th jubilee anniversary

policy and regulation, and even polish those who wish to play a role in global medical politics. We have the ingredients!

The Ideal Professional Association position paper advanced several principles that are still relevant. You will hopefully understand how some of us bled internally when we witnessed the unnecessary conflict that led to a SAMATU breakaway. It was the antithesis of what the founders of SAMA had in mind when establishing the association.

The medical profession certainly needs to safeguard the institutional legacy of SAMA, and use it appropriately. Some of us have sought to do this without making noise or seeking praise. An example is that of the review of remuneration of health professionals employed in public health service, popularly known as the OSD [Occupational Specific Dispensation]. It has its roots on the principle of valuing the professions espoused in the Ideal Professional Association position paper. This is encapsulated in the main purpose, which was declared as “to empower the medical profession to bring health to the nation”. That is why the OSD advanced four major principles, not only salary issues. And performance management was one of these, because the practice of health sciences is premised on harmonisation of theory and practice. It is through this that we nurture our young professionals.

There are other matters that one would have liked to see take off successfully. I have long wished for the health professions to have a structure that would handle their conditions of employment and service matters without dilution by issues of other public servants. Whether that is possible or not when medical

doctors want to retreat to an isolated corner in terms of professional regulation is another matter. Reducing the importance of our leadership role in the broader scheme of things is problematic for me. I must stress that this is a personal view, which I hope we can discuss soon. I am fully aware that it goes against the stance taken by my SAMA leadership.

In conclusion, I still believe that the patriotic role envisaged 25 years ago is possible. Despite internal hurdles, SAMA has made several strides. What some branches are doing for the members is marvellous. One critical stride made by SAMA in its very early years related to its role in supporting the move from a 1-year to a 2-year medical internship. This had a major impact on clinical care and its outcomes. So, it is not all doom and gloom. However, we have a lot of in-house cleaning to do. SAMA could have a major influence not just on health policy, e.g. what to do with the clinical associates programme, which is a major challenge we must address. The medical profession is integral to this, mainly because the policy intention was to structure clinical associates as a mid-level medical profession. So, there are several matters of policy and regulation that need the attention of the profession. SAMA can therefore not fail to play its role.

In celebrating 25 years, I would propose and urge that the board ensures that this moment is celebrated by the broader medical profession, not just by SAMA members. After all, this is the only internationally recognised representative of SA medical doctors. Trust and honest collaboration lie at the heart of whatever endeavours we make.

I thank you.

SAMA 25 years ago – how did it all begin?

SAMA Communications

On 21 May this year, SAMA commemorated its 25th jubilee anniversary. To mark this event, we look back at the role SAMA member Dr Hendrik Hanekom played in the amalgamation of doctors' groups, representing a diversity of interests with the then Medical Association of South Africa (MASA), established in 1927, to form SAMA.

After joining MASA as deputy secretary general in 1987, Dr Hanekom was the initiator and convener of the transformation process. He subsequently became the first chief executive and secretary general of SAMA, a post he held until the end of August 1999. According to Dan Ncayiyana, past president of SAMA: "Without him, nothing would have worked."

According to an editorial in the *SAMJ* (vol 90, issue 1: 2000) written by SAMA members R E Kirsch, B Mandall and D Ncayiyana: "At the time of Hanekom's appointment, MASA was grappling unsuccessfully with political forces, which had torn the medical profession apart. Now, just over a decade later, he has left a united association representing all of the previously disparate groups of South African doctors. It is worth recording Hanekom's role in this transition.

"During the 1980s MASA was increasingly criticised both at home and abroad for its failure to denounce the human rights abuses, which pervaded every aspect of South African society at that time. The death of Mr Steve Biko and the disclosures of Dr Wendy Orr had incensed many doctors, but their criticism was dismissed by MASA as being 'part of a well-planned and co-ordinated attack aimed not so much at the Medical Association of South Africa or against our health services as against our country itself.' Soon after joining the staff of the association Hanekom was sent on a study tour, which included a visit to the German Medical Association. Here, while attending a meeting of the German Medical Assembly, he was confronted with the dramatic unfurling of a huge banner attacking MASA and his presence at the meeting. Hanekom recalls being deeply shocked by this attack on the association to which he was so fiercely loyal.

"However, where others might have retreated into a laager, Hendrik examined the reasons behind the criticism, found many to be valid and proceeded to work tirelessly to transform MASA. A month later he was part of a small group which persuaded the Federal Council of MASA to accept unanimously a



SAMA chairperson, Dr Mvuyisi Mzukwa, cuts the cake at the SAMA 25th year jubilee celebrations

statement calling for the '... abolition of all discriminatory measures in South Africa to ensure the disappearance of the practice of apartheid, so that the human dignity of all people be acknowledged, affording them equal and just opportunities'.

"Hanekom pursued the professionalisation of the organisation with equal vigour. In 1989 he organised the first of a series of strategic planning meetings, which allowed the association to clarify and record its mission, to develop a series of short- and long-term goals and to develop the strategies required to meet these.

"In 1990 MASA hosted a summit on the future of academic medicine. This meeting established the concept of academic complexes, which stretched beyond the confines of the tertiary academic hospitals and recognised the importance of teaching students in primary, secondary and tertiary care facilities. Although the profession was still largely fragmented, Hanekom managed to bring together a large group of health professionals representing all shades of medicopolitical and political opinion.

"Soon after Hanekom's appointment as secretary-general he created health policy, professional affairs, law and ethics and finance

directorates with MASA. These complemented the standing committees of Federal Council. 1990 also witnessed the association's first attempts at achieving unity when Hanekom met with Dr Aslam Dasoo, who was then representing the South African Health Workers Congress (SAHWCO). This was followed in 1991 by a series of meetings between MASA, National Medical and Dental Associations (NAMDA), SAHWCO and other groups, which resulted in the formation of SAMA in 1998. Unity became a reality when the National Medical Alliance (NMA) joined SAMA in May 1999.

At the time the NMA represented the SA Medical and Dental Practitioners, Society of Dispensing Family Practitioners, Family

SAMA would like to extend its sincere gratitude to every single member, both past and present, who have helped forge the association's unshakeable foundation. With your support, SAMA is able to play an increasingly important role in advocating for its members, while bringing about meaningful change to the health industry, as we deliver on our mandate of uniting doctors for the health of the nation.

Practitioners' Association, Dispensing Family Practitioners Association, and the Eastern Cape Medical Guild].

"Hanekom also played a major role in the formation of JUDASA and SEHDASA. He strengthened the support base for the full-time doctors' group and was instrumental in securing their representation in the bargaining chamber.

"Managing a professional association with 14 000 members is not an easy task. The successful introduction of new structures and strategies, with the inevitable changes in representation, which follow, required considerable managerial skills as well as vision. These Hendrik Hanekom has in abundance. Managing an association during a period

of significant sociopolitical change requires additional skills, and above all unquestionable integrity. The successful transition from MASA to SAMA has been in no small measure a reflection of the skill, dedication and total integrity of Hendrik Hanekom."

We caught up with Dr Hanekom recently to ask about the transition.

It was a turbulent time in SAMA's history. What are your overriding memories?

It was a time in my life that that I will not trade for anything. Yes, it was turbulent, but the end result was worth all the effort. I met and interacted with wonderful colleagues and working closely with Bernard Mandell, Zolile Mlisana, Percy Mahlati, Dan Ncayiyana and

many other distinguished colleagues was a very enriching and fulfilling time in my career.

According to 2014 SAMA President Prof. Ames Dhai (SAMJ: June 2014;104(6): "SAMA has transitioned towards a pluralistic, multiracial and multicultural membership that is rich in its diversity and is well into the process of transformation, as evidenced by the trend in its demographic composition since 1998." Looking back now, what are your impressions?

As a deeply patriotic South African, it was an honour and privilege to have played a small part in unifying the medical profession and in that way contributing to a SA that we all love.

SAMA welcomes landmark ruling

SAMA Communications

SAMA welcomes the decision of the Gauteng High Court (Johannesburg) that compels the Department of Health to grant free public health services to pregnant and lactating women, and children under the age of 6 years, regardless of their nationality or documentation status (asylum seekers, undocumented migrants or persons affected by statelessness).

As part of section 4(3) of the National Health Act No. 61 of 2003, these rights override the instruction by the Gauteng Health Department, which in 2020 set out to charge migrants for these public health services.

There are thus national implications, as the court ordered that the National Department of Health must inform all provincial health departments by 15 May of its finding that Gauteng's policy is inconsistent with the provisions of the National Health Act, and therefore unlawful and invalid.

Government respondents (the MEC and head of Department for Health, Gauteng, the Minister of Health and the CEO of Charlotte Maxeke Johannesburg Academic Hospital) are required to report to the court on compliance with each element of the court's order by affidavit, and to appear in court on 23 October 2023 to provide a comprehensive report on their compliance with the order.

Additionally, the court stated that any other similar policies or circulars are invalid,



and the National Department of Health was also ordered to direct provinces to prominently display notices and posters in all public health facilities by 17 July stating that all pregnant women, all breastfeeding women and all children under the age of 6 are entitled to free health services irrespective of their nationality or documentation status, unless they belong to a medical scheme or have travelled to SA for the sole purpose of obtaining healthcare.

SAMA welcomes the ruling that healthcare services will be provided to indigent and

vulnerable patients in this context. SAMA members and all healthcare workers have an ethical duty of care for the patients they manage. This cannot not be constrained by unethical political mandates.

Given that healthcare resources are not limitless, coupled with challenges of poor healthcare services in the public sector, SAMA is of the view that signed memorandums of understanding between SA and the countries of origin of these patients are necessary for the payment of costs incurred when healthcare services are rendered to their citizens.

COVID is officially no longer a global health emergency – here's what that means (and what we've learned along the way)

Simon Nicholas Williams, lecturer in psychology, Swansea University

WHO experts have officially declared that COVID no longer constitutes a public health emergency of international concern (PHEIC). This coincides with the WHO's new strategy to transition from an emergency response to longer-term sustained COVID disease management.

This may not change too much practically. COVID will still have pandemic status, and countries will continue to have their own authority as to whether to treat COVID as an emergency within their territories (some countries, including the US, have already declared an end to the national emergency).

For the global public health community, however, this is an event of monumental importance, drawing to a close the emergency response period which commenced on 30 January 2020.

At the same time, for a large portion of the general public, it may well pass by relatively unnoticed. For many people, it's been a long time since they viewed COVID as an emergency. In the UK, for example, COVID no longer features in the regular Office for National Statistics public opinion survey that asks people what they think the key issues facing the country are. Even a year ago, only two in five Britons were very or somewhat worried about COVID, according to the survey.

