



SAMA ANNUAL CONFERENCE 2024

TOWARDS STRENGTHENING HEALTH SYSTEMS





SAMA is a voluntary membership association, existing to serve the best interests and needs of its members in any and all healthcare-related matters.



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To be the leading and preferred membership organization advocating and supporting medical practitioners in South Africa.



SAMA'S MISSION

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SAMA ANNUAL CONFERENCE 2024

TOWARDS STRENGTHENING HEALTH SYSTEMS

*A special conference edition
compiled by Roy Watson and
Chris Bateman covering the
annual SAMA conference.*

*The 2024 conference took place
from 15 – 17 February at the
Sandton Convention Centre.*

Articles/Photographs
Chris Bateman
Roy Watson

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Look after doctors & hasten SA's economic recovery



**SAMA chairperson,
Dr Mvuyisi Mzukwa**



**SAMA Vice-Chairperson,
Dr E Ngwenya**

With 1 500 vacant, unfunded doctor posts, inadequate infrastructure, essential drugs, equipment, and vaccines, plus a lack of ethical leadership and governance, SAMA will fight for pragmatic reform prior to the introduction of more appropriate universal healthcare.

Dr Mzukwa, said this to 511 delegates at the organization's first in-person conference since Covid, held at the Sandton Convention Centre from 15-17 February.

He said the decline in healthcare standards and availability of resources had been "going on for some time," profoundly impacting the needs of doctors and their patients, leading to burnout, poor care, litigation and increased morbidity and mortality.

"Even attracting and retaining doctors to rural areas is a mammoth task. With our high burden of disease, including HIV and TB, we require significant resources and specialized skills.

It's an ongoing battle, especially when infectious diseases like Covid hit, putting extra strain on doctors, plus security challenges, including violence against doctors and nurses at hospitals." Doctors grappled with complex legal and ethical challenges, including informed consent and medical errors, and patient confidentiality suffered.

SAMA's strategy was one of preserving the medical profession. "At times I feel like we're under attack. Yet our focus on continuous training and education speaks to our efforts to stay abreast of evolving medical practice," he added. Mzukwa revealed that SAMA membership, now at 12 000, (of an estimated 35 000 doctors' country-wide), reached a peak during Covid.

"Our objection to the NHI bill in its current form is supported by 83% of our members and we've collected 73 000 signatures from people across the country who share our views.

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The public has made 367 submissions to parliament, (mostly collective), which demonstrates the depth of public concern.”

He described the SAMA conference as “more than a meeting of minds and networking. “It’s a call to action for all stakeholders and delegates to participate in meaningful dialogue to create a workable, efficient healthcare system and to refine healthcare policy. It’s a platform for knowledge sharing among healthcare professionals at every level, bringing together a variety of experts to contribute and influence the policies that shape our landscape.

We want sector-wide collaboration and high-level consideration on how to advance equality in healthcare coverage – as a fundamental human right.”

He described South African healthcare workers as ‘exceptional in what they do,” when benchmarked against the best in the world.

“We achieve impressive results in spite of our constrained resources. With the national department of health having confirmed 1500 vacant unfunded posts, the minister of health yesterday, (September 13, during the State of the Nation debate), committed to collaborating with us in finding solutions for unemployed doctors.

We’ve always pledged our support and willingness to work with the ministry. We want to be an active participant in shaping health policy,” he added.

He cited Professor William Makgoba, who last year ended his tenure as Health Ombudsman, as saying there was a dire lack of leadership and governance in South African healthcare.

“You can’t fix just one part of a system. Hundreds of doctors are jobless. The ratio of doctors to citizens is 0,3 per one thousand in the public sector, compared to 1,75 per thousand in the private sector.

With those disparities, the system is not ready for an NHI. You have to consider other social determinants of health. If you don’t fix water in municipalities, for example, you can’t expect a healthcare system to reform.

It’s all one system. All departments must speak to what’s happening in healthcare. Funding alone is not a silver bullet,” he said. Government needed to bring doctor salaries on par with those offered by recruiting countries to stem the ongoing exodus.

Mid-career doctors were being paid the same as they were in 2015.

“We’re not talking about overtime here, simply basic income. We’re underpaid and want to say to government; if you want to retain highly skilled professionals sought out by other countries, you need to invest in them – and address their working conditions,” he added.

- **Chris Bateman**



A perfect storm for SA doctors – the exodus continues.

The representation of South Africa's doctors' interests has become hugely fragmented at a time when their working conditions, available jobs, long hours, dismal facility management and criminalization are driving them out of the country.

This was said by the President of the SA Medical Association, world renowned trauma surgeon Professor Ken Boffard, in a keynote address to the association's first post-Covid in-person conference in Sandton City last week.

Speaking on 'The Preservation of the Medical Profession,' Boffard said 'fragmentation' of medical professionals, particularly into specialist organisations, was the biggest threat.

"In reality we have thirty thousand doctors, 12000 of whom are in SAMA. Where are the others in this time of need?" he asked. With all the changes afoot and the disintegration of doctor collectives (including a major specialist exodus from SAMA several years ago, and the breakaway SA Medical Trade Union, SAMATU), many of them with narrow interests not aligned SAMA's mission of professional well-being, "I'm not sure that we're going to be able to influence many things going forward," he said.

The role of SAMA, he acknowledged, had changed in recent times: "SAMA has had no choice but to, in corporate terms, stop representing individual shoppers and start representing medicine, if you like, as a corporation where all our patients and all our doctors are our shareholders.

"We are not a trade union, but our goal is to represent medicine for South Africa and South Africa for medicine."

Preserving the medical profession, given fragmentation and "mismanagement at all levels," (either by shareholders or by deployed cadres), was hardly likely to succeed in the form it was in now.

He cited 2012 Health Professions Council of South Africa (HPCSA), figures (drawn from doctor requests for Certificates of Good Standing needed to practice overseas) of 1000 doctors leaving that year. Current annual graduation from all nine medical campuses is 2 200, (pre community service). He was 'baffled and mystified,' by President Cyril Ramaphosa saying 1 200 doctors were graduating annually during his February 8th, State of the Nation speech.

Boffard served for 12 years on the board of the HPCSA. He is Trauma Director and Academic Head at Milpark Hospital and has worked in multiple overseas countries. He said there were three reasons for the ongoing exodus of SA's well- trained, highly versatile doctors.

