

SAMA INSIDER

SEPTEMBER 2023

**WMA Declaration
of Helsinki revisions:
Africa Region
Consultation to be
hosted by SAMA**

**Why hospital
security guards
can't keep doctors
and nurses safe**



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Diane de Kock
Editor: *SAMA INSIDER*

Safety first

Hospital safety is an ongoing serious concern for healthcare workers in SA. Between 2017 and 2022, more than 200 violent incidents were reported at public hospitals. SAMA has been active in campaigning for increased safety, and the Free State branch (FSB) recently met with the MEC for health at the provincial offices about concerns for doctor safety after recent security breaches.

In his article (page 11), *Bhekisisa's* Zano Kunene writes "that to make hospitals safe, security guards need training to help them deal with angry, emotional or aggressive situations, on top of general safety issues such as protecting property and monitoring access to a facility".

SAMA FSB (page 24) reinforced this recommendation when they met the Free State MEC, Nokwanje Leeto. "Doctors, nurses and social workers are all high on the list of occupations with serious stress levels, while violence in the health sector constitutes almost a quarter of all violence at work".

September 17 is World Patient Safety Day, and this year the theme is "Engaging patients for patient safety", in recognition of the crucial role patients, families and caregivers play in the safety of healthcare (page 13). Through the slogan "Elevate the voice of patients", the WHO appeals to stakeholders to take action to ensure that patients are involved in policy formulation, represented in governance structures, engaged in co-designing safety strategies and active partners in their own care.

Also in this issue, we proudly announce that SAMA will be hosting the African regional consultation of the WMA's Declaration of Helsinki in Johannesburg on 18 and 19 February 2024 (page 5). "The overarching theme of the consultation as determined by SAMA is 'vulnerabilities', says author Prof. Ames Dhali.

Africa's women's rights treaty, the Maputo protocol, turns 20 this year. Anthony Idowu Ajayi (page 6) unpacks the hits and misses and lists what more needs to be done.

Continuing the hospital histories series, with thanks to *Spotlight*, we highlight the 130-year-old Valkenberg Psychiatric Hospital (page 8), focus on leading through a crisis (page 10) and applaud a group of Stellenbosch University students (page 13) who used technology to raise awareness of organ donation.

Our Legal Affairs (page 19) section looks at prescribing and selling medicines, a misdiagnosis claim (page 20), accommodating ill or injured employees in the workplace and suspension as an unfair labour practice (page 21).

Your ideas, submissions and feedback are always welcome. We hope you enjoy this edition.

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

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SAMA petition National Council of Provinces to reject NHI Bill

SAMA Communications

SAMA recently submitted a petition to the National Council of Provinces (NCOP) calling on MPs to revise the National Health Insurance (NHI) Bill. The petition, which was signed by more than 56 000 people, appealed for the NCOP to vote against the passing of the NHI Bill in its current form.

The Bill was passed by the National Assembly in June, and proposes sweeping reforms to the healthcare sector aimed at achieving universal health coverage.

In a letter to the NCOP chairperson Amos Masondo, SAMA chairperson Dr Mvuyisi Mzukwa said the association had made written and verbal representations to Parliament outlining concerns regarding the Bill and its potential implications, but these had largely been disregarded. "Thereafter, we elected to exercise our constitutional right to petition the NCOP as a last resort."

Apart from its thousands of signatures, the petition included 2 000 comments from the public.

SAMA's key concerns include corruption risks, the focus on a funding model without tackling human resource shortages and infrastructure issues in the public healthcare system, a lack of cost assessment and limitations on medical aid schemes.

"We believe that the Department of Health's attempt at addressing some of the abovementioned issues in a statement released by the SA Government News Agency on 5 July 2023, after the adoption of the Bill in the National Assembly, is itself an indicator that the Bill, in its current form, does not address those concerns, as a clarifying statement by the Department would otherwise have not been required," Mzukwa said.

Dr Mzukwa pleaded with Masondo to take a different stance on the Bill.

"As the final house of Parliament that will decide on the adoption of the Bill before it is signed into law, we implore the NCOP to consider the concerns raised," he said.

"We have been ignored since the discussions on the green paper, and despite making submissions, there has never been any consultation or feedback."



Dr Mvuyisi Mzukwa

Health minister Joe Phaahla said that should the Bill, in its current form, be passed, affordable low-cost medical aid plans, along with traditional medical aid schemes, would be scrapped. Clause 33 of the current NHI bill, which is before the NCOP, already states that medical schemes will only play a complementary role under the NHI.

"It must be noted that there is no intention for low-cost to be integrated into the NHI environment. Instead, the intention is to create an integrated health financing system that prioritises the health of all South Africans through ensuring access to a comprehensive set of personal health services," said Minister Phaahla (*News 24*). "Within such a system, medical schemes would only play a complementary role, as suggested in clause 33 of the NHI Bill."

The NHI will create a single fund to which those earning an income will contribute, probably through a payroll tax. As the NHI expands over time, reports *News 24*, the Bill envisages that medical aids will no longer be allowed to reimburse people for services offered by the NHI and will effectively be phased out.

Several NGOs, medical schemes and other institutions have vehemently opposed the proposed single-payer model, which

means that government will buy all essential healthcare products and services. Under the NHI, medical schemes will only be allowed to cover healthcare that is not offered by the government.

The NHI Bill was preceded by two policy documents: a green paper published in August 2011 and a white paper published in December 2015, reports *Business Day*.

The public consultation processes undertaken by government and Parliament to date have been tick-box exercises, said Dr Mzukwa, adding that opposition to the Bill went beyond healthcare workers, as evidenced by signatories to the petition. "It is also communities. People don't trust the government."

"I was born in Flagstaff in the Eastern Cape. In my village there is still no water; it was promised in 1994. Now the government tells them it will give them a healthcare service under NHI. Yet there is not even a clinic. Communities there say there is no truth to this thing," said Mzukwa.

In the media

Since the delivery of this petition to the chairperson of the National Council of Provinces, SAMA chairperson and the starter of this petition, Dr Mvuyisi Mzukwa, as well as SAMA vice-chairperson, Dr Edward Ngwenya, have been on:

- [Newzroom Afrika](#)
- [eNCA](#)
- [Cape Talk Radio](#)
- [SAfm](#)

explaining the reasons for the submission of this petition to the NCOP, in a last attempt not to have the NHI Bill signed into law. The links to these interviews are included.

Online publications on [News24](#) and [BusinessDay](#), among others, have also reported on this important delivery to the NCOP, and the exercise of the constitutional right to petition.

Revisions to the WMA's Declaration of Helsinki: Africa Region Consultation to be hosted by SAMA

Prof. Ames Dhai, SAMA Board member

The World Medical Association (WMA)'s Declaration of Helsinki, which was adopted in 1964, is undergoing revisions, 10 years after the previous one. Thus far, it has been revised seven times, and notes of clarification have been added twice. Globally, the declaration is recognised as one of the most authoritative statements on ethical standards for human research. It is a set of principles that is regularly updated to keep pace with ongoing and rapid advances in science and technology. The last revision was in 2013.

After the end of the Second World War, evidence of lethal human experimentation, including some of the most notorious war crimes conducted by physicians and scientists, emerged during the Nuremberg Trials. Revelations of the horrors of experimentation and relentless exploitation and harms during medical studies on concentration camp inmates were publicised, with the vulnerable considered sub-human, of inferior intelligence, lacking human dignity and of no moral status. The judges of the Nuremberg Trials tasked two of their medical advisors to develop a set of rules for them that could serve as a standard to guide them. A 10-point memorandum entitled "Permissible medical experimentation" was drafted. This later became known as the Nuremberg Code, the first international ethics guidance document for research.

The WMA, established in London in 1946, initially focused on the crimes committed in the doctor-patient relationship during the war, leading to the adoption of the Declaration of Geneva and the International Code of Medical Ethics in 1948 and 1949, respectively. While these are guidance documents for physicians in the context of clinical care, they have a resounding presence in the 1964 Declaration of Helsinki and all its revisions. The 1964 Declaration was adopted after 12 years of debate, and was the first formal declaration by the WMA for physicians doing research. It also served for the first time to distinguish biomedical researchers as a specific class of physicians.

SAMA served on the WMA's Working Group for the 2013 revisions, and is a member of the current revisions Working Group. Thus far there have been two regional consultations, the Asian and South American ones. The African

regional consultation will be hosted by SAMA in Johannesburg on 18 and 19 February 2024. The overarching theme of the consultation as determined by SAMA is "Vulnerabilities". Engaging with communities, in particular when conducting research in resource-limited areas, and vulnerabilities during pandemics and other disasters, will also be explored. Africa is a region of vast differences in health, education and income among its populations. Africa also suffers from many of the health burdens of developing regions, and has not yet recovered from the years of oppression under colonialism. Poverty, conflict situations, civil war and gender-based violence are some examples

For the Declaration of Helsinki to be a truly international guidance document, it would be prudent for the revisions to take into consideration African values, traditions and vulnerabilities specific to the African context

of the lived experiences of people in Africa. For these reasons, many people on the continent are vulnerable and at risk of exploitation in research. Moreover, we have been in the COVID-19 pandemic since 2020, and while the WHO has declared that it is no longer a public health emergency of international concern, the pandemic has not been declared to be over yet. While vulnerabilities increased globally during in particular the first 2 years, certain regions, including Africa, were worse off. Pandemic-specific research needed to be

The African regional consultation will be hosted by SAMA in Johannesburg on 18 and 19 February 2024.

conducted, and is still being conducted in this highly vulnerable context. Africa contributed to the research, but when it came to benefitting from the interventions, Africa was last in line, as has been highlighted by the "vaccine nationalism" that we all witnessed.

African indigenous values contributing to participant protections in health research will be discussed during the consultation. The demand for practising ethics from an African perspective in Africa is growing generally, both in academic and professional circles. Since 1994, the concept of Ubuntu has been systematically drawn upon by the courts to arrive at judgements in SA. The importance of community in African indigenous systems is underscored by Mbiti when he states: "I am because we are, we are therefore I am." This could translate to the importance of participating in health research for reasons of altruism and the greater good for all. This also requires that those participating must be protected against exploitation and other forms of harms. These issues need to be discussed and dialogued with communities. Community engagement is an age-old practice in Africa, e.g. the African tradition of *lekgotla* where all gather under a tree to examine options, opportunities and risks on a topic.

For the Declaration of Helsinki to be a truly international guidance document, it would be prudent for the revisions to take into consideration African values, traditions and vulnerabilities specific to the African context. The quest for a universal ethics document would benefit invaluablely if the moral and ethical values as espoused in the principle of Ubuntu are taken into consideration.

References available on request.