Along with other behavioural scientists, I have been following public experiences of the pandemic for the past 3 years. The results have yet to be peer reviewed, but by summer 2022, many participants in our research described the pandemic as being like "a distant memory" or like it "never happened".

As we move into this next phase, it's time to consider what we've learned about human behaviour during the pandemic, and what happens next.

Old habits die hard

In the early days of the pandemic, many behavioural scientists, myself included, wondered whether some of our pandemic habits were here to stay. Would face masks become a regular wardrobe staple? Would people stop "soldiering on" and going into work when unwell?

It turned out that for most people, the pandemic hasn't permanently changed our behaviour and habits or created a "new normal". Looking again at the UK, face mask use has consistently declined, with figures from last month suggesting that fewer than one in six adults had worn a face mask recently. Regular use is likely much less common.

Social distancing has long since disappeared, except for a relatively small proportion of the public, in particular those most vulnerable to COVID.

The COVID pandemic has taught us how adaptive behaviour can be, in particular how much people were willing to change their behaviour to keep themselves and others safe. Most people followed the rules during the height of the pandemic, no matter how difficult. COVID has reminded us how resilient we humans can be.

These pandemic adaptations, and the fact that our pre-pandemic behaviour bounced back so quickly, shows how important social cues and social norms are to behaviour. Putting on a mask or keeping our distance from others were habits – actions triggered automatically in response to contextual cues, such as seeing signs with pictures of people socially distancing.

Social norms – what we think others are doing – were key to vaccine uptake and to our uptake of preventive measures in general. As these contextual cues disappeared and the social norms started to change, and as vaccine coverage increased and the risk to the majority decreased, our behaviour changed.

The pandemic has also demonstrated how important social connections and social, especially physical, contact can be. This is something we have already argued COVID couldn't keep at bay forever. According to social safety theory, which sees stress and wellbeing as a product of biological, psychological and social factors, COVID posed a threat to the "social fabric that makes humans resilient and keeps us alive and well".

It's unsurprising that life satisfaction and happiness were lowest during lockdowns, and recovered as people started to mix socially again.

The emergency isn't over for everyone

As we mark the end of the emergency phase, it's important to remember the



nearly 7 million lives lost due to COVID since 2020.

And of course, we must consider that for some, especially those who are clinically vulnerable, the emergency is not yet over, and may never be.

Although it's no longer a PHEIC, as the WHO reminds us, COVID is still responsible for millions of infections and thousands of deaths each week around the world. Also, thanks to long COVID, hundreds of millions of people are in need of longer-term care.

In the future, we need to move from relying on the resilience of individuals to building resilience in our institutions. We can all take measures to continue to protect ourselves and those around us from COVID and other respiratory viruses (such as by hand washing and keeping up to date with vaccinations). But responsibility for preventing public health emergencies shouldn't rest solely in the hands of the public.

Actions that governments, employers and health authorities can take now could protect against future public health emergencies. Systematically tackling misinformation, improving ventilation in schools, workplaces and other public indoor spaces, and making longer-term improvements to paid sick leave are all good ways to start building more resilient societies in preparation for the next pandemic. Hopefully this is something we will never see in our lifetimes.

Source: The Conversation, 5 May 2023. <https://theconversation.com/covid-is-officially-no-longer-a-global-health-emergency-heres-what-that-means-and-what-weve-learned-along-the-way-205080>.

A world-class biomedical research facility in Africa, for Africa

SAMA Communications

South African Deputy Minister of Higher Education, Science and Innovation, Mr Buti Manamela, commended Stellenbosch University (SU) recently on its visionary leadership in establishing the cutting-edge Biomedical Research Institute (BMRI) – which will not only benefit the people of SA, but the entire African continent.

“Building on SU’s long tradition of world-class research, the creation of this state-of-the-art facility is a very important milestone in our efforts to strengthen our national system of innovation, and more specifically, the health research innovation and infrastructure of both our country and our continent,” Manamela said at the inauguration of SU’s BMRI. This facility is the most advanced biomedical research complex on the African continent, and is focused on finding solutions to some of the most pressing health issues affecting people in SA and the rest of Africa.

Manamela officiated the opening of this ZAR1.2 billion (approximately USD66 million) facility during a gala dinner held on 19 April 2023 at the BMRI on SU’s Tygerberg campus in Cape Town. The event formed part of a week-long programme hosted by SU’s Faculty of Medicine and Health Sciences (FMHS) to introduce the new facility to the public and the global and local scientific community.

University World News reports that Prof. Nico Gey van Pittius, the vice dean of research and internationalisation, said: “Africa has unique problems and health challenges. It bears the brunt of infectious diseases and has alarmingly rising levels of non-communicable diseases and a growing incidence of mental health challenges. These colliding and interacting epidemics put our health systems under severe strain and adversely affect our people’s quality of life.”

“Our population is unique, and our circumstances are different from the rest of the world – with both factors impacting on human health. We have the largest genetic diversity in the world, and very high levels of stress in some of our countries. At the same time, we have challenges with infrastructure and difficulties in reaching deep rural areas.

“Also, around half of Africa’s population is younger than 25. Compare that to the ageing



Prof. Wim de Villiers (SU rector and vice-chancellor), Prof. Elmi Muller (dean of SU’s Faculty of Medicine and Health Sciences) and Deputy Minister for Higher Education, Science and Innovation, Mr Buti Manamela, cutting the ribbon at the BMRI’s inauguration (photo: Nardus Engelbrecht)

populations of China, the USA and Europe. Obviously, our health problems are going to be different.

“So, we cannot just take solutions developed in other countries and apply them in Africa. Nor can we have ‘parachute research’ anymore. We must look after ourselves and collaborate with the rest of the world as equitable partners. That’s the idea behind the BMRI.”

“The BMRI is not just a facility – it represents a new way of doing science on the African continent. It is a symbol of our commitment to using science to create a better future for all,” SU rector Prof. Wim de Villiers said in his address. “We believe that the BMRI will be a catalyst for change, leading the way in the fight against disease and promoting the health and wellbeing of people throughout the continent.”

SU’s FMHS dean, Prof. Elmi Muller, said: “The investment in the BMRI will allow significant human capacity development through training some of the best students from the continent and exposing them to extensive national and international research networks to result in a next generation of successful scientists.”

The BMRI houses more than 500 biomedical researchers and students, including some of the world’s foremost scientists in the fields of bioinformatics, TB, neuroscience and urology. The leading-edge research emanating from the facility has a decidedly African focus, and seeks to understand the genetic and biomolecular basis of diseases afflicting SA and the rest of the African continent, such as TB, HIV/AIDS and cardiometabolic disorders.

The facility boasts numerous state-of-the-art laboratories, including the largest (600 m²) biosafety level 3 (BSL-3) laboratory and fully automated biorepository in Africa, a bioinformatics hub, electron microscopy laboratories, proteomics and flow cytometry services (FACS) laboratories, a medical morphological learning centre, a Sunskill laboratory and clinical research facilities.

“We see the creation of this facility by SU as an important addition to our country’s scientific resources. The research focus of the facility aligns perfectly with the objectives of government policy – the White Paper on Science, Technology and Innovation and the decadal plan – which aims to strengthen our country’s national system of innovation, to the benefit of all,” said Manamela.

The leadership of multidisciplinary teams for primary care in SA: Lessons from Australia, Indonesia, China and Qatar

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



Multidisciplinary teams (MDTs) in healthcare are teams of medical professionals from various specialties who collaborate to provide patients with comprehensive patient care. MDTs are recommended as the best healthcare implementation strategy. MDTs have been used to take care of patients who require complex care. For example, head and neck oncology teams may consist of specialised nurses, dietitians, oncologists, social workers, oncogeriatricians and speech and language specialists. MDTs are designed to strengthen healthcare delivery systems, improve patient access to care, improve patient outcomes and enhance patient satisfaction. As part of universal health coverage (UHC) strategies, MDTs have found applications in enhancing access to high-quality primary healthcare. The chronic care model, the patient-centred home model and the integrated care model are just a few patient-based models that could be used to implement MDTs.

SA's national primary healthcare policy is geared toward a nurse-led primary healthcare system. Primary care nurses may provide patient consultations with a narrower scope than GPs do. This is referred to as task shifting. Despite nurses' limited scope of medical consultations and prescriptions, there are

concerns that they may partially usurp the role of GPs. One of the arguments for allowing nurses to perform some less complex consultations is the shortage of medical doctors and their unavailability in difficult-to-reach or socially unattractive areas, although some GPs argue that this kind of task shifting could compromise the quality of patient care, and evidence shows that doctors are willing to work in government hospitals in rural and hard-to-reach areas.

Given that the National Department of Health has begun to roll out contracting units for primary care (CUPs) under the National Health Insurance (NHI), the private and public sectors are merging. This means that the government will have more access to GPs because they will be contracted by the government to care for patients who would have been attended to in public sector clinics. The implementation of CUPs and the NHI has reignited the debate over nurse-led v. GP-led primary care. The MDTs are a prominent feature in SA's WHO-supported Presidential Health Compact 2018, and continue to be part of healthcare delivery strategies well into the future. At a policy development level, and to drive change management for policy implementation, an important question for the health fraternity is: what is the best leadership setup for MDTs in primary healthcare in SA, based on global evidence?

The different role-players in MDTs lead different aspects of primary healthcare service delivery. The team's three primary leaders include the medical doctor, nurse and pharmacist. Typically, a clinical leader (often a medical doctor) supervises the team's medical activities. The clinical leader is responsible for clinical management and interactions between the team and other healthcare providers. The nurse leads nursing activities. In instances where there is more than one nurse, a nursing manager can be appointed. The nurse also serves as an operations manager, co-ordinating the activities of the entire team. The pharmacist is responsible for ensuring that all patients receive the best (and most rationalised) medication available, and that the patients receive appropriate medication

education. Other allied professionals, such as nutritionists, physiotherapists and others, provide leadership in their respective fields in highly specialised MDTs.

MDTs face a number of challenges, including communication and co-ordination issues, role confusion, time constraints and a lack of trust, among others. Common communication challenges between individuals due to differences in personality, socialisation and cultural diversity may have a negative impact on effective team co-ordination. In some cases, scopes of practice overlap, which can lead to role confusion and conflict in teams. Lack of trust, which is also prevalent in many workplaces, has the potential to destabilise MDTs, while time constraints in resource-constrained settings may impede effective team functioning.

