

SAMA INSIDER

AUGUST 2021

Choosing which COVID-19 patient to save: Some considerations

SAMA bioethicist a winner



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Diane de Kock
Editor: *SAMA INSIDER*

Good decisions

A decision is an act of selection or choice of one action from several alternatives. This month, several articles aim to inform and assist readers in the decision-making process. SAMA President, Prof. Chauke, unpacks good leadership (page 4), while Brandon Ferlito and Shelley McGee look at the bleak moral quandary of which patients should be prioritised if medical resources are limited. "It is impossible to comprehend how difficult it must be for those who took an oath to preserve human life to make such decisions" (page 5).

The statement by the WHO and the International Coalition of Medicines Regulatory Authorities (page 6) on how COVID-19 vaccines are regulated for safety and effectiveness answers some important questions for healthcare professionals around the development, regulatory review and ongoing safety monitoring of COVID-19 vaccines.

The importance of healthcare professionals working in teams is discussed by Gérard Charl Fillies and Josè Frantz (page 10). "If universities are successful in producing graduates who are able to work effectively in a team, the healthcare system would be strengthened."

We congratulate SAMA bioethicist, Brandon Ferlito, who has been selected as a winner in the health category of the M&G's Young South Africans 2021. This year the theme was "Resilience and innovation for excellence."

Dr Hugo Stark (page 14) shares his 10-year journey with us, tackling a project in George Hospital's theatre complex that helped transform a paper-based system into a digital system. "Typed documents flow from our theatres in a thick stream. Signed, sealed and delivered for the wards."

According to Prof. Utpal Dholakia: "A good decision is one that is made deliberately and thoughtfully, considers and includes all relevant factors, is consistent with the individual's philosophy and values, and can be explained clearly to significant others."

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Good leadership inspires



Prof. Risenga Chauke, SAMA President

There are multiple definitions of leadership, and of what a leader represents. Some authors define leadership as one of the most observed and least understood phenomena on earth. Blanchard and Donahue, in their 2008 article, define leadership as a process of persuading people to act in a particular way or to a particular end.

Leaders are expected to influence or inspire people, and rally them around a cause. SA is currently witnessing leadership successes and challenges related to the vaccine rollout and to service delivery, to name some of the topical issues. It remains uncertain whether followers are being inspired to their doom or to victory by the current leadership. Certainly, SAMA's leadership is meant to inspire its members to greater heights, and to facilitate the necessary changes in the profession and health sector.

What are the qualities of great leaders?

Great leaders have mastered the art of communication. They use their communication skills to articulate their vision and create a sense of belonging among their followers. They practise effective cross-cultural communication that fosters inclusion. The followers of great leaders are ready to lay down their lives in support of such a leader.

Effective and purposeful communication remains a key feature within SAMA, and the

community at large. SAMA's communication strategy has proven to be valuable during the COVID-19 pandemic, from advocating for equitable vaccine access, fighting misinformation, to promoting adherence to public health protocols.

Targeted communication has also been critical in keeping SAMA membership informed about the general happenings within SAMA on issues related to the SAMA and SAMATU matter, labour relations and indeed the cost of living, including the matter of salary increments. The recent successes in the placement of intern doctors by the National Department of Health is an example of robust communication to advocate for our members, and also of SAMA's efficiency in informing members of outcomes.

Leadership and accountability are mutually inclusive. An anonymous author has defined accountability as not only related to what we do, but also to what we do not do. The accountable person must be an individual who is ultimately answerable for an activity or decision. This includes "yes" or "no" authority, and veto power. Only accountable organisations such as SAMA can be assigned to an action. Accountability should not be confused with or equated to responsibility. A responsible person only completes the task assigned to him/her by an accountable person. Thus an individual can be responsible without being accountable. An example to compare and contrast accountability with responsibility would be the case of hired killings. The person who hires someone to go and do the killing is accountable for the killing. The person who pulls the trigger is responsible, but not accountable.

SAMA and its current leadership do not want to be judged by future generations as being accountable for poor health delivery services to our people. SAMA leadership is in the forefront of making sure that health services improve, in terms of both material resources and human resources. Our goal in leadership is to be accountable for our actions, to explore innovative ways of driving our strategy and to be authentic in all that is good and excellent which should be achieved in health, to improve the lives of our people. Our endeavour is also to increase the satisfaction bar of our members in the work that they do to deliver health services, but also in the work that we do to represent them.

Health leaders ought to execute their leadership responsibly, taking into account the ethical values guiding the profession, and the core values of our organisation.

Leaders should provide strategic vision for their organisations. This vision has to be futuristic while navigating the current context. Lack of vision and adaptability threatens the relevance and sustainability of organisations.

**We as doctors
are too few in
numbers to function
divided ... that is the
reason we might fall,
if we do not remain
united**

As the saying goes, "adapt or die." It is important for us as SAMA to maintain the vision and belief of uniting doctors across all spheres, in public and private practice. The COVID-19 pandemic is teaching us that we have to be forward-thinking. As our motto states, we need to be "uniting doctors for the health of the nation". We as doctors are too few in numbers to function divided. That is the reason we might fall, if we do not remain united.

We remain empathetic to those who have lost their loved ones during this pandemic, whether as a result of the pandemic itself or from other diseases or causes that are directly or indirectly linked to it. We have lost many of our colleagues in the line of duty. We, as a profession, are even more vulnerable without them. But we shall soldier on, because we want their deaths not to be in vain. We remain committed to serving this nation, vulnerable as we are. We can only hope that those who lead us as a nation do not take our vulnerability for granted. Empathy is another trait of good leadership, and we are surely bringing it to life as SAMA.

The many other traits of good leadership include humility, honesty and delegation. These traits are not an exhaustive list – there are many others. As SAMA, we pledge to abide by all these leadership qualities in moving our organisation forward.

Choosing which COVID-19 patient to save: Some considerations

Brandon Ferlito, *bioethics researcher*, Shelley McGee, *health policy analyst*, SAMA Knowledge Management, Research and Ethics Department

As the number of COVID-19 cases in SA grows again, a bleak moral quandary arises: which patients should be prioritised if medical resources are limited? Moral philosophy, law, health policy and medical ethics have all grappled with the issue of how to decide which patients receive limited healthcare services during public health emergencies. While to some this distinction may appear relatively simple, it becomes far more complicated when applied to the treatment and care of patients suffering from COVID-19.

As cases rapidly increase and hospitals become overwhelmed with the influx of COVID-19 patients, medical professionals essentially have to choose whom to save. In an article published on 24 June, News24 described how medical professionals recounted the agony of having to choose who survives or dies due to a lack of beds and oxygen. The pandemic has placed on medical professionals the pressure of having to utilise a triage decision-making system, often based on the theory to maximise overall benefits and life expectancy. Treatment beneficence limitations are not a choice, but a necessary response to the devastating effects of the epidemic.

SA COVID-19 triage guidelines

Triage and rationing of restricted resources are unavoidable, especially in ICUs. In normal circumstances, ICU triage is based on a patient's best interests, but when demand exceeds capacity, medical staff must make tough decisions to benefit the larger population while still caring for individual patients. The Critical Care Society of Southern Africa (CCSSA) has accelerated the creation of a triage guidance sheet to inform the proper and equitable use of restricted ICU resources. This triage tool is based on the clinical probabilities of a favourable ICU result, as well as the risk of death and long-term morbidity, both of which have an impact on quality of life. Age and concomitant illnesses are taken into account for their possible influence on clinical outcomes, but they are never the primary reason for refusing ICU care.



Resource rationing of healthcare services

Unfortunately, in such a situation, rationing of healthcare resources – be these human, medication, equipment or places in ICU beds – also becomes a more pressing reality than under normal circumstances. We have addressed the rationing of resources in a previous *Insider* article (October 2020). This rationing can take place explicitly or implicitly, and the distinction is important.

Explicit rationing generally refers to decisions made by an administrative authority (in SA, this may be the government or private medical insurers) as to the amounts and types of resources to be made available, eligible populations and specific rules for allocation. Significant amounts of explicit rationing occur in the public and private sectors in SA regarding levels of available technology, benefit designs, listing of medications on formularies and expenditure levels on specific disease areas and programmes.

Implicit rationing can take place through mechanisms such as patient cost-sharing, waiting lists and forcing allocations decisions at a local level by requiring professionals to work within a constrained budget.

Implicit rationing is considered problematic as it tends to be applied inconsistently and on an *ad hoc* basis. However, in emergency situations, it is almost unavoidable that

many difficult and potentially controversial decisions are made at the bedside.

Ethical considerations

Fairness, the duty to care, the responsibility to manage resources, openness in decision-making, proportionality and accountability are among the key ethical concepts for medical professionals. During a crisis such as COVID-19, where healthcare services are limited and need to be rationed, these principles are put to the test, as clinicians are often forced to pick and choose which patients to treat and, effectively, save.

While it may seem discriminatory for medical professionals to choose who receives treatment and who does not, triage guidelines such as the CCSSA's are considered and created in consultation with the law, health policy and international ethical practices. Although life-saving treatment and care such as ICU admission, oxygen and beds are not always appropriate, available, or possible for everyone suffering from COVID-19, every citizen, according to the Constitution of SA, has the right to receive adequate treatment at a lower level. However, it is becoming clear that with the increase in cases, this may not be achievable.

When scarce resources are rationed to patients who are unlikely to benefit, others who are likely to benefit from those resources

are effectively denied life-saving treatment. Medical professionals therefore need to “fairly discriminate” and decide who is likely to benefit from treatment and care.

