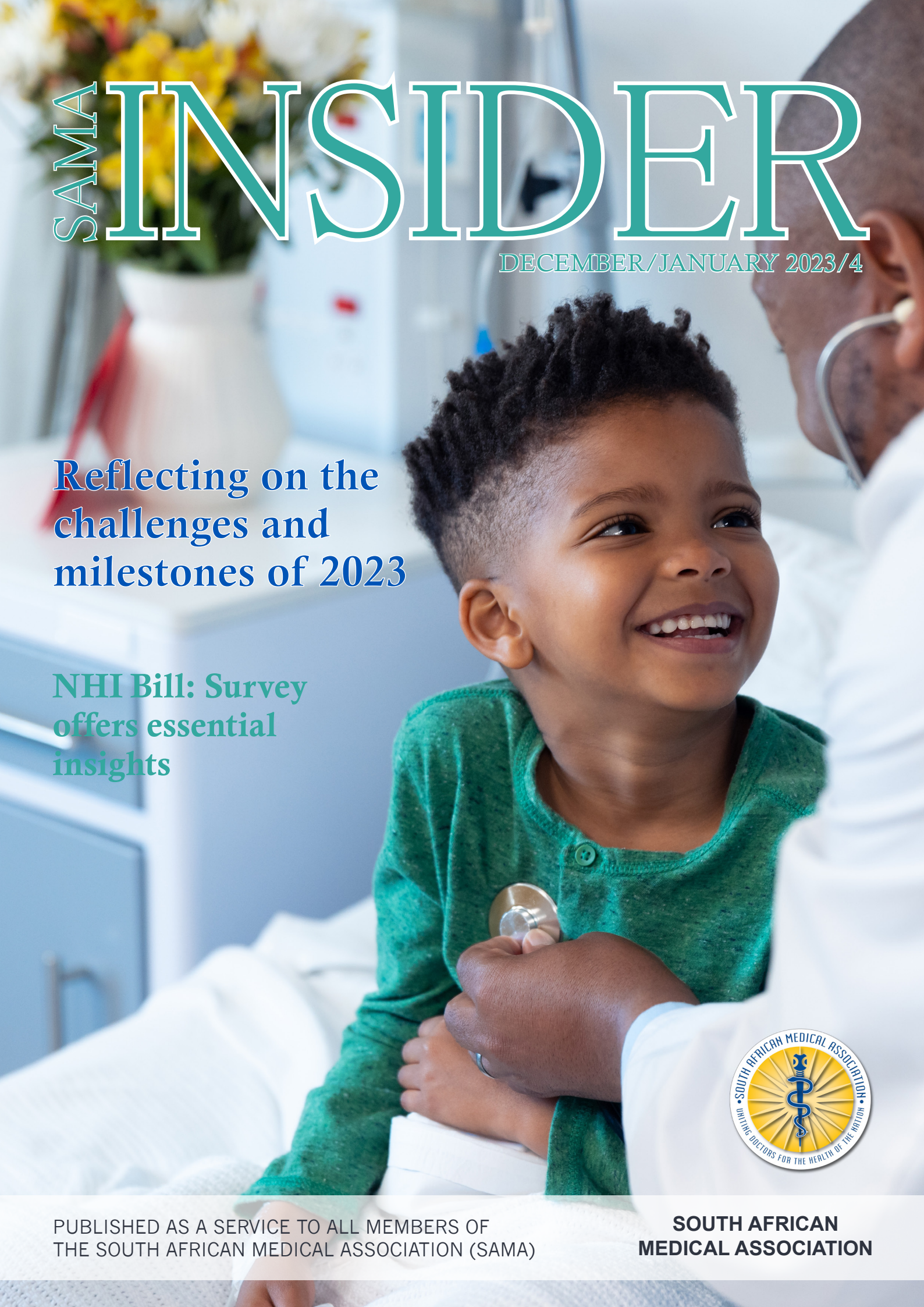
SAMA INSIDER

DECEMBER/JANUARY 2023/4



Reflecting on the challenges and milestones of 2023

NHI Bill: Survey offers essential insights

PUBLISHED AS A SERVICE TO ALL MEMBERS OF
THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

SOUTH AFRICAN
MEDICAL ASSOCIATION

South African researchers win MPS Foundation grants

The MPS Foundation is delighted to announce that three South African projects were successful and have been awarded grants in The MPS Foundation's 2023 Grant Programme. The projects will research:

1. Trusting non-specialist physicians to provide safe anaesthesia care in rural workplaces – led by Dr Gareth Davies, Western Cape Government

2. The compatibility of informed consent and individual autonomy with African traditional values and beliefs in the context of oral healthcare provision – led by Dr Hilde Miniggio, Sefako Makgatho Health Sciences University

3. Precipitating and predisposing factors that lead to dental complaints, particularly the role of social media – led by Dr Jacobus Barnard, Private Dental Practice.

We're proud to be a global research foundation that is committed to funding research into patient safety, risk management, and the wellbeing of healthcare professions, and encourage interest and proposals from different countries, cultures, organisations, and groups.

Pre-register your interest to apply for our 2024 Grant round by completing your details on The MPS Foundation's online grant portal: mpsfoundation.smapply.org

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EDITOR'S NOTE

DEC/JAN 2023/4

Diane de Kock
Editor: *SAMA INSIDER*

Ending the year

Welcome to the final issue of *SAMA Insider* for 2023. We round off the year with an article by the SAMA chairperson and vice chairperson, Drs Mzukwa and Ngwenya, reflecting on the challenges and milestones of 2023 (page 4).

A recent SAMA survey (page 5) on the NHI Bill offers essential insight. "The survey consisted of questions addressing the importance of the NHI Bill, support for the bill, and potential improvements needed for its successful implementation. Out of the 118 respondents across all categories, a significant majority (97%) expressed their opposition to the NHI Bill. Furthermore, 94% of the respondents opposed the bill's progression to the next stage of policy development."

Addressing these concerns is crucial for the NHI's successful implementation, comment authors Dr Mhlengi Vella Ncube, Thokozani Ncube and Dr Ziyanda Mgugudo-Sello.

Top virologist Oyewale Tomori, a fellow at the Nigerian Academy of Science (page 8), unpacks the two most important developments in medicine for Africa: "African countries must reduce their dependence on donor funding for local research, but also stop pleading for the crumbs of equity for their health security, social wellbeing and orderly economic development."

We introduce the first female AO Spine Fellowship-trained surgeon in SA and ask her for some words of wisdom for young doctors (page 9); unpack the vital signs of progress and importance of CPD (page 10); and look at obtaining informed consent from vulnerable patients (page 12).

Dr Randall Ortel has been interacting with patients on a new level, leveraging the power of social media to encourage his followers to take care of their physical and mental health (page 11). "My followers understand that the information I put out there is just a guide. They still need to see a healthcare provider for diagnosis," comments Dr Ortel.

SAMA and Medication in Motion Mediators are launching an alternative dispute resolution unit to provide doctors and patients with a platform where complaints and disputes can be resolved amicably without resorting to costly and adversarial legal proceedings, writes Dr William Oosthuizen, SAMA HoD: Legal Affairs (page 18). This aims to provide an alternative approach when addressing the medicolegal claims crisis, which shows no signs of abating.

The festive season often brings more social occasions and eating out. Primrose Freestone, a microbiologist, gives advise on avoiding food-borne infections (page 15).

We wish our readers a safe, peaceful and restful end to 2023.

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Reflecting on the challenges and milestones of 2023

Dr Mvuyisi Mzukwa, *SAMA Chairperson, and* **Dr Edward Ngwenya,** *SAMA vice chairperson*

Dr Mvuyisi Mzukwa

Dr Edward Ngwenya

Dear Esteemed Members, as we approach the end of another eventful year, we find ourselves reflecting on the challenges we have faced and the milestones we have achieved as the South African Medical Association (SAMA). The year 2023 has been marked by a series of unprecedented trials, pushing the boundaries of our profession and underscoring the crucial role that the medical community plays in safeguarding public health and wellbeing.

In the aftermath of the COVID-19 pandemic, our collective resilience and unwavering commitment to strengthening the healthcare sector have been tested like never before. As an organisation, we reached a milestone of celebrating 25 years of ONE SAMA when our organisation was transformed through the unification of medical doctor associations in the aftermath of our new democracy. We have achieved solidarity and cohesion through the adoption of the memorandum of incorporation at the annual general meeting held earlier this year. For the very first time, SAMA achieved record interaction and attendance, with 1 368 members accessing the platform and a total of 843 votes being cast. This demonstrated that our members have a vested interest in the business of the SAMA.

Systemic inequalities and resource constraints have challenged our continued efforts to promote health equity and access to quality healthcare. As a professional organisation, we have actively advocated for policy reforms of the National Health Insurance (NHI) Bill. We are striving for universal health coverage that ensures that every individual, regardless of their background or circumstance, receives the healthcare they deserve. While Parliament passed the NHI, we petitioned over 70 000 signatures, with more than 2 400 comments from signatories and over 360 submissions against the NHI as we prepare for the National Council of Provinces (NCOP) sitting. Our advocacy for reforms was strengthened by our members' mandate, who voted overwhelmingly against the NHI Bill in its current state.

We have fine-tuned our structures and ensured that our branches are aligned with the country's provinces for better alignment and more streamlined efforts with our regulatory structures. Our committees are strategically working on issues such as protecting our specialists and general practitioners in the corporatisation of healthcare, influencing the Presidential Health Summit and the launch of the Mediation Unit in collaboration with Mediation in Motion. We are pleased that we have launched the SAMA Students Committee, thereby futureproofing the organisation as our work at medical schools intensifies. Women's issues have come to the fore with the launch of the Women's Wing Committee.

SAMA continues to be the biggest voice locally from a media perspective, and globally through our work at the WMA. Webinars have been and remain a steady source of education for members at large, while SAMA journals continue to amplify the work in academic healthcare for our members. Clinical coding has taken vast strides in 2023, and has been instrumental in investigating alternative payment models.

SAMA continues to be the biggest voice locally from a media perspective, and globally through our work at the WMA

Looking ahead to 2024, we are pleased to announce that SAMA will be back with a face-to-face SAMA Conference in February 2024. We are hosting the Clinical Coding Conference, the SAMA Conference as well as the WMA Africa Regional Meeting on the Declaration of Helsinki. This is the second time that the WMA has entrusted SAMA to invite national medical associations from across the continent to our shores.

In the coming year, let us fortify our commitment to deliver to our members enhanced value that answers to their individual and collective needs. We are confident that, with our collective determination and solidarity, we will continue to surmount the challenges that lie ahead. Together, we will steer SAMA towards a future where health is a fundamental right and where the values of compassion, integrity and excellence define the cornerstone of our practice.

We wish you and your loved ones a peaceful and joyous holiday season and a prosperous New Year.

NHI Bill: Medical doctor survey offers essential insights

Dr Mhlengi Vella Ncube, *SAMA Head of Unit for Health Policy and Research,* **Thokozani Ncube,** *SAMA research intern,* **Dr Ziyanda Mgugudo-Sello,** *SAMA Head of Unit for Professional Services*

The United Nations' Sustainable Development Goals (SDGs) are dedicated to ensuring the health and wellbeing of people across the globe. Among these goals, SDG 3 seeks to guarantee universal access to quality healthcare for all individuals. To achieve this ambitious objective, the WHO advocates for universal health coverage (UHC) as a fundamental strategy. UHC strives to provide comprehensive, high-quality healthcare services to everyone, free from financial constraints and available when and where needed throughout their lives. In 2019, the UN designated universal health coverage as a fundamental human right. In pursuit of this objective, the SA government has proposed the National Health Insurance (NHI) as the funding mechanism to attain UHC in the nation.

