

SAMA INSIDER

JULY 2023

Highlights from the 2nd Presidential Health Summit

**South Africa's drinking
water quality has
dropped – new report**



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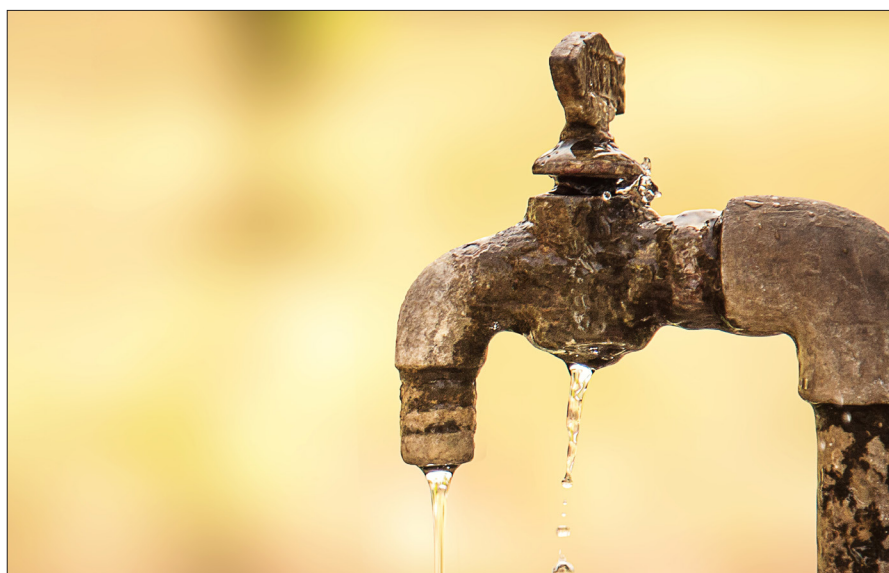
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Diane de Kock
Editor: *SAMA INSIDER*

A critical time

The past few months have been critical for healthcare in SA. How the issues are resolved will impact the futures of all healthcare workers and future patients.

In May the parliamentary committee approved the NHI Bill. "The current NHI bill in its current form sets up the healthcare system for failure at the expense of further deterioration of the health and wellbeing of all who live in the country," said SAMA in a recent press statement (page 4).

On page 5, SAMA reports back on the 2nd Presidential Health Summit. The association chaired Pillar 5 and was represented at the meeting. "SAMA intends to approach the new compact with more initiative, and plans to contribute to important interventions across various pillars, including the new pillar on pandemic preparedness."

SA scientists continue to lead the way – in a first for the African continent, researchers at UCT are using a cutting-edge technique to fast track the diagnosis of disease, ensuring patients receive the correct treatment sooner (page 8).

In an increasingly challenging financial environment, maximising your overall post-tax earnings is critical. Nqobile Ngulani (page 11) lists five effective strategies to lower your tax bill and increase your savings.

A report recently released by the SA government paints a worrying picture of the country's water resources and water infrastructure, as well as the overall quality of our drinking water. Prof. Anja du Plessis analyses the report (page 14) – "recent cholera outbreaks ... have been a warning sign that the country's water is contaminated."

One in five children globally are now zero-dose or undervaccinated, writes Prof. Hannelie Meyer (page 15). "Healthcare providers should check the Road to Health Book at every health visit, to verify that the child's immunisation schedule is up to date."

Groote Schuur Hospital recently slashed its surgical backlog by 1 500 elective surgeries, a project begun in May 2022 (page 16). Prof. Lydia Caincross, head of general surgery at the hospital, said, "In the long term, healthcare systems need to be fixed in order to address issues such as surgical backlogs ... fundamentally we need to fix the health system at a core, structural level."

A critical warning – "The health system is at a precipice," says Prof. Caincross.

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SAMA IN THE NEWS

24 May 2023: SAMA'S victory on the liquidation application

Today's judgement by the Supreme Court of Appeal (SCA) vindicating SAMA and dismissing the appeal application, with costs, by the South African Medical Association Trade Union (Trade Union) is a significant milestone for SAMA. The judgement not only dismissed the Trade Union's attempt to have SAMA liquidated, but also reaffirmed SAMA's position, and refuted the Trade Union's claims of unlawfulness by our organisation.

SAMA will continue to carry out its mandate and ensure that all its members, in the public sector and elsewhere, are adequately represented professionally as well as ethically. The association will strive for a separate and unique negotiation forum where SA health practitioners can address all matters impacting the profession. This judgement acknowledges SAMA's commitment to serving health practitioners, and instead of creating divisions within the profession, SAMA emphasises the need for unity, especially in a time when doctors face numerous challenges.

Moving forward, SAMA will continue to communicate and engage with medical doctors in both the private and public sectors. The organisation is determined to fight for the rights and interests of its members, ensuring that their voices are heard on important issues affecting the medical community. SAMA hopes that the Trade Union will redirect its efforts towards advocating for its own members instead of attempting to gain control over SAMA's assets. It is worth noting that the Trade Union has sought to distance itself from SAMA,

despite using SAMA's name and implying an affiliation.

This judgement serves as a validation of SAMA's integrity and commitment to its members. It provides a clear path for SAMA to continue its vital work of supporting and representing medical practitioners in SA. By fostering unity and focusing on the needs of its members, SAMA aims to tackle the challenges faced by the medical community and ensure the provision of quality healthcare for all South Africans.

To access and read the full judgement visit: <https://www.samedical.org/file/2034>.

26 May 2023: SAMA responds to parliamentary committee approving the NHI Bill

The National Health Insurance (NHI) Bill is at the centre of debates and concerns raised by all healthcare stakeholders, including SAMA. It has been stated many times that the implementation of the NHI Fund alone is insufficient to embody the principle of universal health coverage (UHC) as enshrined in the SA Constitution, and thus while SAMA supports the principle of UHC, it does not support the Bill in its current form. This statement is not a detailed critique of the Bill, but general comments based on recent engagements the SAMA Board has had with the NHI directorate.

The NHI Bill has been developed with disregard for the legitimate concerns and recommendations of experts, particularly on critical issues such as the introduction of contracting units for primary healthcare (CUPS), benefit packages and reimbursement

models, among others. Accordingly, there are significant concerns with regard to the provision of healthcare services to patients in the country should the Bill be taken forward.

Trust in the government's capability to manage the over ZAR500 billion budget efficiently is severely eroded, in particular given, *inter alia*, the mismanagement of COVID-19 funds. Misappropriation of funds in various state-owned entities casts doubt on government's ability to handle the healthcare budget responsibly. The public, alongside healthcare stakeholders, cannot simply entrust their lives to a government with an established history of financial mismanagement.

While UHC as envisaged in the objectives of the Bill intends to improve the health and livelihoods of the citizens of SA, the NHI Bill in its current form sets up the healthcare system for failure at the expense of further deterioration of the health and wellbeing of all who live in the country.

SAMA believes that a robust approach to health systems strengthening is indispensable, as it would rectify the current deficiencies and overcome the challenges posed by the NHI. This approach seeks to enhance the efficiency, effectiveness and resilience of the healthcare system, ensuring the delivery of optimal care to all individuals. Governance within the healthcare sector must be strengthened, with transparency and accountability at its core. Effective management of funds and meticulous budget allocation are imperative to rebuild trust and demonstrate responsible stewardship of public resources.

How to diagnose and treat cholera: A guide for health workers

Dylan Bush and Joan van Dyk, for *Bhekisisa*

- Health workers in all SA's clinics and hospitals should keep their eyes peeled for signs of cholera in their patients, according to the health department.
- Not all people with cholera will experience nausea, but any child or adult who has

watery diarrhoea could be infected and should be treated quickly.

- This short video pulls together expert tips to help doctors and nurses detect the disease. You'll also find tips for which medicines to use and which to avoid.

Watch: <https://bhekisisa.org/multimedia/videos/2023-06-06-watch-how-to-diagnose-treat-cholera-a-guide-for-health-workers/>.

Highlights from the 2nd Presidential Health Summit, 4 - 5 May 2023

Bernard Mutsago and Mhlengi Ncube, *SAMA Health Policy and Research Unit*

The second Presidential Health Summit (PHS) was held on 4 - 5 May 2023 in Johannesburg, as a follow-up to the first Presidential Health Compact, which ran from 2019 to 2023 and came to an end this year. The second summit reviewed progress and mapped a way forward to improve health service delivery. Approximately 1 500 in-person and virtual delegates attended. Members of Pillar 5 ("Quality, safety, and primary healthcare"), which was chaired by SAMA, as well as SAMA representatives from SAMA structures and the SAMA head office, attended. The 5-year progress reports for each of the nine pillars were presented. A new 10th pillar, named "Building pandemic prevention, preparedness, response, and recovery capacity", was launched at the second summit.

After the opening remarks by the Premier of Gauteng, Hon. Panyaza Lesufi, the health minister, Dr Joe Phaahla, and Ms Thulile Zondi, Prof. Shisana gave a presentation on the rationale for the 2nd PHS. According to Prof. Shisana, SA has made significant health progress in recent decades, such as the decline in HIV, TB and maternal and infant mortality. However, challenges remain – for example, the country still has one of the highest mortality rates in the world, and there is a shortage of doctors and nurses. Corruption in the health sector was described as chronic. The Health Sector Anticorruption Forum has been established to prevent and investigate corruption in the healthcare sector. Inadequate staffing in the health system has persisted in contradiction to the objectives of the African Union's New Public Order. Regarding access to medicines, the Procurement Bill, which is expected to reduce the cost of healthcare through a reduction in the costs of medicine, has yet to be passed.

Key issues and progress of pillars

Progress across the nine pillars was hampered by the COVID-19 pandemic. The following was reported by the pillars:

Pillar 1 – Human resources for health

The moratorium on new posts was lifted, a plan for the placement of interns was developed, and the human resources for health (HRH) Strategy and the HRH Plan were launched. The Framework for



the Integration of Community Healthcare Workers still needs to be revisited. SAMA has requested all the abovementioned key documents.