Ames Dhai and Diane Smith are the SAMA leads in the planning of the Africa consultation. Queries can be sent to them directly at samadoh@samedical.org.

Africa's groundbreaking women's rights treaty turns 20 – the hits and misses of the Maputo protocol

Anthony Idowu Ajayi, associate research scientist, African Population and Health Research Center

The year 2023 marks two decades since the adoption of the Maputo Protocol. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) is arguably the most progressive legally binding instrument on women's and human rights instruments globally. A total of 44 African countries have signed and ratified it. The Maputo Protocol provides for extensive and progressive women's rights. These include the right to health and reproduction, inheritance, economic and social welfare, education and training, access to justice and equal protection before the law, and elimination of harmful practices. Reproductive health researcher Anthony Ajayi unpacks the significance of the document in women's lives over the years.

What does it mean for sexual and reproductive rights?

Articles 2 and 14 made specific provisions to protect the sexual and reproductive rights of women and girls.

Article 2 mandates member countries to enact and implement laws and other measures to curb all forms of discrimination, especially harmful practices that endanger health and general wellbeing.

Advocacy efforts to end child marriage and female genital cutting are anchored on this specific provision. Such efforts have resulted in 43 African countries now having laws that put the minimum age of marriage at 18 years old or above for both girls and boys. While some of these countries have parental consent exceptions and parallel customary marriage laws, the past 10 years have seen more countries remove these exceptions. Also, 22 out of 29 African countries practising female genital cutting now have national laws in place banning the practice.

Article 14 mandates member countries to ensure the right to health of women, including sexual and reproductive health. This includes the right to control fertility, decide whether to have children, the number of children and the spacing of children, and choice of any method of contraception.

Has it been effective?

Since the inception of the Maputo Protocol,

most African countries have removed user fees for maternal health services in government-owned health facilities. This has increased access to quality maternal healthcare services for marginalised women and girls. As a result, maternal deaths have declined markedly.

More countries have broadened their laws to allow access to safe abortion in cases of sexual assault, rape, incest, life-threatening fetal anomalies and when a pregnancy endangers the woman's mental and physical health or her life. Between 2000 and 2021, 22 African countries expanded their legal grounds for abortion. Six – Cape Verde, SA, Tunisia, Mozambique, São Tomé and Príncipe (and up to 10 weeks' gestation in Angola) – permit abortion at the woman's request during the first trimester of pregnancy. More countries have developed and launched post abortion care guidelines to expand access for women and girls.

The success of the Maputo Protocol in protecting and guaranteeing the rights of women and eliminating discrimination is quite remarkable. Where the rights of women and girls are violated, the Maputo Protocol has become an instrument for seeking legal redress and a tool for seeking accountability. It was referenced in the below examples:

- A court ruling in December 2020 found that the Kenya government violated several human rights instruments, including the Maputo Protocol, for failing to investigate and prosecute cases of sexual and gender-based violence that happened during the post-election violence of 2007. The government was ordered to pay compensation to four of the survivors, amounting to KSh4 million (about USD40 000) each.
- In December 2019, the ECOWAS [Economic Community of West African States] Court of Justice found that the ban on pregnant schoolgirls going to school in Sierra Leone was discriminatory and in violation of girls' right to education, in breach of articles 2 and 12 of the Maputo Protocol. Since the ruling, the government of Sierra Leone has lifted the ban.
- Article 13 and 17 of Tanzania's Marriage Act, which set the minimum age of marriage at 15 years for girls and 18 years for boys, was challenged at the appeal court in



2019. Citing the Maputo Protocol, the court upheld the earlier ruling that marriage under the age of 18 was illegal.

What have its shortcomings been?

Progress in realising women's and girls' rights remains uneven within and between countries. Eleven countries have not ratified the protocol. Twenty-four haven't fulfilled their reporting obligation to the African Commission on Human and Peoples' Rights. Consequently, discriminatory laws persist. And customary, common and civil laws remain in parallel with constitutional provisions. This creates loopholes for the violation of women's and girls' rights.

For example, 11 countries (Cameroon, Seychelles, Sudan, SA, Burkina Faso, Gabon, Guinea-Bissau, Mali, Niger, Senegal and Tanzania) permit girls under 18 years old to marry. One member state has no minimum age for marriage. But legal reforms are happening in five of these countries.

There's been improvement in sexual and reproductive health outcomes. But sexual and gender-based violence, child marriage and female genital cutting remain high in most African countries. Maternal deaths and new HIV transmission have declined. But incidences remain relatively high in several countries.

Young people, particularly girls, bear a **disproportionate** burden of poor sexual and reproductive health outcomes. This hinders their smooth transition into adulthood and affects their immediate and lifelong health (physical and mental) and socioeconomic wellbeing and empowerment.

What more needs to be done?

More advocacy is needed to ensure that:

- the remaining 11 countries ratify the protocol
- countries with reservations about some of the articles in the protocol address them
- those who have ratified it fully domesticate and implement its provisions.

Such advocacy should be informed by contextually relevant evidence on sexual and reproductive health, including what works in addressing harmful practices, increasing young people's access to information and services, and reducing new HIV infections and maternal deaths.

The partnership between all actors working to ensure that women's health and reproductive rights are realised should be reinvigorated and sustained to make certain that gains are consolidated and not reversed.

Entrenching a culture of equity around sexual and reproductive rights will also require tailored engagement with community and

religious leaders to build their capacity on matters of sexual and reproductive health. Sustained funding of civil society organisations working to ensure women's rights is also key, and so is the need to bolster the women's movement on the continent.

Juliet Kimotho, senior advocacy officer at the African Population and Health Research Center, contributed to this article.

Source: The Conversation, 16 July 2023. <https://theconversation.com/africas-groundbreaking-womens-rights-treaty-turns-20-the-hits-and-misses-of-the-maputo-protocol-209607>.

Africa CDC, WHO and RKI launch health security partnership to strengthen disease surveillance in Africa

World Health Organization

On 18 July 2023, the Africa Centers for Disease Control and Prevention (Africa CDC), the WHO and the Robert Koch Institute (RKI) launched the Health Security Partnership to Strengthen Disease Surveillance and Epidemic Intelligence in Africa. The partnership aims to strengthen Africa's health security capabilities in the areas of biosecurity, integrated disease surveillance, event-based surveillance, genomic surveillance and epidemic intelligence. The partnership seeks to encourage strong country leadership. The first phase will be implemented in six African Union member states including the Gambia, Mali, Morocco, Namibia, Tunisia and SA, and will later be expanded to additional countries.

Strengthened disease surveillance is a foundational requirement for health security. Substantial progress has been made in disease surveillance across Africa over the past decade, but it is worth noting that the continent experiences more outbreaks and other health emergencies than others, and many of these are preventable or controllable with proven public health interventions. The COVID-19 pandemic highlighted the critical role of the public health laboratory in surveillance as well as the necessity

for advancements in data collection, management, reporting and dissemination to ensure evidence-based policy-making during health security emergencies.

In response, the health security partnership in Africa works to improve integrated disease surveillance capabilities across the continent in order to better detect, confirm and notify health security threats. "The multi-country project consultation and launch meeting is a significant milestone towards strengthening surveillance and epidemic intelligence capabilities in Africa. It provides a platform for sharing experiences and best practices, which will be essential for the success of the project," said Dr Yenew Kebede, head of laboratory systems and networks at Africa CDC.

With a shared commitment to supporting African countries to strengthen health systems and safeguard public health, the WHO's regional offices for Africa and the Eastern Mediterranean have been working closely with the Africa CDC under the Joint Emergency Action Plan (JEAP) framework to strengthen public health surveillance, promote regional co-operation and address health challenges in Africa. The health security partnership in Africa will contribute to the overall collaborative framework by

delivering concrete results in the areas of emergency preparedness and response, surveillance and laboratory capabilities, and help protect the health of people in Africa through a better-co-ordinated and more resilient health system.

"Our collective ability to prevent, prepare for and respond to healthy security emergencies remains critical to keeping our communities safe," said Sara Hersey, director of collaborative intelligence at the **WHO Hub for Pandemic and Epidemic Intelligence**. "Through this partnership, the WHO remains dedicated to working with member states to systematically strengthen our capabilities and collaboration across stakeholders, sectors and borders for more effective and collaborative disease surveillance in Africa."

Funded by the government of Canada's Weapons Threat Reduction Program and aligned with the health security objectives of the **G7-led Global Partnership Against the Spread of Weapons and Materials of Mass Destruction**, the health security partnership in Africa signifies a collective commitment to collaboration at the health security interface, and will play a catalytic role in accelerating the building and pooling of capabilities and expertise for disease surveillance and epidemic intelligence in and for Africa.

Hospital histories: Valkenberg today ... and 130 years ago

Biënne Huisman, for *Spotlight*

In Cape Town between the Liesbeek and Black Rivers, Valkenberg Psychiatric Hospital's original building – dating from around 1770 – cuts an imposing silhouette. One of the area's oldest surviving homesteads, it is three storeys high, light pink with a steeply pitched roof and one tall turret flanked by dormers. Around it shrubs are neatly trimmed, lilies bloom in winter-wet soil, and guinea fowl chase around on lawns.

Inside the historic building, now mostly used for administration, the head of the facility's clinical unit, Dr Qhama Cossie, and deputy nursing manager Mapitsi Photo are seated at a small boardroom table. Photo checks their records, saying that on the day of our interview, they have 441 patients. Available beds remain a challenge at the tertiary hospital, affiliated to the University of Cape Town (UCT). Admitting referrals only, the hospital consistently runs at full capacity, with long waiting lists. Currently, their forensic waiting list is 14 - 30 days for minor offences, and for serious offences, 14 months. Hospital staff include 241 nurses, 11 psychiatrists, 7 psychologists, 10 social workers and 8 occupational therapists.

Earlier this year, the man accused of setting fire to two buildings – the National Assembly and the Old Assembly – in the parliamentary precinct, Zandile Mafe, was sent to Valkenberg for psychiatric evaluation, where an initial mental health diagnosis was paranoid schizophrenia. He later applied to the Western Cape High Court to send him for observation at a psychiatric hospital in the Eastern Cape.

The ins and outs of admission

Explaining the admissions process for cases like Mafe's and others, Cossie says that at Valkenberg they have two sections – clinical and forensic admissions.

"So patients enter through two different Acts," he says. "To be a forensic patient, you need to come through via the Criminal Procedure Act [No. 51 of 1977]. So if there's a charge and there's a question [about] mental illness, that person might be sent for observation.

"Let's say there's a crime, but there might be mental illness involved. Then the courts rule that the accused has a 30-day observation period. Over 30 days, you are assessed by



Valkenberg Psychiatric Hospital

a psychiatrist. The decision that they make can be that you're fine, that you don't have a mental illness, or that your mental illness did not influence your behaviour. Then you can go back to court and the court process can proceed.