"There are push factors, like being repeatedly hijacked, their working conditions and/or lack of posts, and the criminalization of doctors. Then there are pull factors like family already being overseas – and willful recruitment by countries such as Australia, Canada, and the Netherlands." He said Canada was targeting SA doctors about to complete their community service, granting them automatic registration, while Australia aimed at specialists, plus general practitioners for their remote rural areas, granting specialists senior registrar salaries until they passed the Fellowship of the Royal Australian College of surgeon exam – after which their salaries were on par with their local peers.



Prof Ken Boffard, President of the SA Medical Association and world renowned trauma surgeon.

"It'll take you three years to get that – and your Australian passport – why would you want to come back?" he asked.

He broke down the annual recruitment of doctors from South Africa as 350 to Canada, 300 to Australia, 150 to the United States and some one hundred to the rest of the world, mainly the Netherlands. Boffard cited a recent Lancet, (a UK medical journal) cover article suggesting that the willful recruitment of professionals from low to middle income countries should be labelled as, "a crime against humanity".

"You also must look at the other debilitating SA environmental factors like the impending NHI, the way provincial hospitals are being managed and how community service officers are being messed around. The moment they're out of community service and fully registered, they're gone," he said.

Hospitals in Europe had a thirty-seven-and-a-half-hour work week, "and if you work more than that, you have to take it off in your next cycle – or the hospital gets fined."

In stark contrast, the average weekly work hours for a South African registrar or junior doctor were one hundred and eight, leading to fatigue and mistakes, (the State bill for adverse events is estimated at R92 billion).

"The number of dropped balls in healthcare has dramatically increased. Patients are not allowed to know who the doctor is, patient names are no longer displayed, and one patient is often seen by several different doctors without vital information being passed on. (Information sharing requires patient consent). A lot of information crucial to patient care is being lost and that leads to medico-legal cases. I don't have to tell you about the breakdown in funding," he added. Boffard cited a British expression; "death by a thousand duck bites," to illustrate that while no single event might kill a patient or lead to doctor burnout, the daily accumulation of traumatic events, including moral and professional injury, would.

"Each little bite diminishes medical care and the preservation of the medical profession as we know it," he asserted.

Instead of taking lessons from the aviation industry where errors were considered normal and as opportunities to gain experience instead of blame, medicine in South Africa had been criminalized, guaranteeing a drop in standards, and losing opportunities for training and education.

"Education is knowing when to do something. Training is the skills required to do it," he said. He said medicine stood on a tripod of factors; resources, the ability to educate and people who would benefit.

By way of illustration, he said Sweden experienced 860 bomb blasts, (mostly gang-related), last year, and 40 hand grenade attacks, the worst in Europe.

"They have limitless resources and educators, but nobody can teach or has experience beyond books. So, their tripod is unstable. I spent seven years there helping," he added.

Dr Mark Human, an orthopaedic surgeon and SAMA executive member, told the same 'Strengthening Health Systems' plenary that since he'd qualified 30 years ago, "we should have 80 to 100 000 doctors by now, (based on accumulated annual graduation from medical campuses)." However South Africa was left with, at best, between 30 to 35 000 medical practitioners.

Chris Bateman/Roy Watson

Patient plea for patient-centred processes up front

"The challenge for the health care industry is to design processes with the patient at the centre and then find ways to optimise everything else.

"Our lives depend on it!" – a quote from a multiple myeloma patient who had already lost a daughter to cancer, presented to SAMA Conference delegates by Campaigning for Cancer's Lauren Pretorius at the conclusion of her talk on "Funding – Patients' Perspective".

"The value of medicine should not be measured by cost alone, but by the benefit it brings to individual patients and to society," Pretorius reminded delegates when introducing her presentation.



"Why are we banging on about value? Value holds everyone accountable. It holds the pharmaceutical companies accountable so that they don't charge too much... because if they do, the value goes down.

"It holds the funder accountable," she continued, asking the question: "Are you spending the limited resources that you have in the best way.

"Value holds you, as the healthcare professional, accountable: are you looking at best practice data, best evidence, and best outcomes for your patients? It pushes you to look how you get the best results and outcomes for this particular patient."

Value also holds the government accountable having been given the constitutional, legal and ethical duty to look after the benefit of both the patient and society we work in.

"So when we talk about price," said Pretorius, "we have to start discussing value and that's why we have heard so much of this word 'value'.

"For me as a patient, value holds me accountable, holds me that I am confined, value holds me that I have to measure expectation, but gives me a way to measure my expectation that is fair and that has taken my consideration, my choices, my side of the story into account and for that I can get behind it."

Turning to the bigger picture, what patients really wanted, she said, was access to effective treatments, timely decisions, to be able to contribute to the decision-making processes, and explanations about the drugs being administered: "If a new drug, for example, is said to be essential, the patient needs to be told why it is essential and to whom...!"

There were three clear priorities that needed to be followed in South Africa in terms of the effective delivery and funding of health care, said Pretorius, starting with leadership: "Here we have to ask the question: are patients getting the right treatment, at the right time, with the least challenges?"

The second was innovation: "If we continue with the same mind set we had before, are we dead in the water?"

And then commitment, which Pretorius warned, should not be dedication to a cause or obligation that restricts freedom of action: "But commitment makes sure that we come out with a result and a result that works!"

When it came to accessing health finance, Pretorius indicated that swift action had to be taken to resolve issues such as those surrounding single exit price (SEP), understanding alternative reimbursement measures (ARM) and the rising concept of value-based care:

"There are 55 million of us and we are five minutes from midnight! Patients are dying! We have to come up with solutions now! In his recent speech, the President said that we punch above our weight on the global stage.

"Hopefully when it comes universal health care and making sure patients have access to the innovation they need, we can punch above our weight in our country."

-Roy Watson

Healthcare managers, 'shape up, or get fired,' – Sooliman



Gift of the Givers' Dr Imtiaz Sooliman in deep interview mode with journalist Chris Bateman.

If Gift of the Givers founder and frequent rescuer of patients from government dysfunction, Dr Imtiaz Sooliman, became Minister of Health tomorrow, he'd add a strict accountability clause to every public health facility manager's contract.

He'd also take a cut in his own salary and that of all his staff and use the money to hire clinical registrars, (whom he says are prepared to work for half their R1 to R1,5 million p/a salary – just to secure a scarce post).

"If there were more staff, there'd be less workload and less burnout – and more healthcare delivery – and we'd stop this vicious downward spiral," he added.

Sooliman said this on the sidelines of the South African Medical Association's (SAMA's) first in-person conference since the Covid pandemic – shortly after publicly raking both private, 'money-oriented doctors,' and the health department over the coals. He got the full attention of the 511 SAMA delegates while sharing his global and local experience of disaster relief during the keynote opening session entitled, 'Strengthening Health Systems,' at the Sandton Convention Centre mid-February.