The NHI Fund, as outlined in schedule 3A to the Public Finance Management Act No. 1 of 1999, is proposed to be an independent public entity. Its core mission is to ensure that every South African, regardless of their financial means or social status, has access to a wide range of high-quality healthcare services, including medications and health-related products. It aims to achieve this without causing undue financial hardship, and with accessibility wherever and whenever required.

To effectively fulfill its mission, the fund will have various pivotal functions. These include pooling allocated resources to acquire healthcare services and products, formulating contracts with accredited healthcare providers, determining annual payment rates, maintaining a national database and actively protecting the rights and interests of the fund's users.

Furthermore, the fund will be empowered to employ personnel, acquire property, invest funds, investigate complaints and promote best practices. It will also seek to eliminate corruption and unethical conduct, collaborate with other public entities, enter contracts for healthcare services procurement and institute or defend legal proceedings. In essence, the fund will play a crucial role in advancing UHC, making quality healthcare services accessible to all.

The NHI policy has undergone several stages of development, including the recent passing of the NHI Bill B2019B in the SA House of Assembly, and awaits debate by the National Council of Provinces. The SA National Policy Development Framework 2020 (SANPDF 2020) underscores the importance of engaging key stakeholders during the policy development process. This is crucial for sound policy creation, and medical doctors, as key stakeholders in healthcare service delivery, hold unique perspectives. The following study delves into the viewpoints of SA medical doctors regarding the NHI Bill B2019B.

SA medical doctors hold diverse opinions regarding the NHI Bill, with the majority opposing its adoption ... Addressing these concerns is crucial for the NHI's successful implementation

SAMA served as the conduit for collecting data on medical doctors' perspectives concerning the NHI Bill. In August 2023, SAMA conducted a survey that remained open for 2 weeks, gathering insights from 118 participants. The survey consisted of questions addressing the importance of the NHI Bill, support for the bill, and potential improvements needed for its successful implementation.

Out of the 118 respondents across all categories, a significant majority (97%) expressed their opposition to the NHI Bill. Furthermore, 94% of the respondents opposed the bill's progression to the next stage of policy development.

Negative perceptions

Survey participants voiced their skepticism regarding the government's ability to execute the NHI Bill effectively. Previous government initiatives characterised by corruption and incompetence have eroded trust among citizens. Some of the participants cited the existing healthcare system's failures as their reason for not supporting the NHI Bill. SA's current healthcare system has faced longstanding challenges, including outdated infrastructure and inadequate service provision. Survey respondents questioned the feasibility of the NHI given the government's historical inability to manage public healthcare effectively.

Positive perceptions

Advocates for the NHI Bill highlighted its potential to provide equal access to quality healthcare, challenging the existing disparities in access based on financial means. Some of those who support the NHI Bill were of the view that the NHI aimed to make medical services more affordable, a welcome change from SA's expensive private healthcare system.

Suggested improvements

Addressing corruption: The respondents emphasised the importance of decisively addressing corruption as a prerequisite for the NHI's success.

Government preparation: Respondents cited the need for significant improvements in healthcare infrastructure, corruption mitigation and funding sources before implementing the NHI Bill.

Amendment section 33: Amendments were suggested on the role of medical schemes to enable the continued capability of medical schemes to fund primary healthcare.

Summary

The results of this survey offer essential insights into SA medical doctors' perspectives on the NHI Bill. Their responses underscore several challenges and concerns. Chief among these is the prevalent mistrust in the government's ability to manage NHI funds, due to the nation's history of corruption and incompetence. The absence of a clear funding plan for the NHI has compounded these doubts. Additionally, the dilapidated state of SA's current healthcare infrastructure and the absence of improvements present significant roadblocks to successful NHI implementation.

Private providers in the healthcare sector are concerned about their role in the NHI scheme, as they anticipate limitations on medical scheme coverage. The potential consequences of these limitations include a reduced role for private providers in the NHI, and a potential erosion of coverage for millions of South Africans currently benefiting from medical schemes.

The NHI Bill's viability and effectiveness hinge on resolving these concerns, fostering collaboration between public and private providers and ensuring principles of competition and patient choice are upheld.

SA medical doctors hold diverse opinions regarding the NHI Bill, with the majority opposing its adoption. Their reservations stem from issues related to government competence, historical corruption and inadequate healthcare infrastructure. Addressing these concerns is crucial for the NHI's successful implementation. To make quality healthcare accessible to all South Africans, the government should prioritise transparency, financial clarity and the improvement of healthcare services and infrastructure. These steps are essential to address the pressing healthcare challenges facing the nation.

Way forward

There is a need for greater efforts towards the co-creation of healthcare policies with key stakeholders such as medical professionals. The SANPDF 2020 encourages such participation by stakeholders. It should be expected that difficult conversations will be held on some issues, and those conversations are critical to the adoption of new policies or changes to existing policies. The development of the regulations that will govern the NHI present an opportunity for government and key stakeholders to co-create an NHI that will be successfully adopted by patients and stakeholders.

Hospital histories: Sizwe, where lives have been saved since Joburg's earliest days

Ufrieda Ho, *for Spotlight*

How the story of a frustrated TB patient raging at doctors and nurses with a knopkierrie in hand transformed into a story with a happy ending sums up a TB hospital where infectious diseases have been treated since 1895.

It was the late 2000s, and the first cases of XDR-TB (extensively drug-resistant TB) had started to surface in SA.

Patient H, diagnosed with such a dangerous form of the infectious disease, was referred to the Sizwe Tropical Diseases Hospital located on the eastern edge of Johannesburg. Doctors knew they were up against the sobering reality of a 90% mortality rate. Patient H knew it too.

"As time went by, he would fight with the staff and get quite aggressive. He even tried to mock-attack us with a knopkierrie. Then he begged us to let him leave. He said he would rather die at home because he didn't have a chance of surviving," says Dr Rianna Louw, CEO of Sizwe Hospital. "We had to calm him down and we had to win his trust to make him stay and tell him we were going to try everything to help him, and we did. He was cured, discharged and went on to get a job and to live his life," Louw adds.

Sizwe receives patients with the most complex cases of drug-resistant TB, and has since 2007 been a dedicated MDR (multi-drug resistant) and XDR-TB hospital. Back in its early days, it admitted patients with every kind of

infectious and tropical disease, including anthrax, smallpox, bubonic plague, typhoid, Congo fever and, of course, TB.

Since Joburg's earliest days

The hospital came into being in the decade after Johannesburg was proclaimed a city in 1886. The infectious sick were sent to the "Rietfontein farm" in what was then the outskirts of the burgeoning gold rush dust bowl. The fresh air and open spaces of the farm were mercy against the ravages of diseases for which there weren't any cures.

Rietfontein farm would become Rietfontein Hospital, and remained as such until it was renamed in the mid-1990s Sizwe

Tropical Diseases Hospital. Remnants of the old hospital are evident across the hospital grounds. The first "Florence Nightingale-style" ward – designed for long corridors of beds – with its original corrugated iron sheeting walls, large wooden windows and wide wrap-around veranda still stands, and so does an old silo. There are also clusters of tombstones dating back over 100 years on the surrounding grasslands. It's believed there are several hundred more unmarked graves dotted across the large plot.

Three headstones that are visible stand as memorials at the entrance of the main reception block on the hospital campus. There is the headstone of a nurse, Emily Blake, who died at age 27 of the bubonic plague in 1904. She is said to have contracted the disease when she kissed a sick child good night. There are also the headstones of Mary Middler, a matron who served for 19 years at the hospital, and Dr John Max Mehliss, the first superintendent of the hospital.

A long line

For Louw, walking to her office every day, the prominence of the headstones is a reminder that she and her colleagues come from a long line of people who are drawn to the distinct particularities of infectious disease care.

"Sometimes we say we have become infected with working to cure TB," she says. "It is a passion. We do also think about what the nurses and doctors from those times went through because they didn't have the same access to drugs, technologies or treatment guidelines and protocols that we have now. We respect the special history at this hospital but we also don't live in the past because things are always changing with TB – there's always more that we can do," she says.

Chief medical officer at Sizwe, Dr Xavier Padanilam, like Louw, has served at the hospital for 16 years. He says Sizwe Hospital has unique qualities, starting with being an unexpected urban oasis.

"Part of the surrounding area is a wetland – so everything just becomes green and lush by summer, which is one of my favourite things about Sizwe," he says. As if on call, the high-pitched squawk of a wild peacock pierces his sentence. The birdlife is diverse here, and vervet monkeys, owls and bushbabies find sanctuary on portions of the farm not yet surrendered to suburban sprawl.

Padanilam says Sizwe is notable too as the hospital that cared for the late Archbishop Desmond Tutu when he contracted the disease as a teenager. Sizwe was also used as a location for scenes in the film version of *Cry the Beloved Country*.

New research into an old foe

Medically, Padanilam says, Sizwe stands out for its research collaborations into a bacterial disease that has been humankind's constant dark shadow for millennia, but still undefeated.

The hospital is the site of "lots of studies", he says. Its proximity to the National Health Laboratory Services across the road also means it has easy access to diagnostics, which is a critical element for knowing which TB treatments to use.

Findings from research conducted at Sizwe Hospital have helped inform national and international TB treatment guidelines. "We're at the top of our game," Padanilam says. Drug and diagnostics matter, he says, and so do the roles of social workers, psychologists, physiotherapists and occupational therapists.

"TB has a slow progression and it can show up differently for each person, and each person responds differently to different drugs," he says of the complexities of treating drug-resistant TB. TB is still one of the top killers in SA, having claimed an estimated 56 000 lives here in 2021, according to the WHO. It is estimated that 304 000 people fell ill with TB that year – 21 000 with drug-resistant forms of the disease.

But Padanilam says successes should be counted. Survival rates have improved and treatment times have contracted. At Sizwe, survival is now above the national average at around 85%, and the average time spent at the hospital is down to around 2 months. The cost of treatment has also dropped considerably from the mid-2000s. Care and treatment for a single patient from the point of admission to being discharged could at that time add up to half a million rands per person, Louw says.

At the start of spring this year, Sizwe had just over 70 patients admitted. It's a 202-bed hospital and has a total staff complement of 427 people. Louw says the seemingly inverted patient-staff ratio has to be understood by the challenges of an infectious care hospital that has to limit "cross-contamination" by staff across the sections in the hospital. Staff numbers, she says, also include the entire staff complement that run a village, which is what Sizwe Hospital resembles. She adds that they are also on alert for an expected post-COVID-19 spike. Pandemic lockdowns led to many more infected people not being diagnosed and treated early enough.

Going home TB-free

The "village" includes an outdoor gym, classrooms for TB-infected children, an open-air church, physiotherapy rooms and an activities centre. The centre is for leisure, but also occupational therapy sessions. One of the major challenges, Padanilam says, is finding ways to help patients fight boredom. Patients who start to feel well again often become agitated and want to leave, but they could still be infectious. And even when they can receive visits from friends and family, no one gets discharged until their final sputum cultures and blood work signal the all-clear.

On a warm Friday morning in spring, some patients are playing a game of pool in the activity centre. Someone else relaxes where sunlight meets a reading spot on a couch. There is a sewing corner and a display of items patients have made. There's also a spot for beadwork and a small kitchen off to one side. This is the domain of Nthabi Chaka.

