

SAMA INSIDER

NOVEMBER 2023

Healthcare workers
and mental health –
a call to action

Tribute to past
SAMA President,
Prof. Hoosen
Coovadia



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Diane de Kock
Editor: *SAMA INSIDER*

Mental health is paramount

According to a recent MPS survey, more than a third of healthcare practitioners in SA say their mental wellbeing is worse now than it was during COVID-19, and a quarter are considering leaving the medical profession or retiring early due to mental wellbeing concerns. The more than 650 respondents said political, economic and financial concerns were impacting their mental wellbeing, while a third cited the impact of exhaustion, burnout or staff shortages on patient safety.

October was mental health awareness month, an opportunity to focus on this important subject. On page 4, we focus on mental health among healthcare workers, and authors Siphesihle Mahanjana and Mhlengi Ncube emphasise that "the journey to fortify the mental wellbeing of healthcare workers is a call to action for all of us".

A number of SA universities recently hosted the book launch of *Doctor of Hearts: The Biography of Bongani Mayosi*, to celebrate and honour his legacy. The biography brings together 78 contributors, including family, mentees, friends and colleagues, to share their journey with Bongani. The launch inspired Prof. Zuki Zingela to write an article (page 12) on how to cope for loved ones after a suicide.

It is time to break the silence on the unique challenges, including neglected mental health and access to care, among the Deaf community in SA (page 17). "Without proper methods for assessing mental health conditions, there is a risk of incorrect diagnosis and treatment, or even undiagnosed conditions," says Dr Ian Westmore, a board member of the SA Society of Psychiatrists.

We also look at the important role clinical associates could play in alleviating the impending healthcare worker crisis (page 6), an SU study that aims to shorten diagnosis for drug-resistant TB (page 9), pay tribute to past SAMA president, Prof. Hoosen Coovadia and introduce the rebranding of the Hospice Palliative Association to the Association of Palliative Care Centres (page 15).

SAMA's legal team covers death notice and death certificates (page 19), navigating the retrenchment process (page 20) and applying the common purpose doctrine in the workplace (page 20).

Central government, state hospitals, private providers and professional societies all have a part in the mental health of our doctors. "If this issue is not properly addressed, I fear SA may face an exodus of healthcare practitioners. More than half of the practitioners surveyed tell us they plan to emigrate or leave the workforce due to wellbeing concerns, which will place even more pressure on the strained healthcare system and those doctors who remain," said Dr Volker Hitzeroth, medicolegal consultant at MPS.

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Guardians of health: Unveiling the lifesaving journey of healthcare worker mental wellbeing

Siphehile Mahanjana, *public health medicine registrar, SMU*, Dr Mhlengi Vella Ncube, *Head of Unit for Health Policy and Research, SAMA*

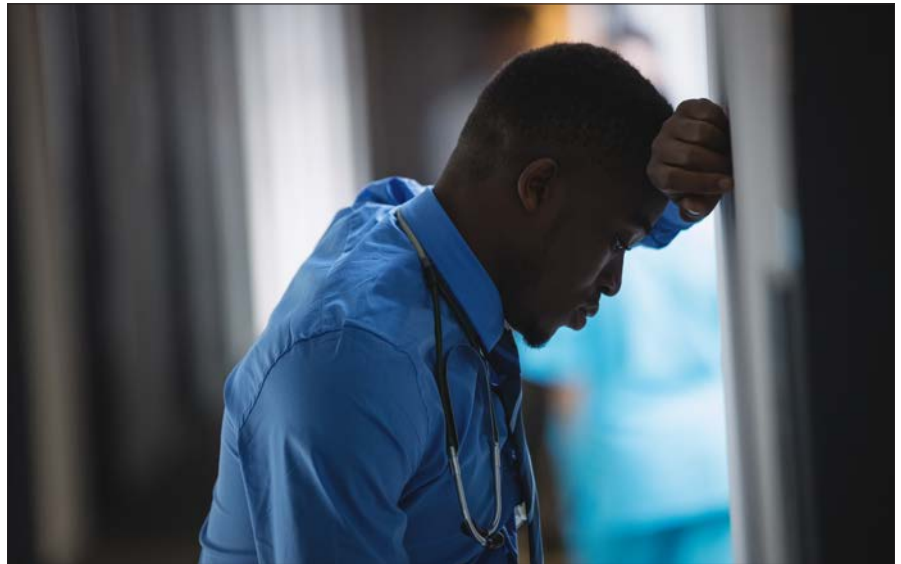
In the realm of modern medicine, where the valiant warriors of health stand on the frontlines, an unspoken battle rages on. The brave men and women who dedicate their lives to saving others often find themselves in the throes of mental health struggles. Recent research has illuminated a disconcerting truth: healthcare workers are more susceptible to mental health disorders than the general population. A groundbreaking study from India revealed that a staggering 30.1% of healthcare professionals wrestle with depression, a rate significantly higher than the 18% seen in the general population. The prevalence of depression, anxiety, burnout and substance misuse disorders among these medical heroes is on a relentless rise. The ramifications of this silent crisis extend far and wide, impacting the individuals, their families, colleagues and, ultimately, the patients they care for. It's clear: safeguarding the mental health and wellbeing of healthcare workers is nothing short of a life-saving mission.

The COVID-19 pandemic, an unprecedented global upheaval, has thrown this crisis into stark relief. The WHO has rightly labeled the support of healthcare worker mental wellbeing as a critical priority. In the face of this ever-looming challenge, we embark on a journey to explore the lifelines and interventions that promise to fortify the mental resilience of our healthcare heroes.

POLI: A strategic shield

Imagine an innovative strategy that weaves through the fabric of healthcare organisations, enhancing both the wellbeing of healthcare workers and the quality of patient care. Participatory Organisational Level Intervention (POLI) does just that. It's a dynamic approach that manages psychosocial risks in the healthcare sector, through a meticulous risk assessment to risk management methodology. Its core mission? To enrich working conditions and boost the job satisfaction of healthcare workers. Central to POLI is the principle of involving employees in collaboration with senior and line management. Here are some electrifying examples of organisational-level interventions that POLI champions:

Wellbeing centres: Imagine stepping into a serene oasis amidst the bustling hospital



corridors – the wellbeing centre. These havens are designed to offer healthcare workers a respite from their high-stress environment, a space to recharge, rest and rejuvenate. But they're more than just a physical space. Wellbeing centres encourage conversations, foster camaraderie, provide access to counselling and psychological support and offer an array of wellbeing resources. Studies have shown that healthcare workers who have availed themselves of these centers report improved mental wellbeing and increased work engagement. While the impact on presenteeism may be modest, qualitative evidence suggests that the wellbeing centres receive a warm and welcoming response from the healthcare community.

PFA: Guiding lights in the dark: In times of psychological distress, the gentle and compassionate presence of psychological first aid (PFA) can be a lifeline. Rooted in evidence-based practices, PFA seeks to alleviate psychological distress by offering a caring and comforting presence, coupled with education on common stress reactions. The outcomes are nothing short of remarkable: reduced anxiety and stress levels, decreased likelihood of depression, improved self-efficacy, enhanced coping skills, reduced burnout and post-traumatic stress, better sleep quality, increased resilience and overall improved psychological wellbeing.

A Blueprint for resilience

In the intricate web of healthcare organisations, adjustments to working conditions emerge as powerful tools for reducing work-related stress. These adjustments span changes in working hours, the provision of appropriate resources and equipment, regular engagement with management, and comprehensive training and capacity building for healthcare workers. The results are striking: reduced stress levels, decreased distress and burnout, elevated job satisfaction, heightened work engagement and improved sleep quality.

Mental health hotlines

Amidst the relentless demands of healthcare, mental health hotlines stand as beacons of hope. These services provide psychological support, resource identification and referrals for healthcare workers in need. Studies reveal that these hotlines effectively reduce the adverse effects of work-related stress. They are instrumental in diminishing anxiety and stress levels, enhancing coping skills and boosting self-efficacy.

Empowering the healers

Now, let's dive into the personal empowerment strategies that healthcare workers can wield to safeguard their mental wellbeing. These individual-level interventions are not just powerful; they can often be seamlessly

integrated into the organisational fabric, serving a dual purpose in the battle against mental health challenges.

Knowledge as a shield

Psychoeducation, a structured approach to providing knowledge, has proven to be a transformative tool. While initially tailored for individuals with mental illness and their families, aspects of psychoeducation have been harnessed to impart knowledge and cultivate coping skills among healthcare workers. The results are astounding: enhanced emotion regulation skills, mitigation of psychological distress, improvements in wellbeing and social participation, increased confidence in managing depressive symptoms and dysfunctional coping mechanisms, greater intentions to seek treatment, improved coping skills and better mental health outcomes.

Harnessing the power of the present

Mindfulness, the practice of being fully present in the moment, has emerged as a formidable intervention for addressing mental health challenges. Guided by psychologists or mindfulness educators, mindfulness exercises hold the key to improving sleep quality, increasing relaxation, reducing symptoms of depression and anxiety, combating burnout, alleviating psychological strain and stress, and even preventing the onset of mental health disorders.

Energising mental wellbeing

Engaging in physical exercise, whether through jogging, sports, or yoga, can significantly enhance mental wellbeing. Healthcare workers who participate in physical activity often report better sleep quality, increased relaxation and reduced anxiety levels. The link between physical activity and mental health is robust, demonstrating that

nurturing one's physical wellbeing also fuels the mind's vitality.

Crafting inner strength

Resilience interventions equip individuals with an array of techniques to fortify their inner resilience, enabling them to better navigate external stressors. These interventions bolster resilience, reduce emotional exhaustion and enhance the quality of the psychosocial work environment. They have been shown to reduce anxiety and stress levels while boosting self-efficacy.

The journey to fortify the mental wellbeing of healthcare workers is a call to action for all of us

A call to action

As we navigate this journey through the landscape of healthcare worker mental wellbeing, it is vital to recognise the power and potential of these interventions. Countless studies have validated their effectiveness in the battle against mental health challenges. However, it's essential that we ensure that these interventions are not just effective, but also adaptable and context-sensitive.

A glaring gap in research looms large: no interventions have been reviewed in the African context, where healthcare workers face exceptionally high levels of stress, burnout, anxiety and depression due to their unique working conditions. It is incumbent upon us to champion more research initiatives aimed at assessing feasible mental health interventions within the African region.

Uniting for mental wellbeing

In our quest to safeguard the mental wellbeing of healthcare heroes, these recommendations emerge as guiding beacons:

- Ensuring collaboration and co-operation at all levels within a healthcare facility is crucial. Employee participation, along with management engagement and support, must be paramount.
- Implementing baseline medical surveillance for all new employees, including screening for common mental health disorders and symptoms, can identify at-risk individuals who may need additional support.
- Making available cost-effective strategies, such as psychoeducation and mental health resources, to all healthcare workers, both physically and online, is essential, while interventions should be context-specific.
- Making PSA available to all emergency department workers and other healthcare personnel, upon request, can be a lifeline in times of crisis.
- Developing responsive policies that ensure healthcare workers are involved in decision-making processes can create an environment that nurtures mental wellbeing.
- Creation of a structured peer support network within healthcare institutions.
- The use of internet-based mental health intervention tools to remotely support healthcare workers in preserving their mental health.