"Or they might say that, actually, you're not fine, you're not well enough to appear in court. Or at the time when you committed an offence, you were sick and influenced by the mental illness. So you go back to court, but the court process doesn't proceed. You are then made a state patient," Cossie explains.

On the other hand, there are clinical admissions. "Then we have the general side, the acute side," he says. "Where people come through under the Mental Health Care Act [No. 17 of 2002] under which you can either be a voluntary patient, where you have an illness and you want help, and you have the capacity to make this decision. Or you can be an assisted patient where you want help, but you lack capacity. And then there's involuntary where you lack capacity, and you don't want help, but you are deemed to need help."

Managing risk

Cossie says mental healthcare has become decentralised, with most patients being treated by general practitioners at clinics or district hospitals nearest to where they live. A contributing factor to this is the availability of

antipsychotic medication. He says only about 10% of mental health patients are referred to psychiatric hospitals like Valkenberg.

"At the hospital, we manage risk," says Cossie. "If the risk is low, then you can take treatment as an outpatient. But if the risk is high, that's where you might need to stay at the hospital. The kind of risk varies. So there [are] people who are at risk to themselves. They might hurt themselves. There [are] people who are a risk to others, [and] there [are] people who are at risk from others, for example, someone who is vulnerable on the streets."

The SA Mental Health Care Act was passed into law in 2004, a major juncture, placing the focus on human rights and the humane treatment of patients.

Cossie says the Act has strict guidelines for aspects such as mechanical restraint and seclusion. "Back in the day, straitjackets and other restraining mechanisms were used. But nowadays we've got chemical restraints – medication. Someone who is very, very ill might need to be held down in order to give them medication. But even that is legislated. So if you do have to hold someone down, you have to report to the mental health review board. And those forms go through to a High Court judge."

A glimpse inside

Around the administration building, a few other historic buildings stand abandoned,

waiting to be restored. Newer buildings and wards have been added, but Cossie says infrastructure remains a challenge.

At a more recent building, Photo guides us past a security guard into the clinical high-care unit, where male and female patients stay in separate wards. The foyer is decorated with fabric applique art. It is quiet with empty grey laminated chairs – visiting hours are only later, from 2 pm until 4 pm. Rules for visitors posted against the wall dictate that no cellphones or cameras are to be used inside and that no glass bottles or tins are allowed.

In the women's high care ward, presently 27 patients are being treated for various illnesses, including borderline personality disorder, schizophrenia and bipolar disorder. At the time of our visit, the patients are seated at tables having lunch. Many are wearing dressing gowns – these are handed to them because of the winter cold, a nurse explains. The seclusion room, where patients might be kept while medication takes effect, has a mattress and a heated floor. Patients at high risk to themselves are not allowed to wear clothes inside the seclusion room, the nurse explains, as they might use the garments to hurt themselves.

Past and present

In the historic administration building, Photo guides us past another security guard along a corridor with wooden floors, past an old marble fireplace and forensic observation consultation rooms, to Valkenberg's museum inside a sunlit room. Here, old equipment and surgical tools are on display, along with old staff photographs and framed extracts from a visitors' rule book dated 1927. "Visitors should be careful not to make any promises to patients or to excite hopes that cannot be fulfilled ..." reads the document.

Adjacent to the museum room is an old isolation room – its walls and door padded. A straitjacket with leather straps is draped over a chair next to a stretcher carved from wood. Also on display are bulky equipment used for administering electric shock treatment, a source of controversy in the past following media depictions such as in the 1962 novel *One flew over the cuckoo's nest*, later made into a film.

Photo explains that these days electroconvulsive therapy (ECT) is administered under general anaesthesia. "It is used when patients do not respond to other treatment," says Photo. "We do it in theatre here. Patients are put to sleep with anaesthesia and then electrodes are applied. It is effective. It works."



ECT is available in SA's private and public sectors and is used around the world for treating major depressive disorders or mania in people who do not respond to other treatments. The procedure sees small electric currents pass through the brain, intentionally triggering a brief seizure. It is believed this can cause changes in brain chemistry, which can reverse symptoms of some mental health conditions.

Valkenberg's museum reflects how attitudes to mental healthcare have changed over the years.

Last October, at an event to mark Valkenberg's 130th birthday (postponed by a year due to COVID), government officials revisited the facility's "scandalous" past, noting how much has changed. At the event, Valkenberg principal specialist Prof. Sean Kaliski said, "This hospital has come through many scandals. When I arrived in 1989 it had about 2 000 beds. Most of the wards had chronic patients living in abysmal conditions... It was horrendous under apartheid. Many of the staff were denigrated, humiliated," as reported in the *Cape Argus*.

During apartheid, black and white patients were separated.

"The hospital used to be on two campuses," says Cossie. "So there's this Observatory campus, which was for white patients and then there's also the Pinelands campus, across the freeway – the Oude Molen side – that used to be the non-white side of the hospital."

Cornelius Valk's estate

UCT Department of Archaeology records note that some of the earliest descriptions of the land stem from Dutch farmer Cornelius Valk's estate in 1721 – which mentions modest dwellings with "afdakjes" (lean-tos). The present building was probably built around 1770 by farmer Cornelis de Waal. In 1881 the Cape Colony Government brought the land for use as a "reformatory."

The archaeology report, dated 1993, states: "In 1891 modifications were made to

the werf [farm yard] and existing buildings to accommodate the needs of the first 250 psychiatric patients housed at Valkenberg Hospital."

The building was declared a national monument in 1986.

Since 1994, notable improvements have been brought about by Friends of Valkenberg, a non-profit organisation founded by Francoise Robertson, wife of then-head of psychiatric services at UCT, Prof. Brian Robertson. The organisation also successfully petitioned against a Western Cape provincial cabinet proposal to close the hospital in 1998 "with the intention of rationalising services".

Over the years, Valkenberg has had many famous patients, including anti-apartheid poet Ingrid Jonker, who was first admitted with depression in 1961. Four years later, Jonker ended her own life. Jonker's mother, Beatrice, was admitted to the institution several times too, notably while she was 7 months pregnant with Ingrid, according to the poet's biography by Petrovna Metelkamp.

Author K. Sello Duiker recalls his time at Valkenberg in his 2001 novel *The quiet violence of dreams*, where protagonist Tshepo is committed for cannabis-induced psychosis. "Sometimes I just pray for the light of day when I will be able to breathe again instead of holding my breath with fear," says Tshepo. Duiker took his own life in 2005.

Speaking in gentle tones, Cossie says patients do get better, though. For him, what sets psychiatry apart from other medical fields is close relationships and rapport with patients. "I think it's more relational," he says. "Even if someone is on medication, you need to have a relationship with them to get them to trust you to take their medication. The key ingredient is rapport."

Source: Spotlight, 10 July 2023. <https://www.spotlightnsp.co.za/2023/07/10/hospital-histories-valkenberg-today-and-130-years-ago/>.

Leading through a crisis: 10 invaluable lessons from a healthcare leader in the COVID-19 pandemic

Dr Brenda Kubheka



As a leader in the healthcare industry, navigating through the pandemic was a disruptive, humbling and eye-opening experience. The challenges we faced included stretched capacity and burnout. The pandemic also highlighted the fragility of the funding model for the emergency departments in the private sector. The experience provided valuable lessons that have transformed how I approach leadership. Indeed, leaders had to go beyond being transactional and adopt a more caring approach towards their team members.

Here are my 10 takeaways:

Wellbeing is the foundation and a non-negotiable: The wellbeing of the individuals and teams directly impacts patient care. Prioritising mental and physical health initiatives within our organisations is a must. Supporting mental and physical health initiatives leads to more productive and resilient teams.

Health workers are human: The pandemic reinforced that our healthcare heroes have lives beyond the workplace. Recognising and supporting their responsibilities as spouses, parents, and caregivers enhances their wellbeing and ultimately boosts morale and productivity.

Vulnerability cultivates psychological safety and builds trust: Leaders don't have to be invincible. Admitting uncertainty and fear humanises leaders and allows for open conversations, bonding teams and fostering a culture of support.

Inclusion improves decision-making: Diverse perspectives drive innovation and better decision-making and enhance patient-centred care – every health worker matters, from nurses to cleaners and porters. Every voice matters when changes are considered and policies developed, because these will impact different people differently within organisations.

Mindfulness increases capacity: Leading in healthcare demands a leader's undivided attention, but it is equally vital to allocate quality time to family, friends and self-care. Leaders constantly make decisions with far-reaching consequences. Distractions can be disastrous to the self, the team and organisation. Integrating mindfulness practices into daily routines enhances resilience and empowers leaders to handle challenges with a clear and focused mind.

Compassionate leadership is vital: Leaders should have empathy and be able to connect and support team members during tough times. Celebrating small wins and recognising efforts fosters a positive work environment. Leaders should use both their hearts and heads to inspire and motivate others.

Adaptability and flexibility facilitate better response to change: The pandemic disruptions reminded us about the fragility of life and the health system. Adapting to changing circumstances with agility ensures that our healthcare services are responsive and relevant to the given context.

Collaboration is necessary: The crisis highlighted the power of collaboration across departments, sectors, organisations and even borders. It was a reminder that health happens outside the health system, therefore calling for health leaders to be

intentional about intersectoral co-operation to improve health.

Preparedness pays off: The pandemic taught us that disaster management is a continuous and integrated process. Learning from the pandemic experience should inform future investment in disaster preparedness plans, skills, financial risk assurance and other resources to ensure effective responses to any future crisis.

Prioritising the wellbeing and growth of the workforce creates an environment where employees feel valued, supported and motivated

Digital transformation accelerates capacity to serve: The pandemic accelerated the adoption of healthcare technology in an unprecedented manner, including rash deployment of some technologies. Healthcare leaders must adopt a holistic approach and assess their organisation's current digital status and skills to inform the adoption of a model that will assist in translating ideas into practical strategies. Critically, leaders need to acknowledge and manage the impact of the digital divide on their employees and its negative impact.

When organisations prioritise the wellbeing and growth of their workforce, it creates an environment where employees feel valued, supported and motivated. A caring workplace cultivates a sense of community and empathy, promoting better mental and emotional health among team members. Ultimately, it becomes a win-win situation, benefiting both the employees and the organisation's overall success.

Why hospital security guards can't keep doctors and nurses safe and how to fix it

Zano Kunene, for *Bhekisisa*

An aggressive patient stabbed two doctors in an emergency room at the Kimberley Hospital.

A nurse shot and killed by her off-duty policeman boyfriend at Tembisa Hospital.

Patients were robbed and one killed in a Northern Cape hospital while recovering after treatment.

