Private Practice Portfolio Feedback from Dr Norbert Welkovics

The 3 waves of COVID have kept all of us extraordinary busy and nothing has really happened with the private practice forum in this time. We will need to regroup following the cessation of this wave but certainly new challenges have reared their heads making the accreditation and recognition of Intensivists mandatory, something that the society needs to drive in order for us to be successful.

1. COVID challenges
- Staffing has been a major issue and although understandable, understaffing has become a everyday occurrence up to the point of placing patient with invasive treatment modalities at significant risk and harm. We as the HCP seem not to have any say in the closing of units when understaffing levels have become unacceptable.
- the availability of equipment has become an issue and this is not been addressed. If we do not have a grading system with an associated level of equipment or that garding (coupled to renumeration ot the health care founders), this will continue to deteriorate
- Garding patients to high care and ICU is at the discresttion of the case managers and not the HCP dealing with the cases. This has created discrepancies with billing and has led to account disputes. This is something that needs to be addressed.
- Units therefore should be
    A. closed
    B. Headed by an ICU director
    C. ICU's need to be graded
    D. with the higher grading of ICU's headed by Intensivists

Although we have been discussing this various times before, no clear way forward has been established or agreed upon but this pandemic has highlighted the need for it.

2. We remain with the challenge that certain specialities are not able to register their sub speciality at the BHF due to a lack of Critical Care codes. I have tried in vain to get into talks with the BHF but was unable to obtain the name of the correct person to talk to> I was merely shunted back to the HPCSA every time, who have noting to do with the subspecialty codes on the RAMS numbers. This is not the same as registering as a sub specialist at the HPCSA which of course is no problem what so ever.

3. The basic model of renumeration is still insufficient and does not address the complexity of the patient and time needed to spend at bedside. A global fee actually discourages a good standard of care and rather promotes prolonged admissions and ventilation. Certain codes such as TPN have become obsolete and codes for HFNC and NIV have not been included in the code descriptions, hence the problems encountered with the COVID mixed ICU/ high care model and billing levels of care.

4. The current model of renumeration does not take account of the level of train air of the HCP ie sub specialist vs specialist vs General practitioner. This has also been discussed before and discouraged but if we plan to grow out subspeciality as well as membership of our own society, I remain of the opinion is crucial. I think that the massive caseloads experienced esp in the last wave have crystallised these problems and we need to pay attention to this to preserve a good standard of care whist encouraging sub specialisation.

5. RMO have been employed by hospital groups and their responsibilities, duties and interaction with the primary health care providers have not been described. I think this should be societal driven

6. The lack of ICU trained nurses and the renumeration of staff working in ICU has been highlighted again, the question therefore arises if we should include nursing representation form private practice on this forum.