The journey to fortify the mental wellbeing of healthcare workers is a call to action for all of us. Let us unite in this noble endeavour to safeguard those who dedicate their lives to safeguarding ours. As we move forward, may the stories of resilience, empowerment and transformation inspire us all in the remarkable mission to revive the healers of the world.

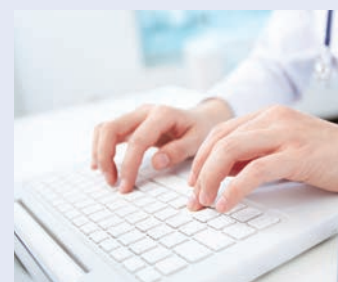
Letters to the Editor

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.



Clinical associates praised at rural health conference

SAMA Communications

On 21 September 2023, *Spotlight* reported on SA's chronic healthcare shortages, and the country's Human Resources for Health Strategy 2030 has warned of an impending healthcare worker crisis, which will be particularly acute in some rural areas.

SA faces chronic healthcare worker shortages, and these are particularly acute in some rural areas.

One solution to the shortages that gained some traction in SA around 15 years ago was the idea that certain tasks could be shifted from doctors to a newish type of mid-level healthcare worker called a clinical associate. The country started training its first clinical associates in 2008 (the course takes 3 years), and there are now some working both in the public and private sector in SA.

But, reports *Spotlight*, the road for clinical associates has been a rocky one, and the potential for this class of healthcare worker to ease the pressure on the public healthcare system arguably remains untapped. The publication of their scope of work was delayed for several years. Some questions also remain over what medicines they may or may not prescribe, and maybe most importantly, they seem not to have been much of a political priority over the last decade.

At the Rural Health Conference recently held in Chintsa in the Eastern Cape, Deputy Minister of Health Dr Sibongiseni Dhlomo said that as a department, they have not really paid much attention to clinical associates. "We just seem to have brushed over it and never really done much on it. I know there are issues that need to be resolved. I promise to listen, but I don't promise to have the answers now. I'm waiting for a report on clinical associates, then I will respond," he told delegates.

The role of clinical associates was a key topic at the conference, themed "Celebrating rural service". Nomsa Ndaba, a clinical associate and a study co-ordinator at the University of the Witwatersrand Vaccine and Infectious Diseases Analytics research unit (Wits VIDA), said there is demonstrated improved patient care when healthcare teams include clinical associates.

She said there are four areas where over 90% of healthcare workers agreed in a survey that clinical associates contributed successfully to the overall management of



Patients queuing at the Macacume Clinic in Sterkspruit in the Eastern Cape

certain conditions. The 45 survey participants included clinical managers, nursing services managers, hospital chief executive officers and human resource managers.

"Clinical associates succeed in the management of HIV and opportunistic infections, non-communicable diseases, tuberculosis as well as injury and trauma conditions," she said. "The clinical workload of medical practitioners is reduced by sharing tasks with clinical associates. Especially in the rural areas, clinical associates reduced the load on overburdened rural medical practitioners."

Dr Grace Cholimbira, who works in local clinics and at Kuruman Hospital in the Northern Cape, told *Spotlight* that she has seen first-hand the value of clinical associates. "Since the inception of the clinical associates programme and their enrolment into clinical practice, we have seen a great improvement in the management of patients, especially in the rural areas. The clinical associates have helped relieve the problem of staff shortages. They provide essential clinical services much needed by the rural health communities and have helped relieve/reduce healthcare worker burnout," she said.

She said that in a staff-constrained environment, clinical associates are able to manage patients without supervision, as occurred from 2011 to 2013 when a hospital in Kuruman had a dire shortage of clinical personnel, and was run by a team of two medical officers and two clinical associates until they received the much-needed help.

"This alone is a sign that we cannot ignore the massive impact the clinical associates have in our facilities. Most outpatient

departments are run by clinical associates in rural areas, and this has significantly reduced patient waiting times. In a nutshell, they have not only added to the staff numbers, but they form the backbone of our rural healthcare service providers," said Cholimbira.

More clinical associates needed?

While there seemed to be consensus at the conference over the value of clinical associates, especially in rural areas, reports *Spotlight*, there also seemed to be a shared view that this cadre of healthcare worker is underutilised and even somewhat neglected.

Aviwe Mgobozi, academic head of the Division of Clinical Associates in the Department of Family Medicine and Primary Care at the University of the Witwatersrand, told *Spotlight* that the clinical associate programme has not been well marketed by the Department of Health. "There seems to be a lack of political will and leadership by the Department of Health, despite the profession being conceptualised by the Department of Health. As a result, there is a slow uptake to conclude and implement new policies and update existing policies to include practice regulations for clinical associates," she said. She added that the reasons for a lack of leadership, lack of championship and slow support by the health department are yet to be understood.

According to Mgobozi, there is a rise in specialists wanting clinical associates to function as co-ordinators of care within their practices, including aiding in patient care and delivery of patient education, and as theatre assistants.

"It is unfortunate that the posts within the public sector are scarce. There is a missed opportunity within the public sector for clinical associates to function optimally within the primary healthcare space to improve access to healthcare and deliver quality healthcare services with the interprofessional teams," she said.

While utilisation of clinical associates has lagged in the public sector, she said, "there is increased uptake of clinical associates within the NGO space where clinical associates are providing HIV/AIDS and voluntary medical male circumcision services to the SA population."

Challenges

Currently, clinical associates can only prescribe medicine up to schedule 4. According to their scope of practice, they can "prescribe medicines for common and important conditions according to the primary healthcare level Essential Drug List (EDL) and up to schedule IV, except in emergencies when appropriate drugs of higher schedules may be prescribed. The prescription must contain the name of the supervising medical practitioner. In the case of drugs not on the EDL, the prescription must be countersigned by a medical practitioner."

According to Mgobozi, this means that clinical associates still need a supervisor's signature, as they are not listed as authorised prescribers in the Medicines and Related Substances Act No. 72 of 2008. She says this can lead to unnecessary delays that affect patient outcomes, especially in emergencies when a script has to be co-signed.

The scope of practice authorises them to prescribe the medicine, but the Act says otherwise. Mgobozi says prescribing rights for clinical associates must be provided for in the Act, and they need to be listed as authorised prescribers, as stated in the scope of practice and training.

This, Mgobozi says, is why the lack of clear policies to guide clinical associate practice must be addressed. "The scope of practice is not widely known by the medical community and by the patients, and the HPCSA, [and we need to] increase awareness of the profession. Stakeholders need to collaborate and work together to develop and implement policies in line with the needs of the provision of healthcare in SA.

The challenges, however, do not end there.

Mgobozi also calls on the health department to create more clinical associates' posts, and says there should be more interprofessional education so that professions do not function in silos, but rather collaboratively to enhance patient care.

Congratulations Dr Bukiwe Spondo, Rural Doctor of the Year

Dr Bukiwe Spondo, who works at Butterworth and Tafalofefe District Hospital in the Eastern Cape, recently received the Rural Doctor of the Year award at the Rural Health Conference.

Just getting to work is a challenge, along a 55 km "terrible" gravel road. Since 2007, despite the challenges, Dr Spondo and her colleagues have offered a number of services in the impoverished Centane village. She moved the hospital's ARV clinic from an outbuilding to inside the premises, thereby reducing stigma, and in 2012 she started driving 40 km a day twice a week to nine clinics in the area, where up to 50 patients would queue to see her. She pre-packed medication to make life easier for her patients, later opening a clinical HIV/AIDS management programme site at Tafalofefe to see complicated cases referred from the clinics. Dr Spondo also opened a multi-drug resistant TB (MDR-TB) review clinic in conjunction with Butterworth Provincial Hospital. "As a rural doctor, you become a social worker, a pharmacist, a priest – you do everything," she says, laughing.

Tafalofefe's CEO, Masizakhe Madlebe, when motivating for Dr Spondo to receive the RUDASA award, pointed out that her work days start at 07h00 and only end when all patients have been seen to, whether at the hospital or at one of the local clinics. In addition, over the years, Spondo has mentored youth in the area, including children whose parents have succumbed to Aids, and schoolgirls on topics such as life goals and contraceptives. He adds that Spondo even reached into her own pocket to pay school fees for children who had no parents.

"Becoming a doctor was just something I always wanted," says Dr Spondo. In her formative years she was a sickly child who often required medical care. This changed, she says. She cannot remember ever being sick as an adult.

Spondo graduated from medical school at the University of KwaZulu-Natal in 2002, completing her internship at Cecilia Makiwane and her community service at Tafalofefe and Frere in 2004. She was happy to bring her healthcare skills back home to serve the community that shaped her.

"I mean, I know these people inside out. I was born in front of them, raised in front of them," she says. "These are our relatives, our aunts, our grannies. It's giving back to them, to the community that raised you, that has done everything for you, who supported you through all these years." She lives with her 8-year-old son in a doctor's house on the hospital premises, travelling to see family in Nqamakwe over the weekends.



Rural doctor of the year, Dr Bukiwe Spondo

Cholombira echoes this, and adds that career and salary progressions are also a challenge. "This has been proved by the lack of further study opportunities by universities, which do not have courses tailored to advancing clinical associates. To date, only Wits University has one course in emergency medicine tailored for clinical associates, but what if one is interested in furthering their studies in obstetrics?"

Spotlight reports that health minister Dr Joe Phaahla earlier this year, in response to parliamentary questions, however, said that discussions are underway to address the occupation-specific dispensation for clinical associates, among others. Phaahla, however, cited the prevailing fiscal constraints government is under that may affect the creation of more clinical associate posts.

After the task team finalised its report and 2 years after the Public Protector's report was released in November 2021, clinical associates were still raising the same issues at the Rural Health Conference, with Dhlomo at least admitting that the department had not afforded the issue proper consideration.

Phaahla, in a parliamentary response earlier this year, said the department is implementing the remedial actions in the Public Protector's report.

Source: *Spotlight*, 21 September 2023. <https://www.spotlightnsp.co.za/2023/09/21/clinical-associates-praised-at-rural-health-conference-but-questions-remain-over-government-backing/>.

Counting down to the SAMA Conference

SAMA Communications

Come February 2024, the SAMA Conference will be held in person for the first time since the COVID-19 pandemic. As a result, this conference offers delegates and key stakeholders an opportunity to establish strategic networks and to influence health policies. This gathering marks a significant milestone in SAMA's ongoing commitment to advancing healthcare, not just as an industry but as a fundamental human right.

The past few years have tested the resilience and adaptability of healthcare systems across the globe unlike ever before. We have witnessed unprecedented challenges, but we have also seen remarkable innovations and unwavering dedication from healthcare professionals and researchers. The theme of "Strengthening Healthcare Systems" couldn't be more relevant or timely. It underscores our collective responsibility to bolster

healthcare infrastructure, improve access and enhance the quality of care provided to every individual, regardless of their background or circumstances. Our mission is not just to mend what's broken, but to build a healthcare ecosystem that is resilient, inclusive and future-ready.

The COVID-19 pandemic brought a lot of uncertainty into healthcare. All economies, in low, middle- and high-income countries, were put under pressure, and this has shone a spotlight on our health system. The healthcare system in SA is in a state of distress, and it is incumbent on all of us in healthcare to ensure that it does not collapse.