"Doctors have lost their way. Materialism has crept in. It's not about patient care, but more about money. When a consultant moonlights (a reference to the Remuneration for Work Outside the Public Sector, or RWOPS), it increases pressure on his colleagues. You never find them in the, (State hospital), wards. When you call them in their practice, they say don't disturb me, I'm busy (making money). Some serious introspection is needed. I mean it's not their family needing help, so why the hell would they care?" State hospital management needed urgent reform.

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"If you're not on site, I'd sack you. We need brutal management reform. Over and over, crises occur, and the medical manager or CEO is looking in the other direction."

During the Covid pandemic, expensive high flow nasal oxygen machines were on order for Tygerberg Hospital but a joint venture between government and the CSIR resulted in the adaptation of 2000 far cheaper CPAP machines for the same purpose at a cost of R250 million – paid for by Solidarity Fund.

"Somebody didn't want the CPAP machines to get to the hospital – machines that use way less oxygen and save lives. We put their availability on the Eastern Cape chat group and every hospital CEO put up their hands. In 40 hours, we'd delivered 900 CPAP machines to that province. One hospital told me that for the first time in months, their post-weekend Monday morbidity and mortality meetings recorded no deaths.

Turning to unions like NEHAWU whose picketing of hospitals has included hauling pregnant women out of ambulances and preventing doctors and nurses from entering facilities, he said a better balance was needed.

"The staff themselves need to stick to their responsibilities. They signed up to fulfil a defined role and need to stick to it. You can't wash linen, or you won't see patients," he said. Sooliman said that despite working with failing infrastructure, a paucity of vital equipment, dismal maintenance, the healthcare human resources crisis and load shedding, doctors needed to do some 'serious introspection.'

"Everybody's talking about fixing the system, but how morally and ethically upright are we? Ask yourself why you became a doctor and then analyze what's happened in the last five years. Why do you charge a tariff that's 300% of the medical aid rates? Is healing and saving lives not critical? So often the patient doesn't know why they went for a test or what for. Sadly, we've lost the human touch," he told his colleagues.

Wherever Gift of the Givers conducted disaster relief, the first thing patients wanted was reassurance.

"In Somalia, with no access to telemedicine, we had long queues of people telling us of minor maladies from several years ago. They didn't want ultrasound, robotics, or high tech, they just wanted the human touch. Whether you used a stethoscope or a BP cuff, it made no difference – they had no interest in medication. They wanted the human touch and to hear they'd be fine. They walked away happy," he said.

He urged delegates to not merely criticize the government. What was missing from the world were compassion, faith and spirituality, "the core values of any human being."

"I've lived this (disaster medicine, humanitarian relief work), for 33 years. During Covid we were dependent on faith to handle the anxiety. You died lonely. Your wife, husband or children could not say goodbye. Hospital workers were blind-sided. You had things like 'the happy hypoxic,' who dropped dead in the car park or as they got to the ward, smiling one minute and dead the next.

Health care workers suffered from secondary traumatization, with people dying in huge numbers. A lot of doctors disappeared but orthopedic surgeons, gynecologists, anesthetists, and general surgeons all came to the fore. We knew who was genuine and committed.

They took up the challenge and sorted out the system, (a reference to innovation and public private co-operation). He listed management by unqualified and unskilled people 'deployed by a political party,' as another curse and praised a major private insurance company for bankrolling the retraining of public hospital CEO's. Eskom power outages aggravated poorly kept, power-dependent essential machinery – and caregiving.

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Sooliman singled out the Gauteng health department for criticism, naming Raheema Moosa and Helen Joseph Hospitals as among the most dysfunctional.

"There are three words not in the government's vocabulary: urgency, emergency, and disaster. There are some good politicians and civil servants, but their hands are tied by red tape. Those who want to do good things are more terrified about what somebody above them will say. I call it ego-inelegance. Don't let anybody fix the system because they'll look better than you," he added. He cited the 2021 decanting of some 700 patients from Charlotte Maxeke Hospital to 17 other hospitals within 24 hours after it was deliberately torched to camouflage storeroom theft of Covid personal protection equipment, and the clearing of another hospital's entire cataract surgery backlog as examples of successful interventions by Gift of the Givers.

"Government said they needed to first draw up a disaster management plan for Charlotte Maxeke, but we just got on with the job," he said.

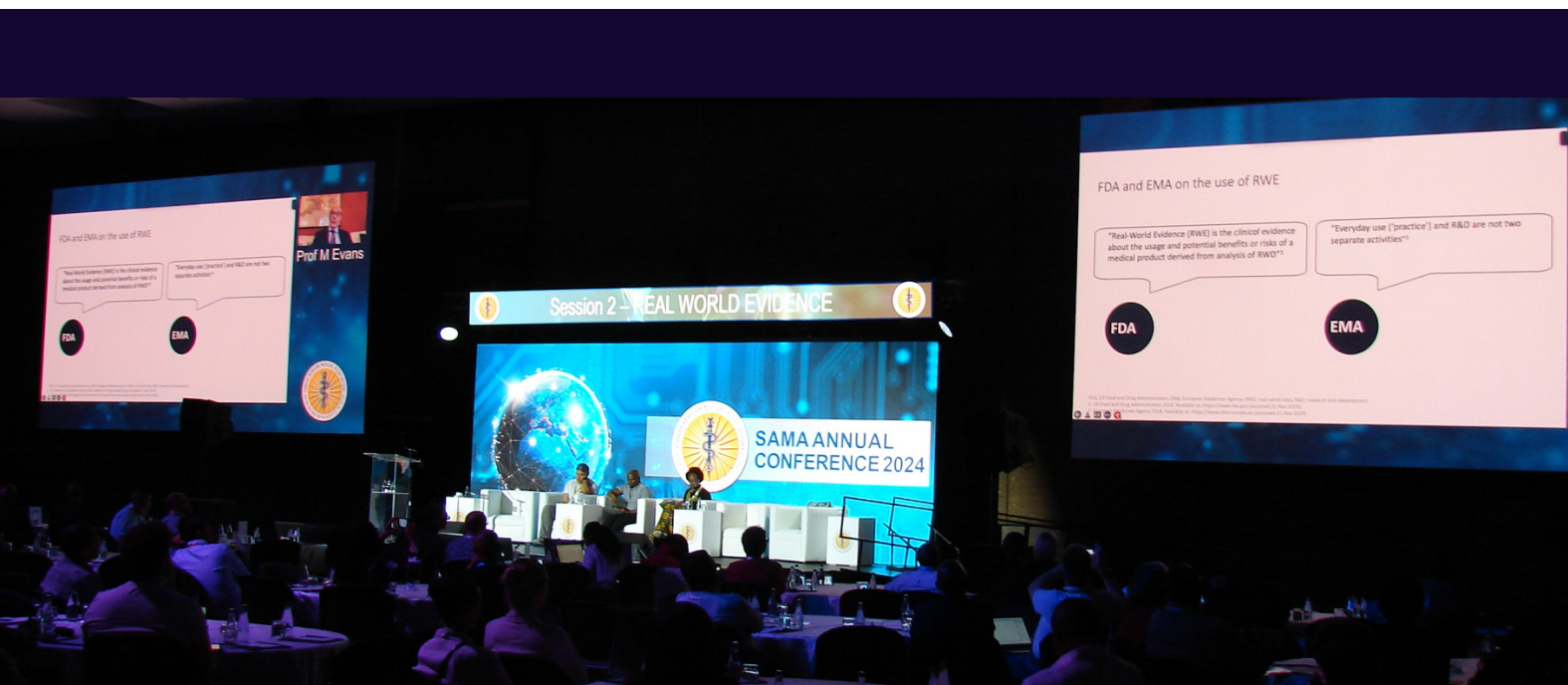
The first words of a blind husband and wife couple to one another after benefitting from a Gift of the Givers intervention were, "but you've grown old!" They'd been waiting for cataract surgery for eight years,