Pillar 2 – Access to medicines, vaccines and health products

The Health Technology Assessment (HTA) committee was put in place; the Health HTA Strategy is still being developed, while work is underway to set up an independent HTA agency, which will be established through regulations to the NHI Bill. Centralised procurement has been enabled (contracts are now managed by the National Department of Health (NDoH), not Treasury). Crucially, the backlog at the SA Health Products Regulatory Authority (SAHPRA) has been cleared, and the Procurement Bill is now in Parliament. A course at Wits University was launched to give pharmaceutical personnel a learning opportunity. The pillar proposes an earmarked budget for medication only.

Pillar 3 – Health infrastructure

Dr Terence Carter highlighted the achievements and challenges under this pillar. He said that it is essential that infrastructure in both private and public sectors meets the requirements of the Office of Health Standards Compliance (OHSC) for accreditation to supply services in the NHI.

Pillar 4 – Private sector engagement

A proposal and a plan for the training of medical specialists were put in place. A study was carried out by the Hospital Association of SA (HASA) and Business Unit SA (BUSAS) on the training of medical specialists. HASA supports the training of medical specialists in private hospitals. However,

support from the deans of medicine to enable implementation of the training has not been received. Medical schemes have developed alternative dispute resolutions and made a submission to the SA Law Reform Commission. The pursuit of nurse training through the private sector remains a key theme in this pillar. The key challenges highlighted include the lack of an effective platform for dialogue and the absence of a service level agreement to allow the NDoH to collaborate with the private sector.

Pillar 5 – Quality of care/service delivery

This pillar was led by SAMA through Dr Lindi Shange. Substantial progress was made through efforts of the NDoH and the pillar, although collaboration was lacking. 50.2% of public facilities were reported to be implementing the National Quality Improvement Plan. The OHSC and Unity Forum are working on a GP inspection tool to be extended to the public sector. All nine provinces are conducting patients' experience of care surveys. PMB review continues, and the costing report of the Preventative and Primary Healthcare Package was completed. Work on social determinants of health and medicolegal issues continues to be undertaken by SAMA and the NDoH. SAMA recommended that the NDoH needs to provide dedicated personnel for each of the identified key projects/indicators in Pillar 5, and also highlighted the need for innovations in fundraising to support pillar work. Pillar participants agreed to carry forward the current targets into the next compact, and to shift the terminology from 'patient-centredness' to 'people-centredness'. The NDoH clarified that it has no policy on complementary health services.

Pillar 6 – Public sector finance management

Positive developments include the new/revised provincial equitable share, which will be phased in over 3 years, and reduced accruals in some provinces. On the downside, concerns have been voiced regarding the very high unfunded government wage increase (ZAR35 billion) that was recently negotiated with worker organisations, and includes roughly ZAR9 billion for healthcare. It was warned that this could result in employment losses. Provincial health budgets in the Western Cape and Gauteng provinces have been labelled as unsustainable.

Pillar 7 – Strengthen governance and leadership

The National Health Commission to drive intersectoral action to address social determinants of health was proposed in 2018. SAMA has sent an inquiry into the progress and composition of the commission. A national research priority list was produced (updated annually), and in November 2022 a health research summit was held. It was proposed that

this pillar must develop and test the delivery model for the NHL.

Pillar 8 – Community engagement

A total of 511 clinics were surveyed on clinic committee functionality. One of the highlighted challenges is the rigidity of the District Health System. Some delegates suggested decentralisation of the appointment of clinic committees, currently done by the MEC, using election and not appointment, as is done in selecting school governing bodies.

Pillar 9 – Health information systems

Only 50% of public facilities are implementing identified coding systems.

Pillar 10 – “Building pandemic prevention, preparedness, response, and recovery capacity”

This is a new pillar. The government recognises the need for localised/regionalised manufacturing capabilities for pharmaceuticals, and the need for a securitised approach. The

pillar will convene a multistakeholder working group to look at key principles for Pillar 10.

SAMA has requested strategic documents that were prepared as deliverables of the Presidential Health Compact and are of importance to the medical profession.

At the summit's conclusion, the WHO and President Cyril Ramaphosa gave concluding remarks. The new compact process and timelines were outlined as follows: in May this year, the technical drafting committee for the new compact, made up of all pillar leads, will be established. The new compact will be drafted in June and July with input from pillar workshops; the compact will then be finalised in August and launched in September. The second PHS is aimed at identifying sustainable interventions that are envisaged to prepare the healthcare system for the implementation of the NHL. SAMA will continue to be the voice of the medical profession in the new presidential health compact, albeit with greater impact.

New SAMA Board members announced

SAMA Communications

Congratulations to the following new SAMA Board members:

Dr Sizeka Maweya is a registered family physician who obtained his MB ChB degree from the University of Pretoria, and later his Master of Science in clinical epidemiology. He worked as a clinical executive director of Pietersburg Hospital, and started the Department of Neurosurgery in 2014. He is a member of the SAFAIDS Board of Directors, and is a health professionals sector leader of SANAC. Dr Maweya is a consultant in the Family Medicine Department at Mankweng Hospital, and senior lecturer at the University of Limpopo. He is a National Council member of the SA Academy of Family Physicians (SAAFP) and the College of Medicine SA (CMSA) family medicine examiner for both diploma and fellowship.

Prof. Dirk Hagemeister is a principal family physician and senior lecturer at University of the Free State (UFS). He obtained his Dr.med. (nephrology) qualification from the Martin Luther University Halle-Wittenberg and a health sciences qualification from the Hamburg University of Applied Sciences in Germany. Locally, he obtained a Diploma in HIV Management, a postgraduate diploma in



Prof. Dirk Hagemeister



Dr Leon Seymore



Dr Sizeka Maweya

internal research ethics, a Diploma in Anaesthetics and a PhD in health science education from UFS. Since 2006 he has been working in clinical and academic functions across various provinces, and for the past 10 years he has been serving in his current joint appointment in the Department of Family Medicine in Bloemfontein.

Dr Leon Seymore is currently in private practice in Pretoria. He was involved in academic medicine at the Universities of Pretoria and the Free State, teaching undergraduates and

postgraduates, and conducting research field trips. Dr Seymore was involved in prison health for 4 years, and worked in a state-of-the-art primary healthcare clinic in Melbourne, Australia. Furthermore, he was a ship's physician in Antarctica, where he experienced first-hand the diseases of the Antarctic. As a night resident doctor during COVID-19, Dr Seymore learned the stressors of high-tech COVID intensive care unit work, and was also involved in designing vaccine programs for the Expanded Programme on Immunisation.

WHO calls for safe and ethical AI for health

World Health Organization

The WHO is calling for caution to be exercised in using artificial intelligence (AI)-generated large language model tools (LLMs) to protect and promote human wellbeing, human safety and autonomy, and preserve public health.

LLMs include some of the most rapidly expanding platforms such as ChatGPT, Bard, Bert and many others that imitate understanding, processing and producing human communication. Their meteoric public diffusion and growing experimental use for health-related purposes is generating significant excitement around the potential to support people's health needs.

It is imperative that the risks be examined carefully when using LLMs to improve access to health information, as a decision-support tool, or even to enhance diagnostic capacity in under-resourced settings, to protect people's health and reduce inequity.

While the WHO is enthusiastic about the appropriate use of technologies, including LLMs, to support healthcare professionals, patients, researchers and scientists, there is concern that caution that would normally be exercised for any new technology is not being exercised consistently with LLMs. This includes widespread adherence to key values of transparency, inclusion, public engagement, expert supervision and rigorous evaluation.

Precipitous adoption of untested systems could lead to errors by healthcare workers, cause harm to patients, erode trust in AI and thereby undermine (or delay) the potential long-term benefits and uses of such technologies around the world.

Concerns that call for rigorous oversight needed for the technologies to be used in safe, effective and ethical ways include:

- The data used to train AI may be biased, generating misleading or inaccurate information that could pose risks to health, equity and inclusiveness.
- LLMs generate responses that can appear authoritative and plausible to an end user; however, these responses may be completely incorrect or contain serious errors, especially for health-related responses.
- LLMs may be trained on data for which consent may not have been previously



provided for such use, and LLMs may not protect sensitive data (including health data) that a user provides to an application to generate a response.

- LLMs can be misused to generate and disseminate highly convincing disinformation in the form of text, audio or video content that is difficult for the public to differentiate from reliable health content.
- While committed to harnessing new technologies, including AI and digital health to improve human health, the WHO recommends that policy-makers ensure patient safety and protection while technology firms work to commercialise LLMs.

The WHO proposes that these concerns be addressed, and clear evidence of benefit be measured before their widespread use in routine healthcare and medicine – whether by individuals, care providers or health system administrators and policy-makers.

The WHO reiterates the importance of applying ethical principles and appropriate governance, as enumerated in [the WHO guidance on the ethics and governance of AI for health](#), when designing, developing and

The WHO reiterates the importance of applying ethical principles and appropriate governance when designing, developing and deploying AI for health

deploying AI for health. The six core principles identified by the WHO are: (i) protect autonomy; (ii) promote human wellbeing, human safety and the public interest; (iii) ensure transparency, explainability and intelligibility; (iv) foster responsibility and accountability; (v) ensure inclusiveness and equity; and (vi) promote AI that is responsive and sustainable.

Honouring a legend, Prof. Hoosen Jerry Coovadia

Nomonde Süßmann, HOD: Corporate Affairs, SAMA

SAMA's 96-year history has been peppered with some of the greatest medical experts in this country. When the annals of history are being written, there will be a name that will be associated with this organisation, and that name is Prof. Hoosen Jerry Coovadia.

A bit of history on who Prof. Coovadia is. Born in 1940 and raised by parents and grandparents who believed in education, he spent his youth at a local library where his curiosity about the English language was nurtured. He attended the medical school at the University of Natal that was meant for black people. He later completed his medical studies in India, where he and other students formed the SA Students Association (SASA).