As the occupational therapist, Chaka works with patients to help them adjust to inpatient treatment with an eye on giving them enhanced everyday skills for when they return to their ordinary lives.

"Sometimes people are bored with hospital food or their medication makes them lose their appetite, so we make pizzas in the kitchen or we bake a cake together," she says. Chaka says there's a lot to balance on the road to recovery for TB patients. Up to 65% of patients at Sizwe are HIV-positive, so it's watching for the side-effects of drug interaction, and there are those who are in withdrawal from drug use, so this has to be factored in. "Some patients can get aggressive or agitated and you pick up on their mood changes, or they get very sleepy. I try to keep activities short, so they can see an outcome of a project or activity we've worked on," she says.

But Chaka, like all the Sizwe staff, does get to see patients make it through one day and then another and another until finally, their sputum test results come back clear. It's at that moment that they might pin a note on Chaka's notice board. Like the one message on the board that says "I love you Nthabi." Chaka smiles. The message is a thank you; it's also a goodbye as one more person gets to go home TB-free.

Source: Spotlight, *4 October 2023. https://www.spotlightnsp.co.za/2023/10/04/hospital-histories-sizwe-where-lives-have-been-saved-since-joburgs-earliest-days/.*

Breakthroughs in medicine: Top virologist on the two most important developments for Africa

Oyewale Tomori, *Fellow, Nigerian Academy of Science*

There have been several important breakthroughs in medical science recently. CRISPR, mRNA, next-generation cancer treatments and game-changing vaccines are some of them. Oyewale Tomori, a virologist with decades-long involvement in managing diseases in Nigeria, gives his verdict on the most significant discoveries and what they mean for Africa.

Are these extraordinary times for discoveries in medicine?

Yes indeed, the world is living through extraordinary times, but not every part of the world has the luxury of these groundbreaking discoveries in medicine. Time stands extraordinarily still for some people in the world, in terms of the application and translation of the accelerated discoveries for medicine.

Which two do you find the most exciting?

The two I find most exciting, among so many other discoveries, are the new mRNA vaccine technology and the two malaria vaccines.

The advancements made in the generation, purification and cellular delivery of RNA have enabled the development of RNA therapies across a broad array of applications. For example, RNA therapy destroys tumour cells in cancer.

Messenger RNA (mRNA), as the name suggests, is a messenger protein molecule that has the ability to deliver a specific set of instructions to the cells of the body to make pieces of protein. Once the protein particles are made, they show up on the cell's surface. The presence of the protein alerts your immune system to mount a defence and create antibodies to fight off what it thinks is a possible infection. The body learns to recognise the viral protein as an enemy.

For example, when the COVID-19 vaccine is injected into the body, the cells are instructed to generate the spike protein that is normally found on the surface of SARS-CoV-2, the virus that causes COVID-19. The protein that the body makes in response to the vaccine causes an immune response without a person ever having been exposed to the virus that causes COVID-19.

Later, if the person is exposed to the virus, the immune system will recognise the virus and respond to it. The mRNA vaccines are safe and they neither alter the DNA nor cause COVID-19 infection.

Previous research laid the groundwork for the technology, which resulted in the development, production, approval and deployment of an effective COVID-19 vaccine in less than a year. The 2023 Nobel Prize in Medicine was awarded to two scientists for "groundbreaking findings" on mRNA COVID-19 vaccines.

Since 2019, when COVID-19 was first reported, the disease has caused over 700 million cases and about 7 million deaths globally. The technology is cost-effective and relatively simple to manufacture, and can be applied to the production of other vaccines, especially for the neglected diseases that are common in Africa. mRNA is a transformative technology for vaccine development to control infectious diseases.

The approval of two malaria vaccines, the RTS vaccine in 2021 and the R21 vaccine this year, though not accelerated discoveries such as vaccines for COVID-19, are a huge step in the right direction. This is particularly exciting for malaria-endemic areas of the world. Malaria causes more than 600 000 deaths annually, the majority in children under five and pregnant women in Africa.

Although the malaria vaccines are no silver bullets, they are steps towards malaria eradication in Africa.

What do these breakthroughs mean for Africa?

The mRNA technology will serve as a template for the development of vaccines against long-standing diseases that are endemic in Africa, Lassa fever and other viral haemorrhagic diseases, as well as cholera, meningitis and others.

What do African countries need to do to ride the wave of breakthroughs?

Africa's vulnerability to lack of access to vaccines was clearly exposed during the COVID-19 pandemic. This calls for greater vaccine-manufacturing capacity and capabilities across the African continent.

Yet, despite numerous declarations in support of vaccine manufacturing in Africa, the African vaccine-manufacturing industry is still nascent, with little progress made. The continent is manufacturing less than 1% of its required vaccine doses.

African countries must realise that investment in science, research and technology will produce significant returns.

Funding science and technology is a good economic bet. A recent Science|Business report suggests the long-term payback is in the order of 20% a year.

Africa's poor public funding for research is well documented. In 2006, member countries of the African Union committed to spending 1% of their GDP on research and development. But by 2019, the continent's funding was only 0.42%, in sharp contrast to the global average of 1.7%.

Africa has about 25% of the global burden of unrelenting endemic communicable diseases and a rapidly escalating incidence of non-communicable diseases.

Efforts should be channelled to find solutions to AIDS, malaria, tuberculosis and other neglected diseases, including Ebola, Lassa fever and mpox.

African countries must reduce their dependence on donor funding for local research, but also stop pleading for the crumbs of equity for their health security, social wellbeing and orderly economic development.

Source: The Conversation, *23 October 2023. https://theconversation.com/breakthroughs-in-medicine-top-virologist-on-the-two-most-important-developments-for-africa-215717.*

First female AO Spine Fellowship-trained surgeon in SA is an inspiration to all

SAMA Communications

Meet Dr Lusanda Bomela, the country's first female spine surgeon to complete an AO Spine Fellowship (an internationally recognised fellowship) at Groote Schuur Hospital. Her love and enthusiasm for helping people, mixed with the profound gratification of being able to treat the patients, are the driving forces behind her achievement. "In general, orthopaedic patients are healthy people. I can repair them, and they resume their pre-injury function. That's really fulfilling for me."

Dr Bomela earned her BSc at Rhodes University after graduating from Treverton College in Mooi River. At UCT, she earned a medical degree before specialising in orthopaedics at the University of Pretoria under Prof. M Ngcelwane. In 2013, she joined AO Spine Fellowship, which is one of the internationally based fellowships from the AO foundation, founded in 1958 and situated in Sweden, currently run by Prof. Dunn in Cape Town. The AO Foundation is a medically supervised, non-profit organisation comprised of a global network of surgeons dedicated to premier education, innovation and research in the surgical treatment of trauma and musculoskeletal problems. African pathology at the AO Foundation is represented at UCT (Groote Schuur Hospital) and in East Africa.

A group of like-minded surgeons teaches juniors through the AO Foundation, exposing them to alternative approaches and opening up opportunities for collaboration. "I spent a year being trained by five spine surgeons. It was a set programme that was very intensive, requiring exciting, gruelling hard work and dedication, but it was very rewarding," said Dr Bomela, who is the only female SA AO Fellowship-trained spine surgeon from the past 10 years. One big benefit of becoming a member is that you are not required to use a specific approach or surgical technique, but in partnership with other members, you can develop your own spine surgery and treatment protocols based on your exposure of multiple spine mentors. "Over the past decade I was trained overall by at least seven spine surgeons in my career. The training was unique and the growth exponential. The advantage for the patient with regard to such extensive exposure is that it is not a singular approach; AO mentors are always available for advice."

Dr Lusanda Bomela

Dr Bomela paved the way for female doctors by breaking down barriers and achieving several firsts, including being the first female head of clinical unit in orthopaedics at Kalafong Provincial Tertiary Hospital, working in the capacity of a head of Orthopaedic Department, the first female to be trained in the AO Spine Fellowship at UCT in SA, the first female to participate in the SA Orthopaedic Association/German Orthopaedic Travelling Fellowship and the first black female Smith and Nephew Travelling fellow in SA.

She presently works at Busamed Modderfontein Private Hospital as a full-time private practice spine surgeon. "My focus is various spinal pathologies such as trauma, degenerative spinal disease, scoliosis, disc prolapse, spinal tumours and spinal infections such as tuberculosis of the spine."

"I believe I am living my purpose," says Dr Bomela, "and I want to go beyond that. I've taught students, consultants and a variety of different people in my academic journey.

"Passion must be part of who you are, you want to do things to the best of your ability and beyond."

We recently caught up with this busy and inspirational surgeon for some words of wisdom for young doctors.

You have come a long way since embarking on your medical career in 1999. What is your advice to young doctors, specifically female doctors?

My advice to young doctors is that they must love what they do, as we spend more than 80% of our lives within the profession. In medicine they must choose a field that inspires and motivates them. When you do what you love it ceases being work, but becomes just an extension of who you are. Most importantly, they must remember that it is a privilege to do the work that we do, and they must revere it.

To female doctors, I would like them to continue and reach beyond what is expected of them. They must not let others limit what they can do. It is not easy to be a female, and you must give 100% of yourself to other spheres of your life like being a mother, wife, doctor, mentor and friend. But belief in oneself is important, and having a village of supporters of both male and female counterparts is crucial. They must not let momentous circumstances define them, but be willing to take the narrow pathway and explore the detours leading to their dreams, as often these make you stronger.

Specialising after completing your medical degree is often more challenging for female doctors because of societal pressures, among other challenges. Was this your experience, and how did you overcome the challenges?

I had often dreamt of being an orthopaedic surgeon, and as a very determined individual I knew that I would not be deterred from that goal. Initially I did not succeed in getting into medicine, and thus first completed a BSc degree. This helped shape my belief that failure does not define you, but that often it's just a deterrent that leads to success if you keep pushing. This helped me to become insightful of my limitations and seek advice and be active when required to work harder. I had to buckle down and be strict when it came to my studies, and miss out on outings and activities that would deter me from my focus. Most importantly, I had family, friends and a village of mentors who always believed in my dream and saw potential in me even

when I doubted myself. I was not afraid to seek advice where necessary as to what textbooks to read, how to plan my study timetable, how to tackle 5 years of work at least 18 months prior to writing my final-year qualification exams. Most importantly, whenever I doubted myself, I ensured that I turned to my faith.

Can you describe what you consider to be the most important attributes of a successful spinal surgeon?

Being a successful spine surgeon requires a holistic approach to patient care, looking at the patient beyond just the spine problem, and working in a multimodal and team setting. One must try all other approaches prior to reverting to actual surgery. It is crucial to have insight and reverence for the spine, as even in the best of hands complications of spine surgery can be devastating for the patient and often scary to the surgeon. It is essential to know what your limitations are, and be humble enough

and honest enough to inform the patient when something is too complex for you to tackle. Also, I believe in having a village of spinal mentors, as the discussions and advice are often beneficial to both the spine surgeon and the patient. Attending workshops and conferences to keep abreast of what is topical is also very important, and ensuring that one always sharpens one's skills is advantageous to the whole team. Being a successful spine surgeon, in my belief, is caring for the patient and understanding the pathology at hand, as it often leads to other problems in the future. Thus, where one can advocate for prevention or awareness of spine health, the surgeon must do so.

What do you do to relax and wind down after a busy day? Your hobbies and interests?