What does it mean to strengthen health systems? The conference theme presents a significant opportunity for industry stakeholders to fortify strategic networks that will ultimately influence health policies and

create a pandemic preparedness framework, post COVID-19. It will also unpack the imperatives that impact both the public sector and private practice.

SAMA's thought leadership comes to the fore when it comes to leading and strengthening healthcare professionals, from medical students to retired members. With a strengthened workforce, taking lessons locally and globally, SAMA in collaboration with our stakeholders will chart the way for solutions to preserve the medical profession.

On behalf of SAMA, we invite our members to join us as we move towards making a profound difference in the world of healthcare.

The SAMA Conference will take place at the Sandton Convention Centre in Johannesburg from 15 to 17 February 2024. For more information and to register, visit www.samaconference.org.

The poster features a blue background with a blurred image of a person in a white lab coat. At the top center is the SAMA logo, a circular emblem with a caduceus in the center, surrounded by the text "SOUTH AFRICAN MEDICAL ASSOCIATION" and "UNITING DOCTORS FOR THE HEALTH OF THE NATION". Below the logo, the text "SAMA ANNUAL CONFERENCE 2024" is written in large, bold, blue capital letters. Underneath this, a yellow rectangular box contains the text "TOWARDS STRENGTHENING HEALTH SYSTEMS" in bold black capital letters. Below the yellow box, a white rectangular box contains the dates "15 - 17 FEBRUARY 2024" and the location "SANDTON CONVENTION CENTRE, JHB" in bold black capital letters. At the bottom, a dark blue banner with white text reads "VISIT WWW.SAMACONFERENCE.ORG FOR MORE INFORMATION OR [CLICK HERE TO REGISTER](#)".

SU study aims to shorten diagnosis for drug-resistant TB

SAMA Communications

Drug-resistant tuberculosis (DR-TB) is a global health threat due to high mortality, cost of treatment and risk of transmission. In 2021, there were an estimated 450 000 cases of DR-TB worldwide, and 191 000 deaths. SA has one of the highest number of drug-resistant patients globally, but shockingly, only 50% of these patients are started on treatment.

“DR-TB threatens to derail the WHO’s END-TB strategy that aims to eradicate the disease globally by 2035. We therefore need new and improved methods for diagnosing DR-TB in the shortest possible time to curb transmission, improve treatment and save lives,” says Dr Brigitta Derendinger from the Clinical Mycobacteriology and Epidemiology (CLIME) Group in the Division of Molecular Biology and Human Genetics at Stellenbosch University (SU)’s Faculty of Medicine and Health Sciences.

Derendinger, who recently obtained her doctorate at SU, examined ways in which existing tests to diagnose DR-TB could be improved. She also characterised the programmatic emergence (non-clinical trial patients) of bedaquiline resistance – the first new TB drug in almost 40 years – in high-risk patients. Bedaquiline is part of injectable-free treatment regimens for DR-TB.

Derendinger points out that Xpert MTB and RIF Ultra are some of the most widely used tests for the diagnosis of TB and drug resistance, but a second sputum is still needed to verify resistance to rifampicin, which is frequently prescribed to treat TB, and to diagnose second-line resistance. In addition, two WHO-endorsed molecular tests (MTBDR_{plus} and MTBDR_{sl}) are done routinely to confirm a drug-resistant diagnosis and to further diagnose resistance to other drugs.

“Since the roll-out of Xpert, Ultra and MTBDR_{plus} in SA, the time from the initial diagnosis of multi-drug resistant TB to when the patient starts to receive treatment has shortened, but this process is still long.

“Furthermore, many countries with a high TB burden lack the biosafety and infrastructure for the extraction of DNA and additional molecular testing. There is, therefore, an urgent need to reduce these diagnostic delays and develop or improve



rapid molecular methods to help minimise the reliance on the collection of a second sputum sample.”

To help address these shortcomings, Derendinger extracted DNA of *Mycobacterium tuberculosis* (the bacterium that causes TB) from used Xpert cartridges (cartridge extract – CE) that would otherwise be discarded by laboratories. She showed this by doing first (MTBDR_{plus}) and second-line (MTBDR_{sl}) TB drug testing from the CE collected from this one cartridge, thus allowing a quicker diagnosis of DR-TB and negating the need to collect a second specimen.

“We have identified ways to reduce the need for collection of a second sputum sample, thereby potentially reducing the time it takes to make a diagnosis from weeks to a few days. A quicker diagnosis will mean that patients can be placed on treatment sooner.

“We have identified thresholds to implement to ensure that no test needs to be wasted on CE likely to give an invalid result. This has profound implications, especially in countries like SA where patients often do not return to give a second sputum, or simply cannot produce one to confirm the diagnosis of drug-resistant TB.

“We also found that by correcting a parameter used in the MTBDR_{plus} and MTBDR_{sl} tests, we can diagnose more patients with DR-TB and place them on effective treatment,” adds Derendinger.

Regarding bedaquiline, she says it is being scaled up rapidly, but largely in the absence of TB drug testing.

“The WHO recommends TB drug testing to be done on all patients receiving bedaquiline, and to monitor their treatment, but this is not done regularly in SA, and only a few centralised laboratories have the capacity to do so, which causes diagnostic delays.

“Clinical bedaquiline resistance is emerging but the data are scarce, especially in settings where patients are more likely to experience delays and drug shortages, receive less support, and are monitored even less than patients on clinical trials.

“Consequently, these patients can be non-adherent, and failing treatment regimens are less likely to be detected, therefore resistance is more likely to be acquired and later transmitted in these settings.”

Derendinger emphasises the need to optimise established molecular DR-TB tests and development of new DR-TB tests to monitor resistance to new drugs such as bedaquiline to curb delayed diagnosis and ongoing transmission.

She says the findings of her study have informed WHO course training material and been incorporated into global laboratory performance and quality assessments.

Derendinger also acknowledges the contribution that Dr Rouxjeane Venter from the Division of Molecular Biology and Human Genetics at SU made to her research.

Tribute to past SAMA President, Prof. Hoosen Coovadia

SAMA Communications

SAMA is profoundly saddened by the passing of a remarkable medical stalwart and political activist, Prof. Hoosen Coovadia, on 3 October 2023 at the age of 83. Prof. Coovadia was appointed the president of SAMA from 2019 to 2020. As an exceptional leader, he brought with him a wealth of knowledge and experience for the benefit of the association. As an internationally acclaimed paediatric immunologist, Prof. Coovadia's main contributions included critical research into the most serious health problems of children in Africa. He published more than 350 research papers in leading international and SA journals on the basic science and pathogenesis, clinical management, epidemiology, prevention and contextual factors for the major causes of morbidity, disability and mortality among Africa's children.

Born in 1940 in Durban, Prof. Coovadia obtained his medical qualification in India, after a short stint at the now University of KwaZulu-Natal (UKZN) (formerly the University of Natal). At the time, a new medical school for black students had been established at an army barracks, next to an oil refinery, and the conditions were not conducive to learning. In 1965, Prof. Coovadia obtained an MBBS degree and returned to Durban to work at the King Edward Hospital. He specialised in paediatrics, and in 1974 obtained his MSc in immunology from the University of Birmingham in the UK. He returned to SA to join the Department of Paediatrics at UKZN.

In 1978, his research on the immunology of measles in children led to him being a recipient of the MD award, and during the



Prof. Hoosen Coovadia

same year he was also appointed principal paediatrician and senior lecturer at the university. This was just the beginning of a medical journey that would blossom into a memorable career spanning more than four decades.

In 1999, the late President Nelson Mandela honoured Prof. Coovadia with the Star of South Africa for his inspiring contribution to democracy and health in the country. The accolades continued to pour in at the turn of the century, where he received the International Association of Physicians in AIDS and Care Award, the Heroes in Medicine Award in Canada, and the Nelson Mandela Award for Health and Human Rights. At the end of 2000, he retired from his position as head of paediatrics and child health at UKZN. He, however, remained actively involved in several key healthcare roles, including serving as scientific director at the Doris Duke Medical



Prof. Coovadia with Dr Marina Xaba-Mokoena at his inauguration as SAMA President

Research Institute at the Nelson Mandela School of Medicine (UKZN).

Internationally recognised and hailed for his pioneering research in the fields of malnutrition, kidney disorders and infectious diseases, especially mother-to-child transmission of HIV through breastfeeding, Prof. Coovadia leaves an indelible mark on healthcare. In remembrance, let us celebrate the life he lived, while honouring his legacy of compassion, excellence and dedication that will continue to inspire future generations of medical professionals. May his memory continue to inspire us all and serve as a reminder of the profound impact that one extraordinary individual can have on the world.

Source: <https://www.sahistory.org.za/people/professor-hoosen-mahomed-jerry-coovadia>.

Prof. Hoosen Coovadia: A life in service to humanity

SAMA Communications

Prof. Coovadia was highly respected by his colleagues (both locally and internationally), the young researchers

he mentored and healthcare professionals. He was a strong advocate for collaboration and interdisciplinary work.

Tributes

Dr Ismail Ticklay, a Zimbabwean paediatrician and senior lecturer in the child, adolescent

and women's health department at the University of Zimbabwe's Faculty of Medicine and Health Sciences, said a set book Coovadia wrote continues to be used by students.

"In April 2021, his textbook, *Coovadia's Paediatrics and Child Health: A manual for health professionals in developing countries*, was released in its seventh edition – 819 pages thick – 37 years after it was first published in 1984.

"Until the early 1980s, paediatric textbooks in SA and the rest of Africa were [primarily] written by British authors with no material and information addressing the particular and peculiar problems of African children," said Ticklay.

"The book is widely regarded as a seminal work in the field of paediatrics and child health. It has been used as a set book for teaching locally and internationally, and has helped to train generations of healthcare professionals," he said.

The University of KwaZulu-Natal (UKZN)'s College of Health Sciences's deputy vice chancellor and head of the college of health sciences at the university, Prof. Busisiwe Ncama, said a giant had fallen. Ncama said Coovadia

was an emeritus professor at UKZN who made many contributions to global health policies.

"With several accolades for his groundbreaking research, he was also a stalwart in the fight against injustices in SA and abroad.

"He is well known for incurring the wrath of Thabo Mbeki's government by insisting on scientific integrity and campaigning for the rollout of antiretroviral therapy, and he has nurtured a generation of medical students with his prolific research," said Ncama.

A legacy in service of humanity

According to the SA National Planning Commission, Coovadia was a founding member of the SA Academy of Science who also held honorary and other qualifications from several institutions, including UKZN in SA, the University of Birmingham in the UK and the University of Bombay [now the University of Mumbai] in India.

The commission said the late professor published papers on the basic science and pathogenesis, clinical management, epidemiology, prevention and contextual factors

causing morbidity, disability and mortality among Africa's children.

The NRF said he was also a recipient of the Nelson Mandela Award for Health and Human Rights, the American Association for the Advancement of Science (AAAS) Award for Scientific Freedom and Responsibility and the Order of the Star of South Africa for his contributions to democracy and health, which was presented to him by the late former President Nelson Mandela.

President Cyril Ramaphosa said Coovadia was an outstanding scientist and committed anti-apartheid campaigner who dedicated himself to SA's liberation struggle.