He returned to SA after obtaining his medical degree in 1965. He specialised in paediatrics and was admitted as a fellow of the College of Paediatricians of the Colleges of Medicine of SA in 1971. His special interest in immunology resulted in him studying for an MSc in immunology from the University of Birmingham in 1974. His work was centred around KwaZulu-Natal Province, and then in 1990 he was made professor and head of paediatrics and child health at the University of KwaZulu-Natal.

Perhaps because of clinical and medical challenges that he had faced in the past, Prof. Coovadia felt the need to enter the political arena, which culminated in him being made an executive in the National Medical and Dental Association (NAMDA), a progressive group that set the precedent for the issues that SAMA is challenging today.

In the early 90s, during the dawn of the country's democracy, Prof. Coovadia returned to medicine when the National Health Policy was formulated. He was instrumental in his role as chairperson of the Maternal and Child Committee, and also chaired the commission on UN/AIDS and the International AIDS Society. He contributed a body of work in the fields of maternal health and HIV mother-to-child transmission, and co-edited a medical textbook.

He is an accomplished scholar with more than 200 articles that he either authored or co-authored, as well as a pedigree of research supervision of over 40 postgraduate students. He has received many accolades and awards both locally and abroad. Currently he is a Victor Daitz Chair in HIV/AIDS Research and a Director of Biomedical Science at the Nelson R Mandela School of Medicine, University of KwaZulu-Natal.



SAMA welcomed Prof. Coovadia during his recent visit. From left: Dr Akhtar Hoosain (SAMA board member), Prof. Hoosen Coovadia (SAMA President 2019 - 2020), Dr Mvuyisi Mzukwa (SAMA chairperson)

He headed SAMA as its president from 2019 to 2020. His leadership was significant in charting the way forward for the association leading up to the COVID-19 pandemic. His work is appreciated by SAMA, as the association believes in the importance of honouring legends while they are still alive.

SA scientists pioneer technique in Africa to speed up medical diagnoses and detect new pandemics

Tatjana Baleta

In a first for the African continent, researchers at the University of Cape Town (UCT) are using a cutting-edge technique to fast-track the diagnosis of disease, ensuring patients receive the correct treatment sooner.

Clinical microbiologists Prof. Adrian Brink and Dr Gert Marais at UCT's Faculty of Health Sciences have operationalised clinical metagenomics in SA, transforming the procedure from a complex logistical procedure to a routine test.

Clinical metagenomics fast-tracks the medical diagnostic process, cutting turnover time down – from sample to result – from



Dr Fadheela Patel, member of the UCT Med Micro sequencing team, performing DNA extraction of MGS study



Dilshaad Hendricks, lysing cells in the DNA extraction lab

weeks or even months to just a few days. It can also be used as a “sentinel surveillance tool” to spot new infectious diseases and sound an early warning alarm for future pandemics.

“This kind of technology has never been used in SA and as far as we know, the African continent. Certainly there’s no diagnostic lab in SA that does it,” says Brink. He and Marais believe they are the first to develop a clinical metagenomics service in Africa.

Clinical metagenomics is [the detailed analysis of all the genetic material \(DNA and RNA\) in samples from patients](#) – including that of the host (in this case, the patient), and of the microbes (organisms too small to be seen by the naked eye) living within the host, like bacteria, viruses and fungi.

The genetic sequences appearing in a sample are compared to a database of all known organisms, allowing any and every pathogen present within the patient to be detected at the same time from just one sample. This metagenomic approach is sometimes referred to as “agnostic sequencing”.

By contrast, conventional diagnostic testing requires testing individually for a specific suspected disease. If the result comes back negative, a new sample will need to be taken and sent for a different test – a lengthy process when lives are at stake.

“In some cases we investigated, patients had a disease that could have been treated if it had been identified initially. But because the diagnosis could only be made months later, it was too late [to save them]. That’s where the idea for our study originated,” says Marais.



Samantha Africa prepares the buffer in the 16S lab

Brink recounts the case of a cancer patient who developed neurological symptoms. “Because he was highly immunocompromised, the list of potential causes for these symptoms was a page long,” says Brink.

The patient passed away, and clinical metagenomics testing of a sample taken at the autopsy revealed he was suffering from *Aspergillus*, an aggressive fungal infection that requires specific treatment.

Although he was already very sick due to cancer, Brink says the untreated central nervous system aspergillosis may have led to the patient’s death. “If clinical metagenomics methods had been available at the time, the right therapy could have been started weeks earlier, potentially changing the outcome for this patient,” he says.

Brink and Marais used clinical metagenomics to diagnose neurological disorders and study the effects of COVID-19 on the brain. It’s an area of healthcare where a timely diagnosis is particularly important. “Once the brain is damaged, there’s no going back,” says Marais. This research is currently under review for publication and expected to be released shortly.

While metagenomics has been applied in research settings in Africa before, this is the first time the method has been fully operationalised for clinical applications on the continent – meaning that all sample processing and analysis can now be done in the same laboratory in real time.

Previously, researchers in Africa have had to send samples overseas to Europe or the USA for processing. The reason: the chemical reagents required to run clinical metagenomic

tests, despite in some instances being as easy to access in Europe as a DHL order, were not readily available in Africa.

Supported by funding from Oppenheimer Generations Research and Conservation, Brink and Marais remedied this by establishing a reagent supplier pipeline for SA, a tricky task when the pandemic had interrupted global supply chains. With a reliable source of reagents, samples can now be processed in labs in SA, opening the door for advances in medicine and research on the continent.

Marais emphasised their focus on upskilling and building capacity for Africa, in contrast to the “helicopter research” that has defined clinical metagenomic work on the continent up to this point. “Our goal was to increase the capacity for infectious disease diagnostics going forward, rather than just coming in, testing a few samples, publishing a paper and leaving,” he says.

According to Marais, most prior metagenomics work in Africa has been in the form of discrete research projects with an international collaborator, or as field work for an international lab, with little investment in local medical infrastructure and capabilities.

Their initial work so far has already created opportunities for skills transfer in genetic sequencing and bioinformatics at UCT medical school and medical research departments, and at institutes in Johannesburg.

Although the high cost of reagents and lack of standardised protocols remain challenges for a clinical metagenomics rollout in Africa, Brink and Marais are confident that the technology can become a cost-effective tool to improve patient individual care and to identify novel pathogens in low- and middle-income countries (LMICs).

Their [new paper](#), co-authored with Associate Professor Diana Hardie and published in *The Lancet Microbe* in December 2022, calls for the expanded infrastructure developed in LMICs for COVID-19 monitoring to be leveraged to improve infectious disease diagnostics through clinical metagenomics.

“We applied clinical metagenomics to the COVID-19 brain, but the picture is bigger than that,” says Brink. Clinical metagenomics can be used for diagnosing an array of diseases across many health disciplines. In collaboration with colleagues at Cape Town’s Groote Schuur Hospital, Brink and Marais are now exploring the application of the technology in orthopaedics, neurosurgery, haematology-oncology and cardiothoracic surgery.

Specifically, they’re looking at patients with prosthetic joint infections, heart valve

infections, brain tumours and leukaemia. The team welcomes collaborators and asks researchers and healthcare professionals across the continent interested in utilising clinical metagenomics to reach out to them.

Brink and Marais are also examining patients suffering from severe respiratory tract infections without a diagnosis, another area where clinical metagenomics is particularly revolutionary.

Because the genetic sequences found in patient samples are compared with a database

of all known organisms, if a sequence yields no match to the database, there's a chance it could be a novel pathogen.

Since its [first reported clinical application in 2014](#), the technology has already supported the discovery of novel viruses, including [identification of the original strain of SARS-CoV-2](#) (the virus that causes COVID-19) in Wuhan, China.

This application is particularly relevant in LMICs where novel pathogens pose a higher risk due to socioeconomic factors and a lack

of infrastructure to deal with local outbreaks. However, despite this, infectious disease surveillance infrastructure is more developed and readily available in high-income nations.

While hurdles remain to be navigated before clinical metagenomics can be widely accessible across Africa, the team is confident that technology holds real promise for advancing the continent's capabilities for medical research and diagnosis. "There aren't a lot of people doing this kind of thing [in Africa], but this is the future," says Brink.

The pulse-taking physician

Dr Chris Ellis, *family physician, South Africa*

The year is 1965 and I am a medical student on hospital rounds. The consultant informs us that there is an interesting patient with a water hammer pulse in bed number 7, and that we should take time to feel and recognise it as a sign of possible aortic valve incompetence. He then goes on to tell us of the anacrotic plateau pulse of aortic stenosis, pulsus bisferiens of aortic valve disease, pulsus alternans of heart failure and pulsus paradoxus of constrictive pericarditis, or so my notes from long ago tell me.

I never got to differentiate the different strengths, rhythms and pulsations, but I have remained an avid pulse-taker for all of my practice life. I count the rate on my wristwatch for 15 seconds or sometimes 30, and then multiply either by four or two, respectively, such is my mathematical prowess. This also allows a pause in the rush of consultations while I go about my task with due ceremony and professional skill. The patient and I silently affirm that all is well and that life will continue on its metronomic journey. Over the years, I have felt so many pulses, I can almost estimate the rate without the watch, although the habit and ritual of connection remain.

I am sure those male Arabian physicians of long ago, who were only allowed to feel the pulse of their veiled and covered female patients, were able to pick up many more subtle strengths and rhythms than we do today. In the high-tech low-touch world that medicine has adopted, the patient often finds him- or herself attached rather than touched. The masked doctor or nurse, anonymous

and self-absorbed at the end of the bed, may scrutinise the tracings on the screens and the rhythms on the echocardiographs while the patient lies unrecognised and unacknowledged in the bed.