Government hospitals and clinics should be safe. But they're not – and at least part of the reason is that security guards aren't trained for every type of situation they have to handle at these facilities.

Between 2017 and 2022, around 200 violent incidents at public hospitals were reported across four provinces. And that's only security issues that were big enough to get noticed. Petty crimes such as theft from patients or staff, verbal abuse or cases where a situation is diffused can easily fall by the wayside.

To make hospitals safe, security guards need training to help them deal with angry, emotional or aggressive situations, on top of general safety issues such as protecting property and monitoring access to a facility.

But they're ill equipped.

Why?

Because to get a job as a security guard at a hospital, tenders require personnel to have only general training – the same as that guards working at, for example, residential complexes or shopping malls must have. Moreover, any setting-specific training, such as knowing how to deal with aggressive patients, is up to the company who gets the government contract.

“Not everyone is a criminal”

Security services at state hospitals and clinics are generally outsourced to private providers after a tender process.

To work as a security officer in SA, someone must be registered with the Private Security Industry Regulatory Authority (PSIRA) and have completed a training course with one of their accredited providers before that.

Training is offered at five grading levels. At the most basic level, grade E, new recruits learn patrolling skills, how to use radios, handle firearms and use equipment such as fire extinguishers, and self-defence. An



A-grade guard can work as a supervisor and so manage groups of security staff working in a facility like a hospital.

In tender documents for providing security services, most security guard jobs at state hospitals and clinics need at least a grade C qualification, which means these workers should know how to handle access registers, search people coming into the facility and make sure everyone on the premises is safe.

Tasks include, for example, controlling access at gates and doors, apprehending thieves, making sure that portable equipment doesn't get stolen, ensuring that patient files are kept safe, monitoring CCTV cameras around the facility and handling emergencies such as a protest.

Although some of these situations need forceful action, dealing with, for example, upset or distraught family members of patients or impatient visitors requires a different approach.

Marié Venn, a doctor who used to work at the psychiatric ward of a public hospital in Cape Town, says the generally required qualification of safety staff doesn't equip them to deal with the human side of managing safety risks.

After having experienced life-threatening incidents herself, like when a patient became

aggressive after being told that he couldn't be admitted, she started *Conquer Crisis*, an organisation that teaches health workers and security guards who work at hospitals skills to diffuse dangerous situations without using force.

“It's important to educate security guards on what kind of patients we see, and that someone at a hospital [a patient or visitor] is not necessarily a criminal,” she explains.

For example, in an emergency room a patient who's been waiting for a long time may become upset and threaten staff or other people in the area.

In an ongoing study investigating the role of security workers at public facilities where aggressive situations may arise, such as hospitals, emergency rooms and psychiatric institutions, researchers from Stellenbosch University found that some of the workers had previously been stationed at shopping centres before being deployed to the hospital at short notice.

According to the small number of security guards interviewed, they had not received formal training to, for example, calm aggressive patients down without using force (called *de-escalation*) or on confidentiality when it comes to patients' diagnoses, to prepare them for the type of patients or situations they might have to

deal with, says Lindokuhle Shongwe, one of the investigators and a researcher from the department of psychology at Stellenbosch University.

This is very different from security risks at, say, a shopping centre, where guards are mostly expected to deal with shoppers who need help (for example, asking for directions) or looking out for property being stolen.

Special safety skills

Phillip Davids,* a security guard who worked at a psychiatric facility, once had to restrain a patient.

"The company I worked for didn't give training, so it wasn't something I knew how to do."

Every healthcare facility has to identify the type of skills their security guards need, says Ugavaree Subramaney, head of the clinical unit at Sterkfontein Hospital.

For example, at a mental health institution, guards should have a general idea of the type of behaviour different patients may display. This can help them understand, for example, when a patient could become agitated, and know how to manage them correctly, says Subramaney.

But in, say, an emergency unit in a children's ward, security guards would need to know [how to handle kids who are upset or lash out](#) and who may need to be calmed down differently from an adult patient or visitor, without using force.

The right type and number of security staff should also be deployed at a facility. For example, for settings where patients could become aggressive or where physical restraint would be necessary, male security guards are likely to be a better fit, simply because they might have more strength, says Subramaney.

Also, a facility like a hospital in a city, which sees many patients, operates around the clock and occupies large premises, would need more security staff than, say, a clinic in a rural town.

For example, a regional hospital in the Eastern Cape, which is open 24 hours a day, has to treat patients in many different wards and has an emergency room, requires [around 120 guards](#). But a [tertiary hospital](#) in the same province (a facility that offers specialised services like intensive care and surgery to patients from regional hospitals) in the same province, only needs [about 64 guards](#).

When safety goes wrong

When a dangerous situation develops at a hospital or clinic, health staff must be able to call a guard. The first-line response should be de-escalation to prevent things from turning violent. But if the person is holding a dangerous weapon or if trying to talk them down isn't working, having to use restrictive measures like [physically restraining someone](#) may be necessary, says Venn.

To make hospitals safe, security guards need training to help them deal with angry, emotional or aggressive situations

Even then, there are better and worse ways to do it. For example, holding someone's arm behind their back to limit their movement can give staff in the unit a chance to [take control of a dangerous situation](#). Healthcare staff from a hospital in Cape Town reported using [physical restraint often to protect themselves and patients](#) who suffer from nervous system disorders. This was mostly to prevent confused patients from falling or pulling out intravenous drips, but in some cases patients also became violent.

If a dangerous situation, and especially one where physical restraint is required, isn't handled correctly, people may get hurt unnecessarily. For example, in Greenville in the USA, [a guard restrained a patient in a facedown position, fatally restricting their airflow](#).

In the [UK in 2017](#), a security officer killed an agitated patient by using too much force while restraining him. An investigation showed that using restraint was "not necessary".

Safe spaces

To improve the way dangerous situations are handled at hospitals and clinics, the Western Cape health department created a course to train security officers working at their facilities.

The course is still being tested, but once it's up and running, security guards will be able to complete it either online (data free) or in person, without having to pay for the training.

According to Mark van der Heever, deputy director of communications at the Western Cape health department, guards will learn in a single 2- to 3-hour session how to handle challenging situations with de-escalation techniques. This will include training on how to communicate well with people in a healthcare setting, and also teaching security guards to look after their own mental health.

In a [2021 study in China](#), nurses at a psychiatric facility who received 1 month of de-escalation training used physical restraint less often to deal with aggressive patients than a group of nurses who didn't get this training. When they did have to use force to calm patients down, they incurred fewer injuries. The first set of observations were 6 months after the training, and the trend continued for another 6 months.

De-escalation training for healthcare staff doesn't necessarily [reduce the number of violent incidents, but rather increases staff's confidence in handling them](#). But some research shows that the [improvement holds only for a short time](#), and so staff [may need regular refresher courses](#).

The Western Cape's course aims to do this, as security guards will receive a certificate after training that will be valid only for 6 months. They will have to do a refresher course after this. For continued safe security services, the department also plans to make it a contracting condition that all guards at healthcare settings must have this type of training, says van der Heever.

Nomawabo Kona, a security guard who's had training specifically for working at a hospital earlier this year, says she now feels more confident in dealing with patients in an emergency department.

"Since getting the training, I learnt how to escort and speak to [difficult visitors] and protect the nurses. I feel better and take charge of the way I work now."

**Not his real name.*

Source: Bhekisisa, 1 August 2023. <https://bhekisisa.org/article/2023-08-01-why-hospital-security-guards-cant-keep-doctors-and-nurses-safe-and-how-to-fix-it>.

World Patient Safety Day 2023: Engaging patients for patient safety

World Health Organization

World Patient Safety Day 2023 will be observed on 17 September under the theme “Engaging patients for patient safety”, in recognition of the crucial role patients, families and caregivers play in the safety of healthcare.

Evidence shows that when patients are treated as partners in their care, significant gains are made in safety, patient satisfaction and health outcomes. By becoming active members of the healthcare team, patients can contribute to the safety of their care and that of the healthcare system as a whole.

Through the slogan “Elevate the voice of patients!”, the WHO calls on all stakeholders to take necessary action to ensure that patients are involved in policy formulation, are represented in governance structures, are engaged in co-designing safety strategies and are active partners in their own care. This can only be achieved by providing platforms and opportunities for diverse patients, families and communities to raise their voice, concerns, expectations and preferences to advance safety, patient centredness, trustworthiness and equity.

Patient and family engagement was embedded in the resolution [WHA72.6 – “Global action on patient safety”](#) and the [Global Patient Safety Action Plan 2021 - 2030](#) as main strategies for moving towards eliminating avoidable harm in healthcare. World Patient Safety Day is one of the [WHO’s global public health days](#). It was established in 2019 by the 72nd World Health Assembly through the adoption of resolution WHA72.6 – “Global action on patient safety”. Its objectives



are to increase public awareness and engagement, enhance global understanding and work towards global solidarity and action by member states to enhance patient safety and reduce patient harm.

Objectives of World Patient Safety Day 2023

- **Raise** global awareness of the need for active engagement of patients and their families and caregivers in all settings and at all levels of healthcare to improve patient safety
- **Engage** policy-makers, healthcare leaders, health and care workers, patients’ organisations, civil society and other stakeholders in efforts to engage patients and families in the policies and practices for safe healthcare
- **Empower** patients and families to be actively involved in their own healthcare

and in the improvement of safety of healthcare

- **Advocate** urgent action on patient and family engagement, aligned with the Global Patient Safety Action Plan 2021 - 2030, to be taken by all partners.

Working together to make healthcare safer

The global campaign for World Patient Safety Day 2023 will propose a wide range of activities for all stakeholders on and around 17 September, including national campaigns, policy forums, advocacy and technical events, capacity-building initiatives and, as in previous years, lighting up iconic monuments, landmarks and public places in the colour orange (the signature mark of the campaign).

For further information, please contact us at patientsafety@who.int.

Stellenbosch University medical students use technology to boost organ donation

SAMA Communications

During International Organ Donor month in August, a group of Stellenbosch University (SU) medical students used technology to raise awareness of organ donation, aiming to reach more than

1 million South Africans by the end of the month.

The initiative, driven by Save7, a non-profit organisation founded by students, plans to share the message that every South

African has the potential to save seven lives by donating their kidneys, heart and lungs after they die.

Third-year medical student Jonty Wright (20) founded Save7 after meeting patients in hos-

pital who were desperately awaiting organs, and harnessed technology to help them.

First he built a website to raise awareness, and then taught himself to program an artificial intelligence (AI) chatbot to answer questions about organ donation in SA. "Think of it like ChatGPT, except it's an expert in the field of organ donation," he said of his invention.