"His pioneering, globally acclaimed research into mother-to-child transmission of HIV has rendered an immeasurable legacy to humanity in terms of which persons living with HIV can live long and healthy lives subject to early detection and access to treatment," added Ramaphosa.

Source: University World News, 12 October 2023. https://www.universityworldnews.com/post.php?story=2023101115040212&utm_source=newsletter&utm_medium=email&utm_campaign=AFNL0424.

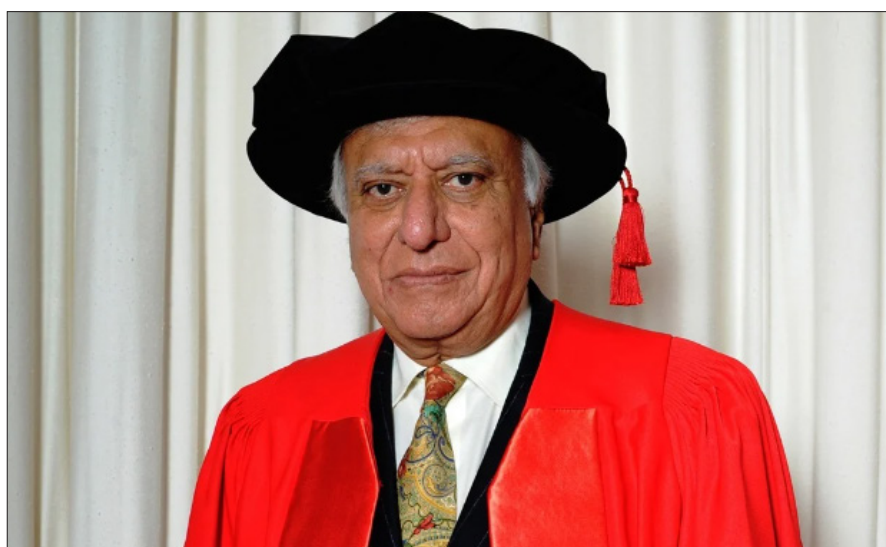
Jerry Coovadia: The SA doctor who led the fight against HIV in children

Glenda Gray, research professor, Perinatal HIV Research Unit and president, SA Medical Research Council

SA-born Prof. Hoosen "Jerry" Coovadia, renowned academic and prominent anti-apartheid activist, passed away on 4 October. As a paediatrician, I was privileged to know and work with him over two decades. Prior to that I knew him when we were both health activists in apartheid SA.

In 2019, Coovadia was profiled in the leading health academic journal, the *Lancet*, as an icon in SA health. The profile described him as the "Nelson Mandela of health". This was in tribute to his dedication to ameliorating the diseases that afflicted children of SA, like malnutrition, measles and HIV, and his role in health activism.

In 2014, in my capacity as the president of the SA Medical Research Council (SAMRC), I was honoured to award him the SAMRC Presidential Award in recognition of his life-long work in child health, his impact in the area of preventing mother-to-child transmission of HIV and the huge influence he had on health in SA.



Jerry was pivotal in proposing the use of maternal antiretroviral therapy to prevent breast milk transmission, which has now

become the norm at a global level. His role in research that led to the control of HIV infection in children was so great that,

in my view, it cannot be quantified in any meaningful way.

Who was Jerry Coovadia?

Jerry was born in Durban, on the east coast of SA, in 1940.

He knew instinctively from a young age that he would become a doctor. He did some of his medical training in India, and then returned to SA, where he was exposed to the atrocities of a two-tiered health system under which black South Africans bore the brunt of poor healthcare.

As a paediatrician, he excelled academically, training in immunology and eventually heading the Department of Paediatrics and Child Health at the University of Natal.

During his time as an academician he became prominent in the anti-apartheid movement.

The AIDS fight

I began working with Jerry in the mid 1990s. His path and mine would intertwine over the next 20 years as we bore witness to the [explosion of HIV](#) in children. He was working at the King Edward Hospital in KwaZulu-Natal while I was at the Chris Hani Baragwanath Academic Hospital in Soweto.

Over the next decade we would “cross horns” on the various interventions to prevent mother-to-child transmission of HIV.

We didn’t always agree on interventions to prevent [post-partum](#) transmission through breastfeeding.

Even though our strategies differed, we were completely aligned in our common goal of trying to mitigate the scourge of HIV in the children we were trained to care for.

His textbook *Paediatrics and Child Health* was my Bible. My colleagues and I revered him as the doyen of child health in SA.

It was a huge privilege to collaborate with him on research to deliver antiretroviral therapy as an intervention to prevent mother-to-child transmission of HIV.

We worked together on studies seeking the most cost-effective way of preventing paediatric HIV using the least amounts of antiretrovirals at a time when these were prohibitively expensive. The two biggest were the [PETRA](#) study, evaluating various short courses of [AZT](#) and [3TC](#) to interrupt perinatal transmission, and the [SAINT](#) trial, which evaluated the role of [Nevirapine](#) for preventing mother-to-child transmission.

Over the years, we would co-publish on these studies and the effect of these various interventions to minimise breast milk transmission.

Activist years

Before I worked with Jerry as a young doctor, we were both health activists. I belonged to

the Health Workers Association, which later became the SA Health Workers Congress; he was a member of the National Medical and Dental Association, and was a leader in the talks to merge these two organisations.

I appreciated his activism and his vision for an equitable health system, which he channelled into his work as a paediatrician, and his work as a scientist.

He demonstrated to us as young doctors the role of social activism in health, and that ill health is inextricably linked to socioeconomic and political factors. If we were to be meaningful in our role as doctors, we had to address these factors with the same vigour as we demonstrated in the wards where we treated sick children.

Jerry encompassed what it means to be a doctor. He always lived by the Hippocratic Oath, basing his practice in medicine on the principles of beneficence, non-maleficence, justice and respect.

I am deeply grateful to have brushed shoulders with this great man. Go well Jerry, a life well lived, and many thanks to your family for sharing you with us.

Source: The Conversation, 5 October 2023. <https://theconversation.com/jerry-coovadia-the-south-african-doctor-who-led-the-fight-against-hiv-in-children-215080>.

When the world ends: Surviving suicide

Prof. Zukiswa Zingela



Suicide hurts. It is an uncomfortable subject that most of us would rather not have to think about, let alone

talk about, because it is associated with pain, helplessness, hopelessness and the beginning of the end. It hurts the one who dies by their own hand. It hurts the family, friends and colleagues who are left behind to deal with the aftermath. In that moment when the sense of peace begins for the deceased, chaos is unleashed for the survivors. In cases of suffering we have witnessed during the life of the deceased, it can bring relief when they do not have to continue living with the pain, whether physical or emotional, or whether experienced in ways we cannot always understand. But how does one even begin to go on when the world ends for the beloved in our lives?

It becomes difficult not to judge, not to be angry, not to be dismissive of the suffering that must have led to that end-of-

life moment. There are many forceful reasons that pull and push one closer and closer to the edge, which we may not even be aware of. We, as the survivors, will never be so deeply immersed in sharing that final moment as to truly understand what pushed, what pulled or what called to our loved one. What cacophony of noise and voices was so strong as to mask our voice as the caring survivors who would have said, “no, please hold on”, if we but had the chance to stop that last act. As much as Freud also described the death instinct, we recognise the survival instinct as one of the strongest drivers of the behaviour of living things. So, when we are confronted with the antithesis of that, we feel helpless and confused. It hurts because it is supposed to. It is distressing because we can see so many ways out of that final moment, such

that we are unable to fully understand how our loved one could not have taken at least one of those paths out of the overwhelming darkness. It generates yearning for a second chance to save our loved ones that will never come because of the finality of suicide. This can lead to a rewind and replay cycle that includes endless rumination about the last moments of interacting with the beloved person who has passed. Maybe I could have done something, said something, given something, seen something, heard something, touched something? How could I not have known? How could I not have seen? How could I not have stopped it?

How do we calm the chaos that rages within when suicide affects us so deeply?

The blanket of grief that one experiences in the aftermath of suicide is difficult to bear because there are always unanswered questions that the survivors have to grapple with. Yes, we can rage against the finality of suicide that takes away second chances. Yes, we can suffer the crushing sadness and sense of defeat in the final battle that we were not even fully aware we were fighting; that of pulling our beloved to remain with us, while the push factors that are just beyond our understanding were edging them closer to the unknown end. But through it all, we must also strive to find our way back to living our lives again, facing a new reality of life without our loved one.

The hardest part for us to accept is that in the final instance, that final act of suicide has very little to do with us, irrespective of what we think we could have done to stop it. The consequence of suicide touches us deeply as the survivors. Yet, the act itself ends suffering in our loved one when they have reached the point when hope is lost, whether the suffering is anticipated or already in motion. Another jarring fact is that suicide says nothing else about us, the living. We cannot judge ourselves by the act of another dying by suicide. Yet, this is the very first thing we do. I didn't love enough, I didn't give enough, I didn't care enough, I didn't dedicate enough. We make it about our failures and our actions. Suicide ends anguish for the person who is feeling it the most acutely before their life ends, but at the same time it heralds new anguish for us, the living. In the aftermath of suicide, the persistent distress these conflictual feelings can stir in us as survivors can mushroom and grow. They can become so strong that they may inhibit our path to healing. We are unable to let go fully of all the anger and

guilt we feel. Irrespective of whether the anger and guilt is directed at ourselves or at the person who died by suicide, or even at the systems around us that we often feel have failed to prevent the death, it inhibits us from dealing with the reality and finality of suicide. As much as this is often the hardest thing to do, striving to let go can help us to find our way back to some semblance of a newly normalised reality, even though we are forever changed when touched by suicide.

In Xhosa, there is a saying, *mkhulule ahambe ngoxolo*. Roughly translated, it means "release them and let them go in peace". This saying goes to the heart of the need to let go, not with the expectation of trying to forget about our loved ones that we have lost, but rather as a means of recognising the sacrifice it takes for us as survivors to look beyond our overwhelming sense of sorrow to the person we loved and lost to suicide. For beyond the point of death and loss, is still the life we shared, the bonds we built and the love we shared. The bonds we shared are always indelible. This is because in general, the bonds we share as living beings who care and get to bond through that caring are incredibly strong. These are the life bonds that bind us as a people and as humans. Ultimately, this means that the life we have lived with our loved one is not erased by suicide. The life they have lived cannot be defined only by how they died. Suicide does not erase a life well lived. Neither are life and love bonds that were shared silenced by death. They may change, they may adapt, but they never cease, even when we die.

Through someone speaking about us after we have passed or commemorating us in different ways, we have succeeded in leaving a part of our essence alive in the hearts of those who loved us or appreciated us. This means we live on in the world around us, manifesting as a written note in our handwriting here, a dress we wore and gave away there, a shared picture with a friend elsewhere, a voice note or song we sang somewhere else, or a good deed we did that warmed somebody's heart. Holding on to these memories and shared moments, letting them take any shape and form that they will, may offer us a way to channel our sense of grief in tangible ways that can help us survive the tragedy that is suicide. This may mean holding on to actual physical reminders of our loved ones, like clothes, physical spaces, photographs, favourite books or music. Even when our own suffering



and confusion are at their worst, the things that can keep us hanging on, that can help us ward off the crushing despair and confusion, are the shared memories that can gift us a way back to healing.