The 4th-century Chinese philosopher Chuang-Tzu told a story about a traveller who came across an old farmer who was struggling to irrigate his fields. He was pulling up a bucket with his hands from the bottom of his well. He explained to the farmer that a machine could be installed at the top of the well that had levers, cogs and weights that would make his work much easier and irrigate his fields more efficiently. The old farmer replied, "I have heard my teacher say that whoever uses machines does all his work like a machine. He who does his work like a machine grows a heart like a machine, and he who carries the heart of a machine in his breast loses his humanity."

As a patient enters the portals of modern healthcare, a gloved hand almost automatically inserts an intravenous line while another is sticking electrodes on the chest and putting a pulse oximeter on the index finger. Unknown figures stand at the end of the bed, eyes gazing downwards, reading the tracings from the machines.

Jalal ad-Din Rumi, who was a Sufi poet and mystic living in the 13th century, wrote a poem called "The Spiritual Physician". In the poem, a sick man went to a physician and asked him to feel his pulse, saying that by doing so, the physician would diagnose the state of his heart, for the hand vein was connected to his heart:



Given that the heart is invisible
to find its symbol seek he who is
connected.
The wind is hidden from the eye
but you can see it
in the dust and the movement of
the leaves.
How is my heart without your
touch?

In our attached yet detached world, the pulse oximeter records the beating of the heart. The touch of the physician's hand, on the other hand, may also feel the movements of the leaves in the wind.

Five strategies for medical practitioners to optimise tax savings

Nqobile Ngulani, registered tax practitioner



As the 2023/2024 tax year began on 1 March 2023, many medical practitioners are seeking ways to minimise their tax obligations. With the rising cost of living, it has become crucial for medical professionals to adopt tax-savvy practices to enhance their overall post-tax earnings.

Taxes can impose on medical practitioners' income in SA. However, there are legitimate methods to reduce your tax liability to the SA Revenue Service (SARS) and retain more of your earnings. Here are five effective strategies that can help you lower your tax bill and increase your savings:

Retirement fund contributions

Contributing to a retirement fund offers you tax benefits while helping you to save for your future. According to current regulations, the retirement fund tax deduction is 27.5% of your remuneration as a medical practitioner, with a maximum deduction limit of ZAR350 000 per annum. Although you can contribute any amount to your retirement annuity, the tax deduction will be capped at the specified limit.

For instance, if your annual income is ZAR500 000 and your tax rate is around 25%, investing ZAR100 in your retirement annuity will only cost you ZAR75 out of pocket. You can claim the remaining ZAR25 from SARS.

As well as tax savings, contributing to a retirement fund provides additional advantages:

- Building up retirement capital: many retirees struggle due to insufficient funds for a

comfortable lifestyle. By saving for retirement, you can ensure financial security and peace of mind during your golden years.

- Investment growth: retirement funds are typically invested in diversified portfolios, offering the potential for higher returns compared with traditional savings accounts. Over time, this growth significantly increases the value of your retirement fund.
- Financial discipline: regular monthly contributions foster financial discipline and encourage a culture of saving throughout your working life. Developing good financial habits can also help you prepare for other long-term goals, such as home ownership or entrepreneurship.
- Protection against creditors: as per section 37A of the Pension Funds Act No. 24 of 1956, your retirement fund benefits are safeguarded and cannot be significantly reduced, transferred, or pledged to creditors.
- Benefiting dependents: in the event of your demise, your nominated beneficiaries will receive the remaining balance of your retirement fund, ensuring financial support for your family.

Considering these advantages, it is strongly recommended that you consult your financial adviser to explore tax-efficient retirement products tailored to your needs.

Leveraging tax-free savings accounts

SARS introduced tax-free investments to promote household savings. Tax-free savings accounts (TFSAs) are offered by various financial institutions, allowing you to invest your funds in a combination of financial products.

TFSAs in SA offer several benefits:

- Tax exemptions: any interest, local dividends, or capital gains earned through a TFSA are exempt from taxes, provided your contributions do not exceed the annual limit of ZAR36 000 or the lifetime limit of ZAR500 000.
- Higher interest: early investments in TFSAs tend to generate higher interest compared to later investments.
- Penalty-free withdrawals: you can withdraw funds from your TFSA before maturity without incurring penalties or additional costs.

- Flexibility: some TFSAs offer flexibility, allowing you to transfer your investment from one TFSA to another or opt out of future contributions.

Maximising medical aid contributions

SARS provides a medical schemes fees tax credit (MTC) to taxpayers who belong to registered medical schemes. This credit aims to alleviate the financial burden faced by individuals who personally cover their medical scheme contributions.

A MTC is a rebate on your tax liability to SARS. To be eligible for this credit, you must:

- be a SA taxpayer
- belong to a registered medical scheme
- pay your own medical scheme contributions.

The credit amount varies based on the number of people covered by the policy. Here are the MTC rates for the 2023/2024 tax year:

- ZAR364 per month for the main scheme member
- ZAR364 per month for the first dependant on the scheme
- ZAR264 per month for each additional dependant on the scheme.

To illustrate, suppose Mandla pays for medical aid for himself, his wife and their two children. In this case, Mandla's tax credit for the 2024 tax year will be calculated as follows:

- ZAR364 for Mandla
- ZAR364 for Mandla's wife
- (ZAR264 × 2) for his two children.

Therefore, Mandla's monthly tax liability will be reduced by ZAR1 256 (equivalent to ZAR5 072 per year).

To claim the MTC, ensure that you accurately complete your tax return, providing all necessary details of your medical scheme contributions and the number of dependents covered. SARS will calculate the credit and deduct it from your total tax liability. By claiming this credit, you can reduce your tax burden and increase your savings.

Supporting charitable causes

In SA, donations to registered public benefit organisations (PBOs) offer tax benefits.

According to the Income Tax Act No. 58 of 1962, qualified PBOs may receive partial tax exemption, and donors can deduct their contributions to PBOs engaged in specified public benefit activities.

Additionally, donations in cash or kind made to S18A-approved organisations during the assessment year may qualify for tax exemption, provided they do not exceed 10% of the donor's taxable income.

Furthermore, certain donations are exempt from SA's donations tax, including contributions to specific public benefit organisations, eligible educational institutions, scientific research bodies or funds, certain trusts, and specific bequests, legacies or dispositions for public benefit purposes.

By donating to charity, you not only support worthwhile causes but also leverage

tax exemptions and deductions, effectively reducing your overall tax liability.

Seeking professional tax advice

Finally, the most effective way to optimise your tax savings is to consult a qualified accountant or tax practitioner. A tax practitioner who understands the complexities of the SA tax system, and is an expert at taxes that are associated with the medical profession, can help you identify all available tax-saving opportunities while ensuring compliance with tax laws and regulations.

In SA, working with a registered tax practitioner is recommended for anyone in need of tax advice or assistance with tax returns. Registered tax practitioners are associated with recognised professional organisations, adhere to specific criteria and possess a tax practitioner number from SARS. By engaging their services,

individuals and businesses can have peace of mind, knowing they are receiving professional guidance and can challenge any unprofessional conduct cost-effectively.

Professional tax consultants or accountants can help you avoid costly tax mistakes, save money in the long run and provide optimal, tax-efficient remuneration strategies and employee benefit solutions. Furthermore, their expertise ensures compliance with direct taxes (such as income and business taxes, capital gains and inheritance taxes) as well as indirect taxes such as value-added tax (VAT).

In conclusion, by implementing the tax-saving strategies outlined above, SA medical practitioners can significantly reduce their tax liability and retain more of their hard-earned income. It is crucial to stay updated on the latest tax laws and regulations, and seek professional advice when necessary.

Depression and anxiety: The untold burden of cancer

SAMA Communications

With more than 30% of cancer patients diagnosed with depression, the SA Society of Psychiatrists (SASOP) called on National Cancer Survivors Day (4 June) for greater awareness of patients suffering from mental health disorders.

Cancer is the second leading cause of death globally, with an estimated one in six deaths (9.6 million). The most recent statistics available indicate that in SA, 108 168 men and women were diagnosed with cancer in 2020.

Dr Michelle King, specialist psychiatrist and member of SASOP says being diagnosed with cancer and being a survivor is a scary and emotional experience, and some people may go through a period of grief before being able to accept their diagnosis. Others may become depressed and anxious.

"Healthcare professionals may miss the diagnosis of depression and anxiety because they have a false belief that these disorders are normal when facing death. If left untreated or undiagnosed, it can impact the patient's ability to function on a daily basis, including going through treatment.

"The sudden nature in which the cancer is diagnosed, and the uncertainty associated, can trigger fear, which could

lead to depression and maladaptive anxiety. Patients may feel hopeless, despair, a sense of failure and grief as their chance of a long and healthy life is under threat. Getting through the day becomes a struggle since they must deal with treatment, symptoms and the uncertainty of their longevity.

"Pain, fatigue, loss of appetite and insomnia are common symptoms experienced by many patients diagnosed with cancer. Poorly controlled pain could lead to or worsen mental health conditions such as depression and anxiety. Those who are survivors might alternate between disheartenment, isolation and fear, to times of hopefulness when returning from a successful follow-up screening. The goal is to find a middle ground for one's mental health between treatments, remission or possible relapse."

Dr King says early referral to palliative care services can produce a significant improvement in terms of reducing suffering and prolonging the patient's life.

"Palliative care is specialised care for people living with a life-limiting illness. It focuses on providing support and helping patients, and their families, make informed decisions about their treatment. As well as providing relief from physical symptoms

and psychological and emotional distress. The team provides an extra layer of support, working closely with the patient's doctor, and is based on the needs of the patient, rather than the prognosis.

"This type of care is appropriate at any age and at any stage in a life-limiting illness, and it can be provided along with curative treatment. The goal is to improve the quality of life of the patient, and their family, by means of a multidisciplinary team. This team provides emotional support and help the patient and their family come to terms with the reality of cancer."

She says that undiagnosed depression and anxiety can impact the patient's ability to cope emotionally. These conditions may also worsen physical symptoms such as pain and fatigue, impacting quality of life, relationships and daily functioning.