The human resources crisis was best illustrated by registrars seeing on average 9 000 critically ill patients a year (24 per day had they worked 365 days a year).

Prayers offered up by patients restored to a normal, economically active life, with enhanced self esteem and able to nurture their children, 'will cover you for life,' he told doctors. Covid had been 'the great leveler,' with hospitals in both the public and private sectors treating the indigent and wealthy equally.

"Covid taught us that compassion, faith and spirituality go a long way,' he concluded.

Chris Bateman



SAMA Conference in session

Impact of NHI plans critical for future of diabetes and related care

When the President signs the NHI Bill, he should do so with a pencil with an eraser handy, well-known specialist physician and immediate past-president of the International Society of Internal Medicine, Dr Adri Kok, advised when introducing her talk on “Policies, Guidelines and Way Forward”.

“It is very important that we cater for all the people of South Africa at this point,” she added. “We’ve heard about the concerns about NHI and I do believe we have to consider very carefully that we make the right decision for everyone in South Africa. It may be a political hot potato at the moment but it has such impact moving forward.” Discussing diabetes in particular, Kok reminded her audience that 7,6% of the total population of South Africa, almost two million people, suffered from diabetes – the leading cause of death, followed by obesity and hypertension.

Human resource shortcomings in this particular area, therefore, were still very worrying, Kok indicated, citing an endocrinologist she had just seen at Chris Baragwanath Hospital on her way to a clinic where there were 200 patients: “How many people were able to help with the amount of patients she had to see? This is the problem we have to deal with on a daily basis.

“Young doctors,” she continued, “don’t have posts, being made redundant because of cost factors. We are at a point now where we have to very carefully consider and understand how this is going to impact care in the long run.

“The Practitioners Forum and many advocates agree with SAMA on the NHI Bill problem, to highlight and overcome these problems to be able to give more care for South Africans,” Kok stressed, alluding to the spiralling effect of many of the current issues such as higher medical aid higher contributions and lower benefits.

Do the doctors benefit? No! The income is not sustainable for them in the long run. The HIV experience and achievements in the aftermath of the early 2000s AIDS denial debacle have shown what can be done at all levels to address serious health challenges.



Noted specialist physician Dr Adri Kok had some advice for the President

Key to this, Kok intimated, was advocacy and the support given to combat the problem.

“The HIV experience for me is absolutely critical because, look what we have achieved? Medications became affordable, patients are tested and monitored properly. The HIV experience has shown that it is feasible and that you really need advocacy from that point of view. “The problem in South Africa is that patients with hypertension, diabetes, lipid disease, and obesity don’t have advocacy. They leave it up to us, the doctors, but do we benefit from this? No! We have zero influence. We can write a letter, motivate it, explain it, only to get a piece of paper saying it is not in patient’s basket of care!”

Kok did indicate, nonetheless, that cost savings can be achieved when adhering to treatment guidelines such as those formulated collectively by the American Diabetes Association and the European Association for the Study of Diabetes. Guidelines, she told delegates, have to be evidence based and that there shouldn’t be financial assessments of the prescribed interventions.

It was also important to note that their detail had been informed by evidence generated in the past three years and, importantly, Kok stressed, greater focus had been placed on social determinants of health, health systems and equality of care, and on holistic person-centred care. – **Roy Watson**

'Hands off our patients,' SAMA warns unions

The National Education, Health, and Allied Workers' Union, NEHAWU, came in for fierce criticism from doctors and two prominent activists, including one of its founder members, at the South African Medical Association's (SAMA's) annual conference last week.

Dr Aslam Dasoo, who helped set up NEHAWU in 1987 and was instrumental in desegregating healthcare, and Sibongile Tshabalala, Chairperson of the Treatment Action Campaign, TAC, slated the union.

Singling out last year's NEWAWU strike, marked by violence against healthcare workers and denying many patients' healthcare, Dasoo, said the union took its lead from 'the plutocratic ruling class,' which had no effective leadership.

"It was very clear there was no leadership during the strike last year. The strikers were pulling pregnant women out of ambulances and nurses were refusing patients treatment. They've taken their cue from the government. I blame the authorities – they've encouraged it by creating this culture of non-accountability and impunity – and then they reward public servants with a 7,5% increase – money they don't have and which in any case should go to healthcare,' he fulminated. He cited one nurse refusing treatment, "until her child is given a bursary to go to university."

"Now here's an employed woman, a professional with medical aid, living properly, yet demanding more handouts. The disjuncture is complete," he added in a post-presentation interview.

Dasoo said that a health budget cut of R1,5 billion for the Western Cape alone illustrated that there "is no connection with the reality of life by the plutocratic ruling class."

He supported the principle of unionization, but not without ethical and moral leadership – "and we don't have that, thanks to this government. They are only interested in maintaining largesse to themselves and nothing else. They'll find ways to stay in power – otherwise most of them will go to jail."



Dr Aslam Dasoo, veteran health activist and co-founder of NEHAWU.

He echoed Professor Mariana Kruger, executive head of the department of Paediatrics and Child Health at Tygerberg Hospital, Stellenbosch University, on the paucity of ethical governance. "She spoke of accountability. If healthcare workers require anything, it's this. When non-healthcare workers are in command of healthcare to the extent that they regard healthcare workers as menial laborers, people to be dominated, you get the disaster that we're seeing."