Legal considerations

SA boasts one of the most progressive constitutions in the world, with human dignity and the right to life being non-negotiable, even during a proclaimed state of emergency. “The Constitution of the Republic of South Africa (1996)[35] (in chapter 2 section 27(3)) states that one may not ‘unfairly [our emphasis] discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth’. Section 27(5) states: ‘Discrimination on one or more grounds ... is unfair unless it is established that the discrimination is fair.’”

The ground-breaking case of *Soobramoney v Minister of Health, KwaZulu-Natal*, offers both implicit and explicit support for necessary triage as a kind of fair discrimination. The appellant (*Soobramoney*) had chronic renal failure and other serious comorbidities, and was repeatedly denied entry to a dialysis programme at a public hospital, based on the institution’s stated triage policy. Based on his fundamental rights, the appellant requested an order granting him access to dialysis therapy. The court stated that the state must “apply a holistic approach to the greater requirements of society rather than focusing on the needs of particular persons within society” when using restricted resources. The court concluded that resource rationing is necessary for providing fair and reasonable healthcare.

The ruling went on to state that the state’s duties related to healthcare access are contingent on available resources, and that

corresponding rights may be curtailed as a result of a lack of resources.

Discussion and conclusions

Unless you are a medical professional confronted with having to decide whom to “save”, it is impossible to comprehend how difficult it must be for those who took an oath to preserve human life to make such decisions. Rationing of healthcare is universally acknowledged to be necessary, unavoidable and fraught with ethical issues. Unfortunately, this is heightened by the COVID-19 pandemic. Policy-makers should do everything possible to avert a scarcity of medical resources and to adequately prepare for public health emergencies, to make sure that clinicians are never placed in situations where they have to decide whom to save.

References available on request.

WHO statement for healthcare professionals: How COVID-19 vaccines are regulated for safety and effectiveness

World Health Organization, International Coalition of Medicines Regulatory Authorities

Healthcare professionals and public health authorities have a central role to play in discussing vaccination against COVID-19 with their patients. Vaccines play a critical role in preventing deaths and hospitalisation caused by infectious diseases. Emerging data on effectiveness indicate that licensed COVID-19 vaccines are contributing to controlling the spread of the disease. Until widespread vaccination has been achieved, both vaccinated and unvaccinated people need to be aware of the additional protective behaviours required to control the pandemic locally.

The global impact of the COVID-19 pandemic has resulted in an unprecedented level of public interest in vaccines. This includes a focus on the development of vaccines and their regulatory review and safety monitoring. Much of this coverage has taken place through mass and social media. Reports of adverse events (side-effects) have led some people to express concerns about getting vaccinated, delay getting vaccinated or even

be strongly opposed to vaccination. There are also differences in individual confidence in national safety monitoring systems. Another challenge in communicating the importance of COVID-19 vaccination is that younger adults are typically less clinically affected by COVID-19 infection, and so may see limited value in getting vaccinated, including until further data confirm that vaccines prevent transmission and are effective against variants. Clear and consistent communication is therefore essential to support people in making the choice to be vaccinated.

We appreciate that you, your colleagues and your patients may have a number of questions around the development, regulatory review and ongoing safety monitoring of COVID-19 vaccines.

Purpose

This joint International Coalition of Medicines Regulatory Authorities (ICMRA) and WHO statement aims to help healthcare professionals answer questions about the role of regulators

in the oversight of COVID-19 vaccines. It explains how vaccines undergo robust scientific evaluation to determine their safety, efficacy and quality, and how safety is closely and continually monitored after approval.

Vaccination has been shown to contribute to reducing deaths and severe illness from COVID-19, and to reduce the transmission of COVID-19. Vaccinating as many people as possible and reducing the spread of disease is important. Vaccination of a significant proportion of the population also protects vulnerable people, including those who cannot receive vaccines, or the small proportion of people who might remain at risk of infection after vaccination. Failure to vaccinate widely also enables continued circulation of the virus and the generation of variants, including some that may pose a greater risk. Widespread vaccination will help prevent people from having to go to hospital, and contribute to fewer people getting sick, ultimately alleviating the burden of COVID-19 on healthcare systems. It will also help allow a

return to normal societal functioning and the reopening of economies.

Vaccines and the regulatory process

How do regulatory authorities evaluate COVID-19 vaccines? Regulators rigorously evaluate scientific and clinical evidence provided by vaccine manufacturers. Vaccine manufacturers are legally obliged to follow defined standards in the data they provide, and their clinical research and manufacturing operations are subject to regulatory oversight. Either full or summary data from clinical trials are made available following vaccine evaluation. Each vaccine is thoroughly assessed for safety, efficacy and pharmaceutical quality to determine whether it can be approved for use. Regulators use available scientific evidence from preclinical laboratory research, human clinical trials and manufacturing information to assess benefits and risks of candidate vaccines.

Regulators may seek additional expert advice from independent scientific advisory committees to help inform their decision on whether to approve a vaccine. These committees are made up of experts in science, medicine (including infectious diseases) and public health, and often include consumer and healthcare professional representatives.

Public health agencies have a different role to regulatory authorities. They develop and deliver vaccination programmes, often working with their expert immunisation technical advisory committees. This includes prioritising and designating populations for vaccination with specific vaccines, issuing additional recommendations and providing information more broadly about vaccines and immunisation. They also collaborate with regulators to monitor the safety of vaccines after they are approved for use.

Globally, the public can have confidence in the rigour of the process used to scientifically evaluate the safety, efficacy and quality of vaccines before they are approved for use in the wider population.

Safety evidence prior to potential regulatory authorisation: Safety evidence is an essential part of each regulatory submission for a COVID-19 vaccine. It is gathered during all phases of the vaccine development process. Robust assessment of safety is carried out in the clinical trials, and submitted to regulators for review as part of the approval process.

All adverse events need to be examined and reported in the regulatory submission by companies for a marketing licence. Typically, regulators will require that participants in

clinical trials have been followed for at least 1 - 2 months after receiving their final vaccine dose. Generally, based on previous experience with vaccines, most adverse events occur within such timeframes, though rare adverse events might not be recognised until after wide population use. There will also be longer-term (for example for 6 - 12 months or more) follow-up of those who participated in the earlier phases of the clinical trials of each vaccine. Many trial participants will also be followed for at least 1 year to assess the duration of protection and longer-term safety of individual vaccines, and safety data from these longer-term trials will be carefully reviewed by regulators as part of post-approval monitoring of safety.

Efficacy: Apart from information on the types of immune responses induced by the vaccine, companies must submit data from well-designed clinical trials to regulators to demonstrate that the vaccine prevents COVID-19. The data must show that there were sufficient numbers of people included in the clinical trials receiving the vaccine that the efficacy of the vaccine can be accurately measured (generally at least 10 000 and usually 15 000 or more people who receive the vaccine, in addition to those in the control arm). Populations in clinical trials should include a range of age groups and people with comorbidities. Given the disproportionate impact of COVID-19 on older people, COVID-19 vaccine clinical trials have included significant numbers of older participants.

Vaccine clinical trials for a new candidate vaccine show that vaccines very significantly reduce COVID-19 in people who are vaccinated compared with a control group of people who did not receive the vaccine, through a reduction in numbers of laboratory confirmed SARS-CoV-2 infections.

Quality: Any COVID-19 vaccine that receives regulatory authorisation must be manufactured according to internationally accepted stringent regulatory standards of good manufacturing practices (GMP). Regulators review data to confirm that the manufacturing process at each production site is well controlled and consistent. This includes data on the composition and purity of the vaccine and its potency, as well as on every step of manufacturing and on the controls used to ensure that each batch of vaccine is consistently of a high quality. Data on vaccine stability must also be provided before a vaccine can be approved. After approval, batches may also undergo evaluation by individual national regulatory authorities to ensure that they meet

national requirements before they can be supplied.

Monitoring safety and effectiveness after vaccine approval: After a vaccine is approved for use, regulators conduct robust effectiveness monitoring as well as monitoring of safety and risk minimisation activities (pharmacovigilance). They need to continuously monitor vaccine safety to ensure that the benefits of the vaccine continue to outweigh the risks. Regulators do this by:

- reviewing and analysing adverse events reported by healthcare professionals and consumers, and requiring industry vaccine companies (sometimes called “sponsors”) to report to regulators on adverse events received both within the regulator’s home country and globally
- in many cases, implementing enhanced passive surveillance systems: these include systems to rapidly compare numbers of suspected side-effects reported with vaccines to the numbers of events expected to occur by chance, and include access to near real-time data on vaccine usage in different settings; several regulators have also implemented traceability systems for different vaccine brands and batches
- taking rapid action to mitigate risks, also considering the information about emerging safety issues shared among regulators and researchers through international collaboration
- reviewing medical literature and other sources of new safety information
- requiring vaccine manufacturers to continue safety surveillance from the ongoing clinical trials of their products
- requiring vaccine manufacturers to have risk management plans describing how they will monitor and minimise risks, including further epidemiological studies, associated with their vaccines.

It is very important that healthcare professionals not only diligently report any adverse events they see in their patients, but also encourage people who are vaccinated to immediately report adverse events to their healthcare professionals or to the medicines regulator in countries where direct reports from members of the public are accepted by the regulator. Reporting all relevant events helps regulators assess the possible role of the vaccine in causing the adverse event, and assists in identifying safety issues relating to newly introduced vaccines.