Making the diagnosis of depression is challenging as there is an overlap between many of the physical symptoms caused by the medical condition with those experiencing a depressive episode.

These symptoms may include:

- loss of energy
- insomnia
- fatigue
- loss of libido

- weight change
- appetite change.

If you are experiencing these symptoms together with any of the following symptoms, please seek support:

- excessive feelings of hopelessness, guilt and worthlessness
- an ongoing depressed or dysphoric mood
- wishing for a hastened death
- suicidal thoughts or plans

- social withdrawal
- loss of pleasure in daily activities
- irritability and agitation
- anxiety
- psychotic features (delusions, paranoia) with a depressed mood.

Where to seek help

PALPRAC, the Association of Palliative Care Practitioners of SA, has a list of palliative care providers and services in your area: <https://www.palprac.org>.

In addition to working with a palliative care team, patients and/or their family members can reach out to the CANSA Help Desk, which provides counselling, support groups and peer-to-peer interaction. Contact them on 0800 22 66 22 to book an appointment, or send an email to info@cansa.org.za.

Join their support groups on social media by visiting: <https://www.facebook.com/groups/ChampionsofHope/>.

<https://www.facebook.com/groups/CANSACaregivers/>.

Celebrating 25 years of SAMA

Nileen Gale, *specialist: SAMA Marketing and Communications*

On 21 May 2023, SAMA commemorated a significant historical milestone, its 25th jubilee anniversary. Special guests came together to celebrate the occasion at an intimate brunch, which served as a valuable networking opportunity to reminisce over the past, while sharing hopes for the future.

To understand how far SAMA has come, one needs to look to the past. The history of the association dates to the 19th century, when doctors practising in the bustling towns of Cape Town, Grahamstown and Durban, to name a few, formed their own associations as branches of the British Medical Association.

It was only in 1927 that these branches amalgamated to form the national Medical Association of SA (MASA). More than seven decades would pass before the formation of SAMA would officially occur through the merger of MASA and the Progressive Doctors Group, the latter of which advocated for equitable healthcare while challenging discriminatory practices in the medical field. On 21 May 1998, the unification of these medical groups birthed the formal reconstitution of the association as we know it today.

SAMA has enjoyed a long and influential history in the healthcare sector, and pre-democracy played a critical role in addressing the inequities and discrimination prevalent in the healthcare system. It actively opposed the racist policies that resulted in disparities in healthcare provision based on race and socioeconomic standing. SAMA advocated for equal access to healthcare and worked to eliminate discriminatory practices within the medical profession.



In the early 1990s, the association focused on transforming the healthcare system to ensure greater equity and inclusivity. It played a significant role in the development of the National Health Plan, which aimed to provide universal healthcare coverage for all South Africans. Furthermore, it also engaged in discussions with the government on issues such as medical education, healthcare funding and the regulation of the medical profession.

Fast forward to 2023, where SAMA continues to serve as the voice of the medical profession, advocating for the interests of its members and promoting high standards of healthcare. It provides various services to its members and remains committed to representing the medical profession in discussions with government bodies, regulatory authorities and other stakeholders,

both locally and abroad, to shape healthcare policies and practices.

SAMA recognises the importance of bringing the organisation together through our ethos of "Uniting Doctors for the Health of the Nation". The One SAMA campaign is an opportunity to refocus and reposition the association as the voice of the entire profession. As the oldest and largest representative body for doctors in the country, our level of engagement should reflect this fact as we unite around a shared vision of universal health coverage.

Looking towards the future, SAMA will continue to be a key player in advocating for equitable healthcare, while shaping the country's healthcare policies and ensuring the wellbeing of both its members and the broader healthcare community.

SA's drinking water quality has dropped because of defective infrastructure and neglect – new report

Anja du Plessis, associate professor and research specialist in water resource management, University of South Africa

A report released by the SA government paints a grim picture of the country's water resources and water infrastructure, as well as the overall quality of its drinking water.

The Blue Drop Watch Report – an interim report because it only assessed a sample of the facilities across the country – focused on the condition of the drinking water infrastructure and treatment processes from a technical standpoint. It also reported on water quality.

The issues of biggest concern that it identified included a collapse of the country's wastewater treatment works and a sharp rise in the number of local authorities that are failing to meet minimum compliance standards.

The report records continued overall decline in the status of the country's water supply services. The findings point to a culture of neglect, non-compliance and systemic collapse. The current cholera outbreak in the country should, therefore, come as no surprise. The interim report shows dysfunctional local municipalities and non-compliant wastewater treatment works.

Recent cholera outbreaks have been a warning sign that the country's water is contaminated

The systemic collapse has been attributed to poor operation, defective infrastructure, the absence of disinfection chemicals, lack of monitoring and an overall lack of operating and chemistry knowledge.

The report shows that the Department of Water and Sanitation issued non-compliance letters to 244 wastewater treatment works in 2022. But only 50% had responded almost a year later.

The report shows a clear and rapid decline in the performance of local government. But only 43 out of 205 local municipalities have



asked for assistance from the department. They are able to ask for financial support and assistance to help with capacity building and skills development.

Drinking water quality

Only a test sample of some of the country's facilities was conducted. Assessments were made of 151 water supply systems – out of the total 1 186 – managed by 140 local municipalities. In addition, 26 water boards and bulk water service providers were assessed. The assessments were done between November 2022 and February 2023.

Most of the treatment plants in the sample were found to be failing to produce acceptable drinking water according to the SANS 241:2015 drinking water standards.

Over 60 systems (41%) of the sample had bad water quality. Another 13 systems (9%) had poor water quality. This meant that they didn't meet clean water standards because of high levels of contaminants such as wastewater and excrement.

Contaminated water poses acute health risks. It is responsible for water-related illnesses such as cholera.

Only 50% of the assessed treatment plants produced drinking water of a suitable quality not contaminated by sewage or other pathogens or chemicals.

A number of water supply systems were flagged as being in a critical condition, requiring urgent intervention.

The report also noted that 11 of the 140 municipalities that were assessed had no

water quality monitoring systems in place, or no evidence of any water testing.

Wastewater treatment works

Wastewater treatment works are assessed in accordance with the set Green Drop audit standards. Of the total 850 wastewater treatment works assessed, 334 (39%) received scores below 31% and were placed under regulatory surveillance. Overall, the country's wastewater treatment works are in a poor to critical state, posing significant risks to public health and to the environment.

SA's wastewater treatment works preliminary report card:

- 208 are at critical risk (24%) – indicating dysfunctional and unsatisfactory performance, with major corrections required.
- 250 are at high risk (29%) – indicating partial functionality and unsatisfactory performance, with major corrections required.
- Half are in poor to bad condition. This is up from 10% in the 2014/2015 auditing period.
- The North West Province recorded the highest proportion of wastewater treatment works at critical risk (60%), followed by the Northern Cape (59%) and the Free State (44%). Limpopo has 38% of its plants at critical risk and 48% as high-risk plants, placing the bulk of its treatment facilities in a vulnerable state.

Other major issues reflected in the report were:

- Only 25 systems (17%) achieved excellent water quality and 20 systems (13%) good

water quality, while 106 systems (70%) failed to achieve chemical compliance. A worrying 83 systems (55%) have bad water quality compliance and 23 systems (15%) have poor water quality compliance.

- Under 40% of systems were compliant on microbiological parameters (pathogens and bacteria such as faecal coliform, *E. coli* and cholera). Just over 10% were partially compliant.
- Only 5% of plants were in a state of high compliance. The rest were in a poor or critical condition (64%) or had some degree of compliance (31%).
- Water losses within municipal water reticulation systems had [increased from 35% in 2015 to 50% in 2023](#). This means that

50% of water is lost within the system before reaching consumers.

Next steps

The findings of the report come as no surprise. Recent [cholera outbreaks](#) in Gauteng and Free State provinces have been a warning sign that the country's water is contaminated.

The current state of affairs was predicted two decades ago by numerous researchers and experts, consistently having highlighted the deterioration of SA's already scarce water resources, dilapidated infrastructure, poor water governance and management, lack of service delivery and the overall threat to the country's water security, calling for urgent action.

The Department of Water and Sanitation has recently proposed the development of a [Water Partnership Office](#), a new procurement office, in an attempt to address the continued water issues. The initiative is still in its developmental phase, but the government hopes it will facilitate private investment in the water industry.

But government will have to regain the trust of private institutions before they will be willing to invest in water infrastructure projects.

Source: The Conversation, 9 June 2023. <https://theconversation.com/south-africas-drinking-water-quality-has-dropped-because-of-defective-infrastructure-and-neglect-new-report-207267>.

Preventing the future burden of disease through childhood immunisation

Prof. Hannelie Meyer, head of the South African Vaccination and Immunisation Centre (SAVIC) at Sefako Makgatho Health Sciences University



Vaccines are the first line of defence against the contraction and spread of harmful preventable infectious diseases, and childhood immunisation is an important part of this. It is one of the most effective means of protecting children under the age of five against life-threatening diseases such as polio, measles, diphtheria, tetanus and many others. Prof. Hannelie Meyer, head of the South African Vaccination and Immunisation Centre (SAVIC) at Sefako Makgatho Health Sciences University, outlines how vaccines function in the body and why childhood immunisation prevents infectious diseases from developing in children who have been vaccinated against them.

The WHO states that there are now vaccines to prevent more than 20 life-threatening infectious diseases, and that childhood immunisation currently prevents 3.5 - 5 million deaths every year, helping people to live longer, healthier lives.

However, there is evidence that vaccine coverage has dropped dramatically since 2020. The COVID-19 pandemic caused severe disruptions and strained global healthcare systems. In addition, children living in fragile and conflict-affected areas had limited access to immunisation. These factors resulted in 25 million children missing out on vaccinations in 2021. This is the largest sustained decline in routine childhood vaccinations in approximately 30 years, as recorded in official data published by the WHO and UNICEF. Globally, one in five children are now zero-dose or under-vaccinated. This means that they have missed out entirely or partially on their routine immunisation.