Tshabalala, who has lived with HIV for more than 20 years and is an advisor to the Steve Biko Centre for Bioethics and a board member of the Rural Health Advocacy Project, said nurse demands for overtime could not be at the expense of patient care.

"They must learn to take their responsibilities seriously," she said. The TAC recently resolved to 'return to the streets,' making their voices heard at the recent budget speech in parliament and at the 'dysfunctional' Nelson Mandela Bay Metropole.

Tshabalala said that in Northern Gauteng, TAC members would be engaging unions on the attitude of healthcare workers to patients, asking them to 'behave more ethically and with respect for patients.' "We're tired of unions striking when patients are dying. At the end of the day nobody is taking responsibility," she said.

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Asked by a doctor during question time whether she thought their protest at the Finance Minister's budget speech would be effective, she replied, "Yes, we do. It's the only language our government is listening to. It's how you bring them to the table to address grassroots issues. If they don't listen to us we'll take them to court, just like we did with antiretroviral drugs. We'd say to the finance minister, 'you can't compromise our people. Everyone has the (Constitutional) right to a quality healthcare service. He has a responsibility to honor that.'"

Dasoo said the healthcare sector was, "the absolute barometer of the state of the country." "Listening to all the other speakers here on ethics and governance, I realize we've kept alive the notion of ethical governance.

I find that Seneca (the Roman philosopher) animates my view of the healthcare world and politics. His credo of Memento Mori (Latin for 'you too must die,' or 'death is inevitable,') is an unspoken and mostly unconscious credo for practitioners in the art and science of healing."

Turning to a group of Pretoria matric girls from the Loreto Convent School attending the session, Dasoo urged them, "pay attention, attention is vitality, it makes you eager – stay eager," before sharing a cautionary quote for 2024 with them. "People never lie so much as after a hunt, during a war or before an election," he quipped.

SAMA chairperson, Dr Mvuyisi Mzukwa, said during question time that SAMA was the only organization in South Africa that roundly condemned the NEHAWU strike at the time.

"Patients were prevented from accepting healthcare, pregnant women were dragged out of ambulances and hospitals were blocked. We need to tell unions straight out; don't touch our patients!" he said.

A copy of this story e-mailed to NEHAWU and requesting comment failed to elicit a reply within five days, despite a follow up phone call requesting one.

Chris Bateman

Future pandemic; build in anti-corruption measures

One of the stand-out considerations when addressing preparedness for a pandemic must be measures to prevent corrupt dealings and activities.

Corruption was experienced during COVID 19 in many countries around the world, Prof Ames Dhai, founder and past director of the Steve Biko Centre for Bioethics at the Wits Faculty of Health Sciences, acknowledged in her talk to SAMA Conference delegates.

"It was a major challenge as the pandemic unfolded in our country and from an African viewpoint, begged the question: what has happened to our moral compass?

"Here is a quote from Waterbury (1973; 533-555) with which we in South Africa can identify: corruption is the 'abuse of public power and influence for public ends'."

In short, as Dhai indicated, society's corruption has a link with political leadership as, for example, was evident locally in the Digital Vibes issue.

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Prof Ames Dhai, former head of the Steve Biko Centre for Ethics at Wits University.

Responding to input from delegates during question time in the Ethics and Advocacy session, Dhai said the initial positive synergy between SA society and the political leadership during Covid quickly fragmented and ‘eroded away,’ as stories of political corruption involving personal protective equipment and Covid awareness campaigns began to emerge.

“The public became disillusioned. This was supposed to be our leadership! Surely it’s not too much to ask that our leadership is clean of corruption? That they have honesty, integrity and respect? Remember it’s the people who put them there so, they should honour the confidence that was put in them.”

A past SAMA President and chair of the UNESCO International Bioethics Committee, Dhai stated categorically that it is the responsibility of the government of a country to prioritise communication and preventive measures right at the outset of a pandemic.

Allied to this was the state’s responsibility to promote health literacy, public dialogue, “address the problem of the digital divide” and to promote health communication as integral to the social determinants of health.

“What is important now is that more research on contextually relevant pandemic communication is necessary and must be conducted before the next pandemic,” Dhai added, stressing that it was the State’s obligation to fund and support these studies.

Among the difficulties highlighted during the recent pandemic were deficits in science communication which contributed to ignorance, false beliefs about scientific underpinnings of public health recommendations, and policy-making.

“Society expects research and science to provide rapid responses, but instead,” Dhai observed, “a lack of understanding of the research process eroded public trust in science.”

This became particularly evident as vaccine hesitancy became more and more apparent. A survey conducted among these individuals in South Africa, Dhai explained, revealed that their hesitancy was largely due to misinformation, beliefs in conspiracy theories, and for religious reasons: “Of those surveyed, 91% indicated that religion was important”.

There was also an ongoing fear and uncertainty about the safety and effectiveness of vaccines.

“There was clearly a negative association between COVID 19 awareness and vaccine hesitancy, highlighting the fact that more awareness and education was needed to reduce the incidence.”

Concluding, Dhai returned to the need for meaningful and honest communication which, she said, was the crux of pandemic management: “People must feel respected and preventative public health measures must be seen to be more acceptable.

“Messaging must be comprehended by all, regardless of age, life circumstances, or level of communication. No-one must be left behind!”

Roy Watson



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New SAMA Women's Wing flies in face of gender inequality



Dr Sharon Harber, Chairperson of SAMA's Women's Wing, with Health Minister Dr Joe Phaahla at the conference gala dinner.

Gender inequality in medicine persists with few women in top management and private sector pay disparities entrenched – but the SA Medical Association's (SAMA's), seven-month-old Women's Wing aims to rectify that.

This assertion was made by Dr Sharon Harbor, Chairperson of the SAMA Women's Wing, who cited studies showing that women work on average 15 hours more per week than men – on unpaid care-giving and domestic tasks.

She was addressing the penultimate session of SAMA's annual conference in Sandton on February 17th this year.

While more women doctors were finally being produced annually, equality in medicine was a long way off, with hollow 'gestures of inclusion,' often in an unfavorable environment,' or mere 'tick-box exercises,' being carried out.

She confessed, "I was raised to respect and honor, more especially older men. So, when I sit in a board meeting and disagree with a male colleague older than I, the mental Olympics I must do to express my views is phenomenal."

Support for young women professionals was needed more than for those who had achieved success in their careers, a distinction many people overlooked.