As part of the safety monitoring and review of all suspected side-effects reporting for

vaccines, regulators have developed lists of “adverse events of special interest”. These lists include some events that have been associated with other vaccines (for example anaphylaxis). Others are included on these lists because they are serious events that are important to monitor extremely closely, even though there is no evidence that they are causally associated with specific vaccines. Having information on the background rates of these events that would be expected in people who have not received a vaccine will help ensure that any increased reporting of these events can be quickly detected and thoroughly investigated by regulators.

The widespread use of COVID-19 vaccines, including in the elderly and in patients with underlying health conditions, will unfortunately mean that there will be deaths and serious illnesses that are purely coincidental and unrelated to vaccinations. The job of each regulator, together with the relevant medical experts and vaccine manufacturers, is to determine causality. There will be a special focus on monitoring safety in some groups of people, such as pregnant women, persons with severe pre-existing illness, older people and children, and in people also receiving vaccines for prevention of other diseases.

Regulators, often in collaboration with public health authorities, are able to take decisive action if a safety issue is identified. These actions might include: issuing safety communications for patients, healthcare professionals and the community; updating the product information or consumer information for the vaccine; preventing the release of a particular batch of vaccine; and taking other regulatory actions such as restriction of vaccine authorisation to a particular subgroup of the community, or revocation of authorisation.

Commonly reported adverse events

The most commonly reported events with COVID-19 vaccines are expected vaccine side-effects such as headache, fatigue, muscle and joint pain, fever and chills, and pain at the site of injection. The occurrence of these adverse events is consistent with what is already known about the vaccines from clinical trials.

Adverse events of special interest

Regulators approve and maintain an approval of a vaccine only if they determine that the known and potential benefits of the vaccine outweigh its known and potential risks.

Anaphylaxis is a very rare side-effect that may occur with any vaccine. There have been some other reported adverse events, which include facial weakness, seizures, loss of sense of taste or smell and cardiac events, but none are confirmed to be causally related to the vaccines.

mRNA vaccines

The major adverse event of special interest reported for these vaccines, which include the Pfizer and Moderna vaccines, is anaphylaxis. Regulators carefully review the reports of possible anaphylaxis to determine whether they are consistent with true anaphylaxis and whether they may have been caused by the vaccine. Anaphylaxis reports remains very rare (in the order of 10 cases per million vaccinated).

Guidance on the management of possible anaphylaxis is included in the product information/label for these vaccines. Routine vaccination procedures include keeping people under observation for at least 15 minutes after vaccination, and having appropriate medical treatment on hand so that anaphylaxis can be rapidly managed. These vaccines should not be given to people with a known history of a severe allergic reaction to any of the vaccine components. A second dose of mRNA vaccine should not be given to those who have experienced anaphylaxis to the first dose.

There have been some other reported adverse events, which include unusual bleeding and blood clotting disorders, facial weakness, seizures, loss of sense of taste or smell and cardiac events. Regulators monitor and carefully review whether there is a causal relationship between the vaccines and those adverse events, and, if appropriate, they will be included in product information/product label of vaccines of concern.

Adenovirus vector vaccines

These include the AstraZeneca, Johnson & Johnson, Gamaleya and CanSino Biologics vaccines. Internationally, the AstraZeneca and Johnson & Johnson COVID-19 vaccines have been associated with a very rare and unusual clotting syndrome involving thromboembolic events (blood clots) with thrombocytopenia (low blood platelet count). This condition has been termed thrombosis with thrombocytopenia syndrome (TTS). Medicines regulators are meeting regularly to share information about cases to better characterise this risk and understand this

syndrome. Less information is available internationally about adverse events following the Gamaleya and CanSino Biologics vaccines.

The overall number of reports received of blood clots in the veins or arteries (including venous thrombosis or venous thromboembolism) occurring without thrombocytopenia is no higher than the expected background population rate for the more common type of blood clots in most countries.

The spontaneous reporting rates of thromboembolic events with thrombocytopenia vary by country and the precise incidences are difficult to estimate, but for the AstraZeneca vaccine, based on substantial use in Europe and the UK, the frequency of such events is very rare. Available estimates are of the order of 10-15 per million people vaccinated (note that for some countries this statistic is based on the numbers of reports of suspected cases of TTS rather than numbers of confirmed cases). Thromboembolic events with thrombocytopenia have also been reported in the USA for the Johnson & Johnson vaccine at a rate of about 2-3 per million doses administered. National regulators are continuing to monitor the issue closely and to publish up-to-date information on the numbers of cases reported and the latest estimates of the incidence.

The cases of thromboembolic events with thrombocytopenia after vaccination were mainly reported for younger rather than older individuals. This, together with the risk of serious illness or death associated with COVID-19 being much higher in middle-aged and older people, has led public health authorities in some countries to recommend that vaccination with the AstraZeneca vaccine not be initiated in younger individuals.

Healthcare professionals should be alert to the signs and symptoms of thromboembolism and thrombocytopenia as well as coagulopathies after vaccination, as TTS requires specific management. Vaccinated individuals should be instructed to seek immediate medical attention if they develop symptoms such as a severe or persistent headache, blurred vision, shortness of breath, chest pain, leg swelling, persistent abdominal pain or unusual skin bruising and/or petechiae (tiny purple, red or brown spots on the skin) mostly occurring within around 4-20 days after vaccination, although some cases have been reported later than 20 days post vaccination. This information is in the Product information/product label of the vaccines as approved by regulators.

Long COVID: Returning to work with brain fog and fatigue poses a challenge for employers

SAMA Communications Department

Struggling to find familiar words, their memories and thinking fuzzy, losing their train of thought mid-conversation, gasping for breath and battling constant, intense tiredness – for COVID-19 “long-haulers”, this is reality for weeks, even months, after contracting and seemingly recovering from the disease.

“Long COVID”, with symptoms of brain fog, fatigue and shortness of breath lasting for 6 months or more, is set to become the biggest health challenge facing business and the healthcare system beyond the immediate crisis of the COVID-19 pandemic.

Prof. Renata Schoeman, head of the Health Care Leadership MBA programme at the University of Stellenbosch Business School (USB), said that the likely long-term impact of long COVID on productivity and employee retention would call on employers to be flexible and adaptable to accommodate employees on the long road to recovery.

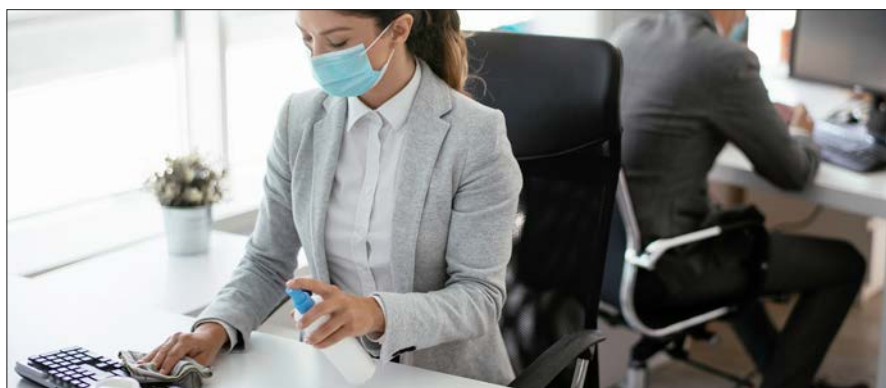
Since the global spread of COVID-19 from early 2020, there is an emerging body of evidence from many countries of a growing number of people who experience prolonged symptoms beyond the initial, acute stage of the disease.

“Individual studies indicate that between 10% and 30% of patients who recover from acute COVID-19 become ‘long-haulers’, still experiencing symptoms 6 months later. In one study, of 3 762 patients who had confirmed or suspected COVID-19, most of whom had symptoms lasting longer than 90 days, 45% needed a reduced work schedule compared with before they became ill, and 22% were not working due to their health conditions.

“This illustrates the scale of the likely impact on employers, employees and the healthcare system that will need to accommodate these patients,” Prof. Schoeman said.

While organisations have so far focused on primary prevention of COVID-19 infection – measures such as masks, sanitising, physical distancing and working from home – Prof. Schoeman said that employers also need to turn their attention to employees returning to work after recovering from COVID-19, and to what is needed to accommodate those suffering with long COVID.

Although definitions and diagnostic criteria have not yet been settled, long COVID is generally seen as symptoms lasting for more



than 28 days after an initial infection or diagnosis of COVID-19.

Long COVID affects multiple bodily systems, with cognitive dysfunction (“brain fog”), fatigue and post-exertional malaise (a relapse or flare-up of symptoms after physical or mental effort) the most common symptoms as well as the most long-lasting, still experienced 6 months after infection.

Brain fog is an umbrella term referring to symptoms such as memory loss, confusion, muddled thinking, poor concentration and generally feeling mentally sluggish, and up to 25% of people infected with COVID-19 experience this and other neurological symptoms.

“Organisations are facing a potential increase in employees needing workplace accommodations for ill health or disability, on long-term sick leave or even medically incapacitated and no longer able to perform their current job.

“Employers need to be reviewing their occupational health services, employee assistance and wellness programmes, policies on sick leave and reasonable accommodation, and post-illness return-to-work plans, and ensure that they are not discriminating on grounds of mental health or disability,” Prof. Schoeman said.

She said that understanding of long COVID was still evolving, and a timeline for when maximum improvement of the condition can be expected remained to be determined.