Life for a doctor is always demanding, so I must be cognisant of the fact that I need to relax. I love going for long walks and curling up with a good fiction book to read. But of late I've taken up gardening, which has proven to be very therapeutic after a long spinal surgery – there's something about nature that just says "relax".

The vital sign of progress: The importance of CPD

Lisa Reid, *SAMA CPD and clinical research ethics officer*

In the ever-evolving world of healthcare, staying current with the latest medical advancements, best practices and clinical knowledge is imperative. Continuing Professional Development (CPD) plays a pivotal role in ensuring that healthcare professionals remain well equipped to provide high-quality patient care.

Medicine is a dynamic and constantly evolving field. New research findings, technological innovations, treatment modalities and best practices emerge regularly. Stagnation in healthcare knowledge can lead to suboptimal patient care, outdated treatment methods and, in some cases, potential harm. To provide the best possible care, healthcare professionals must be lifelong learners, consistently updating their knowledge and skills.

CPD serves as the lifeline for healthcare professionals, offering them an opportunity to adapt to changes in the field, integrate new information into practice and maintain competence.

Up-to-date medical knowledge allows healthcare professionals to make more accurate diagnoses, prescribe appropriate treatments and ensure the highest standard of patient care. CPD enables providers to offer the best and most current evidence-based interventions.

Staying informed about the latest safety guidelines, best practices and patient management techniques significantly contributes to patient safety. CPD helps healthcare providers reduce errors and minimise adverse outcomes.

CPD is not just about maintaining competence, but also about professional growth. It encourages healthcare providers to expand their knowledge, skills and areas of expertise, fostering a sense of accomplishment and confidence in their abilities.

Interdisciplinary teamwork is essential in modern healthcare. CPD can facilitate better communication and collaboration among healthcare providers from different specialties, leading to more holistic patient care.

Laws and ethical standards in healthcare are constantly evolving. Ethical CPD points help providers stay aware of these changes, reducing the risk of legal and ethical dilemmas.

CPD is not just a formality; it's a commitment to excellence in healthcare. It empowers healthcare professionals to deliver the highest quality care, adapt to evolving medical knowledge and ultimately, improve patient outcomes. As medicine continues to advance at a rapid pace, CPD remains an essential tool for healthcare professionals to navigate the complexities of the field, ensuring that patients receive the best care possible. Embracing a culture of lifelong learning through CPD is not just a professional responsibility; it's a commitment to the well-eing and health of all patients.

For further information on accrediting hosted CPD activities, please contact cpd@samedical.org.

Leveraging the power of social media to promote health education

Niémah Davids, *for UCT News*

The University of Cape Town (UCT)'s Dr Randall Ortel has taken interacting with patients to a whole new level – leveraging the power of social media to encourage his followers to take care of their physical and mental health. And while he provides expert advice on a range of health conditions, from cardiovascular disease and diabetes to the potential origin of that nagging back pain, the disclaimer remains clear – always visit a healthcare provider's office to confirm and manage a diagnosis.

Dr Ortel is a family medicine specialist, and an occupational, emergency and obstetric medical practitioner. He's a lecturer in UCT's Department of Family Medicine, which is attached to Groote Schuur Hospital (one of UCT's teaching hospitals). He also serves as the manager for medical services at Karl Bremer hospital – a large district hospital in the Cape Metropole.

"My aim has always been to get people to take better care of themselves. So, I decided that because social media is such a powerful tool that allows us to disseminate information at the click of a button and has the potential to spread rapidly, I thought why not give it a try. I wanted to see if it served its intended purpose and reached a large audience in a short space of time, and it did. The response I continue to receive has been overwhelming and heartwarming," he said.

Ortel circulates health-related content on social media channels such as TikTok, Facebook, Instagram and X (formerly Twitter), and his followers have even extended beyond SA's borders to other African countries including Uganda, Nigeria, Cameroon and Tanzania.

How it all started

But how did it all start? In 2021, during the height of the COVID-19 pandemic, Ortel decided to use his social media platforms to raise awareness on the COVID-19 vaccine. His aim, he explained, was to encourage his followers to get inoculated. By then, thousands of South Africans had succumbed to the virus, and getting as many adults as possible vaccinated was critical to beat the pandemic.

As a frontline worker, Ortel was part of the first batch of South Africans to receive his vaccine, and he documented his vaccination journey. Thereafter, he proceeded to post a series of COVID-19 vaccine videos that covered a range of other topics. These, he added, included its side-effects, the fact that it complies with sharia (Islamic) law and is therefore permitted for use by Muslims, and the importance of booster shots.

Everything skyrocketed from there. These days, his subject matter is all-encompassing. He has presented videos on the benefits of exercise for patients with cardiovascular disease, the tell-tale signs of hypertension, how to use a blood pressure monitor and interpret the readings, the importance of blood donation, and tips on how to manage patients with terminal illnesses – demystifying the stigma around palliative care. He also discusses important societal issues such as gender-based violence (GBV), and his GBV video garnered a whopping 4.3 million views. According to Ortel, his followers were also particularly interested in his series on women's health challenges, which touched on menstruation, menstrual abnormalities such as irregular bleeding and the importance of maintaining a regular cycle, menopause, teenage pregnancy and access to safe abortions.

"I gained so much traction during my series on access to safe abortions and the ethical dilemmas we face with regard to termination of pregnancies. This is also where I gained followers from other African countries, where abortions or termination of pregnancies are illegal. I answered many very important questions on this topic. That experience taught me that while our healthcare system here at home has endless challenges, we've come a long way compared to our African counterparts," Ortel said.

Information and knowledge exchange

While his goal has always been to empower his followers to take charge of their overall health and wellbeing, Ortel said his series on teenage pregnancies and access to safe abortions served as an eye-opener on the value of information sharing on social media platforms.

"Not everyone on the continent has the privilege of accessing healthcare the way we do in SA, and it's especially challenging for women and girls in remote areas on the continent to access gynaecological care. I think that's why my videos on menstruation and safe abortions were so successful and spread so quickly. These women had questions, and I was able to answer them," he said.

He provides succinct, interactive and engaging content that gives his followers the information they need in a short video clip or just a few words. It's free of medical jargon and easy to digest, which means his followers can consume his content just about anywhere – while waiting for a bus or train, during the ride home in a taxi, or even while preparing dinner for the family.

Ortel also hosts TikTok live question-and-answer sessions, which give his followers an opportunity to ask questions, clear up uncertainties and verify information. These sessions allow him to understand his followers' thought processes and how they consume information, which assists with adjusting and improving his material. And he always learns something new from these engagements too.

"I consider myself a lifelong learner, so this process is valuable for me too. I'm always learning from my followers. Their feedback has been great. Patients actually take my videos into their healthcare providers' offices during a consultation to highlight a topic that I discussed and to explain how and why they can relate. This is what I want to see," he said.

Always seek medical advice

But more than raising awareness on key healthcare challenges, he said his content also serves as a wakeup call and allows many of his followers to identify signs and symptoms

that they may have overlooked, and motivates them to visit a healthcare professional for a full examination and further investigation.

With close to 50 000 followers on TikTok alone, 70% of whom are women, Ortel always stresses the importance of consulting with a healthcare professional to diagnose a medical condition. He said that while social media channels are effective tools to create awareness, they cannot be used to make a diagnosis. And although the concept of telemedicine (telephone and online consultations) is gaining momentum globally, Ortel said it remains an illegal practice if a physical examination and diagnosis have not yet taken place.

"Online consultations are not recommended because they are simply not confidential, and information can easily be overlooked. However, those who offer telemedicine as a specialty should follow strict guidelines as prescribed by the HPCSA, which includes having made an in-person diagnosis first," he said.

"My followers understand that the information I put out there is just a guide. They still need to see a healthcare provider for a diagnosis. For me, what's important is that they find value in my content as a starting point, and that I am able to make a difference in their lives by helping them identify certain health concerns, encourage them to reach out to a medical provider for a formal diagnosis and to receive the healthcare they need. That's half the battle won."

Source: UCT News, *22 September 2023. https://www.news.uct.ac.za/article/-2023-09-22-randall-ortel-leverages-power-of-social-media-to-promote-health-education.*

Obtaining informed consent from vulnerable patients

Lisa Reid, *SAMA CPD and clinical research ethics officer*

Informed consent is a fundamental ethical principle in modern healthcare, rooted in the idea that patients have the right to make autonomous decisions about their medical treatment. However, when dealing with vulnerable patients, such as children, the elderly, mentally impaired individuals or those facing critical medical conditions, obtaining informed consent can be challenging.

Informed consent is the process through which healthcare providers engage in open and honest communication with patients, ensuring that they understand the nature of their condition, the proposed treatment or procedure, potential risks and benefits, and alternatives. It is a two-way street where patients provide their voluntary, informed and uncoerced agreement to a medical intervention. This process respects patient autonomy, recognising their right to make decisions about their own bodies and healthcare.

Vulnerable patients encompass a wide range of individuals who, for various reasons, may be at a disadvantage when it comes to decision-making in healthcare. These groups include children, the elderly, mentally ill patients, those with cognitive impairments and individuals facing critical or life-threatening conditions. Vulnerability can arise due to reduced cognitive capacity, dependency on others or social isolation, making these individuals more susceptible to exploitation or coercion.

One of the primary challenges in obtaining informed consent from vulnerable patients is determining their decision-making capacity. For example, children and individuals with severe mental illness may lack the capacity to make informed decisions independently. Healthcare providers must assess the patient's ability to understand and appreciate the relevant information, as well as their ability to communicate their choices effectively.

In situations where a patient is deemed incapable of providing informed consent, a surrogate decision-maker, such as a legal guardian or family member, may be authorised to make medical decisions on their behalf. It is essential to ensure that the surrogate acts in the patient's best interests and respects their values and preferences.

With paediatric patients, it is crucial to involve the child to an appropriate degree in the decision-making process. While children may not have the legal authority to provide informed consent, they can often express their preferences and concerns through a process known as "assent". In some cases, a child may also dissent from a proposed treatment, and their views should be considered seriously.

Healthcare providers should tailor their communication to the patient's level of understanding, using plain language and visual aids as needed. The consent process may need to be extended over time to allow the patient or proxy decision-maker to consider and ask questions.

Healthcare professionals should adhere to all relevant ethical guidelines and legal frameworks that outline specific procedures for obtaining consent from vulnerable patients. These guidelines emphasise the importance of respect for patient autonomy, beneficence and non-maleficence.

In cases where a patient's capacity may change over time, healthcare providers should conduct ongoing assessments and adapt the consent process accordingly.

Informed consent is a cornerstone of ethical medical practice, ensuring that patients have the autonomy to make decisions about their own healthcare. When dealing with vulnerable patients, it becomes even more critical to safeguard their rights, considering their unique needs and limitations. By applying appropriate ethical guidelines, involving a multidisciplinary team and providing continuous support, healthcare providers can navigate the complexities of informed consent for vulnerable patients while upholding the principles of autonomy, beneficence and non-maleficence.

For further information on the SAMA Research Ethics Committee, please contact samarec@samedical.org.

TB vaccine: WHO expert explains why it's taken 100 years for a scientific breakthrough, and why it's such a big deal

Charles Shey Wiysonge, *regional adviser, immunisation, WHO Regional Office for Africa, Stellenbosch University*

The Bacille Calmette-Guérin (BCG) vaccine for TB has been used for 100 years. It is largely effective for children under five, but less so in older people, and can't be used on patients who have certain medical conditions. Today we're the closest we've ever been to discovering a vaccine that might replace or complement it. Charles Shey Wiysonge, the WHO's Regional Adviser for Immunisation, discusses the latest developments in the fight against one of the world's deadliest diseases.