"Take Dr Gwen Ngwenya, (the respected academic, politician and former DA Head of Policy.) Her needs are quite different to mine. That doesn't mean I'm weak or can't fulfill my position as a board member. It just means we're different and these are the differences we need to start talking about. They should be celebrated. I should be able to sit with a group of colleagues and talk freely, without any fear that any interactions may be misconstrued as sexual advancement. This is a privilege I and many other young women do not have, and men need to be aware of," she said.

Harbor quoted a male colleague, telling her a day before the conference, "I don't know what it is, but when I give women in my department an opportunity to lead or take charge, they don't." A female colleague had responded, "You can't plant a seed on a rock and expect it to grow." Harbor continued, "In other words you cannot sow seeds of opportunity on barren ground and expect them to grow. Women need more than mere gestures of inclusion. We require environments which are conducive to our success."

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She said one of her favorite quotes was, “if it is to be, it’s up to me.”

“If there’s a difference I want to see, I have the responsibility to make that change. As women, if gender equality is to be achieved, it is up to us to take up that fight. It’s up to us to create the environment we need to succeed because we know ourselves best. We can’t wait for men to give us opportunities or simply be part of a box-ticking exercise, where we’re set up for failure.

Harbor said the SAMA Women’s Wing, established in August last year, focused on gender-based violence, gender equity, harassment and bullying in the workplace and career advancement for women and marginalized groups, plus advocating for maternity leave.

“We’ll be providing input on legislation and policies affecting women and marginalized groups. We’re not naïve – we don’t think we can do this all at once, but those are the core deliverables you can hold us accountable to.”

The Women’s Wing was setting up a 24-hour hotline for female doctors and medical students in any form of distress and establishing a professional women’s network in medicine, “because not everyone wants to specialize, and we need to strengthen our female leaders. We shouldn’t have to fit into the male norm of leaders. We need to capitalize on our innate strengths, including, but not limited to, our ability to create and to nurture relationships, achieving the right outcome through that,” she added.

With the help of SAMA’s Health, Policy Law and Ethics Committee, policies on maternity leave, support for mothers, and the elimination of harassment and bullying in the workplace would be strongly revisited.

“We believe that if we truly want to make a change, we need to also make a change in the laws that affect us,” she said naming seven SAMA members who “have chosen to take up this fight and improve the lives of women,” eliciting loud delegate applause.

Chris Bateman

SAMA Conference Gala Dinner & Entertainment



Disproportionately high infection-attributable cancers a concern



Dr Tumelo Moyaba, of the Limpopo Oncology Clinic, with concerns about infection-attributable cancers

Lack of organised efforts in cancer screening programmes and prevention of carcinogenic infections was just one of the many challenges facing cancer on the African continent at large.

Exemplifying this point, Dr Tumelo Moyaba, clinical oncologist at the Limpopo Oncology Clinic in Polokwane, explained to his SAMA Conference audience that, being highly curable when diagnosed early, 90% of cervical cancer related deaths on the continent could have been avoided by screening and with HPV vaccination.

“In 2018, 21,7% of all cancer deaths in Sub-Saharan African women were attributed to cervical cancer, making it the most common cause of cancer death in the region.”

Infection-attributable cancers, he said, were disproportionately high in low to middle income countries (LMICs). These included modifiable carcinogenic infections such as HPV, Hepatitis B and C, and H.Pylori, and as already pointed out, interventions like vaccinations for HPV and HBV and early treatment for H.Pylori and Hep C curtail incidences and cancer-related deaths.

“HPV vaccination,” Moyaba observed, “has been a focus programme by the World health Organisation aimed at reducing incidences, but there has been a limited roll-out in the LMICs.”

Among the areas that needed serious attention to address cancer shortcomings were data capturing, early detection and prevention, basic research, shortage of treatment centres and not least, the cost of drugs.

Poor data capturing, largely due to a lack of organised cancer registries and resulting data follow-up issues, Moyaba stressed, was a huge concern. Allied to this was a dearth of research to provide important genetic sequencing data and the participation of African cancer centres in clinical therapeutic trials.

Cancer registries, he reiterated, were aimed at providing statistical information on cancer incidence and outcomes: “This information,” Moyaba stressed, “represented the backbone of an effective equitable National Cancer Control programme.

“Documenting survival at one, three and five years after diagnosis – standard practice in high-income countries,” he added, “has been difficult to achieve in Africa because of the difficulty of tracing patients with cancer once they are discharged.”

Many of these issues and shortcomings, he indicated, could be addressed effectively by centralising and increasing the human resource required.

– Roy Watson

Doctors in SA legally more vulnerable than in UK



Advocate Maude Letzler, an expert in litigation, arbitration, negotiation, and conflict resolution, advised SAMA delegates to “check the small print,” in their indemnity policies.



Dr Graham Howarth, Medical Protection Society Head of Medico-legal Services for Southern Africa.

The threshold of proof when patients die at a doctor's hand is far lower for both murder and culpable homicide in South Africa than in Scotland and England – and urgently needs reform.

This was said by Dr Graham Howarth, a South African-born obstetrician/gynecologist, and Head of Medico-Legal Services for Southern Africa for the London-based Medical Protection Society, (MPS). He was addressing a session on ‘Decriminalization of Medical Errors,’ in South Africa at the South Africa Medical Association's, (SAMA's), annual conference held at the Sandton Convention Centre.

“Just few miles from here, on Monday morning, (12th February), one of your colleagues is defending himself against three charges of murder when he was just doing his job,” he said.

He was referring to the trial of Professor Peter Beale, a renowned pediatrician, after three children died allegedly from complications related to surgeries he performed. The State also charged Beale with two counts of fraud, because he allegedly performed “unnecessary” procedures on the children for financial gain. Beale has pleaded not guilty to all charges.

Howarth showed bar graphs of the different legal thresholds; (intent, recklessness, gross negligence, and negligence), needed to prove either murder or culpable homicide in England, Scotland, and South Africa. The threshold of proof for both crimes in South Africa was lower on this continuum. For culpable homicide, mere negligence was required in South Africa, whereas proof of gross negligence was required in England and recklessness, (one short of direct intent), was a prerequisite in the Scottish legal system.

When it came to murder, SA required mere recklessness to be proven, whereas England and Scotland required full intent.

Howard commented, “What the State is trying to prove against Professor Beale is that he meant to kill – I can't come to terms with that,” he said.

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He explained that it seemed reasonable that the State was not basing their charges on overt intent – i.e. that Prof Beale went out to murder the children.

“So, they must be accusing him of recklessness (*dolus eventualis*), and extrapolating intent from that – which is what I find difficult to come to terms with. To charge a doctor doing his/her job with murder in the absence of intent concerns me. Sadly, occasionally patients die, but to hold a doctor criminally culpable in that environment seems not only unjust but also potentially contrary to patient safety,” he added.