A number of strategies could be used to alleviate the difficulties that MDTs face. To resolve some of the role challenges and promote healthy professional boundaries, role clarification tools could be used. Regular meetings that foster the sharing of information, ideas, concerns and solutions are encouraged. These meetings could also be used to build trust and a collegial environment. Another way to foster trust and collaboration in MDTs is to emphasise patient-centredness at all times, to instill a common goal in the team. Continuous professional development in clinical and soft skills may also aid in the development of successful and impactful MDTs.

To better understand the appropriate leadership structure of MDTs in SA, a global perspective of MDT leadership is useful. The health system of Indonesia has been used to benchmark SA's future health system, due to similarities in healthcare challenges, and could be used to benchmark MDT leadership. Other countries that could be used to benchmark SA's healthcare system and MDT leadership are the BRICS countries, Brazil, Russia, India, and China, as economic partners with SA. Australia, which is currently regarded as having one of the world's most effective healthcare systems, is a great candidate

for benchmarking. Qatar could show MDT leadership structures in an environment where resources are not severely limited. In the selection of countries that are used for benchmarking, it is important to understand that environmental factors, such as disease profiles, healthcare worker-to-population ratios, GDP and political influences, have an impact on how health policy is developed in these nations.

The preservation and clarification of the roles of both GPs and nurses in MDTs for primary care are essential

When analysing MDTs in Australia, China, Indonesia and Qatar, it was found that each member of the team was responsible for different aspects of patient management in the primary healthcare system or establishment. However, the GP was either the clinical leader or part of the team in all of the case studies. The decisions on the diagnosis and broader treatment plans of patients were made by the GP. The GP identified high-level needs such as education and nutrition, and delegated intervention plans to the team's relevant professionals. In SA, however, the GP only attended to the most complex cases, while nurses managed the less complex cases. The nurses' responsibilities included

co-ordination, testing, health education and monitoring treatment plans. The role of the nurse was akin to that of the operations manager or treatment co-ordinator. Necessary training was provided to nurses who served in health education roles. However, specialist health educators were also used to provide health education to patients.

In Australia, China, Indonesia, SA and Qatar, GPs have a critical role in primary care MDTs. This role has the potential to be downplayed in some nurse-led primary care models. There are two different categories of leadership between GPs and nurses in MDTs in Australia, China, Indonesia and Qatar. GPs provide clinical leadership, while nurses provide operational leadership. In SA the situation is different – primary care nurses diagnose and treat cases. According to the SA Nursing Council, a primary care specialist nurse “gets patients/clients directly from the communities. She/he refers to a general medical practitioner, medical specialist, another nurse specialist, and any level of health establishment.”

There is limited evidence to show that nurse-led primary care has significant health benefits for individuals with multiple chronic comorbidities. In SA, the COVID-19 pandemic provided a clear indication of the country's level of non-communicable comorbidities. Given the lack of evidence on the extent to which nurse-led primary care improves health outcomes for patients with multiple or complex morbidities, as well as the quadruple burden of diseases and the level of comorbidity, MDTs in SA must include both doctors and nurses. The roles of GPs and

nurses must be clearly defined in the MDTs using a strategy that takes into account the limited number of GPs that are available in the country.

The concept of GP-led, nurse-driven MDTs may be a more effective implementation strategy for CUPs and MDTs for primary care in SA. In this structure, primary care nurse practitioners could see and document less complex cases. The GP could then retrospectively review a proportion of randomly selected files. All complex cases, as well as those involving multiple morbidities, could be referred to or seen directly by the GP. Subsequently, the GP would be responsible for making referrals to higher levels of care. Using this model, GPs could be responsible for a predetermined minimum and maximum number of primary care centres based on a variety of criteria such as patient volume, community disease profile, etc. The structure of MDTs for primary care could be designed with multi-stakeholder engagement and administered through the Office of Healthcare Standards and Compliance.

Since MDTs are the future of primary healthcare, the most recent proposed amendments to the HPCSA rules indicate a shift toward facilitating the development of MDTs in private practice. The preservation and clarification of the roles of both GPs and nurses in MDTs for primary care are essential to protect the health and wellbeing of citizens. A multi-stakeholder forum is required in SA to define MDTs for primary care, how these MDTs could be implemented and how they could be regulated in the context of NHI.

Top medical student selected to attend WHO meeting in Geneva

SAMA Communications

SAMA member and fifth-year medical student at the University of KwaZulu-Natal (UKZN)'s Nelson R. Mandela School of Medicine in Durban, Mohamed Hoosen Suleman, has been selected as the official SA youth delegate to the world's most important meeting on health, hosted by the WHO in Geneva, Switzerland, in May.

Having recently returned from Denmark as an invited delegate to the European Society

of Clinical Microbiology and Infectious Disease (ESCMID) Conference, Suleman will be jetting off to Switzerland to attend the Youth Pre World Health Assembly (PreWHA) and World Health Assembly (WHA) hosted at the WHO Headquarters.

This future top doctor is widely described as a passionate and dedicated young leader, and is a recipient of multiple prestigious awards and accolades in the medical field.

Suleman was granted special leave by UKZN's School of Clinical Medicine to attend both international meetings and contribute to the discussions related to health policy and diplomacy.

The WHA is the WHO's highest decision-making body meeting, and is attended by world leaders and delegations of its 194 member states.

Attendance at the WHO headquarters is strictly by invitation. A detailed agenda on



Mohamed Suleman in Copenhagen, Denmark

global health is discussed, and a plan of action on priority health areas that countries should focus on is decided in the meeting.

For the last 2 years, Suleman has received the UKZN Best Student Researcher and Best Student Innovator awards. He is also an editorial board member for the *International Journal of Medical Students (IJMS)*, and is among the Top 200 Young South Africans listed by the *Mail and Guardian*.

Suleman is well known within the university community as a student who truly embodies the institution's core principles and ideals of "Inspiring greatness". He remains an inspiration to other medical students.

Associate professor from UKZN's School of Clinical Medicine Prof. Andrew Ross said: "The Department of Medicine at UKZN is absolutely thrilled to learn that Suleman has been selected to attend the WHO's highest decision-making body meeting in Geneva. We wish him well, and we fully support his efforts to ensure that healthcare can be improved, particularly on the African continent. Mr Suleman is commended for his efforts in pursuing academic excellence, and I encourage all students to follow in his footsteps. He continues to inspire colleagues within the faculty. We will also ask Suleman, upon his return from Geneva, to present to the Department of Medicine on the outcomes of discussions at the WHO headquarters."

The WHA will focus on pressing health issues that are globally relevant, and the WHO's four key pillars of the meeting will be explored. These include how the WHO could

provide more effective and efficient support to countries, global guidance on protection from health emergencies, the adoption and implementation of universal health coverage (UHC) policies and advancing the UN Sustainable Development Goal 3 of good health and wellbeing.

Suleman says he is honoured to be chosen for the event, and that he commits to high levels of engagement with leading experts in the field of medicine.

"I am deeply honoured to be shortlisted to attend the meeting and make some contribution to discussions on healthcare policy and diplomacy. An interesting area for me would be discussions relating to the Pandemic Accord proposed by the WHO on preparedness, response and recovery to disease outbreaks, and whether or not this international instrument will be accepted by many countries," says Suleman.

He said he looks forward to the robust discussions and dialogue with like-minded individuals from different parts of the world.

Last year, Suleman was one of only three medical students globally to be selected for the prestigious WHO Changemaker Scholarship.

Suleman will be engaging in scientific discussions in line with the WHA agenda, and how this translates to policy-making and healthcare decision-making. Resolutions adopted at the meeting will subsequently be shared as policy documents with all WHO member states as guidance on priority health issues for the next 12 months.

The youth delegation to the WHO, which includes Suleman and other members of the International Federation of Medical Students' Association, will be submitting nine official statements. These include the following topics:

- health systems resilience and strengthening
- health emergencies and pandemic preparedness
- prevention and control of non-communicable diseases
- sexual and reproductive health, women's and adolescents' health
- human rights, peace and health
- infectious diseases
- one health and planetary health
- health innovation, research and technology
- meaningful youth engagement.

Suleman said he was deeply honoured to be granted the opportunity. "I am deeply grateful to have been selected to attend the conference and discuss current and future developments in the fight against infectious diseases. This has been an area of interest to me, and this served



With the president-elect of the European Society of Clinical Microbiology and Infectious Diseases

as an opportunity to appreciate the complexity of the evolving epidemic of infectious disease and antimicrobial resistance. I will discuss further with the Department of Health in SA on the take-home messages that I was able to grasp. Antimicrobial resistance is also an area that warrants urgent attention if we are to safeguard the health and wellbeing of our population."

He also attended the WHO-ESCMID meeting on antimicrobial resistance (AMR) on 14 April 2023. The meeting focused on key policies and strategies in relation to reducing the global burden of AMR, and was attended by some of the world's leading minds in the field of AMR.

A broad range of topics was covered at the conference. These included research related to syndromic testing for infectious diseases in resource-limited settings such as low- and middle-income countries, diagnostics, management of infectious diseases in immunocompromised patients, infection prevention and control, COVID-19 and long COVID, novel antibiotic use, metagenomic sequencing and its use in early detection of AMR, lessons learned from COVID-19 and monkeypox disease outbreaks, genomic surveillance, artificial intelligence and its use in diagnostics, vaccinations, monoclonal antibodies, HIV/AIDS, influenza, other bacterial and viral infections, TB, Gram-negative and Gram-positive bacteria, social and structural determinants of health and the relationship between politics and health.

#CrazySocks4Docs highlights the importance of mental health in medical professionals and students

SAMA Communications

The 2023 CrazySocks4Docs (CS4D) campaign will once again take place on Friday 2 June 2023. Initiated by the Ithemba Foundation in SA, this campaign sheds light on the need for mental health awareness and care in the medical industry, while recognising and paying tribute to healthcare workers for the invaluable role they play in SA.

"I have too often seen, also in myself, the 'need' to ignore our own warning signs, to push on, to not seek help, or help each other. We spend so much time learning to care for others, but we need to learn to look after each other and ourselves. This will reward the healthcare system and patient care, as well as all healthcare workers," says Dr Geoff Toogood, Australian cardiologist and initiator of the CS4D campaign, in response to why he started this initiative.

The public is encouraged to join in the campaign by wearing bright, colourful, funky and mismatched socks on CS4D Day on Friday 2 June. Post a "sock selfie" on your social media pages with the hashtag #CrazySocks4Docs as a sign of solidarity with healthcare workers and students.

Healthcare workers are under immense pressure

We tend to think of healthcare workers as professionals who we turn to when we are suffering, but they are also just ordinary people who need support. The same applies to students in healthcare professions, who face severe pressure during their studies to become the healthcare workers of the future.