Why has it taken so long?

We do not yet have a new vaccine for TB. But, for the first time, there are several vaccine candidates that are at advanced stages of clinical development.

Vaccine development usually takes decades and unfolds step by step. Experimental vaccine candidates are created in the laboratory and tested in animals before moving into progressively larger human clinical trials.

Clinical trials are research studies that test an intervention such as a vaccine in human beings, and occur in phases, from phase 1 to phase 3. We say vaccines are in clinical development when they reach the clinical trial stage.

A phase 1 trial is a first-in-human study that recruits a small number of healthy people (usually fewer than 100), to assess whether a candidate vaccine is safe.

Phase 2 trials are typically conducted among several hundred participants, to assess whether the candidate vaccine produces an immune response.

For phase 3 trials, thousands of people are enrolled to assess whether the vaccine is efficacious and safe. Phase 3 TB vaccine trials are currently going on in Gabon, Kenya, Russia, SA, Tanzania and Uganda.

Even though we are still, at best, 3 years away from broad regulatory approval of a new TB vaccine, the scientific community can do a lot now to prepare for its use, and to inform the public so that the vaccine may be accepted when it becomes available.

TB vaccines are very challenging to develop. The bacterium that causes the disease is complex, and is proficient at evading the human immune system. We don't yet have a full understanding of how to appropriately target the bacterium, or what kind of immune responses are needed to induce immunity. But there are some interesting approaches in the pipeline and there have been some encouraging data from clinical trials that are providing clues.

Why do we need a new TB vaccine?

TB is a global health emergency. About 2 billion people are currently infected with *Mycobacterium tuberculosis*, and of those, 5% - 10% may become ill with TB and will potentially transmit the bacterium.

In 2021, nearly 10.6 million people developed TB disease and 1.6 million died. We urgently need new tools to fight TB, including new and improved vaccines.

The BCG vaccine has saved tens of millions of lives and is effective in children under the age of five in preventing TB deaths and severe forms of the disease.

The vaccine has variable efficacy for protection against pulmonary TB (TB affecting the lungs) in adolescents and adults – and it is pulmonary TB that's responsible for the majority of TB transmission. So new and improved vaccines that are effective in preventing pulmonary TB in adolescents and adults are essential to control TB, and to reduce transmission to all, including newborn babies.

TB is the leading cause of death among people living with HIV. People living with HIV have up to 20 times higher risk of developing TB disease compared to those without HIV infection. The current BCG vaccine is not recommended for use in people living with HIV, for safety reasons. Although BCG is a safe vaccine in immunocompetent infants (those whose immune systems are working properly), severe adverse events can occur in HIV-infected infants following vaccination with BCG.

These adverse events include a rare but life-threatening condition known as disseminated BCG disease. However, new TB vaccine candidates are being developed and evaluated to offer clinical benefit in people living with HIV.

How effective has the BCG vaccine been?

BCG vaccines are given to more than 100 million children every year worldwide, at birth or soon after. The effectiveness of BCG can vary depending on several factors, including the prevalence of TB in a given area, the strain of the BCG vaccine used and the age at which BCG was administered.

Several studies have shown that the effect of the BCG wanes as children approach adolescence. People may become infected with TB but not be aware of it.

What will happen to the BCG vaccine?

The BCG vaccine will not be replaced by another TB vaccine until and unless there is compelling data on the safety and efficacy of an alternative. Most of the current vaccines in advanced stages of clinical trials are tested in adolescents and adults. Their safety and efficacy would need to be proven in newborn infants to be able to replace BCG.

In addition, BCG vaccination has nonspecific beneficial effects on overall mortality and leads to more reductions in child mortality than would be expected by just protecting against TB. There is thus a great possibility that BCG would remain in use.

What will a new vaccine mean for the fight against TB?

This depends on what the clinical trial data for the new vaccine candidates show. Most importantly, any new vaccine will need to be safe, and it will need to offer clear clinical benefit to populations at risk. We hope that the TB vaccine candidates that are in the pipeline will be effective at reducing TB infection, TB disease and TB transmission and can become part of a combination of tools in the fight against TB.

Source: The Conversation, *30 October 2023. https://theconversation.com/tb-vaccine-who-expert-explains-why-its-taken-100-years-for-a-scientific-breakthrough-and-why-its-such-a-big-deal-215411.*

The danger of dropping the COVID guard

SAMA Communications

COVID is evolving, but are we doing enough to evolve with it? Writing in *The Guardian*, Prof. Sheena Cruickshank says the vaccine-only strategy is inadequate, and there could be a danger of drug-resistance in countries dishing out antiviral medicines.

She writes:

We know COVID hasn't stopped evolving, and we have a good idea about what sort of situations might result in new and dangerous mutations, but with less surveillance of emerging variants and spread, we are losing what used to be a near real-time picture of the situation.

This makes it harder to know which variants are driving the increase in cases (in England). The latest estimates suggest there is a soup, with several variants, including some derived from XBB, which emerged last year, as well as EG5.1 (Eris) and a small amount of BA.2.86 (Pirola), both of which were identified in the past few months.

It seems as though this virus is ever-changing, and as a reflection of that, new data released in the past few days show that the so-called Pirola variant has evolved again – and could be more immune-evasive than the XBB-derived variants.

So what drives this virus to change so much and so quickly?

As viruses rapidly replicate, they are more prone to acquiring mutations. So the larger the number of infections, the more chance the virus will change.

Many countries, such as the UK, have moved to a position of "living with the virus" without investing in testing, ventilation and infrastructure changes, and masking.

Add to this that vaccine coverage and access to boosters is quite limited, and there's a recipe for many COVID infections – and a greater likelihood of the virus changing.

There is also a theory that dangerous variants may be more likely to emerge when immunocompromised people are infected.

Patients who are immunocompromised may struggle to completely clear the infection, and this can enable the virus to persist at low levels and mutate over a long period of time.

This has led to speculation that the BA.2.86 (Pirola) subvariant, which shares some similarities with the older BA.2 Omicron subvariants, may be an offshoot of these viruses that persisted in an immunocompromised host and became dramatically altered over time.

This theory has been proposed for some time for other COVID variants of concern.

It is also becoming clear that the very drugs that can be used to help treat those with COVID can contribute to viral changes.

This has been recently demonstrated with the antiviral agent molnupiravir.

Molnupiravir actually works by creating mutations in the virus genome – many of these mutations stop the viral proteins from working properly, helping tackle the infection. Ideally the mutated virus wouldn't spread, but a team of citizen scientists and researchers in the UK used sequencing data to show this is actually happening.

The types of mutations caused by molnupiravir are quite different from those that occur most often in Sars-CoV-2 evolution, so it doesn't necessarily mean that the use of the drug is driving a more dangerous set of viral variants.

We urgently need a plan across the world that addresses such inequalities – and assesses how we use and prescribe the drugs that can help those most in need

However, it does show that, akin to antibiotic resistance, we need to be aware and vigilant for the possibility of drug resistance emerging.

Molnupiravir is not as widely used in the UK – but it's notable how variable access to antivirals and monoclonal therapies can be.

Countries like the USA widely prescribe antiviral agents, and other countries have enabled such drugs to be bought over the counter, while many middle-income countries have limited access.

The result is a patchwork landscape of inequitable access and potential overuse of particular drugs. This risks increasing viral

resistance, more dangerous variants – and keeping those who need the drugs most without the help they need.

The vaccine-only strategy that the UK is using for vulnerable populations is an insufficient approach.

Even with boosters, not everyone will have as effective a response to the vaccine – for example, if they are immunocompromised or on drugs that affect the function of their immune system.

Any person considered more vulnerable to COVID should be able to access well-regulated treatments, including monoclonals and antiviral drugs, to enhance their likelihood of tackling the virus – and head off the possibility of a chronic infection that could incubate new variants.

In reality, access in the UK is patchy, with a "Goldilocks effect", whereby patients requesting them must be deemed ill enough to warrant the drug(s), yet not so ill the drugs would no longer be effective.

At least 500 000 people in the UK are considered clinically vulnerable.

One recently told me: "I'd feel much braver if I knew there were a backup if I get infected. But it's not clear any treatment would be available, so I feel as if the responsibility for my health falls on me."

We urgently need a plan across the world that addresses such inequalities – and assesses how we use and prescribe the drugs that can help those most in need.

Sheena Cruickshank is an immunologist and professor in biomedical sciences and public engagement at the University of Manchester.

Source: Medical Brief, *11 October 2023. https://www.medicalbrief.co.za/the-danger-of-dropping-the-covid-guard/.*

I'm a microbiologist and here's what (and where) I never eat

Primrose Freestone, *senior lecturer in clinical microbiology, University of Leicester*

Every year, around 2.4 million people in the UK get food poisoning – mostly from viral or bacterial contamination. Most people recover within a few days without treatment, but not all are that lucky.

As a microbiologist, I'm probably more acutely aware of the risk of food-borne infections than most. Here are some of the things I look out for.

Eating outdoors

I rarely eat alfresco – whether picnics or barbecues – as the risk of food poisoning goes up when food is taken outdoors.

Keeping your hands clean when handling food is key to not getting sick, but how often do you find hot running water and soap in a park or on a beach? You can use alcohol hand gels (they're better than nothing), but they don't kill all germs.

Also, food tends to attract an array of flying and crawling critters, such as flies, wasps and ants, all of which can transfer germs, including *E coli*, *Salmonella* and *Listeria*, to your food.

Keeping perishable food cold and covered is essential, as germs can double in numbers if food is allowed to warm up to 30°C for more than a few hours. For barbecues, meat needs to be thoroughly cooked, and a meat thermometer is a good investment to avoid food poisoning. Do not eat meat if its internal temperature is less than 70°C.

Buffets

Knowing what food-related conditions bacteria prefer to grow in, I am very mindful of the microbiological safety of hot and cold buffet displays.

Indoors, food can be exposed to contamination from insects, dust and above all, people. Food poisoning is, therefore, an inevitable risk when dining at a buffet.

Contamination comes from buffet visitors touching food, and germs can be sprayed on to buffets from people sneezing or coughing close to the food. Even indoors, one must consider contamination by insects, such as flies or wasps, settling on the uncovered food. Also, germs may be deposited from the air, which is rich in bacteria, fungi and viruses.

I always look at the clock when I'm at a buffet as there is a 2-hour catering rule: perishable food will become unsafe to eat within 2 hours if not kept covered and refrigerated. The problem is buffets tend to be laid out before you arrive, so it is difficult to tell if the platters of cooked meat, seafood, salads, desserts and appetisingly arranged fruit and vegetables will have been sitting for more than 2 hours when you come to eat them.

For hot buffets, such as those served at breakfast in hotels, I always avoid lukewarm food, as bacteria that cause food poisoning can grow quickly when food is kept at less than 60°C. Hot food should be served hot, that is at a temperature of at least 60°C. If there is any uncertainty about the safety of the food on offer, I reluctantly breakfast on freshly toasted bread and individually packaged marmalade.

Oysters

There are some foods I never eat, and raw shellfish, such as oysters, is one of them. This is because oysters are filter feeders and can concentrate germs, such as *Vibrio* and norovirus, in their tissue.