If you have lost someone through suicide, the finality of the act does not have to be the end of your loved one's story. You know the life they lived before they died, and so does everybody else whose lives they touched. Honour the goodness that you shared by finding ways to honour the good life they lived. Let the good deeds they did while they lived also take prominence in as many ways as possible. Find ways to nurture what you used to enjoy sharing with your loved one (a walk in the park, reading a favourite book, cooking their favourite recipe, writing down their favourite sayings, etc.). If you should find yourself ruminating about the tragedy of it all and your heart keeps breaking over and over again, then try and recall at least one good thing you shared with your loved one, and make a note of it in your mind or on a note pad. Use that to help you keep the memory of the good life they lived alive. Also try and hold on to the fact that a life well lived is not erased by suicide. What this means is that it is ultimately in the survivor's power to ensure that the story of a life well lived is not silenced by the final moments of death by suicide. No matter how they died, a life well lived remains a gift they shared with us. Just as the love we shared with them remains an unchangeable reality, the fact that they lived and touched our lives, if only for a moment, also lives eternal.

WHO welcomes historic commitment by world leaders

World Health Organization

The WHO recently welcomed the historic commitment shown by global leaders, at the UN General Assembly, to strengthen the international co-operation, co-ordination, governance and investment needed to prevent a repeat of the devastating health and socioeconomic impact caused by COVID-19, make the world better prepared for future pandemics, and get back on track to achieving the Sustainable Development Goals.

"The first-ever head of state summit on pandemic prevention, preparedness and response is a historic milestone in the urgent drive to make all people of the world safer, and better protected from the devastating impacts of pandemics," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General. "I welcome this commitment by world leaders to provide the political support and direction needed so that WHO, governments and all involved can protect people's health and take concrete steps towards investing in local capacities, ensuring equity and supporting the global emergency health architecture that the world needs."

The political declaration, approved by Mr Dennis Francis, president of the 78th UN General Assembly, and the result of negotiations under the able leadership of Ambassadors Gilad Erdan of Israel and Omar Hilale of Morocco, underscored the pivotal role played by the WHO as the "directing and co-ordinating authority on international health," and the need to "commit further to sustainable financing that provides adequate and predictable funding to the WHO, which enables it to have the resources needed to fulfil its core functions."

"The lived experience of people who suffered through the COVID-19 pandemic must be at the forefront of our minds going forward in order to realise the clear direction provided by world leaders," said Dr Tedros. "We must learn how to protect our communities better and to engage, inform and empower them to be part of the solution. We need to build stronger clinical care systems that can save lives. Doing so requires concrete actions to ensure equitable access to medical countermeasures, sustainable and adequate financing, empowered and engaged communities and robust, trained and equipped health workers."

"The devastating impacts of COVID-19 demonstrated why the world needs a more collaborative, cohesive and equitable approach to preventing, preparing for and responding to pandemics," said Dr Tedros.

Dr Tedros said governments and multilateral partners have already commenced building the foundations for a safer world, with the establishment of the Pandemic Fund, the WHO Hub for Pandemic and Epidemic Intelligence, the WHO BioHub to voluntarily share novel biological materials and the mRNA vaccine technology transfer hub.

However, Dr Tedros added that the political declaration approved on Wednesday called for further strengthening of the global health emergency architecture to better protect the world from a repeat of COVID-19.

Among numerous measures required, the political declaration recognised the need for member states to:

- conclude negotiations on a WHO convention, agreement or other international instrument on pandemic prevention, preparedness and response, otherwise known as the Pandemic Accord, and continue their work to make targeted amendments to the International Health Regulations (2005) by May 2024
- in line with the Pandemic Accord process, ensure the sustainable, affordable, fair, equitable, effective, efficient and timely access to medical countermeasures, including vaccines, diagnostics, therapeutics and other health products
- take measures to counter and address the negative impacts of health-related misinformation, disinformation, hate speech and stigmatisation, especially on social media platforms, on people's physical and mental health, including countering vaccine hesitancy in the context of pandemic prevention, preparedness and response, and to foster trust in public health systems and authorities, including by increasing public health education, literacy and awareness, while recognising that the effective engagement of stakeholders requires access to timely, accurate and evidence-based information and awareness-raising including through the use of digital health tools;
- protect our communities through investing in primary healthcare and other health system measures, as part of a commitment



to universal health coverage, so as to ensure robust national health systems are in place to respond to future pandemics

- invest in ensuring WHO is strengthened to the level needed to play its role in responding to pandemic threats. Sustainable financing of WHO, and national health systems, is essential for making the world safer
- strengthen health workforce and rapid response capacities, surveillance and supply systems, and local manufacturing abilities, to enable and empower all countries to have the ability to meet their own needs to prevent, prepare for and respond to pandemics
- scale up health system capacities to address pandemic threats in low- and lower-middle income countries, especially across Africa
- leverage the potential of the multilateral system and scale up the multisectoral approach needed to improve pandemic prevention, preparedness and response, due to the multifaceted causes and consequences of pandemics, which support attainment of the Sustainable Development Goals.

Following approval of the political declaration by the UN General Assembly president, leaders of UN member states delivered statements on the critical importance of pandemic prevention, preparedness and response and the need for a robust, co-ordinated and comprehensive global health emergency architecture.

Hospice Palliative Care Association rebrands as the Association of Palliative Care Centres

SAMA Communications



As of 1 September 2023, the Hospice Palliative Care Association (HPCA) is known as the Association of Palliative Care Centres (APCC).

"This rebranding is not just a visual change," says Ewa Skowronska, CEO of the APCC. "It is an important message to all medical professionals and the public that our members (many of whom still refer to themselves as hospices) offer quality, specialised and expert palliative care services. Too many people equate hospice with end-of-life only, and many medical professionals refer very late. This leads to thousands of patients, and their loved ones, missing out on the holistic support that palliative care provides – support that, ideally, should be from diagnosis of a life-threatening illness, and not solely in the last few days of life."

The rebrand includes a new logo element that reflects that palliative care can be provided alongside curative treatments and into end-of-life care, including bereavement support (if needed).

"Our members adhere to the *Standards for Palliative Healthcare Services*, 4th edition, 2020, approved by the Council for Health Service Accreditation of SA (COHSASA) and the International Society for Quality in Health Care (ISQua)," says Leigh Meinert, advocacy and operations manager of APCC. "This is important, as sometimes there is a perception that our members are only servicing patients who do not have private healthcare support and might not be at the same level as private organisations. In reality, they have decades of palliative care experience, and compliance with these standards ensures an ongoing level of excellence."

As much as 90% of APCC member's services are provided to the patient in the comfort of their own home. The patient's loved ones are also supported by way of an interdisciplinary team. Such a team typically consists of a medical doctor, nurse, social worker and home-based carers who can work alongside the patient's healthcare professional and support quality of life.

Palliative care covers conditions such as HIV/AIDS, drug-resistant TB, chronic respiratory diseases, cardiovascular and neuromuscular

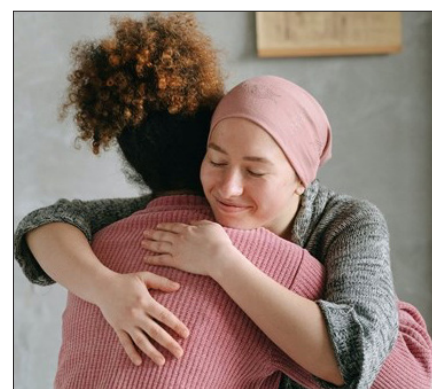
diseases, motor neurone disease and more. "Both adults and children are catered for," says Meinert. "While patients can move in and out of a palliative care service, they may remain beneficiaries of the services for as long as they (or their loved ones) need or wish them to. Patients may be discharged from the service if they are doing well and able to function independently. This is always negotiated between the patient, family and members of the care team. We encourage patients to engage with an APCC member from the point of diagnosis, as this helps to dispel fears and provides insight into the holistic services that can be offered. We believe that all patients have benefited from an improved quality of life through the supportive care received from APCC members."

"APCC has a cloud-based patient care monitoring, evaluation and reporting system able to report in detail on interventions given to any patient," says Skowronska. "Our members are comfortable working alongside the primary clinician or specialist. They can provide a supportive extension of care to the patient and their loved ones and, in most cases, the APCC members' interdisciplinary teams collaborate and work alongside the referring doctors who are treating the patient. They also provide supportive care to the patient's loved ones. This may include advanced healthcare planning, as well as psychosocial and spiritual support."

"Our palliative care definition says it all," concludes Meinert. "Palliative care is the physical, psychological, social and spiritual care provided by an interdisciplinary team of experts to anyone with a life-threatening illness and their loved ones. Care is offered from the point of diagnosis, and extends to bereavement support if needed. Over 90% of the care that APCC members provide is home-based, with a focus on promoting quality of life."

We sincerely hope that this rebranding results in more people receiving the support that they so desperately need during some of the most difficult times in a person's life."

For more info, visit www.apcc.org.za.



About the APCC

Previously known as the Hospice Palliative Care Association (HPCA), the Association of Palliative Care Centres (APCC) is a registered NPO in SA. Founded in 1987, the (now) APCC is a member organisation for palliative care service providers, many of whom refer to themselves as hospices. As a national charity, the association champions and supports 91 member organisations that provide palliative care services to approximately 40 000 people per year. APCC's members are located across SA and care for patients with a variety of life-threatening conditions, predominantly in the comfort of their own homes.

About palliative care

Palliative care is the physical, psychological, social and spiritual care provided by an interdisciplinary team of experts to anyone with a life-threatening illness and their loved ones. Care is offered from the point of diagnosis, and extends to bereavement support if needed. APCC members typically have a team that includes a medical doctor, professional nurse, social worker, counsellor and home-based carers. All staff are trained in palliative care, which aims to ensure quality of life for patients and to prevent and relieve unnecessary suffering.

Why not enough people with HIV are on treatment – and how a new court ruling could help

Lillian Roberts and Linda Pretorius, for *Bhekisisa*

SA came one step closer to getting everyone diagnosed with HIV on treatment that will prevent them from transmitting the virus after last week's [ruling by the North Gauteng High Court](#) that gave the go-ahead for pharmacists to prescribe anti-HIV drugs. The court judgment makes it easier for [HIV-positive people to get antiretroviral drugs](#) (ARVs), or for those who are HIV negative to use a [daily HIV prevention pill](#) because they won't first have to see a doctor.

When someone with HIV takes their daily ARVs correctly, it becomes virtually impossible for them to infect others through sex, because the medicine [suppresses the virus in their bodies to levels too low to transmit it](#).

SA currently struggles to get enough people who know they have contracted the virus onto ARVs.

The [latest figures from Statistics SA](#) show that 8.45 million people in the country are estimated to have HIV. From this, and using the [health department's data on the proportion of people diagnosed and on treatment](#), 7.94 million people know they're infected and 6.11 million of them are on ARVs – in other words, 2.34 million HIV-positive (both diagnosed and undiagnosed) people are not on treatment.