The effects on routine immunisation due to the COVID-19 pandemic were expected, but the decline has continued. What is urgently needed is for the millions of children who missed out on routine immunisation to catch up on their immunisation schedule. Without this, populations may witness more vaccine-preventable disease outbreaks, more sick

children, unnecessary deaths and greater pressure on already strained health systems.

An example of this is how the plan to achieve global elimination of measles was halted and even reversed in 2020, as pointed out by a WHO and US Centers for Disease Control and Prevention (CDC) report. The decline in immunisation coverage can be linked to disruptions in immunisation services and changes in individuals' health-seeking behaviours as a result of the COVID-19 pandemic. Globally, 24 measles vaccination campaigns in 23 countries were postponed in 2020, increasing the risk of measles for more than 93 million people.

The role of vaccinations is to help prevent and reduce the risks of contracting vaccine-preventable diseases by priming the body's natural defences against them. World Immunisation Week (24 - 30 April 2023) aims to bring awareness to this and emphasise the importance of prioritising timely vaccinations for children in order to continue saving millions of lives in the future. Furthermore, with this year's World Immunisation Week, a global year-long campaign with the theme "The Big Catch-up" will commence. The goal is to vaccinate millions of children globally, catch up on missed vaccinations and get countries back on track with vaccination coverage levels.

Vaccines work by preparing the body to fight future illnesses caused by the germs targeted by the vaccines. Each vaccine contains either a weakened germ or parts of a killed germ that causes a particular disease. When vaccinated, the body makes cells and antibodies that recognise specific parts of that germ, thereby priming/training the immune system to fight the disease. This response means that if a person is exposed to the actual disease-causing germ, the cells and antibodies are already present to fight the disease.

An additional advantage of getting vaccinated is that not only the vaccinated person is protected against a particular disease, but the chances of others being infected is also reduced. High vaccination coverage has huge public health benefits as it provides herd immunity, preventing the spread of infectious diseases when people interact with others and their environment, and prevents the spread of antimicrobial resistance. For children, immunisation promotes a healthy start in life and improves childhood life expectancy, but also provides protection from vaccine-preventable diseases throughout the lifespan, from infancy through to old age. Because immunisation protects children against illness, it also prevents absence from school,

with better learning outcomes and less time off work for families to care for sick children, and it prevents additional costs associated with illness. Other public health benefits of immunisation are that it provides protection for at-risk populations due to occupation, displacement or migration. It also supports a healthy and productive workforce in local and global economies, and advances the safety and security of people where they live, work and play.

Vaccines have reduced and, in some cases, eliminated many diseases that killed or severely disabled people just a few generations ago. For example, smallpox was the first disease to be eradicated worldwide as a result of the success of the smallpox vaccine. If parents continue vaccinating their children now, they may in the future be able to see that some diseases of today will no longer be around to harm their grandchildren.

Most of a child's routine immunisations are completed between birth and 6 years old. Many vaccines are given more than once, at different ages, and in combinations, which means that keeping an up-to-date vaccination record is essential. In SA, the Road to Health Book (RTHB) (<https://sidebyside.co.za/resources/road-to-health-book/>), issued at birth, provides a record of a child's immunisations, health, growth and

development from birth to the age of five. Parents and caregivers have the responsibility to ensure that their children's RTHB is kept up to date, while healthcare providers should check the RTHB at every health visit, to verify that the child's immunisation schedule is up to date. If a vaccination has been missed, a catch-up schedule will be provided until the routine immunisation schedule can be resumed. It is never too late to vaccinate, and if a child receives an extra dose of a vaccine, there is no need for concern.

Concentrating on the future, the WHO is now convening over 300 scientists to recommend a list of priority pathogens that need further research and investment. The process will include both scientific and public health criteria, as well as those related to socioeconomic impact, access and equity.

Thanks to advances in medicines, vaccines and technology, children can be protected from serious infectious diseases and even death. Future research and development will make it possible for more diseases to become preventable through immunisation, with the result that many millions of children can be protected and enjoy the long, happy and healthy lives they deserve.

References available on request.

Groote Schuur Hospital clears surgical backlog

SAMA Communications

Much of SA's public health sector is plagued by long waiting times for surgery, a situation that was made much worse by the COVID-19 pandemic, reports *Spotlight* on 26 May. Recently Groote Schuur Hospital's inspiring project reached the target of slashing its backlog by 1 500 elective surgeries – 2 months ahead of target.

At the end of March, a small team of healthcare workers completed the project called "Surgical Recovery". The project ran from May 2022 and was originally planned to conclude 12 months later.

While this hasn't cleared the entire backlog of people waiting for surgery at Groote Schuur, it has helped the hospital return to about the same waiting list level as it had before the COVID-19 pandemic, according to Prof. Lydia Cairncross, the head of general surgery at Groote Schuur.

According to Dr Shrikant Peters, a public health specialist and the medical manager of theatre and intensive care unit services at Groote Schuur, the hospital's CEO Dr Bhavna Patel "had the foresight to request provincial use of COVID funding to develop the space as COVID high care, and eventually to be used long-term as an operating suite and high care ward in line with prior hospital plans".

The project was kick-started by a ZAR5 million donation from Gift of the Givers. The recently established Groote Schuur Hospital Trust focused on Surgical Recovery as their first project to fundraise for. An additional ZAR1 million was raised by the Trust from over 500 corporate and private donors, and the Western Cape Provincial Department of Health donated approximately ZAR6.5 million to the project



An inspiring project at Groote Schuur Hospital in Cape Town has reached its target of slashing its backlog by 1 500 surgeries (photo: Nasief Manie/Spotlight)

from their budget for surgical recovery post COVID-19. The project will continue into its second year.

According to Cairncross, many surgeons, herself included, would come and operate on

patients in addition to their normal surgeries and other duties. The funds, a total of about ZAR12.5 million, were used to pay the staff involved in the surgeries.

According to Peters, the 1 500 operations occurred across all surgical specialities, ranging from cataract to cardiothoracic.

Cairncross attributes the success of the project to the existing systems at Groote Schuur, supportive management and the dedication of the surgical team and surgeons that gave their time to the project. She told *Spotlight* that the project is just a temporary measure. In the long term, healthcare systems need to be fixed in order to address issues such as surgical backlogs.

"The lesson, I suppose, is that these are temporising measures. We can do them, but fundamentally we need to fix the health system at a core, structural level. And we can't work in isolation from the rest of the country because we are one health system and tertiary hospitals are only a part of that ecosystem," she says. "The services at Groote Schuur Hospital, for example, cannot be sustained if the health systems from primary care to district health facilities, in urban and rural facilities, and across provinces are not supported and strengthened.

"The project is just a temporary measure. In the long term, healthcare systems need to be fixed in order to address issues like surgical backlogs."

The health system is at a precipice, according to Cairncross, and big academic hospitals need to be anchoring elective surgical services together with emergency services, as the problem with emergency services will only get bigger down the line if electives aren't dealt with now.

"We know that postponed elective surgery just becomes emergency surgery over time, making cancelling elective surgery a false economy. We need to plan robust systems that ensure all types of surgical services are maintained," she says.



Groote Schuur Hospital



Behind every number on the surgical waiting list is a patient with a story (photo: Nasief Manie/Spotlight)

"The strongest voice [in defence of the health system] is a conscious and motivated health workforce. So, where the nurses and doctors and managers are standing and defending patient services, they are supporting the health system," she says. "I think this is an example of health workers standing up and saying, we can't allow this deterioration in

services. We've got to do more. We really want to tell the story, so that people can see it can be done."

Source: Spotlight, 26 May 2023. <https://www.spotlightnsp.co.za/2023/05/26/groote-schuur-hospital-clears-backlog-of-1-500-surgeries/>.

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.





Keeping patient records – why it matters

Karliën Pienaar, *administrator, SAMA Legal Department*

It is important to keep clear and accurate records of a patient's illness, diagnosis and treatment. Effective communication among doctors, and between doctors and patients, can add immense value to your patients. It is when there is a gap in the notes or information available that the importance of this really becomes obvious, and can have unfortunate implications.

The purpose of keeping good patient health records includes, but is not limited to, having notes or a register of the doctor's findings and the treatment to follow, promoting continuity of care, acting as evidence of the standard of care that was provided, ensuring that the patient's needs were met sufficiently, and lastly, presenting adequate evidence should the practitioner be approached to testify during litigation.

When considering possible litigation, it is prudent to ensure that records are comprehensive, to assist the practitioner who might be requested to supply evidence during court proceedings. Records should always be factual and free from sidenotes of personal observations, which might become problematic for the practitioner in the future when copies of records are requested.

Retention of records

It should be noted that patient records should be retained separately from billing records. According to the SA Revenue Services (SARS), accounting documents should be kept for a period of 5 years from the date of submission of the return, as SARS may request these documents to verify information that has been declared.

Furthermore, patient health records should be retained for a minimum period of 6 years after the file has become dormant (from the last time that the patient consulted with the

doctor). If it is at all possible to keep files for a longer period in an electronic format, that would be ideal – however, is not compulsory.

After the expiry date has passed, the records should be discarded by means of shredding, for example. When a request for copies of patient records is received after they have been destroyed, the practitioner should file an affidavit at any police station to confirm that the records no longer exist. This can be submitted to the requester, and is also an indication that the practitioner is not unwilling to comply with the request, but is no longer in possession of the record.

Exceptions exist where records must be kept for longer than 6 years:

- Minor patients (under the age of 18 years) who have received treatment and healthcare services. This would be most relevant to obstetricians and paediatricians, although not limited to those specialities. According to the HPCSA, young adults up to the age of 21 years can make a claim against a doctor or a health establishment. It should be noted that in terms of the Prescription Act No. 68 of 1969, the prescription period (normally 3 years after the date of injury) can be delayed until 1 year after the minor turns 18.
- Mentally incapacitated patients' records should be retained for the patient's lifetime.
- Records of patients who are diagnosed and treated in terms of the Occupational Health and Safety Act No. 85 of 1993 must be retained for 20 years after treatment.
- Records of patients who have certain health conditions that might take longer to manifest or develop. The HPCSA recommends that the period not be less than 25 years, which should allow the patient sufficient time to access care.