"Awareness about organ donation is especially low among the younger generation, and we needed to make this difficult topic easier for the public to engage with, so we focused our narrative more on 'multiplying life' in the present, than on thinking about death in the future."

"You can use [Save7.org](https://www.save7.org) to sign up and leave a personalised message for your next of kin, which, along with your signature, creates a legally recognisable testament of your commitment to donate your organs. The entire process takes less than a minute and is absolutely free. This is a first in SA!"

"This campaign has the potential to boost organ donation not only in SA, but worldwide. Everyone should support it!"

The Save7 team has also made it easy for users to encourage their friends and family to register as donors and have the same conversations with their family using a WhatsApp application programming interface (API). As Wright puts it, "by signing up, you can save seven lives, but by encouraging your network to do the same thing, you can save exponentially more."

But their efforts don't stop at raising awareness. Since its inception, Save7 has developed back-end data systems that simplify the complex administrative processes involved in transplant referrals and patient support groups. "As you dive deeper into the organ donation ecosystem in SA, you discover that there are many gaps for potential donors to fall through, such as inefficient referral systems, lack of centralised databases and poor patient support, to name a few."

Save7 has teamed up with [VulaMobile](https://www.vulamobile.co.za/) to create an easy-to-use referral portal for doctors



Matipa Ledwaba, a Save7 member with founder Jonty Wright

to refer potential donors to transplant units. "The point is to make this referral as easy as possible for healthcare professionals. It's truly a tragedy when willing donors with healthy organs are missed because the current referral process is inconvenient for doctors."

The Save7 team also established the first renal patient support group at Tygerberg Hospital, which now boasts 50 members. "It's easy to get caught up in solving the big problems and forget about the people in front of us. Our goal with the support groups is not only to provide a much-needed community for our patients, but to create a framework that other public hospitals can use to follow in our footsteps," says Naazim Nagdee, Save7's vice-president.

The support group is driven by former patient and transplant recipient, Melissa Jacobs. "When I was on dialysis, I really would have appreciated some support. Someone coming to educate me about my condition, how to look after my body, how to be self-sufficient, and most importantly, how to handle the emotional and psychological impact that this condition has on me," said Jacobs. "After my transplant my doctor told me about Save7, and I saw the opportunity to get involved and provide to those still on dialysis what I needed."

Prof. Elmin Steyn, transplant surgeon and head of surgery at SU and Tygerberg Hospital, is full of praise for her students' initiative. "It is heart-warming to see compassionate young medical students deploy AI technology and

social media to help the less fortunate. This campaign has the potential to boost organ donation not only in SA, but worldwide. Everyone should support it!"

Their goal is to create a system that can easily be replicated and implemented by other students, doctors, and transplant co-ordinators worldwide. "We're striving for a plug-and-play solution," said Sachin Naidu, Save7 treasurer. This mission involves meticulously documenting their progress, analysing what strategies proved effective and what fell short. They aim to provide structural and organisational templates that could aid future organ donation initiatives across the continent.

"We were inspired by the principle of open-source software – it lays out the basic framework for others to copy and paste to their own unique environments," Naidu explained. The Save7 team believes that by sharing their campaign experiences in a developing country, they can simplify the process for others in similar situations. "We like to think of it as developing a care package that can be deployed anywhere."

Save7 is endorsed by the SA Transplantation Society (SATS), Mediclinic, the Organ Donor Foundation as well as SU, and is entirely student-driven and donor-funded.

If you would like to help them achieve their mission, you can get in contact with them, or donate to support their efforts on [Save7.org](https://www.save7.org).

Loadshedding affects SA healthy lifestyles

SAMA Communications

Loadshedding dishes up a wide range of inconveniences and frustrations, but it may well be having far more serious effects when it comes to our eating habits. There are increasing concerns that extensive and sustained power cuts are leading to a rise in fast food consumption as South Africans experience fewer uninterrupted opportunities to prepare fresh meals at home. It's our health, and the health of our loved ones, that will take a toll from this pivot to takeaway and convenience meals.

Registered dietitian Zitandile Mfono, who is also a spokesperson for the Association for Dietetics in SA (ADSA), says, "It's a pity that the positive home cooking trend we saw during COVID lockdowns is now being reversed due to the frequency of loadshedding during meal preparation times. It's already a challenge for working parents to put healthy, home-cooked meals on the table due to their busy lives, and now they must contend with power outages just as they get home from work and start to focus on making dinner. It's not surprising that people are opting for more convenience foods in these difficult circumstances. However, this means an increase in high-fat, high-salt and high-sugar foods in the family diet. With the country's high rates of obesity and type 2 diabetes, these are the kind of dietary changes our nation cannot afford. In addition, at a household level, increased consumption of takeaway foods leads to higher monthly food costs."

Zitandile recommends investing in, or even making your own, "wonder cooker", which uses heat-retaining technology to slow-cook food without the need for electricity or gas. The wonder cooker, also known as a wonderbag, works like a slow cooker but requires no electricity or gas. It can be used to prepare any recipe that involves boiling, roasting, simmering or steaming food. It can also be used to keep food warm for hours, like a thermos flask. Zitandile says, "You can prepare and bring a pot of soup or pap to the boil in the morning before work, take it off the stove and tuck it into the wonder cooker for the day. The heavily insulated bag will keep it at a low safe temperature for hours, and when you return from work in the evening, you will have warm, fully cooked food waiting for you. Wonderbags are hand-made, and you can find patterns and tutorials online, which makes them an economical solution for families."



According to Chanelle Retief, also a registered dietitian and ADSA spokesperson, there are some hacks that can help you to keep your focus on your family's healthy lifestyle despite the hardships of loadshedding. She says, "We need to adapt to loadshedding as best we can, and while ordering in takeaways can be a quick fix for a hungry family, the longer-term impacts on our health and our pockets mean this is not a sustainable solution."

Chanelle's recommendations are to:

- Invest in an inexpensive gas stove back-up: "You don't have to go out and replace your oven with a gas alternative. Rather invest in a small two-plate gas stove to use when you need to cook while there is loadshedding. The added benefit of gas is that it heats up much quicker than an electric stove, so you should save on cooking time as well as energy costs."
- Focus more on salad-based meals: "Add a few more tasty salad recipes to your repertoire so that you can put together delicious and filling meals when the power is off. When making a salad for lunch or dinner, always try to add a protein source to it by including leftover cooked chicken or meats, lentils or beans, eggs or cheeses. Tinned tuna is also a great loadshedding alternative as it does not need any cooking or heating."
- Plan ahead and in more detail: "The old saying 'failing to plan is planning to fail' is so true when it comes to power outages. It makes it easier to manage the impact of loadshedding on meals if you plan meal preparation, and the details of each of the

upcoming week's meals. Integrate your schedule and the loadshedding schedule, so that when you shop for food, you buy only what you know you need and can prepare."

- Make healthier choices if you are ordering in: "If you really have no choice and you need to buy takeaways – keep the plate model in mind. 50% of your plate should be veggies, 25% should be healthy carbs and 25% should be lean protein. Try and stay away from anything that is fried or 'creamy'. Never opt for the 'upsized' or 'buy one get one free' options."
- Be aware of increased food waste: "If your cooking gets interrupted frequently, or loadshedding often kicks in before you get started, you may find that you are throwing away greater quantities of food. Remember that food waste is a preventable expense. Being conscious of avoiding food waste will help you to use up what you have in your fridge before it spoils. If you don't think it's likely you will consume the food you have in time, then rather donate it."

While we have to live with loadshedding, we can look to mitigate the potential harms. As we adapt to meal disruptions, it may be time to try new ways of maintaining the family's healthy lifestyle. Chanelle concludes, "Despite the hardships of loadshedding, we must keep our focus on the family making healthy eating choices daily. This may mean that we need to try out some new recipes and dishes, such as nutrient-dense smoothies, salads that include protein and grain bowls."

As heat records fall, how hot is too hot for the human body?

W Larry Kenney, professor of physiology, kinesiology and human performance, Penn State, Daniel Vecellio, geographer-climatologist and postdoctoral fellow, Penn State, Rachel Cottle, PhD candidate in exercise physiology, Penn State, S Tony Wolf, postdoctoral researcher in kinesiology, Penn State

Extreme heat has been breaking records across Europe, Asia and North America, with millions of people sweltering in heat and humidity well above “normal” for days on end.

Death Valley hit a temperature of 128° Fahrenheit (53.3° Celsius) on July 16, 2023 – not quite the world’s hottest day on record, but close. Phoenix broke a record heat streak with 19 straight days with temperatures above 110°F (43.3°C), and had more in the forecast, accompanied by several nights that never got below 90°F (32.2°C). Globally, earth likely had its hottest week on modern record in early July.

Heat waves are becoming supercharged as the climate changes – lasting longer, becoming more frequent and getting just plain hotter.

One question a lot of people are asking is: “When will it get too hot for normal daily activity as we know it, even for young, healthy adults?”

The answer goes beyond the temperature you see on the thermometer. It’s also about humidity. Our research is designed to come up with the combination of the two, measured as “wet-bulb temperature.” Together, heat and humidity put people at greatly increased risk, and the combination gets dangerous at lower levels than scientists previously believed.

The limits of human adaptability

Scientists and other observers have become alarmed about the increasing frequency of extreme heat paired with high humidity.

People often point to a study published in 2010 that theorised that a wet-bulb temperature of 95°F (35°C) – equal to a temperature of 95°F at 100% humidity, or 115°F at 50% humidity – would be the upper limit of safety, beyond which the human body can no longer cool itself by evaporating sweat from the surface of the body to maintain a stable body core temperature.

It was not until recently that this limit was tested on humans in laboratory settings. The results of these tests show an even greater cause for concern.

The PSU H.E.A.T. Project

To answer the question of “how hot is too hot?” we brought young, healthy men and



women into the Noll Laboratory at Penn State University (PSU) to experience heat stress in a controlled environmental chamber.

These experiments provide insight into which combinations of temperature and humidity begin to become harmful for even the healthiest humans.

S Tony Wolf, a postdoctoral researcher in kinesiology at Penn State and coauthor of this article, conducted a heat test in the Noll Laboratory as part of the PSU Human Environmental Age Thresholds project. Each participant swallowed a small telemetry pill that continuously monitored their deep body or core temperature. They then sat in an environmental chamber, moving just enough to simulate the minimal activities of daily living, such as showering, cooking and eating. Researchers slowly increased either the temperature in the chamber or the humidity in hundreds of separate experiments and monitored when the subject’s core temperature started to rise.

That combination of temperature and humidity at which the person’s core temperature starts to continuously rise is called the “critical environmental limit.”

Below those limits, the body is able to maintain a relatively stable core temperature over long periods of time. Above those limits, core temperature rises continuously, and the risk of heat-related illnesses with prolonged exposures is increased.