“The implications are far-reaching, and the likes of healthcare funders and income-protection insurers need to be reviewing their policies and guidelines on treatment and disability. The medical profession and policy-

makers need to arrive at objective diagnostic and assessment criteria, and guidelines for best practice in evidence-based treatment and management of long COVID.”

Prof. Schoeman said that developing objective criteria for a diagnosis of long COVID is important since many of its key aspects, such as brain fog and fatigue, are largely “invisible”, and employers would need to guard against abuse of sick leave, flexible work arrangements and workplace accommodations.

Similarly to acute COVID-19 disease, the symptoms of long COVID are diverse and vary between individuals, and also change and fluctuate over time – making it important for employers to discuss their condition with individual employees and understand what support they need, and to allow for flexibility in workplace accommodations.

She said that where long COVID persisted for more than a month, during which the person might need to take sick leave, by the second month the employer would need to be looking at reasonable accommodation and/or reduced responsibilities.

Beyond 2 months, she said it was likely that assessment and treatment by a multidisciplinary team would be the correct approach, involving the GP along with professionals in areas such as psychiatry, neuropsychology and occupational therapy.

For anyone experiencing symptoms of brain fog, Prof. Schoeman recommends tried-and-tested self-care and good mental hygiene – getting enough sleep, regular exercise (gradually phased in if experiencing fatigue and post-exertion relapse), eating healthily and taking time out from digital devices.

Health professionals work in teams: Their training should prepare them

G rard Charl Filies, senior lecturer: Interprofessional Education Unit, University of the Western Cape, Jos  Frantz, deputy vice-chancellor: research and innovation, University of the Western Cape

Good communication and understanding of the roles of other disciplines in a healthcare team have been found to result in fewer medical errors, reduced medical costs and a better patient care experience.

Take this scenario, for example: Mr X has had a stroke and has been admitted to hospital. He sees a doctor who refers him to a specialist. These appointments are followed by others with an occupational therapist, a physiotherapist and a dietitian. These are separate appointments with each medical professional. This is time consuming, expensive and repetitive for Mr X, as he has to give his medical history to several different people, and possibly do similar tests.

This can be prevented if the medical professionals follow a team (interprofessional) approach, which includes more than one professional, as in the example above, working on one case.

Since interprofessional education is a new approach to learning at university in SA, it is important to see how ready students are to follow it at the start of their higher education. The Faculty of Community and Health Sciences at the University of the Western Cape adopted this approach to education in response to the national health policy, which calls for collaboration in healthcare.

Assessing and understanding whether readiness for interprofessional practice actually improves over the years of students' tertiary training as future health professionals is essential. In most disciplines, students exit as frontline workers. They need to understand their role in the health team as soon as they start work.

We conducted a survey among healthcare students at the University of the Western Cape to determine their readiness for learning in an interprofessional manner.

We assessed areas such as teamwork and collaboration, professional identity, and roles and responsibilities. We needed to ensure that when students leave university, they are ready for the world of work.

What we found

The findings from our research revealed that students valued a team approach to learning

with other students from different fields of study. Students enjoyed sharing experiences and, in general, they showed a positive attitude to interprofessional education in all years of study.

The study showed that readiness for teamwork improved from the first year until their final year. This increased the students' competency when entering the world of work as health professionals.

Our study also found that students who were not part of all aspects of the interprofessional education curriculum were less prepared to work together as a team. They lacked the necessary competencies for teamwork.

Our study shows that it is essential to systematically build students' understanding of their role in an interprofessional team. This is supported by previous studies that indicated that a scaffolding approach is beneficial.

In our study, gender seemed to influence the scores, with female students valuing professional identity, teamwork and collaboration. We also found that senior students were more open to teamwork and collaboration than juniors. Senior female students displayed a more positive professional identity than their male counterparts.

When students are ready to work within a team, they are able to effectively communicate, as they understand their role within the team and the roles of all other team members. Another key skill is the ability to resolve conflict effectively.

Lessons learnt

Engaging students in an interprofessional education approach from their first year of study can have a positive impact. It results in a willingness to continue to learn in this manner.

A range of learning activities is needed to produce positive output over the years of study. Examples of these learning activities are case study discussions, workshops, simulation-based activities and common clinical placements. Team competencies during these learning activities can be assessed through reflective clinical portfolios, reflection and evaluations.

Our study also indicated that if health professional students are exposed to positive role modelling throughout their education, it



can help to develop values for working within teams. We found role modelling from peers to be positive.

Other research studies have shown that students whose undergraduate training included an interprofessional curriculum tended to be more confident than those who did not have the opportunity to participate in an interprofessional curriculum.

Going forward

Designing a curriculum that guides students towards interprofessional practice takes careful consideration. The outcomes of the curriculum need to ensure that students attain all the interprofessional knowledge, skills and attitudes (competencies) they need by the time they exit university.

This type of curriculum, with its specific activities and assessment methods, should be packaged in the form of an interprofessional model, to create a clear understanding of the type of health professional graduate that will be produced.

If universities are successful in producing graduates who are able to work effectively in a team, the healthcare system will be strengthened. This would improve the health outcomes for all patients, their families and communities.

Mr X would not have to explain himself over and over to different health professionals. He would receive adequate care from the different practitioners, who could address his challenges from different perspectives.

Source: The Conversation, 5 July 2021. <https://theconversation.com/health-professionals-work-in-teams-their-training-should-prepare-them-163586>.

SAMA bioethicist a winner in *Mail & Guardian's* Young South Africans 2021

SAMA Communications Department

Congratulations to SAMA's bioethicist, Brandon Ferlito, who has been selected as a winner in the health category of the *Mail & Guardian* (M&G)'s Young South Africans 2021. Over 5 000 young people were nominated, and 200 were selected. "We have found 200 individuals who have shown resilience and innovation for excellence against the backdrop of the unique and extraneous economic challenges faced globally due to the COVID-19 pandemic," says Ron Derby, M&G editor-in-chief.

In partnership with the National Lotteries Commission, the M&G this year celebrates 15 years of showcasing SA's eminent and accomplished young people under the theme "Resilience and innovation for excellence".

"As we celebrate 15 years of positively impacting SA's youth, they have to be change agents. They have to create a new and better normal. In this decade we are living in, while it may look more difficult than others, is actually an opportunity to reshape the country we live in for the better.

"The 200 Young South Africans cohort of 2021 can begin that journey, if we just listen ... There is hope, much more than you can imagine," comments Ron Derby.

Brandon has a distinguished academic record, which preceded his present enrolment in the University of the Witwatersrand (Wits)'s PhD programme in bioethics and health law. "His tumultuous childhood as an openly gay youngster in Westbury – an area in Johannesburg that is better known for gang violence and substance abuse than its championing of LGBTIQ+ rights – attests to his gravity-defying upward mobility. He admits that, at one stage, even his prospects of completing matric seemed dubious," states his nomination. "His day job involves advising [SAMA] on various ethical quandaries on a case-by-case basis, and providing research support to its internal departments and committees. Ferlito is candid about his struggles with depression and anxiety, counterweighted by the strength and self-belief that he derives from his work. His message to healthcare workers is to always conduct themselves in a morally and ethically sound manner."

We chatted to Brandon about his work, achievements and challenges.



Brandon Ferlito

You have faced many challenges to date – please tell us more about you, your work and studies. What drives you, and where do you see yourself in 10 years?

To generally describe myself, I would say I am a hardworking and skilled professional, with a passion for research, writing and bioethics, more specifically applied ethics. I currently work as the bioethics researcher in KMRED at SAMA, where I provide SAMA with ethical expertise on issues that affect medical professionals and the public, as well as provide research support to the human rights, ethics and law committee and internal SAMA departments.

After matriculating, I entered the higher education sector and completed my Bachelor's degree in public health and my Honours and Master's degrees in bioethics and health law in just over 5 years – I was and still am fortunate enough to have been granted scholarships to complete my education. In addition to reading for my PhD at Wits, I am also concurrently enrolled for a postgraduate diploma in public health at the University of Pretoria.

Working full time and studying for two qualifications can be exhausting. Therefore, whenever I am afforded the luxury free time, I spend it lazing around with my two morkies, Sussex and Sheffield.

My drive comes from wanting to constantly grow and improve myself. Being born and raised in Westbury, a township in Johannesburg, came with extreme difficulties. There were not many options besides dropping out of

school, abusing substances or participating in criminal activities. I made myself a promise that I would raise above adversity and that before my 30th birthday, I would have my PhD and be an expert in my field.

In 10 years from now, I see myself as a professor at a university, most likely overseas as I plan to emigrate to the USA or Europe. I also see myself owning a bioethics advisory and consultancy company.

What is your research field for your PhD?

I initially wanted to venture into the relatively unknown area of AI (artificial intelligence) and rights. However, after some much-needed reflection, I will be venturing into the areas of humanitarian health, the duties of healthcare professionals and public health emergencies.

Essentially, I want to ask: during public health emergencies, do SA healthcare professionals have an absolute moral duty to care for patients, and do they a right to refuse to care for patients? However, it is early days, and since I recently changed my topic, I still have much research to conduct.

Do you have any advice for others who are faced with similar challenges?

I recently learned that asking for help, whether for professional or personal challenges, is okay. It can be so easy, as I know all too well myself, to not ask for help in fear of being seen as incapable or weak.

Please tell us about your work at SAMA, its challenges and the service you offer to members?