A *Vibrio*-contaminated oyster does not look, smell, or taste different, but can still make you very ill. The US Centers for Disease Control and Prevention estimates that about 80 000 people get *Vibrio* infections from raw oysters, and in the USA alone, 100 people die from vibriosis each year.

It is also possible to pick up food poisoning from eating any raw shellfish (clams, mussels, whelks, cockles). I only eat shellfish that are well cooked because heat effectively kills harmful germs.

Bagged salads

I never eat bagged salads, largely because one of my research areas is fresh salad safety. It has been found that bagged lettuce can contain food poisoning germs such as *E coli*, *Salmonella* and *Listeria*.

My research group has found that these pathogens grow more than a thousand times better when given juices from salad leaves, even if the salad bag is refrigerated. Worryingly, the same germs use the salad juices to become more virulent, and so better at causing an infection.

For those salad lovers alarmed by this information, most bagged salads are safe if stored refrigerated, washed well before use (even ready-to-eat salad should be washed) and eaten as soon as possible after buying it.

If there are salad "juices", throw it out.

Cooking practices

In terms of cooking practices, I have a list of dos and don'ts.

For perishable foods, I regularly check use-by dates, but if it is before the expiry date and the food package looks swollen, or when opened the food looks or smells different than expected, I throw it in the bin as it could be contaminated.

I never use the same chopping boards for raw and cooked foods, and washing my hands before and after handling food is instinctual.

One of my "never do" practices is reheating cooked rice. This is because uncooked rice can contain spores of *Bacillus cereus*, a food-poisoning germ. Although the *Bacillus* cells are killed by cooking, the spores survive. If the rice is left to cool and sit at room temperature, the spores grow into bacteria, which will increase in numbers quickly, as rice is a good *Bacillus* culture medium when at room temperature.

The rice-cultured *Bacillus* can produce toxins that, within a few hours of ingestion, can cause vomiting and diarrhoea lasting up to 24 hours.

Dining out

I find that having a high level of food safety awareness causes me to be first in line for buffets, to be cautious about eating from breakfast bars and to watch the clock for how often perishable food is replaced. I never collect "doggy bags" of food leftovers (they have usually exceeded the 2-hour time limit), even if they really are intended for a pet.

The benefits of being a microbiologist are that we know how to avoid food poisoning and, in return, people have confidence our cooking is very safe to eat.

Source: The Conversation, *28 September 2023*. *https://theconversation.com/im-a-microbiologist-and-heres-what-and-where-i-never-eat-213404.*

Unveiling unemployment in medicine

Dr Ziyanda Mgugudo-Sello, *Head of Unit for Professional Services, SAMA,* **Dr Mhlengi Ncube,** *Head of Unit for Health Policy and Research, SAMA*

Admission to medical school is a great achievement for many students. With only nine medical schools in SA, acceptance into such a programme is a distinct accomplishment and a much-desired privilege. However, a stark reality emerges after a demanding 6-year journey for these newly qualified doctors: the unexpected challenge of securing employment in SA while in possession of a critical skill that is in global demand.

A recent SAMA study involving 56 doctors provided a glimpse into this concerning issue. Over 80% of the participating doctors successfully completed both their internship and community service. They encountered a barrier in the transition from the compulsory phases of training into stable employment. The study revealed a high prevalence of unemployment among medical officers. The duration of unemployment spanned from 1 month to an alarming 48 months, with the majority of those affected enduring a period of 9 months without employment.

A deeper examination of the plight faced by SA medical officers uncovered a crucial trend – unemployment is significantly prevalent among those seeking roles in specific medical specialties. The scarcity of these specialised positions, available in regional and tertiary hospitals, serves as a critical barrier for these aspiring doctors.

Many medical officers are inclined to seek employment within specific specialties, so as to transition into specialist posts once they become available. However, this pursuit encounters a landscape rife with competition, drawing numerous applicants from across the country. To bolster their chances of securing these coveted specialist posts, medical officers vie for roles within specialised fields as a means of better preparation. Working within a specific specialty not only hones their skills but also enhances their eligibility and competence, thus amplifying their prospects of acceptance into specialist roles.

The intensified competition for specialist posts highlights a broader challenge within the healthcare system – a scarcity of opportunities for aspiring specialists. This scarcity, coupled with the heightened competition, underscores the pressing need for a more equitable distribution of specialist positions and an increase in their availability.

For those doctors who enter the specialist programme and succeed, they face a new set of challenges. The study's revelations underscore a concerning pattern: these

newly qualified specialists are often relegated to short-term contracts that swiftly expire without the emergence of funded specialist posts. This leaves them in a perpetual state of uncertainty, unable to secure stable employment despite their qualifications and dedication to their field.

The repercussions of this predicament are far-reaching. Beyond the financial strain and instability faced by these specialists, the healthcare system itself suffers from the underutilisation of their skills and knowledge. This results in the migration of skills to other countries, a loss for SA, which needs the skills and does not get a return on investment. This situation not only hampers the personal and professional growth of these specialists, but benefits high-income countries rather than SA, further exacerbating global health workforce inequalities.

In addition, the journey of SA doctors, especially during their internship and community service, often involves the necessity to relocate to underserved communities. This crucial step in serving these areas comes at a cost – doctors are frequently compelled to leave their families behind, only to face uncertainty upon their return. A disheartening reality emerges as some doctors, upon completing their community service or returning home for family reasons, encounter a distressing hurdle – they struggle to secure employment. This unfortunate predicament highlights a significant oversight within the profession – the lack of consideration for doctors' holistic needs, including the impact of relocation for family reasons. This oversight underscores a lack of comprehensive support for doctors within the profession. It disregards the complexities of their lives outside of their professional duties, failing to acknowledge the strain and difficulties encountered when relocating for family reasons and then struggling to reintegrate into their local communities or find employment upon their return.

In particular, amid the demanding nature of their profession, there is an inadequate support system for female doctors balancing maternity and childcare responsibilities. The study findings shed light on a glaring gap in the system. After the permissible 4 months of maternity leave, female doctors face an uphill battle when they require additional leave. The lack of flexibility in accommodating such instances creates an environment where these doctors feel unsupported, leading some to resign from their positions.

The competitive nature of the medical profession further compounds this challenge. Female doctors find themselves in a conundrum, where taking time off for maternity and childcare becomes a luxury they cannot afford, in a field with limited opportunities for breaks or pauses in their career trajectory. This untenable situation often forces female doctors to make a difficult choice – between pursuing their career aspirations and fulfilling their family responsibilities. The absence of a supportive framework results in an alarming trend where some female doctors opt out of employment, feeling that their profession does not accommodate their needs holistically.

Every doctor deserves the opportunity to contribute their expertise and dedication to the betterment of healthcare without the burden of prolonged unemployment

The study outcomes have starkly highlighted the presence of unfair labour practices within the medical sphere. Instances of bullying and unjust treatment are common, painting a disturbing picture of a work environment that undermines the wellbeing and professionalism of doctors. This insidious phenomenon, often concealed behind closed doors, imposes detrimental effects on the mental health, job satisfaction and overall work experience of doctors. It creates an environment of fear, anxiety and disillusionment, driving some doctors to seek employment elsewhere in search of a workplace free from such toxicities. It is imperative for the medical profession to acknowledge and address these issues head-on. Eliminating unfair labour practices and fostering a culture of respect, support and professionalism will be crucial for the wellbeing and effectiveness of healthcare professionals.

It is time for the medical profession to stand united against unfair labour practices and toxic work environments, promoting a culture where every doctor feels valued, respected and empowered to fulfil their noble calling of healing without fear or discrimination.

This SAMA study sheds light on a critical issue within the medical community. Doctors, armed with education, dedication and practical experience, find themselves in a disconcerting predicament, unable to secure stable employment despite their qualifications and commitment to the profession. The impact of such prolonged unemployment on doctors cannot be overstated. Beyond the financial strain, this situation chips away at their morale, enthusiasm and sense of purpose – qualities crucial in a profession dedicated to healing and caring for others. Moreover, the ripple effects of this issue extend beyond the individual doctors affected. The healthcare system, already grappling with various challenges, suffers from the underutilisation of these skilled professionals who are eager to contribute but are sidelined due to the lack of opportunities.

Addressing this issue necessitates collective efforts from policymakers, healthcare institutions and the community. Advocacy for policies that promote stable employment opportunities for medical officers, measures to streamline the transition from training phases to professional roles, and initiatives to address the root causes of unemployment within the medical community are imperative.

Awareness and acknowledgment of these obstacles is crucial for the wellbeing of doctors and the health system at large. By addressing these challenges collectively, we can pave the way for a future where every doctor can contribute their expertise and dedication without the looming possibility of unemployment.

As a medical profession, by acknowledging and acting upon these findings, we can pave the way for a more equitable and supportive environment for doctors. Every doctor deserves the opportunity to contribute their expertise and dedication to the betterment of healthcare without the burden of prolonged unemployment. SAMA will work together with relevant role-players to ensure that the journey from medical training to meaningful employment becomes smoother and more promising for the passionate doctors in our community.

The medicolegal claims crisis shows no signs of abating – alternative approaches needed

Dr William Oosthuizen, *SAMA HoD: Legal Affairs*

In a recent meeting of the Select Committee on Appropriations, the auditor-general (AG) of SA painted a bleak picture of the state of claims across provincial departments. In a presentation to the committee, the AG indicated that as of March 2022 there were 15 148 claims lodged against departments valued at R125.3 billion. More than half of the claims were from the Eastern Cape and Gauteng, with KwaZulu-Natal and Limpopo also contributing significant numbers. During the financial year, departments paid R855.6 million toward these claims.

A dire situation indeed, especially if one considers that this is money being diverted away from departmental budgets that are meant to improve service delivery and quality of care. This leads to a vicious cycle where a conducive environment for poor outcomes that already exists in under-resourced public facilities is exacerbated by diminishing funds with which to intervene.

The National Department of Health (NDoH) has gotten involved by appointing a service provider to develop and implement a case management system, and they are in the process of implementing a policy and legal framework to manage medicolegal claims. Unfortunately, the case management system has only been rolled out in four provinces, and is only being used by one province.

Other key focus areas have also shown little progress or success. The management of medical records remains a perpetual problem, with administrative staff shortages, ineffective filing systems, poor practices and limited use of electronic processes severely hampering the ability to defend against claims. Existing claims are also often poorly managed due to a lack of suitable human resources and a lack of medical expertise in legal services directorates.

Medicolegal claims have become very lucrative, and the sector is rife with fraud and corruption

To make matters worse, medicolegal claims have become very lucrative, and the sector is rife with fraud and corruption. The Health Sector Anti-Corruption Forum has shone a light on the issue and made commendable progress. The Special Investigation Unit has been authorised by the President to investigate allegations of corruption, fraud and maladministration in the affairs of the NDoH and the provincial departments relating to medicolegal claims under proclamation R74 of 2022, and has already uncovered billions worth of fraudulent claims.

What does the future hold?

Legal reform is seemingly on the horizon. The Law Reform Commission are busy finalising their Project 141 investigation into medical claims in the public sector. An expansion of the project, investigating claims against doctors in the private sector, is also in the pipeline.

One hopes that reforms will not only be aimed at the consequences of claims, but also the causes of claims. As mentioned above, the resource-constrained environments in which the majority of our patients find themselves have likely been a leading contributing factor to poor outcomes. Interventions seeking to address the medicolegal claims crisis must therefore be cognisant of the systemic issues that give rise to adverse events.