When the body overheats, the heart has to work harder to pump blood flow to the skin to dissipate the heat, and when you’re also sweating, that decreases body fluids. In the most dire case, prolonged exposure can result in heat stroke, a life-threatening problem that requires immediate and rapid cooling and medical treatment.

Our studies on young healthy men and women show that this upper environmental limit is even lower than the theorised 35°C. It occurs at a wet-bulb temperature of about 87°F (31°C) across a range of environments above 50% relative humidity. That would equal 87°F at 100% humidity or 100°F (38°C) at 60% humidity.

Similar to the National Weather Service’s heat index chart, this chart translates combinations of air temperature and relative humidity into critical environmental limits above which core body temperature rises. The border between the yellow and red areas represents the average critical environmental limit for young men and women at minimal activity.

Dry v. humid environments

Current heat waves around the globe are exceeding those critical environmental limits, and approaching, if not exceeding, even the theorised 95°F (35°C) wet-bulb limits.

In the Middle East, Asaluyeh, Iran, recorded an extremely dangerous maximum wet-bulb temperature of 92.7°F (33.7°C) on 16 July

2023. India and Pakistan have both reached hazardous levels in recent years, as well.

In hot, dry environments, the critical environmental limits aren't defined by wet-bulb temperatures, because almost all the sweat the body produces evaporates, which cools the body. However, the amount humans can sweat is limited, and we also gain more heat from the higher air temperatures.

Keep in mind that these cutoffs are based solely on keeping your body temperature from rising excessively. Even lower temperatures and humidity can place stress on the heart and other body systems.

A recent article from our laboratory showed that heart rate begins to increase well before our core temperature does, as we pump blood to the skin. And while eclipsing these limits does not necessarily present a worst-case

scenario, prolonged exposure may become dire for vulnerable populations such as the elderly and those with chronic diseases.

Our experimental focus has now turned to testing older men and women, since even healthy ageing makes people less heat tolerant. The increased prevalence of heart disease, respiratory problems and other health problems, as well as certain medications, can put them at even higher risk of harm. People over the age of 65 comprise some 80 - 90% of heat wave casualties.

How to stay safe

Staying well hydrated and seeking areas in which to cool down – even for short periods – are important in high heat.

While more cities in the USA are expanding cooling centers to help people escape the

heat, there will still be many people who will experience these dangerous conditions with no way to cool themselves.

Even those with access to air conditioning might not turn it on because of the high cost of energy – a common occurrence in Phoenix – or because of large-scale power outages during heat waves or wildfires, as is becoming more common in the western USA.

All told, the evidence continues to mount that climate change is not just a problem for the future. It is one that humanity is currently facing and must tackle head-on.

Source: The Conversation, 19 July 2023.
<https://theconversation.com/as-heat-records-fall-how-hot-is-too-hot-for-the-human-body-210088>.



WORLD MEDICAL ASSOCIATION

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For enquiries, email samadoh@samedical.org or doh@wma.net

Why pain is so hard to measure – and how our study of brainwaves could help

Elia Valentini, senior lecturer in psychology, University of Essex

Every individual's experience of pain is unique – but that makes it harder to treat. The experience of pain remains impenetrable to scientists because it is so variable. So researchers and clinicians still rely on subjective ratings, such as asking patients to rate their pain on a scale of 0–10.

But my recent work, in collaboration with my colleague Enrico Schulz and his team, showed new insights into a type of brainwave called gamma oscillations that scientists think may be linked to pain perception.

For the first time, we showed that gamma oscillations differ greatly between people, but that people's response pattern to pain stayed the same over time. In other words, people who show no waves when in pain will probably not show them in a subsequent recording (when experiencing pain again), whereas those who show a large response will probably show it again.

Pain is variable by definition: the International Association for the Study of Pain defines it as a personal, unpleasant sensory and emotional experience that is influenced by biological, psychological and social factors.

Pain is often different in quality (dull, sharp, shocking, throbbing), and it may be hard to remember properly. To complicate matters, although nociception (the unconscious processing of unpleasant stimuli) usually leads to pain, research shows that one can exist without the other.

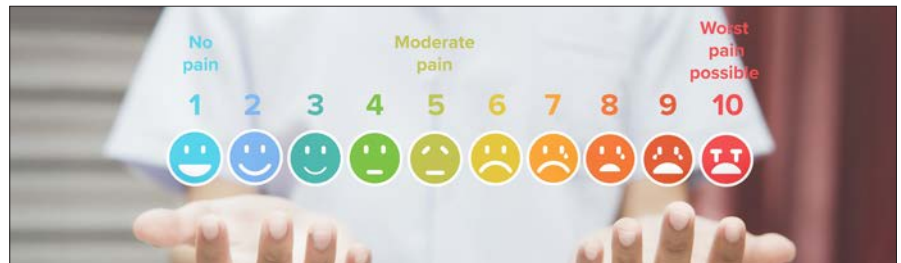
An objective marker of pain would bypass the distortions caused by cognitive and social factors. And it would help patients who cannot communicate (such as those in a vegetative state) as well as young children and babies.

The long search for a pain gauge

Over the past few decades, technological advancements have given researchers the opportunity to finally start developing an objective measurement of pain.

In the early 1990s, neuroimaging techniques such as PET [positron emission tomography] scans and fMRIs became a popular way to study pain. This led to a focus on physiological measures of brain activity.

Scientists became excited by the idea of identifying some sort of "pain centre" or "pain network" within the brain. However, studies of the brain activation during pain experiments



showed that even innocuous stimuli (for example, warmth, touch or vibration when participants weren't expecting it) can activate the brain similarly to painful stimuli.

Studies have also shown that the brain's response to painful heat is strongly influenced by the person's level of alertness and attention. Both your brain response and your conscious perception of pain are influenced by how much attention you pay to it.

There is growing evidence that brain response to pain doesn't always have a meaningful relationship to the level of pain a person is experiencing – heightened brain activity doesn't always mean heightened pain. Contextual factors, study methodology and biological differences between people can all affect brain activity. So, it became clear that technology alone wouldn't give us an objective measure of pain. Researchers needed to understand more about the brain's response to stimulation.

Brain oscillations

Decades of research have shown that the type of brainwaves called gamma oscillations are a good measure of human response to stimulus in general, not just pain. In the 2000s, experimental work showed that gamma oscillations increased in amplitude following both brief and prolonged thermal painful stimuli in healthy volunteers.

Gamma oscillations may control the connectivity between different brain regions. Patient research and recording of electrical activity within the brain seemed to support the idea that gamma oscillations could reflect pain perception better than any other brain response to pain.

Our recent work has demonstrated how gamma waves synchronised with painful thermal stimulation are unique to each person. For our experiment, we briefly induced pain using a thermal laser in 22 healthy male volunteers in

their 20s and 30s, then recorded their gamma wave responses. This not only pinpointed the extreme variability in people's gamma waves, but also showed that a person's response pattern is stable across time.

Our analysis of a separate study published in 2021, independent from ours but using similar methodology, also demonstrated variability between participants in their gamma wave response.

What our results mean

The more we understand about people's unique response to pain, the closer we can get to giving them the right pain relief. Our findings suggest we must rethink our interpretation of the relationship between pain and gamma oscillations, but that it's still too early for general rules. Some people will feel pain and have no gamma response, while others will show a large response.

It is also important to remember that brain mechanisms triggered by experimental pain in young healthy people are not necessarily the same as in those who have been shaped by long-term pain experience. For example, people with chronic pain conditions may have changes in their brain structure and response to pain.

As yet, no clinical trials involving gamma waves have been carried out, perhaps due to technical and ethical challenges involved in experiments that study chronic pain patients.

So, we don't yet know why different people have such different gamma wave responses to pain. But if gamma waves can reliably predict pain in a substantial percentage of the population, we could use this to diagnose, manage and treat pain conditions.

Source: The Conversation, 4 August 2023. <https://theconversation.com/why-pain-is-so-hard-to-measure-and-how-our-study-of-brainwaves-could-help-209823>.



Prescribing and selling of medicines

Karlien Pienaar, *administrator, SAMA Legal Department*

While there are certain benefits to dispensing medicines to patients, as mentioned in an earlier article, there are some aspects to keep in mind that could lead to a practitioner opting for prescribing instead of dispensing, especially for practitioners in urban areas where there are plenty of pharmacies.

Considerations to keep in mind, include the following.

Increased administration

With the dispensing of medicines, there is a responsibility on the practitioner to ensure that there is a safe and regulated dispensary on the premises. The purchasing and selling of medicines should also be regulated, and can add a significant administrative burden to the practice.

Conflict of interest

There is a risk that dispensing doctors could be influenced by the financial inducement to prescribe more medication or to favour certain medicines that they have in stock, for example. Irregular dispensing will also be picked up by medical schemes, and forensic investigations can cause additional and unwanted distress for the practitioner.

Patient safety

There are instances where pharmacists play an important role in patient safety, as they can pick up errors in prescriptions and prescriptions and incompatibilities between different medicines. The pharmacist also spends time advising and educating patients on their medicines.

In SA, the prescription and selling of medicines is well regulated in terms of the Medicines and Related Substances Act (MRSA) No. 101 of 1965, and the following information should be noted when it comes to the Schedules and repeat prescriptions:

"(i) Any schedule 0 substance may be sold in an open shop. It should be noted that doctors may not sell schedule 0 medicines in their rooms, as they are not permitted to keep an open shop in terms of the Ethical Rules of the HPCSA.

"(ii) Any schedule 1 substance may be sold by: a pharmacist, pharmacist intern or pharmacist's assistant acting under supervision of a pharmacist; a manufacturer of or wholesale dealer in pharmaceutical products; a medical practitioner or dentist who may prescribe such substance and is the holder of a licence to compound and dispense as contemplated in section 22C (1)(a); a veterinarian who may prescribe, compound and dispense such substance; and a practitioner, nurse or person registered under the Health Professions Act [No. 56 of] 1974, other than a medical practitioner or dentist, who may prescribe and is the holder of a licence to compound and dispense such substance as contemplated in section 22C (1)(a).

"(iii) Any schedule 2, 3, 4, 5 or 6 substance may be sold by: a pharmacist, pharmacist intern or pharmacist's assistant acting under supervision of a pharmacist who may sell only Schedule 2 substances without a prescription; a pharmacist or pharmacist intern or pharmacist's assistant acting under supervision in possession of a written prescription issued by an authorised prescriber or on the verbal instructions of an authorised prescriber; a manufacturer of or wholesale dealer in pharmaceutical products; a medical practitioner or dentist who may prescribe such substance and is the holder of a licence to compound and dispense as contemplated in section 22C (1)(a); a veterinarian who may prescribe, compound and dispense such substance; and a practitioner, nurse or person registered under the Health Professions Act 1974, other than a medical practitioner or dentist, who may prescribe and is the holder

of a licence to compound and dispense such substance as contemplated in section 22C (1)(a).