Beside providing bioethics expertise and research support, I also engage in ethics programme management, stakeholder relations, learning and growth and expert support to both the association and our members. The challenges working at SAMA are self-inflicted. Working with highly qualified and seasoned industry professionals sometimes makes me doubt myself and my skills – imposter syndrome. I find myself thinking every so often, what can a 25-year-old like myself have to offer? But I am learning to change that mind-set and remind myself that I would not be at SAMA if I did not have anything to offer.

SAMA members are more than welcome to contact me if they need any advice on bioethics issues.



What support do state doctors need against clinical negligence?

By Dr Graham Howarth, Medical South Africa Lead for Medical Protection

While the state assists state doctors with clinical negligence claims, there are many other avenues of criticism against doctors. Find out how Medical Protection provides a full range of support.

While clinical negligence claims against state doctors are handled by the province, the medicolegal risks to healthcare professionals do not begin and end here.

The following case, taken from Medical Protection files, outlines how we can provide assistance to state doctors over and above what their state employer is willing to do.

Case study

Unfortunately a patient had died and Dr S – a community service doctor and Medical Protection member – was concerned that her involvement in the care of the patient was open to criticism. As part of Medical Protection's support Dr S was offered confidential counselling support.

Based on the details of the case and the likelihood of the matter progressing, Medical Protection opened a file and panel solicitors investigated the matter. The medicolegal consultant worked with Dr S to compile a detailed report based on her recollection of events and a copy of the salient clinical notes.

As predicted, an inquest and a subsequent HPCSA complaint followed. Medical Protection's solicitors assisted Dr S with both. It was fortunate that she made additional contemporaneous notes and had a copy of the relevant hospital records, as the hospital had misplaced the file.

Despite Dr S's initial reservations, she was not criticised at either the inquest or by the HPCSA. The family remained dissatisfied, however, and initiated a claim

against the hospital – with Dr S as a named defendant. Although the benefits of Medical Protection membership do not extend to covering claims in state hospitals, Medical Protection's lawyers provided vital assistance in drafting Dr S's report.

The state attorney was also slow in initiating a defence for the member. Medical Protection wrote to the state attorney, reminding the state of its obligations, as set out under Paragraph 12 of the Treasury Regulations (April 2001).

Medical Protection can assist public sector doctors in many areas:

HPCSA referrals

Sometimes it is staff at a state hospital who refer one of their doctors to the HPCSA. Clearly the state would not pay for the defence of one of their doctors at the HPCSA – particularly if they referred the doctor in the first place.

Complaints

Doctors can be asked by hospital managers to respond to complaints about clinical care, essentially a response on behalf of the state. Medical Protection is able to assist members here, particularly to ensure blame isn't unfairly shifted from the state to the doctor.

Inquests

Because conflicts of interest may arise between the state and a doctor during an inquest, it's often not in a member's interests to rely on the representation of a state attorney. Conversely it may not be in the member's best interests to be separated out from the rest of the staff involved. Medical Protection can advise members of the best approach in such situations.

Claims

While Medical Protection does not handle clinical negligence claims on behalf of state doctors, we provide vital assistance in other areas over and above what your state employer is able to do. As seen in our case study example, we can intervene to ensure the state swiftly arranges representation for a member, and through writing of specialist reports.

Criminal investigations and allegations arising from clinical practice

Finally, while it is a sad day when a healthcare professional is accused of criminal conduct, it is a medicolegal risk of which all should be mindful. In the event of a patient's death, the South Africa Police Service and National Prosecuting Authority may investigate the patient's death and bring criminal charges of culpable homicide or murder against the healthcare professional.

While thankfully not widespread, charges of this nature will likely progress to a lengthy and public criminal trial. Medical Protection can and does provide assistance to members for criminal charges – sometimes if necessary, all the way to the Constitutional Court, as we recently did where a conviction of culpable homicide was overturned.

Medical Protection is committed to safeguarding the interests of members and, for both public and private doctors, the discretionary nature of Medical Protection membership means that assistance can be requested for a wide range of difficult scenarios.

Changing the way we treat TB in children and adolescents

SAMA Communications Department

Around 1.2 million children worldwide are exposed to drug-resistant TB (DR-TB) in their households each year, according to WHO. About 25 000 to 30 000 children are estimated to become sick with DR-TB – yet less than 2 000 (0.01%) of them are diagnosed and receive treatment.

The historical “public health” approach to TB excluded children because it was felt that they did not contribute substantially to disease transmission. As a result, TB diagnostic, treatment and prevention strategies are geared toward adults, and the impact of the lack of child-focused services is glaringly obvious in the field of paediatric DR-TB.

Globally, few household contacts are offered access to preventive treatments after exposure, even though this reduces the risk of developing DR-TB by 90%. If a child is diagnosed, (s)he is often confined to a hospital for months to receive treatment, disrupting family bonds and normal school and social activities.

The old approach is disruptive, painful and problematic

“Outdated and ineffective methods of screening for DR-TB mean that many people who are sick are simply missed,” says Dr Jennifer Furin, Doctors Without Borders (Médecins Sans Frontières; MSF) DR-TB medical officer with the Khayelitsha Project in SA. “This problem is especially significant among children, since many can’t produce the sputum needed to diagnose DR-TB. Instead, they must undergo gastric washing, an intrusive and painful procedure where a tube is placed down a child’s nose into their stomach to try and suck out any sputum they may have swallowed. This sputum is then tested to confirm if they have TB.”

In many places, children are unable to access the most effective medications, including newer drugs such as bedaquiline and delamanid, because they were not included in studies of these life-saving treatments. Instead, they are given old, often toxic medications, which come as adult-sized



Atul Loke/MSF

tablets that have to be cut, crushed and mixed before being ingested. In the worst instances, children are treated with a daily injection, even though there are more effective oral medicine options. These injections are not only extremely painful, but also put hearing at risk, a devastating complication for a developing child.

Our teams are addressing these family issues in our projects in SA and India. Through our post-exposure protocols, we are actively seeking out people who may have contracted DR-TB, and screening all children and adolescents in a household where someone has been newly diagnosed. We are piloting the use of stool samples, rather than gastric washing, to test whether children have TB in both hospitals and communities. Treatment is free of charge, and we address other socioeconomic needs through transportation support and food parcels, and by working with partner organisations to address other social needs.

In one project in SA, our teams are giving exposed children and adolescents preventive treatments to dramatically decrease their chances of developing DR-TB. By actively looking for the disease, we are finding those who are infected much earlier, allowing us to

treat most of them in a community setting. In SA, all children receive injectable-free treatments.

MSF has also ensured that children in the places where we work have access to new, highly effective TB drugs, including bedaquiline and delamanid, in order to be treated with shorter regimens. We provide them with nutritional support, and have developed family counselling programmes to ensure their mental wellbeing is looked after while they are receiving treatment.

By actively looking for the disease, we are finding those who are infected much earlier

While MSF’s work has benefitted hundreds of children and families, there are tens of thousands still in need. Stakeholder commitment and greater resources are essential to rapidly increase the scope of these child-friendly initiatives.

A culture to capture: Reflections from a rural surgeon

Dr Hugo Stark, general surgeon, George Hospital



2021: It is the information age. Life has never been so captured, measured, calculated, extrapolated, evaluated, predicted. It has become more important than ever to be able to search for anything, find everything and to know something. We are wearing things that tell the time, report on the weather, read our emails, remind us to stand up and sit down, update our ECG, Facebook and WhatsApp status. We Tweet, Skype, Zoom, Teams, we swipe, stream, blog and meet, in the cloud, off our feet, in the comfort of a seat. We have an insatiable desire for data. To keep the phone charged is as important as the next breath ... the depleted battery the start of technological palliative care ... "Does anybody have a charger!?" The pin to unlock modern living lies in the grooves of a fingerprint, the strands of an iris, the biometrics of a face, the frequency distribution curve of a voice. We have replaced "I wonder" with "Did you know?" The secrets to life's everyday data have been unhidden. Despite the supposed binary anonymity, we are connected to everyone and everything, even if we are desperately alone.

Many recent innovations have resulted because of the limitless capacity to generate data, yet healthcare services, especially in low- and middle-income countries, have failed to compete in this data race. Everybody acknowledges the problem, and yet every solution surrounding improved healthcare efficiencies offered starts with statements that echo the importance of data – data that is not readily available, lost within illegible notes made in a hurry, by a desperate healthcare worker trying to get to the next patient. No

time to reflect, because literally, there is no time. And there is no money to buy a system to do this for them, because that is just it, there is no money. So they follow the true health north as pointed out by others.

This realisation, in 2011, at George Hospital, triggered the start of a process to combat this local data drought. It was a process that developed over many years, through trial and error, to encourage staff within our theatre complex to own the data that we create. Ownership of the data was going to be the foundation from which we would reflect, address our inefficiencies, and become better at what we do. There was no template to use, no previous experience to fall back on, just piles and piles of paperwork that stood and saluted the old way, and for many the only way.

A step needed to be taken, but where to, and with what? I was trained to be a surgeon! PowerPoint was a strong opinion, Access was a way in, Word was a noun, and Excel was a verb. Solutions were crafted at the sharp edge of shiny steel! We capture sickness in specimen bottles! The focus of a surgeon's professional agenda is centred on patients and pathology, not pixels. And yet the technology of web-based database everything was shaping new possibilities for everyone. The solution was waiting in the cloud – I just needed to figure out how all of this worked, and then we were going to be off! But bureaucracy and policy have often stranded enthusiasm.