Howarth, who completed his MPhil in bioethics at Stellenbosch University before founding the department of bioethics at the University of Pretoria, said he recently reviewed all the criminal cases brought against MPS subscribers world-wide.

He found that South Africa had more doctors up for culpable homicide cases than all the other countries combined.

“That’s in the context of the MPS having 25 000 members world-wide and just 2 500 members in South Africa he stressed.

“We’re not talking about criminal day-to-day medical negligence here, but cases where charges are laid, where a patient dies and there’s a link between death and a lack of care. Also, this is not about medical negligence on a balance of probabilities, but criminal charges where guilt must be established beyond reasonable doubt – the burden of proof is greater – an extremely important point in law,” he said.

Howarth’s talk was entitled, “the low threshold for criminalization of medical error in South Africa – understanding the issues.”

He said the SA Law Reform Commission was, “nibbling at the idea of looking at this.” Advocate Maude Letzler, a specialist in litigation, arbitration, negotiation, and conflict resolution, advised doctors to “check the small print,” in their indemnity policies.

Among the most important were medical aid auditing; checking that they had sufficient savings to continue their practice if payments were withheld, that there were settlement reserves in case of sexual harassment complaints. Letzler explained that this was the most common guilty finding by Medical and Dental Professions Board, (MDPB), disciplinary hearings.

“Then there are third party complaints related to your practice such as your locum, admin staff or colleagues – this is the most common complaint, especially to hospital management.” Doctors needed to ensure that their litigation costs were covered for both personal and professional liability.

She suggested having at least five million rand cover in place for legal fees, but up to R49 million if doctors were in higher risk specialities like obstetrics/gynaecology where adverse events leading to cerebral palsy were common.

Then there were risks like patients “slipping and falling in your practice –old or injured, not enough seats, no paraplegic entrance and parking safety.”

Added to this was the risk of equipment failures.

“Warranties on your equipment may cover select aspects – what if a new receptionist spills her orange juice on your fancy laptop/phone?” she posited.

Costly cyber threats also existed like raids on a doctor’s online portal while others risk included theft, fraud, and fire.

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Choosing whether the policy was adequate to their needs depended on, “what you do, how you do it, with whom, where you practice, third party risk exposure and personal risk that could be age, injury or chronic disease related,” she added.

Her advice to doctors who experienced an adverse outcome, complication, or negligence, was to report it immediately (30 days from ‘awareness’ was the time constraint for coverage), collating all records, noting down a verbatim account of your recollections as soon as possible, identifying potential witnesses and not discussing the case with potential expert witnesses in your speciality, as this could disqualify them from testifying.

“Also, don’t onboard hearsay evidence as your own version, you’ll get killed in cross examination,” she cautioned.

She advised doctors to keep a notepad handy to jot down any new information they might remember and to keep hard copies and cloud versions of all documents – which needed safe storage for at least 10–15 years.

When it came to telemedicine, she referred doctors to the Health Professions Council of SA’s ethical guidelines and reminded them that the ethical rules of conduct for health care practitioners remained in force.

Letzler said claim repudiation was a real phenomenon.

She warned against skipped indemnity cover payments, policies that were not retro-active, changing cover without checking the fine print, having upskilled (without adjusting cover) and not reporting to their indemnity cover agent, (or lawyer), immediately they became aware of a potential claim. Dr Mark Human, who facilitated the session and is Vice Chairperson of SAMA’s Health Policy, Law, and Ethics Committee, said 10% of all hospital admission in the United Kingdom experienced ‘some kind of adverse event.’

He said doctors needed to “think about the feedback loop.”

“The first person a patient usually complains to is us. Your response to that complaint is very often what will trigger or not trigger the legal process. They can take the MDPB line, the criminal, or the civil prosecution path, but all they really want is to understand exactly what happened.”

“Yes, sometimes they’re looking for retribution, but you would have had to really upset them – or they think you’re more than careless. You cannot bring back a dead child,” he added.

Human said patient education was ‘key’ with the lack of a proper patient lobby in South Africa ‘a major problem.’

“When something happens, they don’t know who to turn to,” he said.

Howarth said the South African legal system had “already decided on our behalf that negligence is blameworthy.”

The MPS began lobbying for legal reform nine years ago. Since 2020, as part of its campaign to have the law surrounding the criminal liability of healthcare professionals following a medical error reviewed, MPS had:

- Coordinated a joint letter by a coalition of nine leading medical organisations, calling for a review of the law, sent to the justice minister and the South Africa Law Reform Commission
- Held three stakeholder roundtables aimed at getting collective agreement from medical organisations on the need for reform and the best way to achieve this.
- Written extensively about this issue with almost forty articles published in the national and medical media.
- Spoken about the need for reform at many different conferences and events.
- Surveyed members about how the fear of criminalisation impacts their practise.

Infectious disease outbreaks: 'prevent, detect, respond!'

Although there has been a considerable drop in malaria transmissions annually – from 50000 in 2000 to approximately 12000 now – it must not be forgotten that malaria is still a fatal disease. Treatable within one to three days if and when diagnosed in time, there were still ongoing challenges in the prevention of the highly contagious disorder, not least cross-border control and the prevalence of parasitic reservoirs.

Exposing just some of the current issues surrounding the impact of infectious diseases such as malaria, rabies and cholera in the region, Prof Lucille Blumberg, until recently the Deputy Director at the National Institute for Communicable Diseases (NICD), of the National Health Laboratory Service and now a Consultant at Right to Care, warned SAMA Conference delegates to be constantly aware of the signs of the disorders and the respective actions to be taken.

"Clinical recognition and infection control are still key in this regard," she said, finding the need to remind doctors that every patient with a fever or flu-like illness – in particular one who might have travelled to or who is actually resident in an acknowledged malaria area – must be deemed to have contracted malaria until disproved: "And this would still be irrespective of consideration for COVID-19. Being a rapidly developing fatal disease, diagnosis via a blood smear or rapid antigen test had to be conducted as a matter of urgency and if positive, treatment administered immediately. "Current treatment is still effective," Blumberg added, expressing a preference for Coartem for an uncomplicated strain and Artesunate for a more complicated condition. There was no need, she indicated, for the use of quinine any longer.

In her new Right to Care role Prof Blumberg is focussing on creating a One Health programme especially for rabies: "Rabies is one disease we should not be seeing in 2024, but is endemic in Africa and is earmarked for elimination with strategic interventions," she assured her audience.