"(iv) In terms of section 22A (6)(f) of the said Act, a practitioner may provide a patient with a repeat prescription, which prescription shall not be repeated for longer than 6 months, in the case of schedule 2, schedule 3, schedule 4 or schedule 5 medicines. In the case of schedule 5 medicines, the prescriber must indicate on the prescription the number of times and the intervals at which it may be dispensed. Only where a schedule 5 substance is used for its anxiolytic, antidepressant or tranquillising properties, shall it not be prescribed for longer than 6 months unless the authorised prescriber has consulted a registered psychiatrist (or another registered psychiatrist) before issuing a new prescription; its analgesic properties it shall not be prescribed for longer than 6 months unless the authorised prescriber has consulted another medical practitioner before issuing a new prescription.

"(v) In terms of section 22A (6)(i) of the said Act, schedule 6 medicines shall not be repeated without a new prescription being issued and may only be sold if the course of treatment does not exceed 30 consecutive days. Schedule 6 medicines may not be repeated without a new prescription being issued.

"(vi) No person shall acquire, use, possess, manufacture or supply any schedule 7 or schedule 8 substance or manufacture any specified schedule 5 or schedule 6 substance unless he or she has been issued with a permit by the director-general for such acquisition, use, possession, manufacture or supply."

Any further queries may be directed to Karlien Pienaar, administrator in the Legal Affairs Department via email: karlienp@samedical.org.

Sources: MedCity News; *Medicines and Related Substances Act No. 101 of 1965*.

Claim defended over alleged misdiagnosis

Peter Mordecai, *claims manager, Medical Protection Society*

Patient K presented to consultant nephrologist Dr L with a history of pseudoseizures and reflux oesophagitis. An examination was performed where patient K was noted as having a low-grade fever, oedema of the limbs and a tender abdomen. Dr L diagnosed patient K with an infection.

Patient K returned to Dr L the next day, and informed them that they were also experiencing lethargy and lower limb discomfort and swelling. They informed Dr L that the symptoms were making it difficult for them to mobilise. Dr L therefore decided to perform a number of tests including autoimmune profiling. This came back with moderately positive anti-cardiolipin Ig G antibodies. Dr L decided to perform a skin biopsy 2 days later. The biopsy was reviewed and the specimen was consistent with scleroderma. Dr L therefore prescribed mycophenolate mofetil.

Patient K returned to Dr L 2 months later, informing them that their symptoms had worsened and that it was extremely difficult to mobilise due to the joint aching, stiffness and fatigue. Dr L decided to perform a second skin biopsy, which came back with the same conclusions as the first biopsy. Dr L therefore changed the prescription to rituximab.

Patient K's symptoms did not improve, and therefore they sought a second opinion, where they were diagnosed with chronic pain syndrome with elements of fibromyalgia and reflex sympathetic dystrophy.

Patient K brought a claim against Dr L alleging that:

- there was a failure to take a sufficient medical history
- there was a failure to conduct sufficient examinations
- there was a misdiagnosis of scleroderma
- patient K was prescribed immunosuppressants incorrectly
- there was a failure to refer patient K to a rheumatologist
- there was a failure to obtain informed consent.

How did MPS assist?

Dr L did not have any knowledge of a potential claim until they received a writ of summons and statement of claim. Upon receiving this, Dr L contacted the Medical Protection Society (MPS), who immediately instructed local panel solicitors to file a defence on behalf of Dr L.

In addition, MPS instructed the panel solicitors to obtain patient K's medical records and a witness statement from Dr L. The evidence was reviewed internally by MPS's claims manager and medicolegal consultant, who agreed that further evidence was required. MPS therefore instructed panel solicitors to obtain an expert report from a consultant rheumatologist. The expert supported Dr L's diagnosis of the scleroderma, and found that the treatment was not unreasonable.

In order to support Patient K's position, their legal team produced an expert report from a consultant rheumatologist who took the position that:

- patient K's symptoms did not correlate with a diagnosis of scleroderma
- patient K should not have been prescribed the immunosuppressants
- patient K should have been referred to a rheumatologist.

Upon receiving the report, the content was discussed with our expert. He agreed that while symptoms were not suggestive of scleroderma, the biopsy results were definitive in their conclusions, and therefore the diagnosis was correct. In addition, while the expert agreed that a rheumatologist should have been involved in patient K's care, the expert accepted that Dr L had some experience of managing the condition and the medication prescribed. The prescriptions were therefore reasonable and did not result in any harm to patient K.

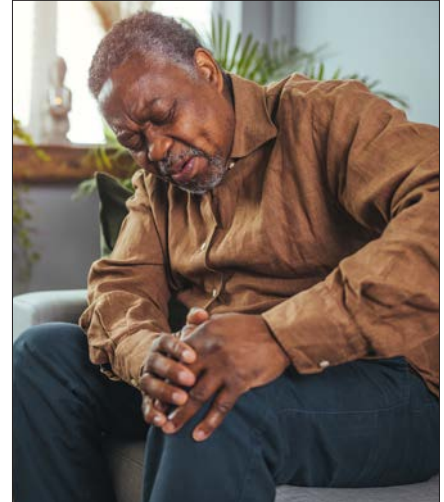
MPS assessed the evidence and proceeded to defend Dr L at trial.

Outcome

The judge heard the conflicting evidence from the medicolegal experts and concluded that:

- Dr L was not negligent in the diagnosis of patient K
- Dr L was not negligent in prescribing mycophenolate mofetil and rituximab for the treatment of scleroderma for patient K
- Patient K did not suffer any pain and suffering as a result of taking mycophenolate mofetil and rituximab prescribed by Dr L.

Despite conflicting medicolegal expert evidence, MPS was successful in defending Dr L in this matter.



Learning points

- Always consider whether it is appropriate to involve a colleague from another discipline of medicine. In this case, both experts agreed that a rheumatologist should have been consulted; however, MPS's expert agreed that this omission did not cause any harm to patient K.
- Explain within your medical records the reasoning for your differential diagnosis or suspicions and your strategy going forward. In this case, both experts agreed that the symptoms were not suggestive of scleroderma. However, Dr L suspected an autoimmune condition and implemented a strategy to investigate their suspicions.
- Explain within your medical records how the test results are feeding into your differential diagnosis. In this case, the moderately positive anti-cardiolipin Ig G antibodies enhanced Dr L's differential diagnosis of an autoimmune condition and led to the skin biopsy.
- When a diagnosis is made, consider whether it accounts for all the patient's symptoms. In this case, patient K not only had an autoimmune condition, but also chronic pain syndrome with elements of fibromyalgia and reflex sympathetic dystrophy.
- With any diagnosis and prescription, make sure you are comfortable managing them and any potential issues or side-effects that might arise.

Accommodating ill or injured employees in the workplace

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

As humans, we generally treat the sick or injured with a little more compassion than we do others. Our labour laws reflect similar sentiments, in that they are generally designed to protect ill or disabled employees from mistreatment at the hands of their employers. The Employment Equity Act No. 55 of 1998 (LRA) in its Code of Good Practice on Disabilities sets out very specific guidelines on measures an employer must consider in making reasonable accommodation for a disabled employee. This includes adapting the working environment and the way in which the work is done.

The Labour Court has indicated that it expects a lot of effort from an employer in a case where the employee is disabled. This includes considering consulting an occupational therapist or health specialist to assess the situation and to make recommendations on whether it is possible to make reasonable accommodation for the employee so (s)he can stay employed. This might involve moving the

affected employee to another department that is better suited for them to continue working, bearing in mind that the LRA requires that employers consider dismissing incapacitated employees only as a last resort. In a recent Standard Bank case (Standard Bank of SA vs CCMA (2008,4BLLR 365)), an employee was injured at work and could no longer perform her normal duties. After an extensive counselling process, the employee was dismissed for incapacity. The Commission for Conciliation, Mediation and Arbitration (CCMA) found the dismissal unfair, but the bank went on review. The Labour Court considered everything the bank did to try and accommodate the employee. It noted that the bank:

- got advice from a doctor
- looked for and found various alternative jobs
- did not reduce the employee's pay even though the alternatives were more junior
- sent her home when she was in pain
- paid an extra 3 months' leave for her to recuperate.

Despite these efforts, the court concluded that these were not enough, because the bank had failed to:

- consult an occupational therapist on possible ways to accommodate the employee
- give the employee a phone headset and a comfortable chair to ease the pain
- allow the employee to do data capturing because her medication might reduce her concentration.

The above case confirms that any employer in such a situation must go all out in accommodating the ill or injured employee, consult with the employee on the matter before dismissing the employee, seek and carry out recommendations of medical experts and attempt to modify the physical workstation of an injured employee if such injury interferes with their ability to work. Employers must seek legal advice before deciding that nothing more can be done to salvage the situation.

Suspension as an unfair labour practice

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

Section 186(2)(b) of the Labour Relations Act No. 66 of 1995 (LRA), as amended, provides protection of an employee against unfair suspension and other disciplinary action short of dismissal. It is necessary to distinguish between suspension as a precautionary measure and suspension as a punitive measure. At first glance, it may appear as if the LRA provision only applies to punitive suspensions, but arbitrators and the courts have consistently accepted that precautionary suspension also falls within the ambit of this provision (see for example Long v South African Breweries (Pty) Ltd & Others (2019) 40 ILJ 965 (CC)).

Regulations, collective agreements and policies may require the employer to follow certain procedures before implementing a precautionary suspension, and failure to do so may render the suspension unfair. The Disciplinary Code and Procedures for

the Public Service, resolution 2 of 1999, as amended, requires that in instances where serious misconduct is alleged, the employer may suspend someone on full pay. This includes all remunerative benefits, but it excludes commuted overtime, as this can only be paid if the work is indeed performed. This creates a lot of frustration among our members as it obviously has a financial impact on the suspended employee.

The practice in the public service is that the employer would, in line with the *audi alteram partem* principle, give the employee an opportunity to make representations before suspension, in order for the employee to give reasons why the suspension should not be implemented. However, the Constitutional Court, in the abovementioned Long case, did not regard the pre-suspension hearing (even by means of written representations) to

be important. We have, however, seen that the state as employer still allows for written representations to be made.

In section 193(4) of the LRA, provision is made for a commissioner to make a decision on an unfair labour practice, which includes unfair suspension, to be determined on terms deemed reasonable, and an order may be made for the reinstatement of the employee. The employee would be justified in seeking the upliftment of the suspension, for example, in instances where the suspension has been unreasonably long or procedurally unfair. In such instances, a dispute can be referred and the suspension can be challenged.