Numerous statistics show that mental health issues are particularly prevalent among healthcare professionals. In fact, studies show that suicide is regarded as an "occupational hazard" for physicians. Suicide is the only cause of death that is higher in physicians than non-physicians. In addition, a Cape Town study found that 30% of public primary healthcare doctors are living with moderate to severe depression.

Suicidal ideation (contemplating suicide) is far more commonplace among medical students than other groups. One analysis found that 24.2% of medical students reported suicidal ideation during the year under research. A specific SA study estimated that

around a third of SA medical students have suicidal thoughts, and that over 6% of medical students go on to attempt suicide.

If you or someone that you know is suffering from a mental health condition or have suicidal

thoughts and need help, you can call the South African Depression and Anxiety Group (SADAG) 24-hour mental health helpline on 0800 456 789 or WhatsApp 076 88 22 777 for free counselling.



Calling all medical students: You're invited to enter Ithemba Foundation's CS4D competition! Here's how:

- Post a picture of your crazy socks on Ithemba Foundation's Facebook @lthembaFoundation1 or Instagram @ithembafoundation pages (or both!).
- Ask family and friends to like your "sock selfie".
- If your post has the most likes on your medical campus, you will win a ZAR1 000 cash prize.

About Ithemba Foundation

The Ithemba Foundation is a non-profit entity (registration no. 2012/171250/08; PBO no. 930/048/019) with the public benefit goals of raising awareness of depression and related diseases as biological illnesses, and raising funds for research. If mental illnesses are the illnesses of despair, we need to constantly focus on hope (*ithemba* means hope in isiXhosa). We can all be ambassadors of hope by talking openly about mental ill-health to break the silence and the stigma surrounding these biological diseases that can also be fatal. For more information: <https://www.ithembafoundation.org.za>.

Interview: Being a good doctor requires empathy, says outgoing health ombud Prof. Malegapuru Makgoba

Biënne Huisman, *Bhekisisa*

As a young boy surrounded by hills in Limpopo, Malegapuru William Makgoba says he used to rest in the shade of marula trees, minding his father's ducks, sheep and goats, while pondering the wonders of nature. His childhood was happy, with a sense of benevolence and belonging.

At the age of 11, he saw his father, Morithi Makgoba, enter a diabetic coma in their home district of Sekhukhune. He recalls that his father's life was saved at a hospital 20 kilometres away. It was an early encounter with medicine and the healthcare system, which would become his life's work.

Apart from a passion for medicine, the need for equal opportunity would also become a driving force in his life. When he was 14 years old at boarding school, a teacher suggested that he skip a grade. Makgoba, squirming away from special treatment, asked that all his classmates write a test to check for such eligibility. This, he says, resulted in five pupils, including himself, attaining 85% or more, and being pushed a year ahead.

In the more than five decades since then, Makgoba – now Professor Emeritus and retired vice-chancellor of the University of KwaZulu-Natal (UKZN) – would come to shape SA health policy, notably through his critique of AIDS denialism in the 2000s, and later through his appeal as Medical Research Council (MRC) president to provide antiretroviral drugs to people living with HIV. This saw him in conflict with some of the country's most powerful politicians. A profile interview in the US scholarly journal *Science* in 2000 quotes Makgoba as lambasting then-President Thabo Mbeki. "The sad part is, [Mbeki] is trying to politicise scientific facts, and that's what the Nazis did," he said at the time.

Makgoba's trademark forthright manner manifested in his job as SA's first health ombud, a position he assumed in 2016 and which saw him release stinging public reports. His tenure draws to an end next month.

A revelation

For the past 7 years, Makgoba has led a Pretoria-based staff of 30 who investigated patient



Now Professor Emeritus and retired vice-chancellor of the University of KwaZulu-Natal, Malegapuru Mokgoba helped shape SA health policy (photo: NRF/Twitter)

complaints against health practitioners, hospitals and clinics across the private and public sectors. And while his ombud office email did not work at the time of this interview, he calmly implies this is a temporary glitch. He says his office has processed some 10 800 complaints since its inception.

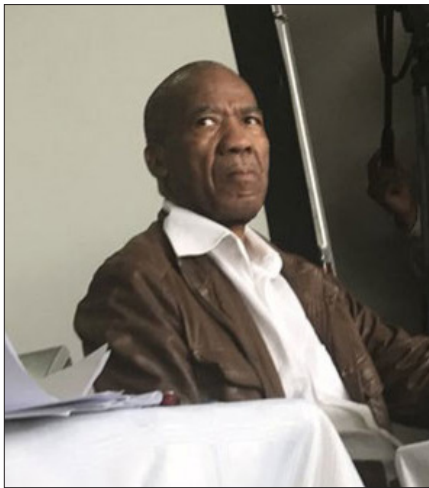
Reflecting on his tenure, he recalls some of the most jarring incidents. He singles out the [Life Esidimeni](#) tragedy, which saw an estimated 144 psychiatric patients die due to starvation and neglect in 2016 after they were transferred to under-resourced NGOs and psychiatric facilities in Gauteng (his initial report on the affair is [here](#)).

"This for me was a revelation of the health system," says Makgoba. "How it interacts with politics, and how political power and lack of accountability can result in human rights abuses to the extent that vulnerable people, such as mental health patients, could be treated the way they were treated, resulting in deaths and so forth. I mean, people in power denying that their actions could have been responsible for what happened. It was a failure of basic common sense. That was really just horrible as an investigation."

The ongoing Judicial Inquest into the deaths of the Life Esidimeni mental healthcare users, which started in 2021, has had many delays, with the latest postponement granted to the lawyers of former Gauteng Health MEC, Qedani Mahlangu. Proceedings are set to resume on 2 May.

As health ombud, Prof. Malegapuru Mokgoba led various headline-making investigations into the Life Esidimeni tragedy and conditions at Rahima Moosa Mother and Child Hospital. He handed over the investigation report into conditions at Rahima Moosa Hospital in March. The [damning report](#) on the conditions at the hospital included shocking revelations about how the health and dignity of patients were compromised.

To *Spotlight* he says, "It was just a litany of deficiencies. Here you have an 80-year-old hospital that has really been neglected over the years. It used to be an excellent hospital that won awards. I mean, it's a hospital that deals with obstetrics but which doesn't even have a blood bank. One of the most common causes of maternal death is blood loss. People lose a lot of blood giving birth. It's overcrowded and run down – just horrendous and unhygienic, with women who have just



Prof. Malegapuru Makgoba was among the first to give testimony during the Life Esidimeni Arbitration hearings (photo: Gauteng Health/Twitter)

delivered or pregnant women sleeping on the floors.”

Side-stepping Mandela

The 70-year-old scholar speaks openly about his political non-affiliation.

During his studies at the University of Natal Medical School, he says he was inspired by Steve Biko and the Black Consciousness Movement. However, he felt that belonging to a political party would curtail his scientific freedom and thinking.

Makgoba chuckles, recalling how he even side-stepped an invitation from former president Nelson Mandela to join the ANC.

He says he met with Mandela at Luthuli House in Johannesburg in 1990. At the time, Makgoba was living abroad, and Mandela asked him to consider returning home.

“He [Mandela] said I should think about returning to SA, that I should think about joining his new movement, his philosophy of reconciliation. And of course, he put me in a corner because he wanted to know whether I was a member of the ANC. And I said no. And he said, well, I’ll take you downstairs so you can join. And I said, no thank you. Fortunately, as we were talking, his PA knocked on the door and said there’s somebody who wants to see you. That’s how I escaped. I mean, the pressure to be told by such an important person to become a member of a party! The fact is I don’t belong to any political party. It has something to do with my independence, my freedom of thinking, my training.”

A long and varied career

During the interview over Zoom, Makgoba’s office walls appear bare behind him. He

says that he keeps relics of his long and varied career at his home in Schoonoord in Sekhukhune, explaining that he feels no need to “intimidate people with certificates of his education on his office walls”.

At the height of apartheid in 1981, Makgoba won a prestigious scholarship to study toward a PhD at the University of Oxford in the UK, where in 1983, he completed his thesis in human immunogenetics. At the time, Makgoba’s supervisor, Prof. Andrew McMichael, said this about him: “Overall, he [Makgoba] was one of the most broadly able and interesting students I have seen. A good scientist, but with a mission to do something special for his people.” Makgoba would continue doing research in England and in the USA, focusing mainly on genes and cell surface proteins involved in the immune response.

From 1986 to 1988 at the National Cancer Institute in Maryland in the USA, he was part of a team of researchers headed by Dr Stephen Shaw. Makgoba explains that at the time, immunology was preoccupied with T-cell receptors (a protein on the surface of T cells – the white blood cells that drive the immune response) and T-cell recognition; thus how these cells remember and learn, tailoring specific immune responses, somewhat similar to human memory or the nervous system.

“Dr Steven Shaw had a view that there must be something that makes the cells communicate with each other and tell each other before a specific response is triggered, and he came up with a theory of cell adhesion molecules, especially in T-cells. It opened up something new about how T-cells may be useful in surveying for cancers in the body because they have these structures that allow them to move around and crawl and sniff other cells and say, there is something here that’s not normal, and so forth. It was a fashionable field, a popular field, a competitive field to be in. It opened a whole area of biology and even up to this day, those papers are still being quoted.”

Accolades and outrage

In 1993, Makgoba accepted the position of deputy vice-chancellor at the University of the Witwatersrand (Wits). Here, his drive for higher education transformation caused clashes, with some of his Wits colleagues describing him as “an unapologetic radical”, and in 1995, his detractors lodged a 297-page dossier of complaints against him. Makgoba responded by describing his detractors as an “inbred elite” and racist. Indeed, while Makgoba’s views on transformation earned him accolades, they sparked outrage too. Over

the years, controversy followed him around SA campuses and committees – skirmishes that he brushes off. Looking back, Makgoba says peers saw his writing on “decolonisation and Africanisation” as a threat instead of a push for positive change. “Instead of being embracing, they grew defensive,” he says.

After Wits, he joined the SAMRC, and in 2002 he became vice-chancellor of the University of Natal (later UKZN). Here, signing graduation certificates was a highlight, he says. Makgoba recalls being on holiday one Christmas at the Livingstone Hotel on the Zambezi, where an old English couple recognised him as the man who graduated their daughter.

“When you cap people [tapping a student’s head during graduation], pictures are taken,” says Makgoba. “I think they took this picture and framed it and it was somewhere in their lounge or whatever. And they came up to me and said but we know you because your picture hangs in our house. And I said I’m not sure. They said, well, you capped our daughter. And they bought me a bottle of champagne. Moët & Chandon.”