The court decision follows after a doctors' group called the Independent Practitioners Association Foundation took the SA Pharmacy Council (SAPC) [to court in 2022](#) for starting the Pharmacist-Initiated Management of Antiretroviral Treatment (Pimart) programme. Through this programme, pharmacists would be able to, once having completed a training course and obtaining a [special permit](#) for dispensing schedule 4 drugs, advise clients on taking ARVs, and follow their treatment.

ARVs are classified as [schedule 4 medicines](#) according to SA law, and so should conventionally only be prescribed by a doctor, says the [Medicines and Related Substances Act](#) No. 101 of 1965.

The WHO says that [widening the circle](#) when it comes to managing patients' primary healthcare – such as for treating or preventing HIV infections – is a good idea.



Why?

Because the easier it is for people to get ARVs, the closer we'll be to ending the epidemic by 2030.

In order to do this, the Joint IN Programme on HIV and Aids wants all member countries to reach something known as the [95-95-95 goals by 2025](#). That means governments, including SA, would need to have, by 2025, 95% of people with HIV diagnosed, get 95% of diagnosed people on ARVs and, in turn, get 95% of those on treatment to have viral levels so low that they can't infect someone else (called [viral suppression](#)).

But, show figures from the health department, we're far behind on the second 95: getting people who know they have HIV to take up treatment.

Knowing our numbers

By May, 95% of people with HIV in SA knew they were infected. But only [77% of them were on ARVs](#). And of those, only 92% were virally suppressed.

"We're not satisfied with where we're at," says Thato Chidarikire, the health department's acting chief director for HIV, when asked about the country's progress on our 95-95-95 goals.

[New guidelines from the WHO](#), released in July, could help to change the picture, though.

Generally, when there are fewer than 20 copies of the virus in a millilitre of blood, someone is said to have an undetectable viral load (that is,

the amount of virus in the body), and the virus is virtually untransmittable. This idea is called [U=U: undetectable equals untransmittable](#).

Now, the WHO says that if someone has a viral load anywhere below 1 000 copies per millilitre – which will still be picked up by a test – the infection is controlled enough that there's an ["almost zero or negligible risk"](#) of passing HIV on to a sexual partner.

Treatment gap

Why does SA struggle to get diagnosed people on treatment – and help them to stick to it?

Francois Venter, executive director of the Ezintsha research centre at the University of the Witwatersrand, explains: "People may be in denial [after being diagnosed], feel stigmatised or be scared. Or the health services may be unfriendly or inaccessible."

To keep viral levels suppressed, someone with HIV has to stick to their treatment – meaning [taking ARVs for the rest of their life](#). But, says Venter, this is hard – despite side-effects of the medication as a reason for people to stop taking their pills being "vanishingly rare" now.

"New drugs have far fewer side-effects, to the point that almost all patients tolerate their drug combinations extremely well. We also see far less [\[drug\] resistance](#) – there's more forgiveness for the occasional lapse in adherence. [Treatment] really is so much easier than before," he says.

So, why the difficulty in keeping people on their pills then?

Says Venter: "It's all social – just the chaos of everyday life. Changing jobs, provinces, moving house, stresses. You name it. There are so many reasons for interrupting therapy, and the system doesn't make it easy to move clinics or to come back after you've stopped your treatment. The healthcare workers routinely yell at you. It's a huge disincentive to come back."

How to get to the finish line

Chidarikire agrees. To help people get – and stay on – treatment, we have to make access to medication easier. SA already follows a [differentiated service delivery model](#), she says, as recommended by the WHO. This means that instead of having a one-size-trying-to-fit-all approach to HIV treatment, the way people get tested and treated for HIV is adapted to fit their circumstances.

"We may have reached the first 95, but the second and third [ones] still need a lot of effort, both on the demand and supply side," she says.

Enters Pimart. Under this programme, someone can go to a qualifying pharmacy (that is, one that has a [section 22A\(15\) permit](#)) to get HIV prevention drugs, have an HIV test or pick up their ARVs – without having to see a doctor first for a prescription. If this is close to where they live or work, and if the process is fast and efficient, it will be easier for people to stay on treatment or protect themselves from getting infected in the first place.

In the case of treatment, pharmacists will only be allowed to issue [first-line ARVs](#) (the first type of regimen – in the form of a three-in-one daily pill – that a newly diagnosed person is put on).

But getting your HIV treatment from a private pharmacy won't be free. Pharmacists will be able to charge the single exit price for

the medicine plus a professional fee, as set by the SAPC. The cost of treatment in the private sector therefore could be a barrier to people who use government facilities, says Andy Gray, senior lecturer in pharmacology at the University of KwaZulu-Natal.

SA currently struggles to get enough people who know they have contracted the virus onto ARVs

"PrEP [pre-exposure prophylaxis in the form of a daily HIV prevention pill] may be a more affordable option and may be more widely used by key populations [groups who have a bigger chance of getting HIV than the general population, such as sex workers and men who have sex with men] and who are being missed by the public sector now."

Yet, says Gray, someone who doesn't (want to) use the public health system can now choose to go to a private pharmacy instead – even if they have to pay for the pills themselves (or claim it from their medical aid).

Despite having to pay for the medicine, Natalie Schellack, a professor in pharmacology at the University of Pretoria, said at an SAPC press briefing last week that the [hidden expenses of getting treatment](#), such as travelling to a government facility and waiting in line, add considerable cost to treatment – which could make getting your pills at a private pharmacy attractive.

Indeed, [studies show](#) that having HIV services such as testing and medicine collection at a private pharmacy ups the demand for these. Moreover, clients who choose to have a trained pharmacist follow the progress of their ARV treatment get to viral suppression just as well as patients who are treated by a doctor.

Gray adds that Pimart also offers an opportunity for the government programme to expand access to ARVs by potentially supplying free state stock to these pharmacies, in the same way as getting childhood vaccines or contraceptives via a private facility, even when the pharmacy can charge a service fee.

The health department has not yet announced whether they will have such partnerships with private pharmacies. *Bhekisisa* has asked the health department for a response and we will update the story once they have responded.

In July, [the WHO also said](#) that using a spot sample of dry blood for a viral load test at a clinic can help to check how well people are doing on their medication, especially in rural areas where it might be difficult to get liquid samples to a lab. For this, someone's finger is pricked and [a drop of blood is dabbed onto a special paper card](#), which is then analysed.

Will these plans get us to our 95-95-95 goals in the next year and a half?

"It's complex," says Venter.

"We've done the easy stuff. The last 20 - 30% will take far more effort to work out. I suspect making both testing and getting on treatment easier will go some way in getting us there, but not all the way."

Source: Bhekisisa, 23 August 2023. <https://bhekisisa.org/health-news-south-africa/2023-08-23-why-not-enough-people-with-hiv-are-on-treatment-and-how-a-new-court-ruling-could-help>.

Breaking the silence: Mental health not recognised enough among the SA Deaf community

SAMA Communications

In SA, the Deaf community faces unique challenges, including neglected mental health and access to care. Often overlooked and marginalised, this community grapples with a host of emotional, psychological and societal issues that can significantly impact their wellbeing.

According to the [World Health Organization](#), over 1.5 billion people, nearly 20% of the global population, live with hearing loss, while 430 million of them experience disabling hearing loss. Researchers project that by 2050, the number of individuals with disabling hearing loss could surge to over 700 million.

Within SA, a staggering [12 million](#) people contend with some form of hearing loss that has a devastating impact on the individual, manifesting in academic difficulties, heightened unemployment rates, poorer general health and social isolation. The Deaf community, like any other, is not immune to

mental health challenges, with depression, anxiety and substance abuse being common adversaries.

Dr Ian Westmore, a board member of the SA Society of Psychiatrists, underscores that one of the most prominent obstacles facing the Deaf community is communication.

"Despite Sign Language being one of the nation's 12 official languages, it remains largely unrecognised and unspoken by most hearing individuals. This lack of proficiency extends to medical professionals, creating a significant hurdle for deaf individuals in expressing their emotions, thoughts and feelings. This lack of communication can breed isolation, frustration, and exacerbate pre-existing mental health conditions."

He says there is a glaring lack of awareness among healthcare providers and policy-makers regarding the unique mental health needs of the Deaf community. This oversight has resulted in the underdevelopment and inadequacy of services tailored to their specific requirements.

Dr Westmore emphasises, "The mental health challenges faced by the Deaf community are fundamentally distinct from those of the general population. Healthcare professionals must account for gaps in knowledge and emotional vocabulary, cultural backgrounds and the inability to communicate mental health symptoms."

"Communication within the Deaf community presents its own set of challenges. In many cases, certain mental health concepts cannot be adequately conveyed through Sign Language alone. Lip-reading often falls short, and written communication cannot fully substitute spoken language. Additionally, the availability of interpreters proficient in Sign Language is limited, further complicating matters. Interpreters can, in addition, inadvertently introduce barriers that hinder the expression of emotions, ultimately leaving individuals feeling uncomfortable or misunderstood.

"Without proper methods for assessing mental health conditions, there is a risk of incorrect diagnosis and treatment, or even undiagnosed conditions."

In addition to the communication barrier, stigma remains a harsh reality for many Deaf individuals. Social stigmatisation and discrimination frequently plague the Deaf community, leading to issues such as low

self-esteem, anxiety and depression. Access to crucial information and resources is also severely limited, impeding early intervention and support.

For those born deaf, Dr Westmore says early life stressors associated with the disability can exacerbate mental health conditions later in life.

"The mental health challenges faced by the Deaf community are fundamentally distinct from those of the general population"

"The inability to communicate and participate in conversations, linguistic neglect, poverty, trauma and abuse can influence a child born deaf's functioning and stress response, which, in turn, impacts how they cope with stressors in adulthood."

"Access to quality education is another challenge, particularly for deaf children in SA. This educational disadvantage can lead to lower socioeconomic status and heightened stress, contributing further to mental health issues."

Additionally, there are varying degrees of deafness, including those born with the disability and individuals with sensorineural hearing loss due to inner ear damage or age-related factors.

"Sensorineural hearing loss, one of the most common types of age-related hearing loss, is often overlooked, but significantly diminishes the quality of life. It leads to feelings of isolation, reduced social activity, and a sense of exclusion, culminating in a higher prevalence of depressive symptoms."

Dr Westmore underscores that addressing mental health within SA's Deaf community is an urgent matter requiring both acknowledgment and action.

"It is vital that society recognises the unique challenges faced by Deaf individuals and takes proactive steps to address them. By breaking down communication barriers, improving access to mental health services

and raising awareness, we can ensure that the Deaf community in SA receives the support and care they deserve, ultimately improving their overall mental wellbeing."

Dr Westmore offers several potential solutions:

- Training of medical professionals: GPs and clinics are in many instances the first point of call for patients. Healthcare providers need to be trained in basic Sign Language to help bridge the communication divide and improve the quality of care for Deaf individuals.
- Deaf-friendly mental health services: Specialised mental health services designed to cater to the Deaf community should be established, providing a safe and welcoming environment where individuals can seek help without fear of miscommunication or discrimination.
- Awareness campaigns: Initiatives to raise awareness about the mental health challenges faced by the Deaf community are essential. These campaigns can help reduce stigma and foster greater understanding among the general population.
- Community support: Peer support groups and community organisations can play a crucial role in providing emotional support and resources for Deaf individuals struggling with mental health issues.
- Education: Mental health providers need a deeper understanding of hearing loss, its association with psychiatric disorders, and the treatment of these disorders. Accurate diagnoses hinge on healthcare professionals' familiarity with the unique challenges faced by the Deaf community and the profound impact of hearing loss on their lives.
- Checklists: All healthcare professionals should be equipped with symptom-based checklists that the Deaf person or their family member can complete, keeping in mind poor literacy and educational attainment.
- Careers in mental health: Encouraging members of the Deaf community to consider careers in mental health can help bridge the gap in accurately diagnosing conditions and providing culturally sensitive care.