Members are invited to contact us as soon as the employer issues a suspension letter, as SAMA can assist with written representations and the general managing of the suspension process.



Welcome to SAMA

SAMA welcomes the following new members who joined the association in July and August 2023.

Border Coastal branch

Mabutho Malothe
Tembisile Mguli

Cape Western branch

Ragmah Fakier
Asiphesande Juleka
Lisa Benjamin
Unalo Nonkongolo
Angus James Kennedy-Smith
Felix Rabe
Maxwell Graeme Houliston

Eastern Highveld branch

Vuyo Sontshaka
Shanel Naicker
Onele Phangumso
Andisiwe Buso
Muimeleli Ndou

Eastern Province branch

Zamayedwa Marhedu
Nompumelelo Mlenzana
Winny Leribako Masha
Nolwazi Nonjabulo Gumede
Kyra Grace Mol
Mia Patricia Janse van Rensburg
Tyne Brooke Rouquette
Kean Louis England
Xolile Prudence Khalishwayo
Lusonda Bianca Donklara
Sinethemba Happiness
Hlatshwayo
Cassy Mahasha
Katekani Mercy Chavdlala
Uganda Zubenathi Njadu
Basesana Maleka
Minenhle Olwethu Nene
Mosuli Notatyela
Nontokozo Ntuli
Andani Vision Mudau
Sibahle Macakatsha
Warona Bridget Olyn
Sibusiso Prosper Shongwe
Nomcebo Sangweni

Vukani Siphakamiso Gina
Majaram Jonathan Moshoeshe
Qaqawuli Zozibini Matshayana
Minenhle Sbhongakoonke
Zamaswazi Nyembe
Antonia Ninotchta Nhlengeleri
Dambuza
Asavela Mntonga
Hareaepa Treasure Khusu
Ntokoto Vunene Mathebula
Lebogang Onkarabetse Seleke
Quqamba Mvenya
Mandisa Duma
Khanyisile Felicia Mtsweni
Lilonke Rengqu
Sinelizwi Moete
Nomathamsanqa Mashaba
Ndivhuwo Malima
Thandolwethu Request Nxumalo
Lukho Nyameni
Hlumelo Azola Mboniswa
Mthobisi Gigijimi
Bongeka Ndlovu
Puseletso Ngwanamagasa Mohlala
Angelique Roodt
Noreen Arlene Nieuwoudt
Carlene Hattingh

Free State branch

Nomonde Nomdzinwa
Albert Ngeleka Lufuluabo
Elroy Smith

Gauteng branch

Rudzani Lufuno Tshivhase
Birgit Katharina Bothne
Samuel Hwanano Habangana
Anneke Weidemann
Muhammed Alli

Gauteng North branch

Zikhona Zizipho Zabathwa
Mzamane
Bandile Sakhile Quintin Nkosi
Gillian Sarona Siwela

Lusizo Nzo
Morongoa Letsoalo
Anna Maria Brooks
Fezile Marin Dube
Lethabo Prudence Selolo
Lourinda van Schalkwyk

Goldfields branch

Masoono Blessing Maoto

KZN Coastal branch

Rafiek Ricardo Rodriques
Clive Schalk Schmuck
Linda Jessica Sobekwa
Felix Chukwuemeka Okonkwo
Kelly Jade Fredericks
Naeem Mahomed
Ntokozo Myeza
Zethembiso Siyabonga Praisegod
Ngubane

KZN Midlands branch

Abdul Haq Yusouff
Luthfiya Tayob

Limpopo branch

Dzhivhuwo Shylock Ndou
Benjamin Mbhiko
Fumani Berrywhite Nkuna
Bishop Amos Mulanga
Reginald Thabang Mohlaba
Goitsemodimo Gift Pitso

Lowveld branch

Lindiwe Mbambo-Williams

North West branch

Jo-hanne Linde
Modise Hendrick Setsetse

Transkei branch

Nokukhanya Natasha Nondula
Bulelani Mbhele
Anathi Phafa
Geinashe Nomula Bhungeni

Lerato Kimberley Mphephu
Sethu Rosemary Siganga
Mthokozisi Hegler Nzimande
Ukhona Xhanti Mhlauli
Yamkelani Arotl
Busisiwe Dyasi
Sisanda Mavivane
Semihla Starr
Sipho Tsarwa
Kananelo Letele
Yondela Mbadu
Byhle Paul Dlomo

Tygerberg Boland branch

Bellona Sabela
Victoria Beeka
Queren Kamunya
Jessica Wolf
Jacobus Botha
Richard Marshall
Nonopha Nukuna
Racheal Ngyenda
Afroze Chiktay
Hulisani Mushanganyisi
Rolivhuwa Mokuma
Glen Thatcher
Nonsikelelo Gwala
Abram Jacobas Booyens
Kelton Reece Poultney
Kayla Swartz
Alex Leslie du Plessis
Daniel James le Roux
Shabir Abdulhusein Karim
Tristan Michael Botha
Loenka Megan Lombard
Erin Anthony Booth

West Rand branch

Nompumelelo Angela Masango
Tshepo Tlhabanyane

Unattached

Morton Jacob Abrams

FSB collaborate and support

The Free State branch supported the Search and Rescue SA Free State (SARZA) at the successful Boeremark in Bloemfontein on 5 August 2023. SARZA's mission is to provide competent, efficient volunteer emergency search and rescue services dedicated to saving human life and able to operate in rough and difficult terrain conditions alongside other search and rescue services in times of natural or man-made civil disaster or emergency.

SAMA was visible and present at their exhibit and supported SARZA in their fundraising. The event was open to the public, and SAMA welcomed both local and visiting doctors to their table.



SAMA and SARZA at Boeremark in Bloemfontein

GWB host successful intern function in Kimberley

The Griqualand West branch hosted a beneficial intern function at the Ambassador Lodge in Kimberley on 10 August 2023.

Dr Esmari Koch, Griqualand West JUDASA representative, delivered a presentation on SAMA member benefits and medicolegal aspects as an intern, and spoke about the importance of joining SAMA. The topics discussed at the event, presented by Dr Arun Nair (intern curator and acting head of unit of family medicine at Robert Mangaliso Sobukwe Hospital) and Dr Lesego Diphatshe (SAMA GWB treasurer), were "A few basics of the handbook of internship training" and "Life after internship".

Dr Arun Nair qualified as a specialist family physician with an MMed Fam Med from the University of the Free State and FCFP (SA) from the Colleges of Medicine of SA, and is currently working full-time in the public health sector in Kimberley. He is acting head and consultant specialist in the Department of Family Medicine at Robert Mangaliso Sobukwe Hospital, and an affiliate lecturer with the Department of Family Medicine at the University of the Free State.



Dr Lesego Diphatshe (SAMA GWB treasurer), Sultana Hartzenberg (SAMA GWB branch administrator), Dr Arun Nair (acting head of unit of family medicine, and intern curator), Ms Olebogeng Mojanaga (acquisition manager, Free State and Northern Cape Standard Bank), Mr Donato Kok (professional accountant and financial planner, Standard Bank) and Dr Esmari Koch (JUDASA NC chairperson)

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

Dr Lesego Diphatshe qualified as a medical doctor from the University of Pretoria, and is currently working full-time in the public health sector in Jan Kempdorp, Northern Cape. Dr Diphatshe is the current treasurer of the SAMA Griqualand West branch.

Free State branch meets with MEC of health

On 1 August, SAMA Free State branch held a meet-and-greet session with the MEC of health at the provincial offices (Bophelo House) of the Free State health department.

Discussions at the meeting were around concerns for the safety of medical doctors at the hospital facilities in the Free State Province, and a request for stringent security measures to be put in place across the board.

SAMA made the following recommendations:

- Trained and skilled security guards should be posted in front of the psychiatric ward/ patients as it poses a huge risk for the safety of patients as well as the staff if there are no trained security staff.
- Given that the building infrastructure at hospital facilities is not conducive for mental healthcare users, SAMA recommended that the facilities should be repaired and upgraded, or that a new structure is built to accommodate mental healthcare users or a mobile park home unit is positioned on site.
- SAMA remains concerned about the delay in the pay progression to doctors, and requested that the Treasury assists by making funds available.
- SAMA requested that the cafeteria at the Pelonomi Hospital Complex be re-opened.
- The concern for health and safety is



Prof. Steven Matshidza (SAMA FSB chairperson), Prof. Dirk Hagemeister (SAMA Board of Directors and SAMA FSB treasurer), Ms Nokwanje Leeto (MEC of health, Free State) and Dr Deon Menge (SAMA FSB councillor)

legitimate in every context of human enterprise, as people are seen as one of the most important assets in an organisation.

- Stress and violence are increasingly noted in health sector workplaces. Doctors, nurses and social workers are all high on

the list of occupations with serious stress levels, while violence in the health sector constitutes almost a quarter of all violence at work. Employers and workers are equally interested in the prevention of violence and severe stress at the workplace.

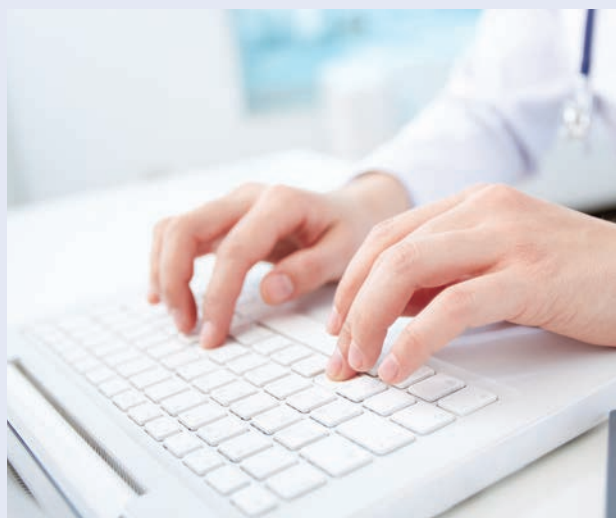
Letters to the Editor

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

Please note that letters:

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

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





CPD FOR HEALTH PROFESSIONALS ABROAD

A SAMA Member Benefit:

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

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

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

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

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

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



Did You Know?

SAMA Offers The Following Legal Assistance & Advice to SAMA Members:

- Expert legal advice and support to SAMA and its members
- Managing and resolving medical scheme disputes and forensic audits
- Assisting members with HPCSA matters and disciplinary proceedings
- Advising on business/practice management issues
- Assisting in medico-legal matters
- Mediation of disputes
- Establishment of new practices (Employment contracts, lease agreements, business law advice etc.)
- Assisting with ethical and professional compliance issues
- Strategic litigation on matters affecting SAMA members