What’s next?

With his time as health ombud coming to an end, going forward, Makgoba says he is busy writing a book on his life and experiences.

His obvious passion and decades of experience suggest he will remain engaged in SA’s ongoing healthcare reforms, although it is not clear in what capacity.

On SA’s proposed National Health Insurance (NHI) system, he says, “This is a very excellent concept, but for it to work, poor infrastructure needs to be addressed, poor leadership, inadequate human resources, and poor governance in health need to be addressed.”

Wrapping up our interview, Makgoba says that being a good doctor requires empathy and a deep understanding that every single patient craves 100% care. Such empathy is not something that can be taught or learned from books, he says. It is something people are born with. It derives from a person’s nature and values.

With his time as health ombud coming to an end, going forward, Makgoba says he is busy writing a book on his life and experiences.

Source: Spotlight, 17 April 2023. <https://www.spotlightnsp.co.za/2023/04/17/interview-being-a-good-doctor-requires-empathy-says-outgoing-health-ombud-prof-malegapuru-makgoba>.

Dr Bester receives honorary fellowship to the American College of Physicians

SAMA Communications

The Free State branch council recently congratulated Dr Freek Bester, specialist doctors representative of the SAMA Free State branch and previous president, on his admission to the American College of Physicians.

At the beginning of May, physician Dr Freek Bester returned to Bloemfontein after receiving an honorary fellowship of the American College of Physicians. He is one of only five South Africans who have received this honour. His honorary membership of the college recognises his work as president of the Faculty of Consulting Physicians of SA (FCPSA), his contribution to the development and training of young physicians and his mentoring of clinical assistants, particularly because there is a shortage of physicians in SA. He has been president of the FCPSA for more than 20 years, and is also a member of the executive committee. Last year the FCPSA honoured him with a lifetime achievement award.

Dr Frederik Bester qualified as a medical practitioner at the University of the Free State, and went on to specialise in internal medicine, later obtaining the following qualifications: MB ChB, FCP (SA), MMed (Internal Medicine). He now works full-time in the private health sector in Bloemfontein at the Life Rosepark Hospital. His clinical interests include rheumatology, gastroenterology and pulmonology.

On 10 May, the Life Rosepark Hospital, where Dr Bester works, celebrated his award by rolling out a red carpet to welcome him home. The reception was attended by doctors, nurses and administrative personnel. Hospital administrator Hein Rossouw praised Dr Bester for his passion for his patients and his commitment to the hospital, and congratulated him on the award he received in the USA, which has also brought recognition for the hospital.

Dr Bester was also praised for the outstanding work he did in the Free State during the COVID-19 pandemic amid very difficult circumstances, and for assisting with the training of hospital staff.

The hospital presented him with a gift and an olive tree. When thanking the hospital, Dr Bester said that the recognition he received in the USA is not only for him,



Dr Bester with colleagues Dr Johan Jordan, Dr James Fortein and Marelize Niewoudt at Rosepark Hospital (photo: Herman Groenewald)



Dr Freek Bester (photo: Herman Groenewald)

but also recognises the support he received from his profession. "Receiving this honorary Fellowship is not an individual effort, you are not able to get to that level of recognition if you do not have support from the people around you. None of us walk this road alone in life. We are a team, who support our patients and support each other. I want to thank my partner in my practice, my family at home and the doctors and staff of Rosepark Hospital. They are a very special group of doctors and



Nursing manager, Marelize Niewoudt, presents an olive tree to Dr Bester (photo: Herman Groenewald)

we have become a very tight-knit team to help patients. We work as a team, we never work alone," said Dr Bester.

"The olive tree is my favourite tree and it will be planted in a special spot in my garden, and I will honour it in your name everyday," said Dr Bester.

How good is ChatGPT at diagnosing disease? A doctor puts it through its paces

Stephen Hughes, senior lecturer in medicine, Anglia Ruskin University

For years, many have feared that artificial intelligence (AI) will take over national security mechanisms, leading to human slavery, domination of human society and perhaps the [annihilation of humans](#). One way of killing humans is medical misdiagnosis, so it seems reasonable to examine the performance of ChatGPT, the AI chatbot that is taking the world by storm. This is timely in light of ChatGPT's recent remarkable performance in passing the US [medical licensing exam](#).

Computer-aided diagnosis has been attempted many times over the years, particularly for [diagnosing appendicitis](#). But the emergence of AI that draws on the entire internet for answers to questions rather than being confined to fixed databases opens new avenues of potential for augmenting medical diagnosis.

More recently, several articles discuss the performance of ChatGPT in making medical diagnoses. An [American emergency medicine physician](#) recently gave an account of how he asked ChatGPT to give the possible diagnoses of a young woman with lower abdominal pain. The machine gave numerous credible diagnoses, such as appendicitis and ovarian cyst problems, but it missed [ectopic pregnancy](#).

This was correctly identified by the physician as a serious omission, and I agree. On my watch, ChatGPT would not have passed its medical final examinations with that rather dead performance.

ChatGPT learns

I'm pleased to say that when I asked ChatGPT the same question about a young woman with lower abdominal pain, ChatGPT confidently stated ectopic pregnancy in the differential diagnosis. This reminds us of an important thing about AI: it is capable of learning.

Presumably, someone has told ChatGPT of its error and it has learned from this new data – not unlike a [medical student](#). It is this ability to learn that will improve the performance of AIs and make them stand out from rather more constrained computer-aided diagnosis algorithms.

ChatGPT prefers technical language

Emboldened by ChatGPT's performance with



ectopic pregnancy, I decided to test it with a rather common presentation: a child with a sore throat and a red rash on the face.

Rapidly, I got back several very sensible suggestions for what the diagnosis could be. Although it mentioned streptococcal sore throat, it did not mention the particular streptococcal throat infection I had in mind, namely [scarlet fever](#).

This condition has re-emerged in recent years and is commonly missed because doctors my age and younger don't have the experience with it to spot it. The availability of good antibiotics had all but eliminated it, and it became rather uncommon.

Intrigued at this omission, I added another element to my list of symptoms: [perioral sparing](#). This is a classic feature of scarlet fever in which the skin around the mouth is pale but the rest of the face is red.

When I added this to the list of symptoms, the top hit was scarlet fever. This leads me to my next point about ChatGPT: it prefers technical language.

This may account for why it passed its medical examination. Medical exams are full of technical terms that are used because they are specific. They confer precision on the language of medicine, and as such, they will tend to refine searches of topics.

This is all very well, but how many worried mothers of red-faced, sore-throated children

will have the [fluency in medical expression](#) to use a technical term such as perioral sparing?

ChatGPT is prudish

ChatGPT is likely to be used by young people, and so I thought about health issues that might be of particular importance to the younger generation, such as sexual health. I asked ChatGPT to diagnose pain when passing urine and a discharge from the male genitalia after unprotected sexual intercourse. I was intrigued to see that I received no response.

It was as if ChatGPT blushed in some coy computerised way. Removing mentions of sexual intercourse resulted in ChatGPT giving a differential diagnosis that included [gonorrhoea](#), which was the condition I had in mind. However, just as in the real world a failure to be open about sexual health has [harmful outcomes](#), so it is in the world of AI.

Is our virtual doctor ready to see us yet? Not quite. We need to put more knowledge into it, learn to communicate with it and, finally, get it to overcome its [prudishness when discussing problems](#) we don't want our families to know about.

Source: *The Conversation*, 27 April 2023. <https://theconversation.com/how-good-is-chatgpt-at-diagnosing-disease-a-doctor-puts-it-through-its-paces-203281>.

Five steps in 15 minutes: This plastic sheet and pouch can stop thousands of women from dying after giving birth

Zano Kunene *for Bhekisisa*

Scientists have found that a plastic sheet with a funnel-like pouch attached to the bottom edge can, along with a few other steps, cut life-threatening bleeding after vaginal births in hospitals by 60%. This is according to a study presented at the [International Maternal Newborn Health Conference](#) held in Cape Town last week. The research was also [published](#) in the *New England Medical Journal*.

The piece of plastic, which researchers call a “drape”, is slid in underneath the patient and tied around her waist after she’s given birth. It collects blood in a pouch that hangs off the bottom end of the hospital bed – and it costs less than ZAR30.

In SA, [one of the most common causes of women dying as a result of pregnancy](#) is excessive bleeding. If someone loses more than half a litre of blood in the first 24 hours after giving birth vaginally, it is called [postpartum haemorrhage](#).

Often, people die because health workers don’t notice soon enough how much blood the new mother has lost, the study’s authors explained in a [press release](#).

But their simple, three-part solution could prevent 22 000 people from bleeding to death from childbirth each year, according to estimates shared at the conference.

The study was conducted in 78 hospitals across SA, Kenya, Nigeria and Tanzania between August 2021 and the end of 2022, with 14 of the hospitals being in SA. Facilities could only be part of the study if they handled between 1 000 and 5 000 vaginal births each year.

Sue Fawcus, a gynaecology professor at the University of Cape Town and who led the local arm of the study, says SA could easily roll out this monitoring method at state hospitals.

The first step is to set up the “drape”. Drapes have [previously been tested](#) as well, for instance, in India, but in this study, using a pouch with markings to show how much blood somebody has lost meant a health worker could act before it’s too late.

If a nurse or midwife sees that the new mother has lost 300 mL of blood in the first hour after having given birth – so, 200 mL *before* postpartum haemorrhage sets in – they can start the second part of the solution.

This is to check whether the patient’s blood pressure or heart rate is also dropping.

If so, step three kicks in. A health worker should then do [five things](#) the WHO says to help to stop dangerous bleeding after childbirth.

These include: giving the patient a minute-long uterus massage (or a massage until the uterus contracts); administering a medicine that causes contractions (which, in turn, cuts blood supply to the uterus and slows bleeding) or giving the patient a drug used to stop heavy bleeding, putting them on a drip; and finally, checking for blood clots or tears in or around the person’s vagina.

Step three has to happen within 15 minutes of somebody losing 300 mL of blood, the researchers explained at the conference – and the actions have to occur in order, one after the other.

This is different from [how follow-up care after childbirth usually goes](#), as a nurse or a midwife would wait a while before doing the next thing on the list to see if their actions have made any difference.

The quicker health workers step in when someone starts to bleed, the better the patient’s chance of surviving, explained Arri Coomarasamy, co-author of the study and professor of gynaecology at the University of Birmingham at a media briefing.

The study’s results could lead to a change in the WHO’s recommendations, but it might take a few months for the global health body to consider the new evidence, said Olufemi Oladapo, who heads up the WHO team looking at birthing mothers’ health.