For more information contact:
[South African National Deaf Association.](#)
[National Institute for the Deaf.](#)

Death notice and death certificates

Karlien Pienaar, administrator, SAMA Legal Department

It is possible that every doctor at some point will come across a scenario during their career where they are required to issue a death notice. A couple of questions were recently raised regarding the person who completes the Death Notification Form (DNF), whether a medical practitioner must be present, and more.

If you have questions in this regard, please take note of the following information.

Who may complete and submit the DNF?

According to the Births and Deaths Registration Act No. 51 of 1992 (the Act), it is important to determine whether the death was due to natural or unnatural causes. Section 14 of the Act states the following:

"Death due to natural causes –

(1)(a) In the case of a death due to natural causes, *any person who was present at the death, or who became aware thereof, or who has charge of the burial concerned*, shall give, as soon as practicable, by means of a certificate mentioned in section 15(1) or (2), notice thereof to a person contemplated in section 4.

(b) Where notice of a person's death cannot be given by means of a certificate mentioned in section 15(1) or (2) because a medical practitioner did not attend him or her before his or her death, or was not available to examine the corpse, *any person who was present at the death, or who became aware thereof*, must give notice of the death in the prescribed manner, and the person contemplated in section 4 must deal with such notice in accordance with the prescribed procedure."

Certificate by a medical practitioner

Where a medical practitioner was present and is available to issue a notification of death, it is important to note that section 15 of the Act states the following:

"Certificate by medical practitioner

(1) Where a medical practitioner is satisfied that the death of any person who was attended before his death by the medical practitioner was due to natural causes, he shall issue a prescribed certificate stating the cause of death.

(2) A medical practitioner who did not attend any person before his death but after the death of the person examined the corpse

and is satisfied that the death was due to natural causes, may issue a prescribed certificate to that effect.

(3) If a medical practitioner is of the opinion that the death was due to other than natural causes, he shall not issue a certificate mentioned in subsection (1) or (2) and shall inform a police officer as to his opinion in that regard."

A community service doctor as well as an intern may complete and sign the DNF, as they are both registered with the HPCSA as medical practitioners. In terms of the Internship Handbook 2017 of the HPCSA, it is stated that even though interns are permitted to sign and issue any certificate or document, it is advisable for an intern to seek guidance from their supervisors in the workplace, particularly when issuing death certificates. It is advised that it would be "kinder to the intern that a more senior person does so".

Natural/unnatural causes

As stated above, where the deceased was under the treatment of another practitioner who is not available at the time of death, the medical practitioner who is requested to complete the DNF must examine the corpse to satisfy him/herself that the death was due to natural causes.

If it is found that the death was due to unnatural causes, the medical practitioner should not issue a certificate, as per section 15(3), and immediately inform a police officer, who will start an investigation in terms of the Inquest Act.

Different sections to be completed by different persons

Form DHA-1663 (Notification of death/stillbirth) must be completed in duplicate when reporting a death, and the following persons need to complete the different sections of the DHA-1663 form:

- (i) the person reporting the death
- (ii) a medical practitioner (where a medical practitioner is not available to complete this form, in rural areas for example, a traditional leader may complete the form)
- (iii) a Home Affairs official (where an official from the Department of Home Affairs is not available then a member of the SA Police Services may be approached to complete the form).

The purpose of the first page of the detachable form (DHA-1663) is that the burial can be authorised by Department of Home Affairs. The cause of death can only be indicated as natural or unnatural on this page, and must be detached before handing it to the undertaker or the family.

The second page is confidential and mainly used by the Department of Home Affairs to collect statistics. The medical practitioner may insert the medical cause of death on the second page, and after completion, the second page should be folded and sealed to ensure that confidentiality is maintained. The sealed document/envelope may be attached to the first page and then handed to the informant (family or person in charge of the funeral for purposes of arranging) for registration of death and a burial order. Therefore, the content of the second page should not be shared with the family, the undertaker, the insurer, or any other interested party.

As soon as the death has been registered, the form will then be forwarded to Statistics SA, who record the second page for purposes of the statistical reports.

Who to report the death to?

The Act requires that a person's death be reported to any one of the following people:

- specific officers at the Department of Home Affairs; or
- SA Police Service members, especially in areas where the Department of Home Affairs has no offices; or
- any SA embassy, mission, or consulate if the death occurred abroad; or
- funeral undertakers who are appointed and recognised by the law.

Who will issue the death certificate?

When the appropriate authorities are satisfied with the supporting documents and forms submitted, a death report or the DHA-1680 will then be issued after the death has been registered by a designated and authorised official (authorised by the Department of Home Affairs).

References available on request.

Navigating the retrenchment process in SA: Rights, regulations and responsibilities

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

The retrenchment process (dismissals based on operational requirements) in SA forms an integral part of our labour legislation, and it is important for medical practitioners as employers to be informed about the guiding principles, to ensure compliance with legalities. SAMA's Employment Law Unit frequently receives queries from members in the private sector contemplating closure of practice, or who have already closed their practice and are facing a legal dispute with a former employee due to non-compliance with retrenchment processes. In this article, we will explore the retrenchment process in SA, focused on the legal framework.

The retrenchment process is often an emotionally charged event for both employer and employee. It is thus of vital importance for medical practitioners to be informed of how the retrenchment process at all times should be followed during the closure of practice.

The legal framework

The retrenchment process is governed by the Labour Relations Act No. 66 of 1995 (LRA), specifically section 189, and dictates the following:

Notice of intention: Employers must inform employees of their intention to dismiss employees based on operational requirements, and invite them and their representatives to consult.

Consult: Employers must consult with employees and their representatives prior to implementation in an attempt to reach consensus on the terms and conditions of retrenchments. However, it should be noted that it is not a requirement for consensus to be reached prior to implementation of the retrenchment.

Severances and statutory monies: Employers must pay the legally mandated severances to affected employees, calculated at 1 week's salary for each completed year of

service. Employers should also pay affected employees the monetary value of any annual leave credits due to them on date of termination.

Notice of termination: Employers must provide adequate notice (4 weeks), as required by the LRA. This notice period should be worked by the employee, but employers could also choose to pay in lieu of notice and allow employees to use this as an opportunity to explore other employment opportunities.

Conclusion

Considering the above, it is vital for members as employers in the private sector to ensure compliance with the guiding principles as dictated by the LRA when closing practice, and thus prevent any adverse award at the Commission for Conciliation, Mediation and Arbitration (CCMA). SAMA members are urged get in touch with SAMA's Employment Law Unit for assistance by sending their queries to labour@samedical.org.

Applying the common purpose doctrine in the workplace

Simon Buthelezi, labour law advisor, SAMA Legal Affairs Department

The doctrine of common purpose in SA can be traced back to section 78 of the Transkei Penal Code Act No. 9 of 1983, which is a version of the Native Territories Penal Code of 1886, section 78. This code states that if several persons form a common intention to commit a crime or assist each other therein, each of them is party to every offence committed by any one of them. This provision assumes that persons will know the consequences of such offence and can easily disassociate themselves from it if they want to do so.

The early application of this doctrine in SA cases originates from Roman-Dutch law, which held that any person who counselled or gave assistance to another to commit a crime became punishable in the same manner as the main offender. This is also a common law stance on such matters. In *R v Peerkhan & Laloo*, Judge Innes T held that our law calls

a person who aids, abets, counsels or assists in a crime a *socius criminis* or accomplice, or a partner in crime.

The above implies that in the opinion of the court, any person who does something to further the purpose of another to commit an offence, by assisting at the offence, is also an offender, and therefore the judge simply needs to ascertain whether the accused assisted or intentionally helped the offender to execute the misconduct.

Constitutional Court approach

A case in point is that of NUMSA obo Dhludhlu and Others v Marley Pipe System (SA) (Pty) Ltd (CC) (unreported case CCT233/21, 22-8-2022), where a disciplinary hearing against 148 of the employees took place during July - August 2017. The employees were charged with embarking on unprotected strike action

and assaulting a fellow employee who was the head of human resources. Pursuant to being found guilty of both counts, all 148 employees were dismissed.

Twelve of the employees were found to have been directly involved in the assault of the head of human resources, while the remaining employees, on application of the doctrine of common purpose, were found guilty of the same charge. The Constitutional Court reiterated the point that in applying the doctrine of common purpose, an employee can be found guilty of misconduct if they actively associate themselves with the misconduct either before, during or after the act.

Conclusion

The common purpose doctrine is very complicated, and members are advised to always seek advice when contemplating any course of action.

Claim defended over alleged misdiagnosis

Peter Mordecai, *claims manager, Medical Protection*

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 Medical Protection 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 Medical Protection, who immediately

instructed local panel solicitors to file a defence on behalf of Dr L.

In addition, Medical Protection instructed the panel solicitors to obtain Patient K's medical records and a witness statement from Dr L. The evidence was reviewed internally by Medical Protection's claims manager and medicolegal consultant, who agreed that further evidence was required. Medical Protection 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.

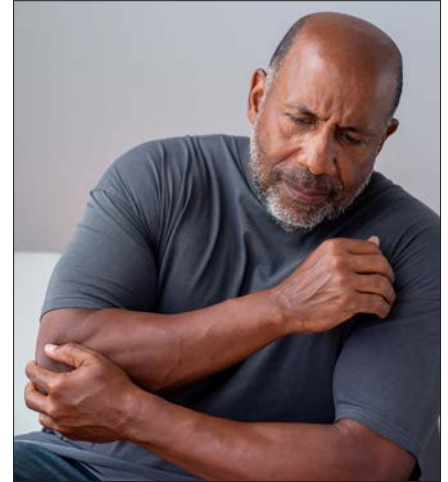
Upon receiving the report, the content was discussed with our expert. He agreed that while symptoms were not suggestive of scleroderma, the biopsy results were definitive in their conclusions, and therefore the diagnosis was correct. In addition, while the expert agreed that a rheumatologist should have 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.

Medical Protection 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, Medical Protection 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, our expert agreed this omission did not cause any harm to Patient K.

It is also important to 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.

Free State host successful annual gala function

The SAMA Free State branch (FSB) held their annual gala function at the Faculty of Health Science, University of the Free State in Bloemfontein on 1 September 2023.

The branch invited members, non-SAMA members and the 5th-year medical students to a dinner party in celebration of their commitment to SAMA, and to encourage doctors to become members.

The branch expressed their appreciation to the keynote speaker, Prof. Lucille Blumberg, for gracing the event with her presence and delivering such an inspiring speech.

Dr van der Bijl, vice-chairperson of the branch, presented the SAMA welcome speech and gave an oration to the medical students. On behalf of the branch council he also thanked guest speaker, Dr Johan van der Merwe.