Again, what should not be overlooked is that rabies has the highest fatality rate of all infectious disease. A common outcome is fatal encephalitis, but the incidence of this can be reduced significantly with the vaccination of dogs. "Rabies is preventable with pre- and post-exposure prophylaxis, but key to its prevention is the vaccination of dogs and the World Health Organisation," Blumberg noted, "has set the year 2030 as the target date for the elimination of human rabies from dogs."

The rise in the incidence of cholera particularly in the proximity of two of South Africa's major commercial and industrial centres, Blumberg went on to note, was a major concern. Alluding of course to the recent Hammanskraal outbreak, this, she stressed, highlighted once again the critical importance of access to clean water. But cholera was not only a South African problem, Blumberg referring to a media report explaining that, according to a WHO update on the global cholera situation, in January alone, 40 900 cases and 775 deaths were reported from 17 countries.

"Exacerbating the problem in the region was vaccine stocks being 'empty' as cases surged in neighbouring Zimbabwe and Zambia as cases surged earlier this month." While these did present problems in terms of people movement in particular, the most important anti-cholera prevention measure was "to ensure safe water and sanitation for all". Prof Blumberg's final message: "Prevent, detect and respond...!" **–Roy Watson**



Prof Lucille Blumberg, former head of the National Institute for Infectious Diseases, NICD.

Traditional clinical trial findings still pertinent in modern outcomes-based decision making

The findings of traditional randomised control clinical trials are still key to improving the standards of healthcare delivery when combined with “real world evidence” through outcomes-based decision making.

Equally important is regularly reviewing and analysing current outcomes data to identify areas for improvement.

Discussing outcomes-based decision making in general at the SAMA Conference, Dr Sandile Mhlongo, a qualified Medical Doctor and Health Economist with a special interest in Healthcare Financing and Purchasing and now Managing Director & Chief Health Economist at Curis Solutions, acknowledged that there were challenges faced in the South African healthcare environment which created difficulties in accruing critical outcomes-based data.

These were largely due to barriers to access to healthcare such as availability of providers, distribution in rural and urban areas and transportation issues. Also problematic, Mhlongo pointed out, were suitable interpreters and culturally competent care providers.

Nonetheless, he indicated, it was prudent to press ahead with developing structures and process to arrive at patient outcomes to include measures such as improvements in health status, quality of life, functional ability, and importantly, patient satisfaction.

“It is important, therefore, to implement strategies to enhance the quality and effectiveness of care delivery by integrating the best available evidence from research with clinical expertise and patient values and preferences,” Mhlongo added.

To achieve this and promote continuity, rigorous measurement and evaluation needed to be undertaken “which may involve using clinical indicators, patient-reported outcomes and other relevant metrics” to assess the impact of interventions on patient health. Ultimate objective in this regard, Mhlongo noted, was to provide measurable value-based care.

“Value-based care, or optimising the value of healthcare delivery,” he reminded his audience, “could be measured by the equation Value equals Best Health Outcomes over Lowest Possible Cost.

“We should therefore be continuously focusing on outcomes and value in order to prioritise interventions that deliver the greatest benefit to patients and minimise or preferably eliminate waste and inefficiency.”

Outcomes to improve access in health systems, he concluded, should be a patient centric and purpose driven, knowledge-based by being linked to reimbursement and financial decisions while cognisant of the relevant clinical guidelines and disease burden costs.

“Ultimately they should be inclusive and equitable”.

– **Roy Watson**



**Health financing and purchasing specialist,
Dr Sandile Mhlongo**

Covid: health professionals still reeling - experts



Dr Kerry Wilson, an epidemiologist with the National Institute for Occupational Health, and Professor Glenda Gray, CEO of the Medical Research Council, shortly after delivering their mental health presentations.

A full fifty-seven percent of Gauteng health workers were distressed and displayed three or more symptoms of depression or anxiety during the first year of the Covid pandemic.

The survey, conducted by the National Institute for Occupational Health, (NIOH), coincides with similar 2019 findings published in the South Africa Journal of Psychiatry showing that 41% of interns at national tertiary hospitals were depressed with 13% reporting severe symptoms while 51% reported feeling burnt out. Many reported that taking anti-depressants helped, but there was a large treatment gap.

These findings were shared by Dr Kerry Wilson, an epidemiologist at the National Institute for Occupational Health, during the first South African Medical Association, (SAMA), in-person conference since the Covid pandemic. The conference was held at the Sandton Convention Centre from February 15-17.

Wilson said health worker distress 'significantly increased' with work stress and perceived risks but was mitigated by workplace relationships and training. She defined workplace 'relationships' as trust in management, safety awareness, an ability to report incidents, and the presence of a health safety committee. She said that even before the Covid pandemic, doctors in KwaZulu Natal were charting at 60% for burnout, 20% for anxiety and 20% for depression. She attributed these conditions to a lack of clinical supervision and a paucity of hospital resources.

Wilson told delegates that understanding the development and results of life stages among individual doctors, including gaps and the current impact that life events had on them were important, as was early identification of symptoms, treatment, and the reduction of stigma.

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Key life events could lead to periods of loneliness and/or mental health issues and aggravate work and environmental stresses.

"Recently somebody from the department of health asked me whether people with mental health issues should be employed. He was worried about whether they'd be violent," she said with some irony.

Simple interventions like headphones for people on the autism spectrum should be equated with physical hazards like heat and dust, not to mention far more commonplace wheelchair ramps.

"It's all about the work environment," she stressed.

Professor Glenda Gray, CEO of the SA Medical Research Council and Principal Investigator in the Sisonke vaccination trial of healthcare workers during Covid, predicted that non-communicable diseases, cancer, and metabolic syndrome would put even more pressure on the health care system and workers, Covid having resulted in 70% to 80% mortality during the early stages of the pandemic.

"You have this picture of queues of cars outside hospitals, oxygen in the car parks – just extraordinary physical and emotional stress in health professionals."

Gray said training in emotional intelligence was vital, with the academic debate currently revolving around what stage of medical training to introduce it. Her preference would be at undergraduate level, but she urged SAMA to advocate for it to be included in all post graduate training of medical doctors.

"We need moral justice for moral injury. South Africa's an interesting place. There are a lot of doctors in both systems who have access to private medical care or augmented care, but even with that privilege, they suffer the abuse of not being able to access medication and treatment," she said.

There was currently no way of addressing these healthcare worker injuries that displayed appropriate support. A better support mechanism was needed for doctors and nurses in precarious situations, facing infectious diseases and systemic workplace dysfunction.

And that's a wrap!



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TOWARDS STRENGTHENING HEALTH SYSTEMS

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