SA’s [maternity treatment guidelines](#) already include the WHO’s list of five things to deal with postpartum haemorrhage, although doctors and midwives usually do them one by one and wait a while between steps. This also meant that the medicines needed for the study were already in stock at state pharmacies.

How did the study work?

It was a [randomised control trial](#), which researchers say is the best way to see how well a medicine or action works because the investigators try hard to eliminate any factors that may skew the results.

They do this by splitting the study participants into two groups, which have the same characteristics. But the treatment being investigated is given only to one group.

In this after-birth bleeding study, it was the hospital that was assigned to either of the groups, rather than patients. Hospitals included in the treatment group all got drapes with volume markings to use during vaginal births. Maternity-ward staff were also trained on how to do the five actions in the WHO’s recommended list.

The “placebo” group – that is, the hospitals that did not offer the treatment being investigated – used drapes without volume markings, and midwives or nurses didn’t get any training on following the list of WHO actions. Other than this, patients at these facilities got the usual care that birthing women could expect at that hospital.

How well did the three-part plan work?

The volume-marked drapes and doing the list of five things to stop bleeding as one set saved lives, the research shows, because it helped health workers to catch instances of dangerous blood loss early. This meant that they could do something to help in time.

In the hospitals where the new plan was followed, excessive bleeding was noticed in time in 90% of the patients, whereas it was picked up soon enough only in half of the patients in hospitals where the usual approach was still followed.

The success comes down to the volume markings taking the guesswork out of knowing how much blood a patient has lost, explains Coomarasamy, and this is why health workers could respond fast enough.

What does this mean for SA?

The marked drapes used in the trial were made in India and cost just ZAR26 each, the authors explained at the conference. Fawcus says they are considering approaching the health department to investigate local suppliers and making the trial’s interventions part of SA’s national guidelines for maternal health.

Until then, the 14 hospitals here that took part in the study will keep getting drapes with volume markings for another year.

Source: Bhekisisa, 15 May 2023. <https://bhekisisa.org/health-news-south-africa/2023-05-15-5-steps-in-15-minutes-this-plastic-sheet-and-pouch-can-stop-thousands-of-women-from-dying-after-giving-birth/>.



Make sure to pay your HPCSA annual fee

Karlien Pienaar, administrator, SAMA Legal Department

In the past couple of months, we have been inundated with queries from our members regarding their HPCSA annual fee payments, as well as from doctors who have been suspended for non-payment or underpayment of fees. Here, we provide the relevant information to take note of and to bear in mind to avoid being suspended.

Practitioners are required to be registered with the statutory council, i.e. the HPCSA, to practise their profession. The HPCSA does not consider it their responsibility to remind practitioners that their annual fees are due, and places the onus on the doctor to ensure that the correct amount is paid by 1 April annually, to remain registered.

Fees payable

On 13 February 2023, the HPCSA published the annual fees payable in the Government Gazette. The fees are as follows:

Medical practitioner: ZAR3 116.00

Medical practitioner (specialist): ZAR3 159.00

Please note that this is not relevant for practitioners registering for the first time with the council, in terms of the Health Professions Act No. 56 of 1974.

Practitioners were advised by the HPCSA to wait for an invoice with the appropriate amount payable and then, as far as possible, effect the payment via the online portal. In many instances, doctors have a credit available on their account, mainly due to overpayment (payment made in 2022 prior to the reduction of the annual fee) or double payment (payment made by 1 April 2022, only to learn that the government would be implementing PERSAL deductions, which took place only in July 2022).

Please ensure that the correct amount is paid via the online portal, to the correct banking details of the HPCSA, using your medical practice number as a reference. Practitioners should be able to download the registration card as soon as the HPCSA have processed the payment.

If a practitioner is struggling to access the online portal or to obtain a statement or invoice from the HPCSA, please contact our offices for assistance, as SAMA can lessen that

burden for its members by communicating with the HPCSA on a doctor's behalf.

PERSAL deductions

In 2019, a resolution was reached between the Department of Health (employer) and the unions in the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) that the payment of annual fees be made via PERSAL deduction, although not all the provincial departments of health have acted on this agreement yet.

It is therefore advised that all public health employees liaise with their respective human resources offices to ascertain whether the relevant provincial health department will be implementing the PERSAL deductions this year prior to paying their HPCSA annual fees. According to the HPCSA, the PERSAL deduction process may take up to the end of July 2023 to be finalised. This would avoid any double payments of the annual fee, as the process to be refunded can take up to 6 months, if not longer.

The HPCSA should send a reminder that the annual fee is still outstanding. However, each practitioner remains responsible for ensuring that outstanding fees are paid, and can confirm via the online portal that the annual fee had been allocated to his/her online account, to remain registered and avoid being suspended from the register.

Suspension from the HPCSA register

Practitioners who have been suspended due to non-payment or under-payment of the HPCSA annual fee are liable to pay the relevant penalties for restoration, in terms of section 19 of Board Notice 398 of the Health Professions Act, which stipulates as follows:

"(a) The restoration fee payable by a health practitioner if he or she applies for the restoration of his or her name to a register, from which it was removed under section 19(1) (b) or (d) of the Act, or from which it was suspended under section 19A of the Act –

- (i) within a period of SIX MONTHS after the date on which it was removed, shall be equivalent to TWO (2) TIMES THE APPLICABLE ANNUAL FEE for the current year, plus the OUTSTANDING FEE or fees;
- (ii) AFTER a period of SIX MONTHS BUT WITHIN 12 MONTHS, shall be equivalent to FOUR (4) TIMES THE APPLICABLE ANNUAL FEE for the current year, plus the outstanding fee or fees; and
- (iii) AFTER a period of MORE THAN 12 MONTHS had expired since the erasure date, shall be equivalent to FIVE (5) TIMES THE APPLICABLE ANNUAL FEE for the current year plus the outstanding fee or fees."

The proof of payment together with form 18 (restoration form) should reach the HPCSA as soon as possible to avoid any unnecessary increases of the penalties payable to be restored.

Exemptions and voluntary erasure

Practitioners who turn 71 years old before 1 April of the particular year will be exempt from paying the HPCSA annual fee. These practitioners may remain registered with the HPCSA and will be required to keep up their CPD points.

Voluntary erasure may be requested in terms of section 19(1)(c) of the Health Professions Act by submitting a written application before 31 March of the particular year by practitioners who turn 71 years old before 1 April.

Should a practitioner wish to submit for voluntary erasure due to ill health, a medical reported issued by a registered medical practitioner should accompany the application.

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

Sources: HPCSA website; Health Professions Act No. 56 of 1974.

Is it acceptable for a medical practitioner to treat family members and friends?

Avanya Dhanuk, *MacRobert Attorneys*

Many medical professionals are approached by family members and friends for medical advice, consultations and treatment. This situation probably arises because the medical professionals are known to them, so the family members or friends may feel more comfortable or expect a certain degree of special treatment and prompt care. This also means that the practitioner takes on the role of a family member or friend as well as the professional practitioner role, creating a dual relationship. The question is, however, whether it is acceptable for a family member or friend to be a patient, and the implications thereof.

Benefits to the patient

Patient autonomy dictates that competent adults have the right to make informed decisions about their own medical care. This includes the right to choose a particular medical practitioner for service, provided that such choice is not contrary to the ethical standards applicable to the medical practitioner. This means that a patient is entitled to choose a practitioner even though that person is a family member or friend.

It can also be beneficial for medical professionals to treat family members or friends, as there is already familiarity and the medical professional is a trusted confidant. The consultation and consent-taking process may also be easier considering that in all likelihood the patient's background is already known to some degree. Another factor is a possible reduction in medical costs, which is beneficial to patients.

The disadvantages that can arise

There are also a number of disadvantages that can arise from the nature of this dual relationship. The medical practitioner will no doubt be invested in the relationship over and above his or her professional role. This is not necessarily a problem unless such investment compromises the practitioner's professional and clinical judgement.

Medical practitioners have to respect the right of patients to be fully involved in decisions about their treatment and the right of patients to refuse treatment or to

seek a second opinion without prejudicing their future treatment. These rights may be transgressed if the practitioner chooses not to afford family members or friends the same respect as they would another patient.

Another factor to consider is that family members or friends may withhold certain confidential medical information, and this is not conducive to the doctor-patient relationship.

Medical practitioners also need to exercise caution in protecting all personal and confidential information acquired in the course of their professional duties, including information about family members and friends. This will also apply if family members or friends who are patients disclose confidential medical information outside of the professional setting, such as at a gathering, as this could be in transgression of the rules and guidelines on confidentiality.

Record-keeping

Medical practitioners need to ensure proper record-keeping, to the same extent as they would for any other patient, in accordance with the HPCSA guidelines. The records must show that the practitioner acted in accordance with ethical practice, and must justify any assessment, investigation or treatment. These records could also assist the practitioner to defend a decision made during his or her treatment of the family member or friend, should it be questioned at a later stage.

What if there is an adverse outcome?

Should the treatment or diagnosis result in an adverse outcome, the family member or friend has the right to act against the practitioner in the same way that (s)he would if the practitioner was not a family member or friend. This includes lodging a formal complaint to the HPCSA or instituting a civil claim. This can impact both personal and professional relationships negatively.

Immediate family members and intimate friends

It is important to draw a distinction between a practitioner's immediate family members or intimate friends, and more distant family



members or friends. With the former, it is generally recognised that there is too great a danger of subjectivity, whereas with the latter, treatment may be deemed more acceptable.

A practitioner's children, spouse or parents are all examples of close relatives. In all likelihood, the doctor is emotionally invested, and this is likely to impact his or her objectivity and cloud his or her judgement. Another consideration is that the immediate family member or intimate friend might feel reluctant to disclose the full particulars of their problem or to receive examinations that are sensitive or intimate in nature. The immediate family member or close friend may even feel obliged to comply with the instructions of the doctor despite feeling uncomfortable in the situation. The consent process may also be unbalanced as the practitioner might be inclined to force his or her opinion onto the patient, and this affects a patient's right to make a personal healthcare decision.

When a practitioner chooses to treat an immediate family member or a close friend, especially if this is on a regular basis, then the practitioner needs to ensure that this is not deemed unethical practice. This is because it may be considered unfair financial gain where the immediate family member's medical aid scheme is constantly being billed, even if only for materials or dispensary medication.

Despite the aforementioned, it may be acceptable or even necessary to treat a close family member or friend in emergency

situations. However, as far as possible, a doctor should attempt to refer the person requiring emergency assistance to a colleague.

What is the current position in SA on this topic?