The SAMA FSB council also thanked the Standard Bank team, Mr Ehren Steenkamp and business associates for their informative presentation and participation and very generous sponsorship in hosting the annual gala event, as without their support and contribution, the goal to host the event would not have been possible.



Front row, left to right: Ms Michelle Coetzee (Standard Bank), Ms Olebogeng Mojanaga (Standard Bank), Dr Chantelle van der Bijl (SAMA FSB vice-chairperson), Dr Johan van der Merwe (guest speaker), Prof. Lucille Blumberg (keynote speaker) and Prof. Steven Matshidza (SAMA FSB chairperson). Back row, left to right: Christian Lipali (Standard Bank), Dr Jomarie Oliver (SAMA FSB general practitioner representative), Dr Liam Selfridge (SAMA FSB councillor), Prof. Dirk Hagemester (SAMA Board of Directors and SAMA FSB treasurer), Dr Freek Bester (SAMA FSB specialist doctors representative), Dr Deon Menge (SAMA FSB brand amplifier), Dr Benjamin de Bruin (SAMA FSB honorary branch secretary), Prof. Nicholas Pearce (head of medical school, UFS), Mr Ehren Steenkamp (Standard Bank) and Ms Nolwazi Nkeane (Standard Bank).

Informative CPD meeting hosted by GWB

The Griqualand West branch hosted a CPD meeting on 28 September 2023 at the Kimberley Anne Hotel in Kimberley. The topics discussed at the meeting, presented by Dr Peet Potgieter and Laetitia Wolfswinkel, were "Female hormones in clinical practice" and "Locums and session doctors – employees or independent contractors".

Dr Peet Potgieter qualified as a doctor at the University of the Free State, and went on to qualify there as a specialist obstetrician and gynaecologist. He is currently in private practice at Mediclinic Kimberley in SA. He has a special interest in diabetes in pregnancy and female endocrinology, and his surgical focus is on minimally invasive surgery and urogynaecology.

Attorney Laetitia Wolfswinkel qualified as an attorney at the University of South Africa and the Law Society of SA. Laetitia worked for SAMA for 10 years before leaving to live in Germany for 5 years, where she obtained a



Back row: Dr Jimmy Amsini (SAMA GWB vice-chairperson), Laetitia Wolfswinkel (SAMA labour law advisor), Dr Charnè Theys (SAMA GWB honorary secretary), Dr Peet Potgieter (specialist obstetrician and gynaecologist), Gabalaiwe Makokoe (Absa) and Wian du Plessis (Absa). Front row: Sultana Hartzenberg (SAMA GWB administrator), Mangaka Ncubukezi and Refoloe Quali.

Master's degree in law, and returned to SAMA in January 2023.

The SAMA Griqualand West branch council thanked the Absa bank team, Mr Gabalaiwe Makokoe and business associates for their

presentation, participation and very generous sponsorship in hosting the CPD event.

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



Welcome to SAMA

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

Border Coastal branch

Pamela Gumenge

Cape Western branch

Tracy Peter Ward

Waldo Piater

Matome Maruma

Eastern Highveld branch

Vusumuzi Victor Dhlamini

Likeleli Philadel Mokokoana

Eastern Province branch

Sihle Dayimani

Renelle Reddy

Lungisani Mgenge

Yi-Chia Lee

Kerusha Indurjeeth

Nosipho Mbeje

Free State branch

Katleho Gilbert Chabeli

Keamogetswe Primrose Setouto

Yashna Allopi

Lehlohonolo Smous Semoise

Syamdumisa Cedrick Buthelezi

Mpho Gladys Letsatsi

Amani Abdulla Sujee

Gauteng branch

Aadil Cassim

Meghan Bruton

Hussein Nabi

Didintle Edmunds

Fatima Abilu

Nhlahla Cassius Mathebula

Anele Bekwa

Nadia Redelinghuys

Thandi Nehume Chwayitha Maseko

Aphiwe Ntshanga

Lusindiso Mbali

Gauteng North branch

Albert Morake Matji

Lunathi Bongoza

Robyn Dormehl

Mesobotse Elish Kgaphola

Chibuike Okorie

Rudzani Mulaudzi

Ofentse Kelebogile Mangope

Ruo Hui Huang

Danielle Minnaar

Cornell Juta

Shamil Shyam Jeram

Ampfarisaho Madzivhandila

Buhle Kekana

Mitchell Ramonyai

Teboho Sam Hlatshwayo

Cuan Matthew Edwards

Fathima Bibi Shaik

Karen Fourie

Annemarie Deppe

Kearabetswe Molaiwa

Mushaisano Sivhaga

Zakariyya Ellemdin

Lerato Rasemane

Thato Motaung

Avuyile Makhombo Tracey

Bronwen Crawford-Brunt

Khethukuthula Skosana

Mohammed Ismail

Zukisani Goodman Ngcanasa

Nompumelelo Saule-Mudau

Tiego Moropane

George Ngwenya

Ndzhaka Khosa

Luke James Heger

Deliwe Skosana

Jordan Fitzjohn

Tshembisa Chuma

Chante Bosch

Sihle Mogorosi

Ofentse Kiba Molapo

Rochelle Oosthuizen

Mine van Nieuwenhuizen

Mikael Ebrahim

Funanani Mudau

Vhulenda Muthelo

Zanele Baloyi

Zamanguni Gumedde

Reuben Emiel van Rooyen

Takitsi Mbali Phumlile Mvakali

Kamogelo Queen Hayane

Julie-ann Zeta Potgieter

Cuma Yongama Mancotywa

Nina Paige Saby

Sgcino Banningi Ayanda Mnguni

Jacques Nel

Jabulile Makane

Thutego Phemelo Reamogetse Tsheole

Mary Lesego Mokoka

Kamva Jokozela

Megan Jane Spitaels

Julia Skye Moody

Anya Danielle Wille

Alida Marianne Boon

Kelly Rundle

Jade Fieldgate

Wynley Sharna Flanagan

Tshepang Moloi

Mahlatse Mahlobogoana

Andrea Reddy

Nkosikwenzile Forgiveness Sibisi

Jonathan Wai-Chung Au

Phakisho Raboshaba

Letlhogonolo Sekwele

Thato Nokhomatha

Tania Mejanie

Alvin Grace Nyango Drabile

Thokozile Tiyana

Sabrina Cirone

Danielle Scheepers

Ruben Reeves

Nicola Steenekamp

Zenelle Hayes

Cara Burger

Dzannisani Grace Shimange

Catherine Elizabeth Wilcocks

Keren Leah Welgemoed

Bryson Pillay

Monja-Lili Oelofse

Megan Oosthuizen

Lesego Chauke

Caitlin Rajchrt

Nkosinathi Mvambo

KZN Coastal branch

Tyrell Pillay

Skhona Letsipa

Asive Ndzandzeka

Pfunzo Mukondeleli



Mishael Hurbans
 Siphelele Nsibande
 Shadia Pillay
 Siphamandla Sibisi
 Carson Van Vollenhoven
 Mokgadi Mashudu Alexius Mathedimosa
 Bevan Owen Abraham
 Kimera Maniram
 Velenkosini Thakasani Lamula
 Ziphozonke Sicelimpilo Lamula
 Zanoluhle Ngcobo
 Nomfundo Precious Mkhumane
 Zesuliwe Patricia Mkhwanazi
 Ida Mahwasane
 Smangaliso Percival Maphumulo
 Minenhle Nolwazi Mthembu
 Nontando Pretty Mthembu
 Phumelele Nothando Mshengu
 Siluleko Simelokuhle Mtshali
 Thabisile Ncube
 Nonkululeko Shoba
 Melisizwe Comfort Ndabandaba
 Winile Snethemba Sikhakhane
 Nomvuyo Ntombikayise Khumalo
 Samukelo Handsome Zondi
 Nosihle Ntshangase
 Pralishia Pillay
 Diyajal Ramraj
 Nosipho Lusiwe Mhlongo
 Snothile Jacinta Mahlinza
 Timera Naidoo
 Jade Karan Naidoo
 Tuvir Jugganath
 Thembelihle Angel Maziya
 Thabiswa Dimpho Mbanjwa
 Xolisile Pretty Xulu
 Ayabonga Awethu Ndlovu
 Alulutho Mthimkhulu
 Sphumelele Halala Asanda Mdlalose
 Bulela Mkani
 Danielle Lottering
 Pearl Phakedi
 Luyanda Barry Sambo
 Lungelo Nhanyiso Simelane

KZN Midlands branch

Buhlebenkosi Mbeje
 Nokubonga Zondi
 Travis Kyle Peters

Limpopo branch

Mmapheladi Mosly Maesela
 Abegail Tsundzukani Sithole
 Jason Debeila
 Khethani Thuli Sihlangu
 Karli Strydom
 Dineo Jermaine Ratshipaladza
 Phathutshedzo Muyahavho Shamane Ratombo
 Juliet Mahlatse Mohlala
 Munzhedzi Praise Masiavhula
 Ronewa Mbedzi
 Vhuthu Matsheketsheke
 Khomotso Cedrick Phaladi
 Thekgo Maremeke Maoto
 Rhulani Mambane
 Khuliso Evans Ramatsitsi
 Mamolapong Titelo Tshilwane
 Mokoti Brain Tema
 Wanga Rambuwani
 Marybeth Sithole
 Sonwabise Mbali
 Lefa Lebelwane Mokabane
 Nicole Busisiwe Kunene
 Thubelihle Makhanya
 Makhanana Ngobeni
 Indiphile Memani
 Tshegofatso Mokgoadi
 Thabo Molema
 Reratilwe Sekhula
 Flora Bopape
 Mapula Leago Shogole
 Maite Florah Letsoalo
 Separitle Jackson Tjebane
 Khaahule Ratshili
 Nhlanhla Leasia Rikhotso
 Tumelo Bridget Chapepe
 Siphesihle Sibeko
 Kanego Sonia Nyalunga
 Tlou Davis Ngoepe
 Luyanda Mhlaba
 Kamogelo Selepe
 Cassandra Sibiyi
 Motsatsi Veronica Manyama
 Masego Malongoane
 Rikonise Matsenene
 Josi Chipane Mailula
 Sequence Kutullo Ncube
 Latifah Thobejane
 Naledi Modirwa Ledwaba

Utopia Masingi
 Zingiswa Ngcobo
 Isaac Sifunda

Lowveld branch

Nomathemba Princess Mokoena
 Nkosinathi Tshabalala

North West branch

Claudia Boitshoko Moloabi

Outeniqua branch

Zilla Maria North

Transkei branch

Lihle Khulwa
 Alulutho Mazwi
 Manyano Matshoba
 Nokonwaba Msengana
 Florence Joao
 Lindani Ethan Mzize
 Odwa Nkalane

Tygerberg Boland branch

Bonolo Nape
 Sabelo Silangu
 Palesa Ntshwarang
 Bianca Tout
 Zama Buthelezi
 Sean-Michael Bhikha
 Abigail Sieberhagen
 Dana Becks
 Annah Musandiwa
 Luyanda Sikhakhane
 Robyn Liebenberg
 Lara Amanada Rossouw

West Rand branch

Keamogetswe Malope
 Jarryd Nicholas Brown

Unattached

Ivone Shadjuuka
 Velisha Pillay



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



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**