They can take your plane and your crew, roll up the runway and hand you a skateboard. No badge, no engine, no inflight drinks, no joy. And so, the only cloud I was going to see was the fog around our hospital.

But without warning, the fog was lifting. Maybe it was because of the heat generated in dealing with the frustrations of discussing change and how to effect it, the friction of confronting inertia, of negotiating buy-in, or the regular refuelling of the engine of anger towards the power of the status quo. But the fog was lifting, and it was slowly starting to expose a green creature, a hulking technological fugitive. One that was forced into hiding because of its intimidating skin. Skin that reflected cells and formulas of agony, rows and columns of misery, and sheets and sheets of despair. It just needed to be pushed out from the shadows of its ever-more-popular blue sibling. The poster boy of the office. The most decorated go-to application for everything document.

It is difficult to explain how the success of our digital system for the most part up to now has relied on the paper documents it produces. I do not think it could have been more ironic. But the reality of everyday theatre life is that as the patient leaves the theatre, there are expected documents accompanying them back to the ward. I was not going to change that, but maybe the status quo was begging for a facelift. For something more elegant. Something more

legible, more efficient, cleverer, maybe even digitally charming. The bait was placed, and it was green. Convince them to capture all data variables relevant to every theatre case and produce every possible document required by all users with the click of a button. Documents first. Capture once will be our method, and our mantra. We were going to establish a new culture: a culture to capture. And behind the scenes all these variables will be submitted to stakeholder-specific databases that were going to become the sandpit for all things research and academic. Data second. It was going to be beautiful. Word got out; we were going to be Excel-lent. The green creature was waiting for me.

10 years later, the documents still come first, and the data comes second

I started from scratch, but persistence is the fuel of new learning. She too was patient. Selflessly allowing me to selfishly dig into that mysterious evergreen matrix that made her Excel. Selecting her every cell, dissecting out her formulas, cutting into her rows and pasting into her columns, printing her potential.

She was bold. She was preparing a feast at her tables. It was even more graphic than I anticipated. She demanded accuracy, but her rewards were mesmerising. Imagination. Innovation. Exhilaration.

There is something unique about being both a user and a developer of a system. Anticipating and intercepting issues or irritations and dealing with them before other users ran into them. I consider it a bit of an unfair advantage over traditional developers being sourced for projects where meetings on meetings are often held to understand context and expectation. I understood both first-hand. It was the developing that

required a different type of understanding. In hindsight, I see the patience of a bird watcher, the caffeine intake of an addict, the attention to detail of an obsessive-compulsive disorderly and the curse of an insomniac, all waving from the foundations of the system. I salute them.

And 10 years later, the documents still come first, and the data comes second. Typed documents flow from our theatres in a thick stream. Signed, sealed and delivered for the wards. The sandpit, however, still only reflects small footprints on the surface. The plans have been submitted, but no castles have been built yet. Was it worth it? Hell yes!

SAMA fights – and wins – on behalf of its members

SAMA Communications Department

SAMA prides itself on providing professional services to its members. These services include labour advice and assistance. Through its Employee Relations Department, SAMA diligently advises, assists and represents members on issues relating to their employer-employee relationships.

The association was recently involved in a legal action where it represented five of its members at the labour court in a matter against the Department of Health. This matter related to the non-payment of the rural allowance to a group of five doctors. SAMA initiated the legal action to ensure that hundreds of thousands of rands owed to these members were paid.

SAMA remains committed to fighting labour and legal battles on behalf of its members

SAMA's involvement in the matter saw the labour court ruling in favour of the five doctors, and it also ordered the Department of Health to pay legal costs.

In another matter, the labour court in Gqeberha ordered re-instatement, and retrospective payment, for a member also represented by SAMA.

In a third matter, the labour appeals court ordered in favour of SAMA acting on behalf of a member who had been dismissed 8 years ago. The court ordered that the member be re-instated, and that he be paid for all the years that he was unemployed.

These three examples demonstrate that SAMA remains committed to fighting labour and legal battles on behalf of its members. Members are invited to contact SAMA on labour@samedical.org should they require assistance.

Blunting the impact of poor social conditions in SA will have big health benefits

Ebrahim Samodien, *post-doctoral researcher, South African Medical Research Council*

Poverty and socioeconomic disparity are among the greatest obstacles facing South Africans. About 63% of children younger than 6 years old live in poverty. The country is also experiencing increasing levels of unemployment. In addition, there is a high prevalence of femicide and inter-partner violence, which is often associated with excessive alcohol consumption and substance abuse.

Harsh socioenvironmental factors, especially when they happen in the early years of a child's life, can establish a developmental "biology of misfortune". This involves neurobiological and epigenetic processes that go on to steer a person's life towards poor health, unrealised potential and a shorter life.

Neurobiology here refers to normal brain development. This is, at times, controlled by epigenetic mechanisms. These are biological reactions involving certain proteins that interact with DNA, physically altering its structure. Epigenetics can be influenced by our physical environment and surroundings. Adverse environments can profoundly alter gene expression and have detrimental health effects, including disturbed brain development.

There are clear disadvantages to ignoring the physical environment in relation to adverse epigenetic programming. Firstly, it can result in a future population with deteriorated physical and mental health – these individuals would also be more susceptible to infectious diseases. Secondly, it can affect the future health and economic development of the country.

That's why child and adolescent health is an urgent priority and should be placed at the centre of the healthcare system.

In our recent article, my colleagues and I described how adverse socioenvironmental factors in early life can program the outcome of obesity, diabetes, cardiovascular disease and mental health disorders in adulthood. These noncommunicable diseases are on the rise, and are taking a heavy toll on people's lives, and the country's healthcare system.

We set out the social and environmental conditions experienced by young South Africans, and discuss the potential contribution of epigenetics to the current and future prevalence of noncommunicable diseases.



We also unpack some early interventions that can help improve child and adolescent health. The cornerstones are: providing optimum nutrition, providing a secure environment, physical activity and education.

Social conditions

SA is one of most unequal societies in the world. Children who are exposed to such levels of poverty can suffer both immediate and long-term effects. Children from poor families have higher rates of chronic illness, and experience worse health in adulthood.

More than half (55%) of the population experiences poverty, with childhood poverty affecting 63% of children.

With diet being intertwined with emotions, cognition and behaviour, close attention should be paid to nutrition.

Research has shown that certain diets are hugely beneficial to peoples' health. One example is a diet that is high in polyphenols. These are plant compounds found in tea, chocolate, herbs and spices, fruit, vegetables and nuts. Several have been shown to be able to reduce illnesses by preventing oxidative stress and inflammation in the brain.

On top of this, SA sits on a botanical "goldmine" of indigenous medicinal plants. Many have anti-obesity, anti-cancer, anti-diabetic as well as anti-ageing properties, among others.

Finally, while the benefits of breastfeeding for both mother and child have long been known, SA, like most countries, is still not doing enough to support mothers to breastfeed, despite the immense economic implications.

Champions

The failure to optimise nutrition, especially during the critical periods of development for vulnerable young children, should be avoided at all costs. There is a definite requirement for efforts directed at improving the national diet.

But healthier foods are far more expensive than less healthy, nutritionally poor foods. Products such as lean meat, fish, fruit and vegetables generally cost more than oil-heavy processed foods that contain more sugar and fat.

This makes the promotion of a quality diet difficult, because it is simply unaffordable for many South Africans.

International research has shown that the best strategies for changing the dietary environment in favour of healthier foods are those aimed at population level, and are accomplished by mass media nutrition campaigns and transparent food labelling. Some countries have taken more drastic action through regulation and taxation of unhealthy foods.

SA needs champions for child and adolescent health. The plight of young children needs to be prioritised and placed at the centre of the country's goals.

An early investment in children's health, education, development, security and wellbeing would provide benefits that compound during a person's lifetime. It would improve their prospects – and those of their children, and thus society as a whole.

Source: The Conversation, 22 June 2021: <https://theconversation.com/blunting-the-impact-of-poor-social-conditions-in-south-africa-will-have-big-health-benefits-161830>.

Obituary: Beorn Cloete Uys, 21 August 1929 - 18 May 2021

Dr Andre du Plessis, *past president, Border Coastal branch*

Beorn was born in Amersfoort in the old Transvaal in 1929, at the start of the Great Depression. His father, Adriaan Uys, was a paediatrician who trained in Holland. His mother, Edna, was an educator who enrolled at Stellenbosch University at the age of 14 and attained her MEd. Beorn knew by the age of 5 that he would follow in his father's footsteps.

Hopefully this obituary will encourage young doctors to emulate this amazing man

He matriculated with distinction in 1946 at Parktown Boys' High, and then headed off to Wits Medical School with his good friend Rae Glyn Thomas. During the holidays, Beorn spent time learning nursing skills at Addington Hospital. This was an experience that shaped him to value nursing and nurses. Beorn completed his MB ChB in 1952, and was awarded the Abelheim Prize and medal for obstetrics, and the Horace Wells Medal in anaesthetics. He completed postgraduate training at Johannesburg General, Baragwanath, Queen Victoria and Edenvale hospitals.

In 1955, Beorn left for England with his new bride Midge, a midwife. He spent 3 years at St Mary's in Manchester, and in the Canterbury and Isle of Thanet Group in Kent. Beorn gained his MRCOG in 1958, and completed his training at King Edward VIII Hospital in Durban under the tutelage of Derk Crichton.