Currently, there is no law that prohibits a medical practitioner from treating his or her family members or friends. There is also no mention of this in the current HPCSA Ethical Guidelines for Good Practice in the Health Care Professions.

The last available guideline on the treatment of immediate family members was when the Medical and Dental Professions Board resolved in October 2007 at a board meeting that it was permissible for a practitioner to treat his or her immediate dependants. It was not, however, permissible for a practitioner to render accounts for services rendered to such dependants, except in the case of laboratory fees and material for which it would be permissible to render an account. It was further mentioned that the expression "material" could be interpreted to include "dispensing of pharmaceuticals". The aforesaid guideline was never amended or addressed further in the new guidelines or rules.

It is important to note that the above guideline only referred to "immediate family members" meaning dependents of the practitioner, and not to other family members

or friends. There is therefore not much guidance in SA on this topic.

The American Medical Association adopts the view that generally, practitioners should not treat members of their families, as their professional objectivity may be compromised.

The General Medical Council of the UK advises that, wherever possible, practitioners should avoid providing medical care to anyone with whom they have a close personal relationship. There is no prohibition, and the guideline is in place to ensure that practitioners are wary of the potential risks involved. However, the General Medical Council ethical guidance makes specific mention of prescribing any medicine to someone close to the practitioner. The ethical guideline requires a practitioner to make a clear record of such a prescription, mention the relationship and include the reason why it was necessary to prescribe. The ethical guideline also forbids the prescribing of controlled drugs to someone close except in an emergency.

Conclusion

As there is no law prohibiting the treatment of family members or friends, and no updated guidance from the HPCSA, it appears that a practitioner may treat a family member (immediate or not) or a friend, and also charge

a fee for rendering such professional service. It is, however, important to consider the ethical rules of the HPCSA, and ensure that the dual relationship will not result in the transgression of either ethical rules or patient autonomy. This will be difficult in practice, as there is a risk of a lack of objectivity, especially in a situation where the practitioner intends to treat an immediate family member (spouse/parent/child).

A practitioner needs to assess each situation individually, and also consider whether his or her objectivity will be compromised in any way. My view is that it is advisable to refrain from having family members or friends as patients, and only to assist in emergency circumstances. If a practitioner chooses to treat a family member or friend, (s)he needs to be able to defend his or her decisions and prove objectivity should his or her actions be brought to the attention of the HPCSA. Any complaint will be considered on a case-by-case basis, but could be frowned upon.

In conclusion, while it is legally acceptable to treat someone close to you, this can be fraught with difficulties and be questionable ethically. A practitioner needs to ensure that professional care is optimal and in the best interests of the patient. If a practitioner has any concerns about this issue, it is advisable to contact his or her medical defence organisation for advice.

Deductions from employees' salary – what is allowed and what isn't

Laetitia Wolfswinkel, *labour law advisor, SAMA Legal Affairs Department*

The Basic Conditions of Employment Act No. 75 of 1997 (BCEA), at section 34, states that an employer may not make deductions from an employee's salary unless:

- the employee agrees in writing to the deduction in respect of a debt specified in the agreement; or
- the deduction is required or permitted in terms of a law, collective agreement, court order or arbitration award.

Lawful deductions would include statutory deductions such as Unemployment Insurance Fund (UIF), Pay As You Earn (PAYE) and Workmen's Compensation. Furthermore, the employer may deduct personal or study loans, union subscriptions, deductions in terms of a garnishee order, recovering of overpayments,

personal or study loans or even payments for loss or damage in instances where the employee has agreed to the value of the loss or damage. Apart from deductions relating to UIF, PAYE and Workmen's Compensation, the employer needs to obtain consent from the employee in order to make deductions from his or her remuneration. It should, however, be noted that according to the BCEA, the deduction may not exceed 25% of the employee's remuneration.

What happens in instances where an employee takes sick leave and does not furnish the employer with a medical certificate to substantiate his or her absence, as is required by section 23 of the BCEA? Or a situation where an employee does not report for duty and does not have a reason for the unauthorised absence? The employer may deduct the said

days from the employee's leave complement, if the employee has leave to his or her credit.

The perception seems to be that an employer may not make deductions from an employee's salary if (s)he does not have leave days that can be deducted in lieu of the absence. Or, rather, that such deductions may only be made with the employee's consent. That is not true, and the employer would be entitled to deduct the days from the employee's salary, or in other words, grant the employee unpaid leave. Such deductions are not punitive in nature, and by electing to deduct or grant unpaid leave, the employer would be well within the law. Should an employee make a habit of being absent without authorisation, the employer may even issue a warning or take disciplinary action against the employee.

Successful defence of a brachial plexus injury claim

Louise Morgan, litigation solicitor at Medical Protection Society

Dr M, a specialist anaesthetist and Medical Protection Society (MPS) member, contacted us for assistance in respect of a claim being brought against him for alleged clinical negligence relating to his management of a patient, Mrs D, during a cholecystectomy operation. Mrs D complained that under anaesthesia she had suffered from a brachial plexus injury, which had caused her to suffer a permanent injury to her dominant hand.

Dr M was served with a formal letter of claim. The case was investigated by the MPS legal team, and independent expert evidence was obtained. A letter of response was served on behalf of Dr M, denying the allegations in full.

Mrs D did not accept the denial of the allegations. At this stage, the case was transferred to the MPS specialist litigation team.

The case

Mrs D had a history of symptomatic gallstones. She had consulted with a specialist colleague of Dr M's and had decided to proceed with elective cholecystectomy. Dr M was the specialist anaesthetist responsible for the anaesthetic care of Mrs D during the procedure.

Mrs D had obesity but was otherwise considered sufficiently fit to undergo the operation. Dr M administered anaesthesia, and Mrs D was then handled for the purposes of the transfer into theatre by several theatre staff, all of whom were experienced with appropriate manual handling for a patient under anaesthesia.

The operation was uneventful, but on waking, Mrs D complained that she had altered feeling and tone or power to her right arm. Dr M attended Mrs D and considered that the altered feeling would resolve with time. Dr M arranged to review Mrs D later the same day.

After this discussion, Mrs D was attended by nursing staff and it was recorded that she was able to squeeze lightly, but she was complaining of breathlessness. An hour later, Mrs D reported that the feeling was returning, but was then not able to squeeze the nurse's hand and her arm was noted to be slightly discoloured. A few hours later, Mrs D reported improvement in feeling, but that she was not able to now use her hand. By the evening



her sensation and feeling were reported to nurses to be returning slowly. Mrs D was duly discharged as she was improving the following morning.

A day after her discharge, Mrs D attended her GP complaining of continued arm weakness. The next day, Mrs D attended the emergency department complaining of back pain and general breathlessness as well as a continued problem with her arm. Mrs D continued to complain of altered sensation and an inability to use her arm, such that a neurology review was arranged. Mrs D's reflexes were normal and neurophysiology studies did not reveal any evidence of significant injury to the brachial plexus or cervical nerve roots. MRI also did not reveal any abnormality of the spinal cord, and no brachial plexus oedema or traction diverticulum was noted.

Mrs D continued to complain of paralysis and loss of use of her arm. Over time she reported new symptoms, including that she had started to limp. Mrs D's treating specialists thought that she may have had a minor cerebral infarct, but that she had probable overlay in relation to her symptoms. Mrs D's limp resolved after a specialist neurologist told her that there was no known cause for the symptom.

The claim

Mrs D pursued a claim against Dr M, alleging that she had suffered a brachial plexus injury

that had been caused during the operation. Mrs D alleged that the injury had been caused by Dr M, either by using excessive traction or failing to exercise due care when moving Mrs D from the trolley to the operating table and vice versa, or by permitting Mrs D's arm to assume an inappropriate position or by failing to support Mrs D's arm during the surgery.

MPS's defence team conducted a thorough review of Mrs D's medical records and noted that she had a long history of unexplained medical symptoms, which had started during childhood and which included orthopaedic injuries, deafness and post-obstetric injury.

Breach of duty was denied on behalf of Dr M. Mrs D had been handled by at least three theatre staff using appropriate procedures during transfer and there was no evidence that excessive traction had been applied by any member of theatre staff. Dr M's evidence was that Mrs D's arm had been appropriately positioned and properly supported throughout the operation.

There was no evidence from any treating clinician that Mrs D had, in fact, suffered any brachial plexus injury, with MRI and neurophysiological testing being normal. It was denied that Mrs D had sustained a brachial plexus injury as alleged.

Outcome

Dr M's legal team maintained that there had been no breach of duty of care and that Mrs D had not suffered any injury as

a result of any action on the part of Dr M. Mrs D pressed forward with the case, which was set to proceed to a trial when Mrs D's legal team requested a meeting be held to discuss possible resolution of the claim. This was agreed before trial. We made it very clear to Mrs D's legal team that the purpose of the meeting was only to see if the issues in dispute could be narrowed in advance of the trial, as settlement of the claim was not indicated on behalf of Dr M.

Dr M's legal team attended the meeting and maintained their defence of Dr M,

refusing an invitation to settle the claim. At the conclusion of the meeting, Dr M's team confirmed to Mrs D's legal team that they were confident that Dr M would succeed at trial. Two weeks later and just over 3 weeks before the trial, Mrs D discontinued her claim against Dr M.

Commentary

Dr M was a very caring and careful practitioner. In the immediate aftermath of the operation, when faced with Mrs D's unusual complaints, he had made sure to

visit her frequently during her stay in the hospital to check on her progress, and referred her for a neurological review.

The presentation of the legal claim therefore caused some anxiety. Nevertheless, Dr M was fully engaged throughout the process, and ultimately was successful in his defence of the claim. This case shows how important it is to undertake a thorough investigation of claims, including looking into a claimant's previous history, as this may be relevant to a full picture being obtained.

The procedural fairness of a dismissal

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

As an employed doctor, it is important for members to be aware of procedural rights with regard to dismissals. Procedural fairness involves an inquiry that has to be held, and in such be compliant with the *audi alterum partem* (to hear the other side) rule. The aim of this article is to provide a brief overview of these rights with reference to legislation and applicable case law.

Procedural fairness requirements are set out in schedule 8 of the Labour Relations Act No. 66 of 1995. Item 4 in schedule 8 prescribes the following:

- The employer should notify the employee of the allegations using a form and language that the employee can reasonably understand.
- The employee should be allowed the opportunity to state a case in response to the allegations.

- The employee should be entitled to a reasonable time to prepare the response.
- The employee has a right to be represented by a trade union representative or fellow employee.
- After the inquiry, the employer should communicate the decision taken, and preferably furnish the employee with written notification of that decision.
- The employee should be informed of his/her right to an appeal.