The management of patient safety incidents and patient complaints is vital. Unfortunately, provincial departments lack dedicated staff and co-ordinating structures, leading to significant delays and unresolved cases. If facilities do not intervene effectively at this crucial point, patients will in all likelihood turn to litigation to seek redress.

Proper complaints management and alternative dispute resolution (ADR) could be a large part of the solution. SAMA and Mediation in Motion Mediators are launching an ADR Unit to provide doctors and patients with a platform where complaints and disputes can be resolved amicably without resorting to costly and adversarial legal proceedings. Members and patients can access this valuable service by contacting mediation@samedical.org.

May a patient record a consultation with their doctor?

Sadhana Dhanilal, *senior associate, MacRobert Attorneys*

A medical practitioner (Dr A) was recently faced with a dilemma when she discovered that a patient had recorded a consultation. The practitioner was taken aback by the patient's actions, and queried whether the recording of a consultation was permissible in terms of SA law.

Most people would agree that patients, when visiting their treating medical practitioner, are probably ill and distressed due to this illness. As a result, the patient might not be able to remember all the information discussed during their consultation. This could be one reason why a patient would choose to record their consultation with their medical practitioner. There might, of course, be other, less positive, reasons for doing so.

The relevant legislation to look at when assessing this dilemma is the Regulation of Interception of Communications and Provisions of Communications-Related Information Act No. 70 of 2002 (RICA).

According to RICA, all intentional interceptions of any communications are prohibited. This means that, as a general rule, RICA prohibits the recording of a conversation.

However, in section 4(1), RICA lists a few factors that limit this general rule. The limitations to this general rule are as follows:

- Any person may intercept any communication if he or she is a party to the communication (unless the interception is performed for purposes of committing an offence).
- Any person may intercept any communication if one of the parties to the communication have given prior consent (unless the interception is performed for purposes of committing an offence).
- Any person, in the course of carrying on of any business, may intercept any indirect communication that relates to or takes place in the course of carrying on of that business

Turning to the dilemma faced by Dr A, the patient did not obtain Dr A's consent to record the conversation, and there was nothing to suggest that the recording was made in the course of carrying out any business. The patient was, however, a party to the conversation held during the consultation with Dr A, and was therefore entitled to record that conversation/consultation.

POPIA

The right to privacy is enshrined in section 14 of the Constitution of the Republic of SA. One of the main purposes of the Protection of Personal Information Act No. 4 of 2013 (POPIA) is to give effect to this constitutional right. Given that we are discussing a dilemma that could be seen as a possible breach of privacy, it is only fit to consider POPIA and the provisions thereof.

POPIA applies to the exclusion of all other legislation that relates to the processing of personal information that is materially inconsistent with POPIA. This means that if any other legislation contradicts POPIA, the provisions of POPIA override such legislation.

According to POPIA, personal information may only be processed if the data subject consents to the processing thereof. It follows that you may only record a conversation if you have the consent of the person whose personal information is being discussed.

POPIA provides an extensive definition of the term "personal information" – that is, information relating to an identifiable, living, natural person (and where applicable, an identifiable, existing juristic person). The Act lists a number of categories of information that fall within the definition, such as:

- information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, wellbeing, disability, religion, conscience, belief, culture, language and birth of the person
- information relating to the education or the medical, financial, criminal or employment history of the person
- the personal opinions, views or preferences of the person.

The above are just a few of the categories of personal information listed in the definition. It is important to note that the list of categories of information under the definition of the Act is not an exhaustive one.

While, in terms of POPIA, it is a contravention to process personal information as defined in the Act without a person's consent, one has to consider that a patient, in terms of the Promotion of Access to Information Act No. 2 of 2000 (PAIA), is entitled to copies of their treating medical practitioner's medical records, which may contain the medical practitioner's professional opinion in relation to the diagnosis of a patient's medical condition and treatment thereof.

So, in Dr A's scenario, we can confirm that the recorded conversation:

- was made by the patient during their consultation with Dr A (i.e. the person who recorded the conversation was a party to said conversation); and
- did not include any of the medical practitioner's personal information, but rather information regarding the patient's treatment and management.

Point 1 clearly falls within the provisions of RICA, and so the provisions of this legislation have not been contravened. It does not appear that the provisions of POPIA come into play in the light of point 2. Given these two defining factors of the recording, it appears that the recording by Dr A's patient was lawful in terms of both POPIA and RICA.

It is therefore advisable for all medical practitioners to be mindful that their consultations may be recorded by patients, even without their express consent, so to avoid any unwanted surprises such as faced by Dr A.

On the other hand, medical practitioners may also wish to record consultations as a form of record-keeping. If this is the case, consent must be obtained from patients, as their personal information will be recorded. Such a recording may be useful should a medical practitioner receive complaints from patients or should they institute legal proceedings against the practitioner. However, practitioners should be cautious when making such a recording, as a patient would be entitled to a copy of that recording. The recording could make it easier for a practitioner to prove, for instance, informed consent, but could also be used by the patient to prove the lack thereof.

As a final word of caution, it is always recommended that discussions held with patients be detailed and remain topical, but this is even more the case if the consultations might be recorded.

Bullying is a form of harassment in SA

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

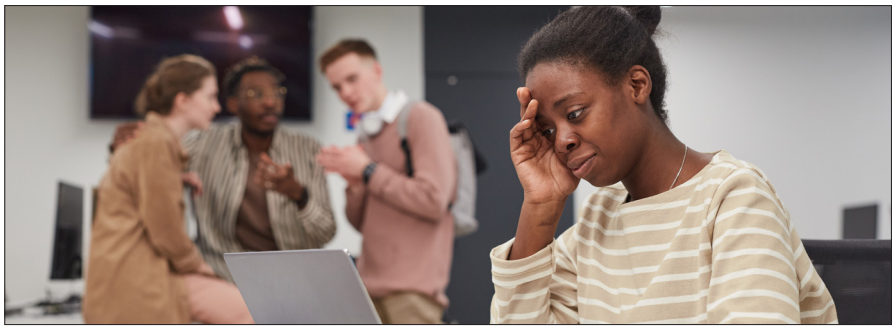
The new Code of Good Practice on the Prevention and Elimination of Harassment in the Workplace, which took effect in SA on 18 March 2022, has placed a duty of care on employers to pay their part in preventing bullying in the workplace. The code describes harassment, as, among other things, "unwanted conduct which impairs dignity and which creates a hostile or intimidating work environment for one or more employees". The code applies to all employers in all sectors, including the informal sector.

What to do

What should managers/employers do when dealing with incidents of bullying? Employers must take steps to maintain a work environment in which bullying does not take place. There must be stipulated measures and

actions in place that discourage bullying, and deal with it quickly and effectively if it happens. Specifically, employers must:

- take a clear, zero-tolerance stand against bullying and any other form of harassment in the workplace
- ensure up-to-date policies and procedures are in place that address issues related to employees respecting one another in both the physical and remote workplace
- provide and promote easy access to impartial communication channels and support systems
- process complaints fairly by implementing a standard investigation process to evaluate the reported incidents without victimisation
- act swiftly, because the code highlights the fact that employers are under obligation in terms of section 60 of the Employment Equity Act No. 55 of 1998 (EEA) to take proactive and remedial steps to prevent all forms of harassment in the workplace
- ensure that employees who report allegations of any form of harassment will not be victimised or subjected to any reprisals.



Consequences

The consequences of ignoring workplace bullying incidents or acting within a reasonable time include:

- employers who fail to take adequate steps to eliminate bullying maybe found liable in terms of Section 60 of the EEA
- employers are, in terms of the EEA, also vicariously or indirectly liable for the wrongful acts of their employees if these are committed in the course and scope of employment, unless it can proved that the employer has taken all reasonable steps to prevent this happening.

A take home note for employees

- Employees who make false allegations in bad faith may also be subjected to disciplinary action.
- Employees who are found guilty of harassment, including bullying, may, in certain circumstances, and depending on the severity of the conduct that is complained of, be summarily dismissed.

In case you get stuck, please contact SAMA Legal Affairs Department!

Dealing with incompatibility in the workplace

Simon Buthelezi, *labour law advisor, SAMA Legal Department*

Incompatibility can be generally defined as the subjective relationship between an employee and co-workers within the employment environment, regarding the employee's inability to maintain cordial and harmonious relationships with his peers, especial if the employee's inability to fit into the environment disrupts harmony, thus retarding expected productivity. A good example is that of an employee who continuously causes conflict among colleagues in the workplace, despite several corrective action attempts by the employer, but remains incorrigible. The employee may be dismissed from the workplace for these reasons.

It is, however, very difficult to define incompatibly in a uniform way, as different organisations have different corporate cultures. It is therefore up to the organisation to define its culture, and guide employees towards loyalty to the set rules. Incompatibility can manifest itself in various ways in the work environment. An employee may relate poorly to colleagues and clients, affecting the employee's ability to work according to his or her contract, or may be disruptive to others to such an extent that they cannot fulfil their contractual obligation.

Incompatibility should not be ignored or tolerated, as in the long term it may prove costly for the organisation. There are various ways to deal with incompatibility. The most common one is considering it as a form of incapacity, and the incapacity procedure can be invoked. It can also be dealt with as misconduct if the employer code allows it, and the employee has been made aware of it. SA courts have dealt with incompatibility in various ways. In Jabari v Telkom SA (Pty) Ltd [2006] 10 BLLR 924 (LC), the Labour Court highlighted important characteristics in explaining the nature of workplace incompatibility. It said that:

"…incompatibility refers to the employee's inability or failure to maintain cordial and harmonious relationships with his peers. Incompatibility is a form of incapacity and incompatibility is an 'amorphous nebulous concept' based on subjective value judgments".

The case of Chemical, Energy, Paper, Printing, Wood and Allied Workers' Union obo Mokoena/Sasol Chemical Operations (Pty) Ltd [2022] BALR 105 (NBCC I) at the CCMA was related to alleged unfair dismissal for reasons of incompatibility, where the employee lodged "endless complaints" and continuously displayed aggression to his immediate superiors. The employee claimed that his complaints arose from disagreement with his poor work performance rating by the employer.

In this matter, the commissioner found that the employee had disrupted the harmony of the workplace, warranting dismissal. He had been counselled but had refused to co-operate with remedial measures or to sign minutes. The termination of his employment was the last resort, since the employer had invested a lot of time in considering his grievances, which were unfounded and baseless.

Incompatibility is a serious and complex matter; it is always advised that members should seek advice before dealing with it.

References are available on request.

Mismanagement of diagnostic injections risks cord damage

Dr Dudley Bush and Dr John Adams, *Medical Protection medicolegal advisers*

Mrs J was a 32-year-old female patient with a long history of neck pain following a road traffic accident. The pain was localised to the left side of the neck and left shoulder, with only very occasional paraesthesia in her left hand. Despite regular analgesics and exercises, the pain was still troublesome, and she was keen for a specialist opinion.

Mrs J was referred to Dr M, a pain consultant. Dr M noted slight restriction in neck movement on the affected side, and elicited tenderness over the left C5/6 and C6/7 facet joints. Imaging revealed fusion of the C3 and C4 vertebrae and some loss of normal cervical spine curvature, but the vertebral bodies and spaces remained otherwise well preserved.

Dr M recommended C5/6 and C6/7 facet joint treatment, and told Mrs J that there was a 50% chance of getting long-term pain relief. He suggested two diagnostic injections with local anaesthetic followed by radiofrequency lesioning if benefit was felt. Dr M went through the risks of the procedure with Mrs J, including lack of benefit, relapse of pain, infection and damage to nerves.