Beorn entered Johannesburg private practice in 1961 with Dela de la Hunt, and was joined later by Louis Coetzee. In 1968, while working at Marymount Maternity Home, Beorn was approached to build a new maternity home. This subsequently gave birth to a new concept of integrated medicine at an upmarket clinic. This eventually led to the construction of the Sandton Clinic in 1975.

Those were the heady days of the early 70s, and following 7 years of hard work, Beorn realised his dream with the help of his brother Deryck. However, this project took its toll on Beorn and later, the clinic was acquired by the Rembrandt group under Dr Edwin Hertzog. Sandton Clinic became the foundation stone of the Mediclinic Private Hospital Group.

The legacy of Sandton Clinic (as explained by Beorn) was that it was "the first fully integrated purpose-designed hospital in SA to have all theatres with laminar flow. It was the first to be licensed to carry out legal terminations of pregnancy. It was also the first carpeted hospital, the first to incorporate a Montessori school and one of the first early units dedicated to reproductive surgery. It was also the first hospital acquired by Mediclinic."

After 25 years of practising in Johannesburg, Beorn semi-retired to East London in the Eastern Cape, heading up the maternity unit at Frere Hospital. Beorn was appointed honorary senior lecturer, and mentored many young doctors for 11 fruitful years. Beorn was always ready for change, and he embraced the then-new technology of ultrasound, taking on the role of chief ultrasonographer in the unit.

His humble attitude, ability to listen, exceptional skills and boundless enthusiasm made him very popular, and he took a personal interest in everyone. Under him, the obstetric unit at Frere Hospital thrived.

Dr Uys joined SAMA in 1959. He was a branch councillor in Border Coastal branch (BCB) for 14 years, and branch president in 1993. He received the branch award for meritorious service in 1997, and he was the editor of the branch newsletter for many years, for which he received the president's floating trophy. He played an intricate part in the life of the branch. Dr Uys was very popular and respected by colleagues. He acted as MC at a number of BCB annual dinners. Beorn also assisted in the development of the UCT-affiliated resource centre attached to Frere Hospital.

Among Beorn's other achievements was the writing of two books: the *History of Obstetrics and Gynaecology in South Africa* and the *History of the South African Society of Obstetricians and Gynaecologists*. Writing was a passion, and he even tried his hand at



Dr Beorn Uys



Dr Uys graduated from Wits Medical School

sonnets. He was a humble man of science and history, a teacher, a philosopher and a dedicated husband and father.

Beorn enjoyed his twilight years in the Eastern Cape after finally retiring at the age of 85. He is survived by his loving wife Midge and his four children, Amanda, Chris, Gus and Sue, and his five grandchildren.

Hopefully this obituary will encourage young doctors to emulate this amazing man, and bring back memories for those of us privileged enough to have been touched by his professionalism and enduring optimism.

SA doctors look to medical consultation technology solutions

In an economy largely enabled by technological advancements, and at a time when this is more important than ever before, virtual healthcare consultations are the logical “next step” for doctors, any other healthcare providers and their patients. Faced with the challenges of personal safety, many are now seeking solutions for contactless consulting.

Dr Samuel Abura, a GP in Port Elizabeth/Gqeberha, points out that the need for remote healthcare consultation existed for some time before the advent of COVID-19 and has, until now, most commonly been met with telephone calls and text messages. “While these remain useful tools, there is a significant demand for platforms with dynamic functionalities that are also efficiently streamlined.”

Addressing important consultation requirements

Dr Abura was the first doctor in SA to sign up for uConsult, a new multi-sided virtual consultation platform making private home-based care singularly accessible in SA to anyone, regardless of whether they have medical scheme membership.

Virtual appointments enable safe and confidential consults during COVID-19 and beyond

According to Dr Johan Pretorius, chief executive officer of Universal Healthcare – the creators of uConsult – this fully integrated system allows users to connect from their web browsers, so there is no need to download an app or software, an important factor for flexibility among the healthcare community.

Unlike other virtual consultation platforms, uConsult connects healthcare providers and patients using safe, scalable microservices technology, making it accessible any time from any smart device with internet connectivity. It also allows for full POPIA (Protection of Personal Information Act) compliance, now an essential component to the legal framework of patient management in SA, even in times of a healthcare crisis such as COVID-19.

The platform enables providers to video chat and screen share with their patients, and to issue encrypted prescriptions and medical certificates, pathology forms, radiology forms and specialist referral letters electronically. In many cases, the patient is therefore able to experience the full journey from consultation to having their medication delivered without ever leaving the comfort and safety of their home or office.

Better access for chronic patients

Dr Abura notes that many chronic illness patients monitor their conditions closely at home, and being able to connect virtually adds a further layer of communication and control to this. “Some of my patients with hypertension, for example, have blood pressure readers at home and can relay the relevant data to me remotely. If their blood pressure is higher than it should be, we can look at the display on the reader over the virtual platform in real time and adjust their medication with a new script without them needing to come in and see me.

“The same applies for those patients who monitor their blood sugar levels at home. Naturally this can be a real lifesaver for patients who might otherwise avoid a check-up, and it has benefits that extend well beyond the additional safety provided during this time of COVID-19, such as the ability to consult with a doctor anywhere, regardless of physical location.”

Broadening connectivity

Patients can search for GPs on uConsult by name or geolocation, and virtual consultations can take place no matter where the patient is based, locally or internationally. Providers from other medical disciplines will soon be joining the platform as well. Patient and healthcare provider are also able to connect with other practitioners without having to switch between systems – a revolutionary development.

Streamlining administrative tasks

From a doctor’s point of view, Dr Abura says that uConsult has the benefit of providing a central working environment where patient information can be stored safely in one space. “You can log in, retrieve your patient file, review your notes, conduct a consultation, send scripts or lab forms and it’s relatively easy. It reduces the amount of work I would



Dr Samuel Abura

have to do co-ordinating all that information if I were trying to conduct consultations telephonically, or back and forth via text message.

“I have tried two other consultation platforms recently, and this one was far more user-friendly in that the registration was very quick and the communication with patients is simple and straightforward, where other platforms can be quite complicated to navigate.

“My personal preference is to use my smartphone, and I registered on that device. The registration took approximately 15 minutes and I did everything from my cell, including taking the photo of my signature to upload to the system. I received all the one-time passwords straight to my phone, so it was really easy to view and input them. The registration confirmation email came through not long after, and I’m now set up and enjoying using the platform,” says Dr Abura.

Technology of the future, now

uConsult was designed and developed at the Universal office in Silicon Valley, California, and was built from the ground up by Universal’s international team using the latest technology.

“COVID-19 has changed the face of healthcare and indeed how we communicate. It is the beginning of a new era for the management of health, and this must come down to innovating and creating solutions that ultimately hinge on so much more than convenience – it is about making inroads into inclusivity, sustainability and connectivity for healthcare providers and consumers alike, within and beyond our borders,” concludes Dr Pretorius.

For more information, please visit www.u-consult.co.za.

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SAMAREC networking meeting provides valuable insight

Adri van der Walt, SAMAREC officer, SAMA

When submitting an application to an ethics committee, one usually works through the administrator of the committee.

Feedback from the committee is almost always in the form of a formal written response.

In an effort to build relationships and also help clients to become more familiar with the ethics committee members, the SAMA Research Ethics Committee (SAMAREC) had a networking event to give current and prospective clients the opportunity to learn directly from the committee, via formal presentations. This event also gives attendees the opportunity to discuss concerns and queries face to face with committee members.

This year marked the third biannual networking meeting. While the meetings were held in person in the past, the current social distancing regulations led the committee to rethink the past strategy, and the meeting was held on an online platform.

This proved to be very successful, as various stakeholders, in the form of pharmaceutical company representatives, study staff and those generally interested in research ethics, had the opportunity to attend the event from the comfort of their own homes.

The meeting was held via the Zoom platform on 6 July 2021.

Along with a record number of more than 60 attendees, the chairperson of SAMA, Dr Angelique Coetzee, was also present. She has been a keen supporter and very actively involved in SAMAREC, and indicated her support for doctor-initiated studies – one of the main topics discussed.

With ample opportunities for direct queries and on-the-spot clarification, the event offered two formal presentations, offered by two of the committees' most experienced members.

Through the eyes of SAMAREC

As the lay member of the committee since 2006, Brenda Fineberg has reviewed countless studies. Brenda is a teacher by trade, and a head of department at a private school in Pretoria where she manages the life sciences, physical sciences and information technology departments.



Brenda Fineberg gave an insightful presentation on what an ethics committee looks at when reviewing research

Brenda gave a very insightful presentation on the major matters that an ethics committee looks at. A major cornerstone of ethics review is the Declaration of Helsinki (2013), which in essence states that in medical research involving human subjects capable of giving informed consent, each subject must be adequately informed of the study aims, methods, source of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail, post-study provisions and any other relevant aspects.

Considering the above, the following are key questions to address when submitting an application for ethics review:

- What is the research question? Clearly state what exactly it is that you want to know.
- Why do the research? Here, the hypothesis and the motivation to do the research come in. Providing a literature review at this stage is appropriate as this will give your research context.
- When are you planning to do your research? Specify the time frame for preparation, data collection, data preparation for publication, etc. Consider external factors, e.g. seasonal



Prof. Jacques Snyman discussed doctor-initiated research in SA

changes and the current COVID-19 social distancing protocols. Appropriate study insurance to cover the period must also be in place.