Section 188(1) of the Act stipulates that a dismissal is unfair if not in accordance with a fair procedure.

In a recent matter, SAMA's legal department referred an unfair dismissal dispute to the Public Health and Social Development Sectoral Bargaining Council, in which case a member was deprived from the above rights, challenging the procedural

fairness of the dismissal. The arbitrator, however, concluded that the factors to consider determining substantive and procedural fairness are intertwined, and ruled in favour of the employer. Not agreeing with the ruling, SAMA, on behalf of its member, applied to the Labour Court to have the arbitrator's ruling reviewed and set aside. The Labour Court ruled in favour of SAMA and its member, concluding that the arbitrator misconceived the inquiry in deciding whether the dismissal of the member was procedurally fair, and awarded compensation in an amount equivalent to 3 months' salary.

Conclusion

In summary, employed doctors have several procedural rights when it comes to dismissals, and are urged to reach out to SAMA should they be subjected to any adverse actions on the part of the employer.

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.



More than 80% joined SAMA

Free State branch hosted a very successful and well-attended intern orientation event at the National District Hospital in Bloemfontein on 5 April 2023.

Prof. Dirk Hagemeister, SAMA Free State branch treasurer and national Board of Directors member, opened and welcomed everyone. Dr Benjamin de Bruin, Free State branch honorary secretary, delivered a presentation on SAMA member benefits and spoke about the importance of joining SAMA. Mr Johan Crous and Mr Cornè Nel, financial advisors from Efficient Wealth and PPS, enlightened the intern doctors on financial wellbeing and services offered to medical professionals.

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



Dr Benjamin de Bruin (SAMA FS honorary branch secretary), Mr Johan Crous (Efficient Wealth), Mr Cornè Nel (manager of PPS), Dr Maresa van Lill (family physician consultant) and Prof. Dirk Hagemeister (SAMA FSB treasurer and national Board of Directors)

Successful CPD symposium sparks debate

The Griqualand West branch hosted a CPD symposium on Saturday 15 April 2023 at the Kuruman Hospital. The topics discussed at the symposium, presented by Dr Mbesi Ngundu (SAMA GWB chairperson since 2017), were "Latest updates on the management of diabetes mellitus", "Drunk but never touched alcohol. What could it be?" and "The doctor and the law in SA".

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

- Diploma in Public Health from MEDUNSA (SA)
- Certificate in HIV management from FPD (SA)
- Certificate in Advanced Course in Diabetes Care for Health Professionals from CDE (Centre for Diabetes and Endocrinology), SA
- Master in Public Health (MPH) from MEDUNSA (SA)
- Master of Medicine in Family Medicine (MMed Fam Med) from University of Pretoria

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



Dr Guy Loledu (clinical manager at Kuruman Hospital, Kuruman), Mr Christiaan Engelbrecht (financial advisor at PSG), Ms Mariska Adam (manager at PSG), Dr Mbesi Ngundu (SAMA Griqualand West branch chairperson), Mr Claude Strauss (financial advisor, PSG) and Mr Jaco van der Sandt (manager at PPS)

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

Dr Ngundu has particular interest in research, diabetes management, HIV/AIDS and drug-resistant TB. He is a member of the PHREC (Provincial Health Research and Ethics Committee) and PCR (Provincial Clinical Review) committee dealing with drug-resistant TB and HIV complicated cases. Dr Ngundu is also a master trainer in ESMOE (essential steps in the management of obstetric emergencies)

and CPR for Professionals under the RCSA (Resuscitation Council of Southern Africa).

He was also the co-principal investigator in published research on "Factors contributing to the emergence of drug-resistant tuberculosis in the Northern Cape".

Dr Ngundu is running dedicated diabetes clinics in the Frances Baard Health District in Connie Vorster Memorial District Hospital, Jan Kemp Dorp CHC and Ritchie Clinic, hence the interest in discussing diabetes management in resource-limited settings.

The very informative symposium was well attended, and the excellent presentations sparked much discussion.

Handing out information packs to students

Free State branch hosted a very successful and well-attended student event at the Faculty of Health Sciences at the University of the Free State in Bloemfontein on 4 May 2023. Information was exchanged by handing out a branch information pack and SAMA-branded items to the students.

A total of 42 new members signed up with SAMA.



Medical Students at the University of the Free State

Putting the Lowveld branch on the map

Lowveld Branch administrator, Karen Potgieter, has been putting the branch on the map! In April, Karen met Lizwe Mkhumane, son of the late Dr Mkhumane who was murdered about 7 years ago. Lizwe is part of the Benevolent Fund supported by SAMA, and has been doing extremely well at the national athletics championship. "He has more medals than I have rands in my bank account," says Karen, "something to be very proud of."

The branch partners with MedEvents on all CPD events in the Lowveld, and assists doctors by offering 50% discounts or obtaining sponsorship in order to reduce costs for members. Recently, the

branch supported a MedConnect paediatric surgery skills event at the Rob Ferreira Hospital and Kiaat Hospital theatre. Two branch members, Dr Veronique van der Linde and Dr Nombuso Nkosi, signed up, and strongly recommend that other doctors participate in the Lowveld branch-training schedule for the rest of the year. The event also provided a platform for SAMA to network, recruit new members, update records and assist members in the area.

Vice chairperson Dr Bongi Baloi and other SAMA members also supported a Busamed art and culture evening on 22 April to increase the SAMA presence in the area and to show support.



At the surgical skills CPD event – Dr van der Linde and Dr Nkosi are in the middle of the front row



Karen Potgieter and Lizwe Mkhumane



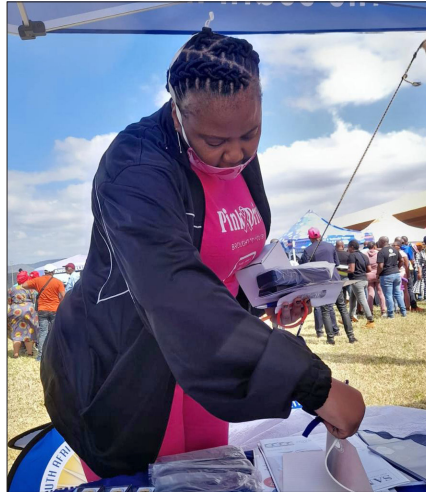
Vice chairperson Dr Bongi Baloi attended the art and culture evening

Promoting SAMA in Limpopo

Limpopo branch recently attended a cancer awareness drive at Mokopane Stadium, attended by University of Limpopo medical students, to promote SAMA, recruit new members, encourage students to become doctors and promote cancer testing. Branch chairperson Dr Daniel Mokumo and JUDASA chairperson Dr Johannes Matsobane Molomo attended the event.



Dr Daniel Mokumo (second from left), SAMA Limpopo chairperson, explains to other doctors what SAMA does



Dr Rosey Mamagale signs up as a SAMA member



Dr Johannes Molomo (left), JUDASA chairperson, at the stadium

Discussing sepsis at CPD meeting

The Free State Northern Division branch hosted a successful CPD meeting on Wednesday 12 April 2023 at the Country Club Golf Course in Kroonstad. The topics discussed at the meeting, presented by Dr Coenraad Brink, were on sepsis.

Dr Brink graduated from the University of Pretoria in 1965, and went on to qualify as a specialist general surgeon in 1979. He is currently practicing as a general surgeon in Kroonstad. Dr Brink has been a member of SAMA since 1973, and served on the Free State branch council for 21 years, being president in 1985. Alongside a number of colleagues, he is a member of the Association of Surgeons of SA (ASSA) and a member of the Trauma Society of SA. He has published 12 articles in the *South African Medical Journal (SAMJ)* and is a rural member of the medical library of the University of Pretoria.

The meeting was well attended with excellent presentations, and was a very informative session.



Dr Coenraad Brink (SAMA FSB Northern Division branch chairperson) presenting to the delegates at the CPD meeting



Welcome to SAMA

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

Cape Western branch

Monya Bianca Pelsier
Carina Leonora Lategan
Aqeelah Wentzel

Eastern Highveld branch

Siphehile Brainwell Hadebe

Free State branch

Caro Louw
Joshua Boanerges Lusamba Kiluba
Palesa Nyakallo Mohale
Nepo Ketso
Santhani Rungan
Mabonang Edith Rametse
Mayanda Tshisulu
Rethabile Safiya Clarke
Sehrish Gite
Boingotlo Charles Gaserotse
Rethabile Bogatsu
Jana van Niekerk
Frederick Rapudi
Lefu Edward Seeta
Shanice Sewnarain
Luphelo Stokwe
Janita Jane Jacobs
Karabelo Hope Makale
Piet Mamogwaepe Makgobathe
Lebohang Bolae
Tema Letsatsi
Maelane Lovey Maelane
Zandile Moreen Kumalo
Koketso Manchidi
Sam Tengané Marilele

Tsholofelo Joy Molefe
Karabo Michelle Mofokeng
Seitlheko Paul Bolibe
Mbalenhle Malindi
Rivoningo Phil Mabuza
Moeketse Mokowe
Kgabiso Kitso Warona Kaitshane
Vhazwothe Munzhelele
Keamogetse Motadi
Refilwe Mbele
Sinothile Zamaswazi Mngomezulu
Busiswa Stofile
Michael Matthew Maya Chilinkhwombe
Tshepang Batholomeo Modise
Lebogang Mariam Sethomla
Ilias Pendo Masinde
Paul Monyeki
Masehloho Palesa Moletsane
Fokotheo Semallane
Daniella Nkashama

Gauteng branch

Rebecca Groome

Gauteng North branch

Thabiso Moletse Malefahlo
Lekgetho Lekgetho
Raghav Bharat Lodhia
Morongwa Jacinda Thindisa
Ivan Corneis Moller

Goldfields branch

Musawenkosi Nkanyiso Mthembu

Griqualand West branch

Tebogo Ephraim Keaeletsa
Charles Obakeng Molusi
Tshitenge Raphael Tshibwabwa
Maytho Lerato Leburu
Omphile Gwendoline Segano
Thandiwe Patricia Difolokwe
Ruta Philadelphia Montshiwa

KZN Coastal branch

Sandile Elphas Khoza
Yonela Tuswa
Ruari Newton Baker
Asthira Ramsakkan
Keshav Moethilalh
Nkosikhona Majozi

KZN Midlands branch

Luné Smith

Limpopo branch

Sello James Mengwai
Lehutjo Lebolai Tjebane
Tokyo Nchabeleng

North West branch

Tasmina Shah
Samantha Anie
Thatoyaone Victor Madikong

Vaal River branch

Bongwa Ruth Ngobale



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