Mrs J returned for the first of the two diagnostic blocks. The block was performed in the lateral position, and Dr M injected a mixture of 0.5% levobupivacaine and triamcinolone. The block provided good pain relief and Mrs J felt it was easier to move her neck.

Mrs J later returned for the second diagnostic injection. Mrs J was placed in the prone position and local anaesthetic infiltrated into the skin. Using biplanar fluoroscopy, 22G spinal needles were inserted toward the C5/6 and C6/7 facet joints. Dr M then attempted to inject a mixture of lignocaine and triamcinolone at the lower level. Unfortunately, as soon as Dr M started the injection, the patient jumped with pain and her left arm twitched. The procedure was abandoned.

Despite a normal neurological examination immediately after the procedure, the patient later the same day developed numbness in her left arm and right leg. She also complained of headache when sitting up, as well as pain in her left neck and shoulder. As she felt dizzy on standing, Dr M decided to admit Mrs J for overnight monitoring and analgesia.

Learning points

Although it is commonplace for a doctor to assume multiple roles, this case highlights the risks during an individual procedure. Dr M was acting as an anaesthetist providing sedation, analgesia and reassurance, while at the same time carrying out the facet joint injections.

Although Dr M warned the claimant about the possibility of nerve damage, this does not mean that a defence can necessarily be made. Both the expert pain consultant and radiologist concluded that neither needle was positioned as intended prior to the injection, and that the lower needle tip was clearly within the spinal canal and thus potentially within the substance of the cord.

The experts were of the opinion that a pain medicine consultant should be confident in interpretation of live radiological imaging, including needle trajectory, and accurately determining needle trajectory and position prior to performing the procedure. It is important to allow the necessary time regardless of other pressures and to follow appropriate guidelines published by the relevant professional societies/bodies. A practitioner must also be aware of current best practice.

When an elective procedure or service has been offered to a patient, the practitioner may feel an obligation to fulfil this, even when they may not be entirely confident about doing so. Where there is any doubt or concern, it is far better to abandon the procedure or seek a second opinion, particularly where a mistake may lead to a serious complication.

The next morning, Mrs J was no better. She felt unsteady on her feet and complained of a burning sensation in her right leg, as well as weakness and shooting pains in her left arm. Dr M decided that a second opinion was required and referred Mrs J to a neurosurgical colleague. An MRI was arranged, which unfortunately demonstrated signal change in the cord at a level consistent with the intended facet joint injection.

Over time, the MRI changes improved, but Mrs J continued to suffer from terrible neuropathic pain. It affected many aspects of her daily life and she found it difficult to return to work as she was not able to sit for any length of time. A spinal cord stimulator was inserted by another pain specialist to try and help with the pain, but this was largely unsuccessful and was later removed.

Mrs J subsequently lost her job and, following that, decided to bring a claim against Dr M.

Expert opinion

The case was reviewed for Medical Protection by Dr F, a specialist in pain management. Dr F was of the opinion that the initial assessment and management plan were entirely appropriate. She was somewhat critical of the approach used by Dr M for the diagnostic injection, as it was not consistent with the planned approach for the radiofrequency lesioning and, in her opinion, was more likely to be associated with the possibility of damage to the spinal cord. She also felt that the use of triamcinolone in the diagnostic injections could be criticised, as injection of particulate matter into the spinal cord is known to be associated with a higher risk of cord damage.

Dr W, an expert neuroradiologist, was concerned about the images he reviewed from the second diagnostic injection. He concluded that neither needle was within the respective facet joint and that the lower needle tip was within the spinal canal at the level of C5, less than 1 cm from the midline. Dr W also confirmed that the MRI abnormality corresponded with the position of the lower needle tip.

Dr F concluded that insufficient images were taken to satisfactorily position the needles. She also noted that only 40 seconds had passed between the images taken for the first and second needle insertions, inferring that the procedure had been carried out with some haste.

Medical Protection then instructed a causation expert to comment on Mrs J's progression of symptoms. Prof. I concluded that the development of neuropathic pain in the right limb was understandable, although the disabling effects were more than he would have expected. While the patient did have a history of neck pain, the patient's symptoms were consistent with a lesion affecting the spinothalamic tract on the contralateral side of the cervical spinal cord.

The case was considered indefensible and was settled for a considerable sum.

Adherence to international humanitarian law is non-negotiable in Gaza

SAMA Communications

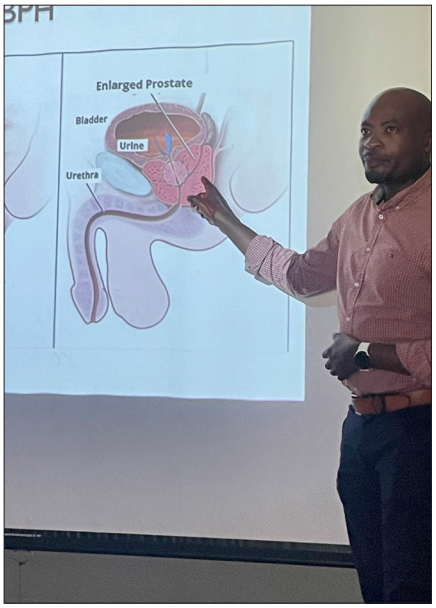
SAMA is deeply concerned about the recent escalation of violence and tensions in the Gaza region, and stands in solidarity with the WMA and WHO in calling for adherence to international humanitarian law (IHL).

IHL serves as a crucial framework designed to mitigate the impact of armed conflicts on civilians, ensuring their protection during times of strife. With the situation in Gaza deteriorating rapidly, it is essential that all parties involved uphold the principles enshrined in IHL. This includes ensuring the safety and wellbeing of civilians, regardless of their nationality, ethnicity or political affiliation.

For SAMA and the WMA, this entails, *inter alia*, not using health facilities as military depots, and not targeting health personnel, facilities, infrastructure and vehicles. IHL involves providing health personnel with an adequate environment to treat patients with humanity, and in adherence to ethical values of the health practitioners' profession, including medical neutrality. Additionally, SAMA calls on humanitarian corridors that will permit safe provision of health equipment and humanitarian supplies in Gaza. Our mandate as SAMA is to preserve life. Health practitioners on both sides of the conflict must be permitted to treat the victims of this violence.

The association is hopeful that the international community, regional actors and all parties involved in the conflict will prioritise the safety and wellbeing of civilians, particularly the most vulnerable, including women, children and the elderly. Strict adherence to IHL is not only a legal obligation, but a moral imperative. SAMA calls upon governments and humanitarian organisations to work together to ensure the provision of immediate humanitarian assistance to those affected in Gaza, and to support diplomatic efforts aimed at finding a peaceful and just resolution to the conflict.

Prostate cancer – raising awareness



Movember, the month formerly know as November, is when brave and selfless men around the world grow a moustache or step up to support, raise awareness and spark conversation about men's health – specifically prostate cancer, testicular cancer and mental health.

To mark the month, SAMA head office organised a brunch for men at the Irene Country Club. Urologist Dr Craig Mamitele delivered a presentation to spread awareness about prostate cancer to our colleagues. He enlightened the audience with information about the prostate, conditions of the prostate (benign prostatic hyperplasia, prostatitis and prostate cancer), risks and what to look out for. Prostate cancer is the most dominant cancer amoung men in SA. His take home message is:

- Urinating is easy; if difficult, consult.
- Blood in the urine is abnormal.
- Life begins at 40 – do your prostate check.
- We can help – look at me, I am not scary!

The state of men's health is in a crisis. Simply put, men are dying too young. The impact of prostate and testicular cancer on lives is substantial, with prostate cancer being

the second most common cancer in men worldwide, and the number of cases are expected to almost double to 1.7 million by 2030.

This is why people from across the globe become a united voice every Movember, bringing vital funding and attention to the hidden men's health crisis.

Flying the SAMA flag high

SAMA Free State branch attended the Standard Bank stakeholder event in Bloemfontein in October. Present at the networking opportunity were: Nolwazi Nkeane (Standard Bank), Shereen Stamier (Standard Bank), Sultana Hartzenberg (SAMA FSB and GWB administrator) and Kefilwe Mokoto (Standard Bank)

Attending the NHI public hearing in Bloemfontein recently. FSB branch administrator Sultana Hartzenberg (above) found the event informative.

Flying the SAMA flag high – current treasurer of the Free State branch and board member Prof. Dirk Hagemeister recently presented on the ethical topic "Consent in healthcare" at the Mediclinic CPD symposium in Bloemfontein

Welcome to SAMA

SAMA welcomes the following new members who joined the association in November and December 2023

Border Coastal branch
Saurav Subrata Sarkar

Cape Western branch
Neo Mashala

Eastern Highveld branch
Lomena Jean Marc Mukombola
Henry Ifeanyi Chiamonwu
Marios Samuel Mashaba

Free State branch
Willem du Preez
Boitumelo Palesa Makaulule
Isaac Itumeleng Mokoena
Safiyyah Matthews
Mashudu Raphdana
Maryke Prinsloo

Gauteng branch
Catherine Jean Dold
Richard Joseph Burman
Kivania Pillay
Rezaan Suliman
Abdul Matin Gori
Ffion Evans
Adbul Aziz
Tamir Naftali Bender
Yikhokonke Ntakaso Kunene
Lesego Collen Mahlasi
Thalutshedzo Ngobo Mudau
Musundwa Monicca Matshisevhe
Danika Ramlakan
Kelebogile Esther Mlambo
Pheladi Gwendolin Mashiane

Gauteng North branch
Sandile Welcome Ngwenya
Ndaedzo Nobert Mufamadi
Dhiya Rangasamy
Faheem Aziz Muhammad
Simisonke Funuel Sibanyoni
Khadija Mansoor

KZN Coastal branch
Simri Harslief
Nkululeko Handsome Jali
Zaakirah Khan-Bhamjee
Muhammad Irfaan Bhamjee
Lwando Majikija
Waaris Aboobaker

KZN Midlands branch
Brett Lyndall Singh
Hombisa Precious Gcbashe

KZN Northern branch
Khayalethu Mdunge

Limpopo branch
Peggy Serotse
Madira Lydia Malebana
Wamashudu Malada
Silindile Prince Bongani Bota
Kamogelo Ofentse Mabotja
Charlotte Majatladi Malata
Abdullah Bemath
Kgabo Seema
Nyiko Nkosi

Transkei branch
Sabelo Apleni
Nikita Soni
Andiswa Ndzube
Gwiba Wanda Kene
Lona Mbengashe
Lisakhanya Peter
Manelisi Phika
Kuselo Nkululeko Ndabula
Numfuneko Soji
Philisile Thandeka Goodness Magagula
Siphesihle Ayanda Msomi
Xolisa Ndwandwa
Olwethu Mbem
Sive Sigenu
Siyamamkela Mpetshwa
Zilungile Mdunyelwa
Sneziwe Perseverance Nompukane
Lindelo Legomo Mahlangu
Awande Ndlovu

Tygerberg Boland branch
Zacko Greeff
Lianke Potgieter
Mihlali Yelani
Amy Page
Mutakali Rasikhanya
Markus Arne Nel
Rachl Maria Gallimore
Marni Opperman
Cornél Vlok
Robin Elaine Bowden
Chane Nel
Asiya Sonday
Leon Abraham Coetzee
Andile Monica Mtsweni
Astrid Sass

Unattached
Michaela Tahlia Singh

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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