- Statutory obligations may prescribe a specific period.

Ownership of records

When considering who owns the patient records, a distinction is made between the public sector and private sector.

In the HPCSA's Guideline on the Keeping of Patient Health Records, it is stated that:

"8.3. In the case of state institutions, where records, e.g. radiographs, are the property of the institution, original records and images should be retained by the institution. Copies must, however, be made available to the patient (or referring practitioner), on request for which a reasonable fee may be charged in terms of the Promotion of Access to Information Act.

8.4. In the case where patients are required to pay for records and images (e.g. private patients or patients in private hospitals), such patients must be allowed to retain such records – unless the healthcare practitioners deem it necessary to retain such records for purpose of monitoring treatment for a given period. Should the patient however require the records and/or images to further or protect an interest (such as consulting with another practitioner) he/she must be allowed to obtain the originals for these purposes."

It is, therefore, clear that patient records are owned by the doctor or institution that generated the records. Where a private patient (whether cash paying or medical scheme funded) had to pay for the records (X-ray, blood tests, etc.), the patient is entitled to the original document, and a copy may be retained by the practitioner. Where the doctor has generated notes, these are the property of the doctor, although access must be granted to the patient by providing a copy

(or summary of the contents) to the patient, when requested.

What then happens to patient records when a doctor decides to close the practice?

Within 3 months of closure, all patients must be informed in writing of the specific date that the practice will be closed. Patients may request that their health records be transferred to another doctor of his or her

preference, or they may remain with the practice and with the new practitioner who purchases the practice. When the practice has been closed, the records must be held safely and confidentially for another period of at least 12 months.

If the practitioner dies, the executor of the estate should inform all patients in writing accordingly. When another doctor takes

over the practice, the executor will carry over the patient records to the new owner of the practice. All remaining patient records should be kept safely and confidentially for a period of at least 12 months.

The HPCSA Guideline on Keeping Patient Records may be requested from Karlien Pienaar via email at karlienp@samedical.org, and any questions or input are welcome.

Bullying in the workplace

Simon Buthelezi, labour law advisor, SAMA Legal Affairs Department

Bullying in the workplace can be defined as the ongoing and deliberate misuse of power in the work environment through repeated verbal, physical or social behaviour that intends to cause physical, social or psychological harm, where the perpetrator has got the upper hand over the victim, as for instance a supervisor over a subordinate. In terms of existing labour laws, bullying is not specifically defined or referred to in any legislation, including the Labour Relations Act No. 66 of 1995, the Basic Conditions of Employment Act No. 75 of 1997 or the Employment Equity Act (EEA) No. 55 of 1998.

However, section 6(1) of the EEA does contain a prohibition against unfair discrimination, at it states that "No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including race, gender, sex, pregnancy, marital status, family responsibility, ethnic or social origin, colour, sexual orientation, age, disability, religion, HIV status, conscience, belief, political opinion, culture, language, birth or on any other arbitrary ground."

Section 6(2) of the above-mentioned Act also provides that "Harassment of an employee is a form of unfair discrimination and is prohibited on anyone, or a combination of grounds of unfair discrimination listed in subsection (1)." Generally, bullying will be recognised as harassment, and therefore unfair discrimination. Even if the reason for the bullying is not one of the listed grounds (race, gender, etc.), provided that the reason can be demonstrated, a case for harassment can be made out.

According to Bradley Workman-Davis of Werkmans Attorneys, the statistics are startling. Even though SA statistics are sparse, and US statistics cannot necessarily be assumed to apply to SA workplaces, a Workplace Bullying Institute poll showed that 68% of executives considered

"workplace bullying a serious problem", and the 2014 survey showed that 48% of Americans are affected by workplace bullying.

Ground-breaking bullying cases in SA

In the case of Mkhize and Dube Transport (2019) 40 ILJ 929 (CCMA), in which the employee referred a complaint for bullying to the Commission for Conciliation, Mediation and Arbitration (CCMA) as an unfair dismissal claim, the CCMA exercised its discretion to assess the real reason for the employee's referral, and determined that although the employee had referred a dispute for unfair dismissal, the true complaint was about victimisation in the workplace. The employee had alleged that the human resources manager of the employer was bullying and victimising her, both inside and outside of the workplace, and that although she had ultimately been dismissed for medical incapacity, the employer had actually sought to use this as a convenient method to get rid of her, after having lodged a grievance about the bullying allegations. Although the CCMA did not have to contend with the facts of the matter, it confirmed that where an employee has a dispute about bullying, victimisation or harassment, although the CCMA can always conciliate the dispute, if the parties fail to agree on a resolution, the next step (arbitration) must be at the Labour Court, as the dismissal then could be an automatically unfair dismissal, which the Labour Court has exclusive jurisdiction to determine.

The above approach, which established bullying as a form of harassment, also asserted that it should be dealt with in terms of the EEA as unfair discrimination, and this was also recently confirmed in Private Sector Workers Trade Union on behalf of Opperman and Gerrie Ebersohn Attorneys (2019) 40 ILJ 1159 (CCMA).



If the employee has not been dismissed and remains employed, the appropriate referral would be for unfair discrimination in terms of the EEA. If the employee has been dismissed, the appropriate referral would be for automatically unfair dismissal based on unfair discrimination. In the case of Simmadari v Absa Bank Ltd (2018) 39 ILJ 1819 (LC), the Labour Court found that these two referrals are not mutually exclusive, and a dismissed employee may refer both claims simultaneously.

Conclusion

Both employees and employers should be aware that instances of workplace bullying should be dealt with quickly and decisively, and that bullying should not be tolerated in the workplace, as a failure to confront it may expose the employer to up to 24 months' remuneration if the employee is found to have been dismissed due to bullying, and unlimited compensation claims if the employee is found to have been the victim of unfair discrimination due to bullying.

References available on request.

A manslaughter investigation leads to an inquest

Marshal Ahluwalia, solicitor and case manager, Dr Clare Devlin, medicolegal consultant, Medical Protection Society

Dr A, who had graduated in SA and recently completed her community service, decided to get some experience in the UK, and so worked as a locum. After returning to SA, she contacted the Medical Protection Society (MPS) to seek advice and guidance on whether it was appropriate to disclose a deceased patient's medical records to the police, who were investigating a crime of possible manslaughter against the patient's daughter.

The patient was in her early 90s and had significant limited mobility and ongoing dementia concerns. The patient required a significant amount of care from her relatives, in particular her daughter with whom she lived. Dr A and another professional colleague made arrangements for a home visit to see the patient, after safeguarding and wellbeing concerns were raised by one of the patient's other children who lived abroad.

When Dr A and her professional colleague attended, the patient and her daughter were present. Dr A and her colleague explained that they wanted to do some assessments on the patient, including blood tests, a memory assessment and a mobility assessment. Before any attempts at assessing the patient's memory could be made, the daughter intervened. It was explained to the daughter that it was the patient who needed to respond to Dr A's questions. Dr A attempted to take a blood test from the patient to rule out an organic cause for her apparent poor memory and mobility. The patient's daughter vehemently objected to Dr A taking any bloods from her mother. Despite her best efforts in seeking an explanation for the daughter's inexplicably hostile, challenging resistance, the reason for her refusal was not clearly articulated in a comprehensible manner to Dr A.

Dr A explained several times the importance and reasons for doing blood tests. However, the patient's daughter would not allow her to take her mother's blood. Although the patient seemed completely amenable to Dr A taking her blood tests, the daughter had become extremely agitated and created a major fuss. Dr A and her colleague both found the daughter's behaviour most unusual and extremely unnerving. Dr A decided that for both her own and her colleague's safety, they should abandon the home visit at that point, and discuss the next steps when back at the surgery.



Dr A discussed her concerns when she arrived back at the surgery, and although she did not have any immediate safety concerns about the patient, she concluded that it was still appropriate to complete a safeguarding referral, as she had concerns that the patient was vulnerable and at risk of neglect. After the safeguarding referral was made, a social worker subsequently contacted the surgery to arrange a joint visit to the property to re-attempt to engage with the patient and carry out a physical health assessment. The patient's daughter refused access to the property. A plan was then agreed by professionals for there to be a multi-agency meeting to discuss the next steps. Dr A and her colleagues then made numerous attempts to engage the patient's wider family to see if it was possible for one of them to bring the patient to the surgery to have the physical health assessments completed. However, nobody else in the family was prepared to get involved and help facilitate this.

The practice was informed by extended members of the family that the patient had developed an infection in her toes and shin and had lost a lot of weight. After further unsuccessful attempts were made to access the premises, Dr A decided to phone the police and call an ambulance. Dr A also phoned her local emergency department to make them aware of the safeguarding concern.

Very sadly, the patient passed away shortly after paramedics gained access to the premises and admitted her to hospital. The police commenced a manslaughter investigation in relation to the daughter, and contacted Dr A to seek disclosure of the patient's records. In keeping with the usual practice regarding

inquests in the UK, Dr A was then also contacted by the local coroner who asked for a statement.

How did Medical Protection help?

In addition to seeking advice about disclosure of the deceased patient's records to the police, Dr A also sought assistance and advice with regard to her draft statement for the coroner. Dr A gave permission for MPS to contact and communicate with the coroner on her behalf.

After submitting her statement, Dr A was informed by the coroner that she was a "witness of fact" and her attendance at the inquest would be necessary. Fortunately, MPS was able to arrange with the coroner for Dr A to attend the inquest virtually, via Zoom.

In the UK, it is possible for a clinician to be called to give evidence at an inquest in one of two ways:

- As a "witness of fact". This generally indicates the coroner believes the clinician's involvement in the case to be peripheral rather than pivotal.
- As an "interested Person" (IP). IP status could be given to a clinician who the coroner believes is pivotal to the case, or has sufficient interest in the inquest. Being granted IP status means a clinician will have the following rights: the disclosure of all the documents the coroner intends to rely on at the inquest, and also importantly, the right to legal representation.

At 14h30 on a Friday, just 1-and-a-half working days before the start of the inquest, which was due to commence on the following Wednesday, the coroner's officer sent MPS an

email to say the coroner had decided very late in the day to make Dr A an IP, and that she was no longer a witness of fact. The coroner's officer explained that the reason behind this decision was that a number of other parties who were previously witnesses of fact had been given IP status (and hence were entitled to be legally represented), and the coroner felt it was only fair to make Dr A an IP as well, in all the circumstances. Late on Friday afternoon, MPS instructed its UK panel solicitors, who attended the inquest on the following Wednesday and asked for the hearing to be converted into a pre-inquest review, which would enable Dr A and all the other parties who had recently become IPs to be given the opportunity to properly prepare for the inquest. The coroner agreed for the inquest to be adjourned, and the inquest hearing was converted into a pre-inquest review hearing.

The inquest

When the inquest eventually commenced, Dr A attended remotely as an IP, and was represented by MPS's instructed panel solicitors. Prior to attending the inquest, a

Learning points

- A doctor who is asked for a statement should seek early advice from MPS, and we can assist in finalising the statement. While in the UK it is quite common for such a request to come from a coroner, similar requests from an inquest magistrate in SA are less common. The principle, however, remains the same – seek assistance, as criticism by a coroner or inquest magistrate can have serious consequences.
- It would be wrong to assume that, once a coroner has identified a clinician as a witness of fact, this status will remain throughout the whole lifetime of the inquest process. It is possible for a clinician to be a witness of fact one minute and an IP the next, and this conversion of witness status could take place very late in the day depending upon the particular circumstances of the inquest. Keeping MPS promptly updated enables us to assist in a timely way and provide support and representation when required.
- In this case we were able to assist Dr A despite the unusual geographical circumstances. MPS is a global organisation, and Dr A was able to port her existing membership over to the UK by notifying MPS she was moving there.

number of virtual meetings with our member and panel solicitors took place to ensure that our member felt fully prepared to assist the coroner in the best way possible, complying with their professional regulatory obligations. At the inquest, the coroner concluded that the patient's death was a consequence of a failure to treat an infected pressure sore. In

issuing a narrative conclusion, the coroner determined that there was neglect on the part of the deceased's daughter due to her failure to procure medical treatment, despite it being palpable that there was a clear need to do so. There was no criticism of Dr A, and in fact the coroner commended the way Dr A gave her evidence.

Understanding employee rights and employer obligations when transferring a business

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

When a business undergoes a transfer or change in ownership, it is crucial to ensure that employers ensure that they are compliant with section 197 of the Labour Relations Act No. 66 of 1995 (LRA). The transfer of a business can occur through mergers, acquisitions or even outsourcing arrangements. SAMA has received queries from members in private practice when a practitioner intends to sell his/her private practice. This article aims to shed light on the right of employees and the obligations on the employer during a transfer of business.

Section 197(1) of the LRA defines a "business" as "includes the whole or a part of any business, trade, undertaking or service".

Section 197 (1) of the LRA further defines a "transfer" as "the transfer of a business by one employer ('the old employer') to another employer ('the new employer') as a going concern".

Section 197(2) further states as follows:

"(a) the new employer is automatically substituted in the place of the old employer in respect of all contracts of employment in existence immediately before the date of transfer;

(b) all the rights and obligations between the old employer and an employee at the time of transfer continue in force as if they had been rights and obligations between the new employer and the employee;

(c) anything done before the transfer by or in relation to the old employer, including the dismissal of an employee or the commission of an unfair labour practice or act of unfair discrimination, is considered to have been done by or in relation to the new employer; and

(d) the transfer does not interrupt an employee's continuity of employment, and an employee's contract of employment continues with the new employer as if with the old employer."

Section 197(6) allows for the old and new employer to reach an agreement that dictates how the transfer with regard to employee's rights will take place. Should no agreement be agreed upon, section 197(2) would automatically be in force.

Conclusion

During a transfer of business, employers should ensure the protection of employee rights afforded to them by section 197 of the LRA. Employers have a legal and ethical responsibility to communicate effectively, consult with the employee and/or representatives, and ensure a smooth transition that minimises disruption. Understanding section 197 of the LRA can help employers navigate through any transfer of business. Members in private practice are urged to reach out to the SAMA legal department for assistance should they contemplate a transfer of their practice to ensure compliance with legal requirements in terms of section 197.

Glittering gala dinner a huge success

Lowveld branch recently held a gala dinner for SAMA members to facilitate one-on-one interaction with SAMA benefit partnerships and other local industries. The event was also the perfect opportunity to build relationships with VIP guests.

Each guest was announced when they arrived, and ushered to a table hosted by representatives from Haval, Mercedes, Mitsubishi, Efficient Wealth, Labournet, EMD, Sukuma & Zimela pharmacy and Daisy Lee events, among others. Everyone moved around to each table during the evening.

Members, young and old, new and lifelong attended the event – the first Lowveld branch secretary Tannie Frannie de Bruyn attended with her daughter Dr Leah de Bruyn Joubert, and the youngest council member, Dr Siyabonga Mbatha, met the eldest member at the event, Dr J Craig.

Thanks to Karen Potgieter, Lowveld branch administrator, for organising such a successful and productive event.



The first Lowveld branch secretary Tannie Frannie de Bruyn, Karen Potgieter (Lowveld branch administrator) and Dr Leah de Bruyn Joubert



Dr Siyabonga Mbatha with Dr J Craig



Dr F van der Westhuizen with Dr Cecelia Cumbi (branch treasurer)



Medical interns from Rob Ferreira Hospital: Dr Leighann van der Berg and her husband, Dr Hadaway and Dr Deletic

Free State branch invited to CMSA office opening

SAMA FSB was invited to attend the University of the Free State's opening of the College of Medicine SA (CMSA)'s Bloemfontein office, which took place on Wednesday 14 June 2023.

The event comprised of the dean of the Faculty of Health Sciences, Prof. Gert Van Zyl, welcoming everyone, and Dr Abigail Haswell, SAMA FSB registrars' representative and vice-chairperson, UFS Registrars Executive Committee, spoke on behalf of the registrars. Prof. Steven Matshidza (SAMA FSB chairperson) and Prof. Dirk Hagemeister (SAMA board member) also represented SAMA at the event.



Mrs Yolokazi Kanzi (CMSA academic registrar), Mr Rivalani Mkansi (CMSA deputy academic registrar), Prof. Johan Fagan (CMSA president), Dr Abigail Haswell (SAMA FSB registrars' representative and vice-chairperson, UFS Registrars Executive Committee), Prof. Mthunzi Ngcelwane (CMSA honorary registrars ECC), Prof. Flavia Senkubuge (CMSA immediate past president), Prof. Eric Buch (CMSA chief executive officer), Prof. Gert van Zyl (dean of the Faculty of Health Sciences, UFS), Dr Japie du Toit (doctor stakeholder manager, Life Healthcare) and Prof. Steven Matshidza (SAMA FSB chairperson).

Free State congratulate Prof. Hagemeister

Free State branch congratulate Prof. Dirk Hagemeister on his appointment to the SAMA board of directors. From left: Dr Deon Menge (SAMA FSB brand amplifier), Dr Jomarie Oliver (SAMA FSB general practitioner representative), Prof. Steven Matshidza (SAMA FSB chairperson), Prof. Dirk Hagemeister (SAMA FSB treasurer and member, SAMA board of directors), Dr Benjamin de Bruin (SAMA FSB honorary branch secretary) and Dr William Selfridge (SAMA Eastern FSB councillor and SEDASA representative).



Welcome to SAMA

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

Cape Western branch

Dawie de Koker

Eastern Highveld branch

Nkululeko Cayicayi

Eastern Province branch

Luyanda Mchunu
Alexandra Sharon Glover

Free State branch

Muddassir Ahmed

Gauteng branch

Neil Gillies

Gauteng North branch

Walther Ross
Isabella Akhere Okonofua
Courtney Whitfield
Lizzy Mofokeng

Nokulunga Zwane

Henryke Garbers
Jualene du Preez
Nokuzola Melane
Ingrid Hauptfleisch
Vincent Mathenjwa
Bono Sigudu
Halatedzi Ramuthaga
Brian Tshawe
Lumka Kraulana
Delmonique Martin
Muhammad Bilal Abbas
Denzel Magunje
Kopao Kwele
Jacqueline Nel
Nicolas Johannes du Plessis
Azwianewi Hercules Netshipale
Zahra Khan
Ameer Khan
Jonase Sem Chauke
Anthony Thomas Nkosi

Nigel Kearabilwe Modibedi
Ewan Cornelius
Arjan Abraham Schouwstra
Nelisha Schouwstra
Sphiwe Lovemore Mvulane
Thandokuhle Slondiwe Faya
Mzukisi Qezu
Thabo Gulwako
Rozanne Nicola Bruwer
Noniakhosi Ndau
Mpho Sekome
Sixolisiwe Swartbooi
Vongani Tlakula Tlakula
Libokanyo Viola Jafeta
Manthibu Modisha

KZN Coastal branch

Andile Zulu
Andiswa Jwara
Joash Moodley
Kathrada Reesa

Byron Perumal
Bianca Annina Bock
Ramashlana Athingahanpwi
Aphiwe Princess Sibisi
Prudence Maimo Mulaudzi
Samkelisiwe Angel Buthelezi
Ellezae Claudelle Moosa
Kelly Tanika Koetsie

KZN Northern branch

Andile Zwane

Limpopo branch

Rembuluwani Setsheni

Unattached

Kathryn Green
Yumna Dindar
Tania Pillay



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

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