- Who will be involved in the research? Naturally there will be a study population (a set of participants or a patient group), but it is vital to remember that the study staff and sponsor (if applicable) are also vital in terms of who will be actively involved in the study. Study staff involved must be adequately trained in the specific field of research. Factors relating to participants/patients must also include their age group, as, for example, an assent document will be needed if participants are younger than 18 years.
- How? Clearly describe the methodology to be used. If the testing of a medicine or device is included, approval to do so is needed (in addition to ethics approval) from the SA Health Products Regulatory Authority (SAHPRA). If a full clinical trial is being done, the trial must be registered on the SA National Clinical Trials Registry (SANCTR). Regardless of the methodology to be used, it is essential to include what will be measured/observed, by whom and how often.

Although these are guidelines for the general assessment of submissions, SAMAREC does ensure that individual attention and feedback, in context to the submission, are provided.

Doctor-initiated research: SA context

SAMAREC has seen an increase in doctor-initiated research over the last few years. Our chairperson and also principle investigator on various doctor-initiated studies, Prof. Jacques Snyman, discussed this important emerging topic, considering the SA context.

The main advantage of doctor-initiated research is to record what is truly happening to real patients, where patient behaviour as well as environment (e.g. family support

structure) will impact the effect. This is called real-world evidence (RWE).

Is there a place for RWE studies in SA? The clear answer is yes!

RWE studies have no in- or exclusion criteria. A patient of any age takes the medication (as prescribed), and adverse events and tolerance issues are observed. Comorbidities that were excluded during phase 3 studies are now exposed, and genetic background changes such as ethnicity and environmental factors are now also part of the patient experience. Co-committing medicines and food types are taken with the medicine, and can be assessed for their effect on the medication.

RWE can be collected in the form of as a simple systematic recording as part of a normal day, or in retrospective chart

reviews, historic overviews, case series or registries.

RWE does not replace or in any way diminish the importance of randomised control trials (RCTs). RCTs demonstrate what can be achieved, while RWE describes what is being achieved in a real-life setting. By conducting RWE studies, we are not only adding information to an existing body of knowledge, but adding to the holistic care and consideration of each individual patient.

Conclusion

Although the networking event is scheduled to take place every 2 years, any existing and potential researchers are welcome to contact the SAMAREC officer on 012 481 2046 or samarec@samedical.org.

Breastfeeding and labour laws

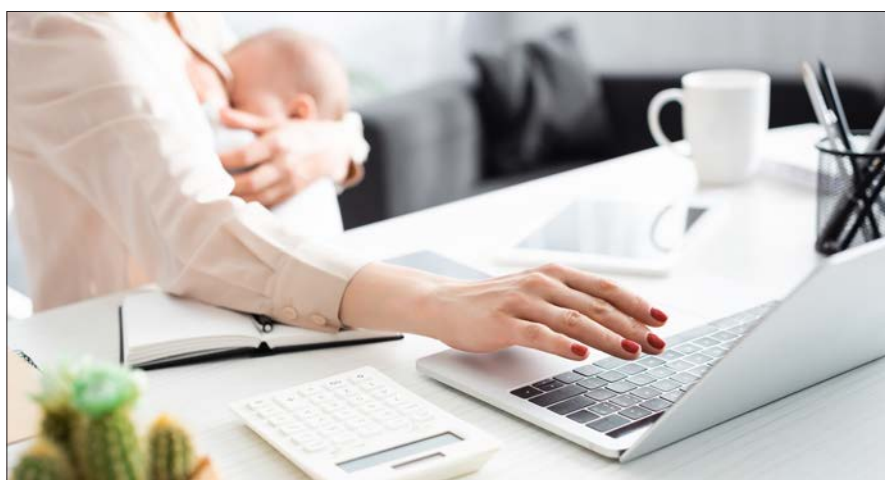
Phumzile Gwala, *employee relations advisor, SAMA Employee Relations Department*

Are you among those workers who wonder whether there is any law that grants breastfeeding moms much-needed permission to breastfeed their children at work? Well, this article is for you.

In SA, in terms of the "Code of good practice on the protection of employees during pregnancy and after the birth of a child" (one of the codes of the Basic Conditions of Employment Act No. 75 of 1997; BCEA), arrangements should be made for employees who are breastfeeding to have breastfeeding breaks of 30 minutes twice per day, each working day for the first 6 months of their child's life.

What is a breastfeeding break? A breastfeeding break is a period that a breastfeeding mother takes during her work day either for breastfeeding her child or expressing her milk. These breastfeeding breaks are paid time, and the legal length of time that a mother can take breastfeeding breaks is from birth until the child is 6 months old.

Are the 30 minutes a day sufficient? Although every woman and child are different, on average it should take about 15 - 20 minutes for a mother to express her milk. Then she needs to wash her hands and prepare the milk storage, which brings the time to 30 minutes. If the mother has her



child onsite, 30 minutes should be ample time for a feed.

A mother might instead prefer to take the break in one session, to shorten work hours. In such an instance a woman may merge her breastfeeding breaks, and take the time at the beginning or end of her normal work day. This might be because she lives far away from her job, or there are no proper facilities for childcare near her workplace. This allows her to work a shorter day and have an extra hour at home with the baby. She may still opt to express milk during her usual lunch break.

What kind of space or facilities are needed for breastfeeding breaks in the workplace? The International Labour Organization (ILO) Maternity Protection Recommendation No. 191 of 2000 says that "where practicable, provision should be made for the establishment of facilities for nursing under adequate hygienic conditions at or near the workplace".

Basically, a clean space with room to sit down, privacy, access to clean water and a secure storage place for expressed milk is needed. Cleanliness, accessibility and security are key features. Important note: a toilet is not suitable for this purpose!

What legislation and laws are there to protect pregnant and breastfeeding women? As mentioned earlier, there is the code of good practice on the protection of employees during pregnancy and after the birth of a child. This code is issued in terms of section 87(1)(b) of the BCEA.

The code is intended to guide all employers and employees concerning the application of section 26(1) of the BCEA, which prohibits employers from requiring or permitting pregnant or breastfeeding employees to perform work that is hazardous to the health of the employee or that of her child.

The code also contains a section on the right to breastfeeding breaks.

What are some of the hazards that can affect pregnant and breastfeeding women in the workplace?

- physical hazards (including exposure to noise, and work in extreme environments)
- ergonomic hazards (including heavy physical work, repetitive work and standing for long periods)
- chemical hazards (contact with harmful chemical substances may cause infertility and fetal abnormalities; some chemicals can be passed to a baby during breastfeeding and could possibly damage the health and development of the child)
- biological hazards (bacteria and viruses can affect the unborn child if the mother is infected during pregnancy; they may also be transferred through breastfeeding).

How can pregnant or breastfeeding women be protected from hazardous work? Section 26(1) states that employers must assess and control risks to the health of pregnant or breastfeeding employees, and that of the fetus or child.

Employers should identify, record and regularly review potential risks to pregnant or breastfeeding employees within the workplace, and protective measures for pregnant or breastfeeding employees.

Where appropriate, employers should also maintain a list of employment positions not involving risk, to which pregnant or breastfeeding employees can be transferred.

Women should also notify their employer as soon as possible when they become pregnant, so that appropriate health and safety measures can be taken.

What are some of the obstacles facing breastfeeding women in the workplace? Some women do not know that it is their right to take breastfeeding breaks, and some employers do not know that breastfeeding breaks are legal. Some trade unions employee representative bodies do not see the breastfeeding break as an important issue to support, and some workplaces do not provide a clean, private, appropriate space for women to breastfeed or express milk.

Some women do not believe that they can feed their child on breast milk alone for 6 months. They may worry that they need to add formula or bought milk to the baby's diet.

How can we protect the right of women to breastfeed, particularly in their workplace? Firstly, we need to ensure that this right is known about. We need to defend the right, as this will ensure that more women are able to breastfeed their babies for at least 6 months.

We should draw to supervisors' attention the fact that the SA Department of Health is in support of breastfeeding, and has made a booklet available entitled "Supporting breastfeeding in the workplace", which is a guide for employers and employees.

Should you feel that your employer is denying you this right, please do not hesitate to seek help by contacting the SAMA

Employee Relations Department on labour@samedical.org.

Case law

In the case of *De Beer v SA Export Connection cc t/a Global Paws* (2008, 1 BLLR 36), the employee gave birth to twins, and took 1 month's maternity leave by agreement. As the babies were both ill by the time the 1-month period was up, the mother applied for another month off. The employer granted her only 2 more weeks' leave and, when she did not return to work thereafter, she was dismissed. The employee referred the matter to the labour court, claiming that the dismissal was automatically unfair because she had been fired for reasons related to her pregnancy. Section 187 of the Labour Relations Act No. 66 of 1995 (LRA) classifies a dismissal as automatically unfair if the reason for the dismissal is related to the pregnancy of the dismissed employee. The employer argued that the illness of the children did not relate to the pregnancy. It argued that the phrase "reasons relating to pregnancy" refers to the mother herself, and not to the newborn children.

The labour court decided that:

- the phrase in the LRA "reasons relating to pregnancy" refers not only to the mother herself but also to the newborn children and the mother's right to nurture them;
- the agreement entered into by the parties limiting the maternity leave to 1 month was null and void;
- the employee was legally entitled to take the remainder of her maternity leave to look after her babies;
- the dismissal was automatically unfair; and
- the employer was to pay the employee 20 months' remuneration in compensation, plus the legal costs of the employee.

Mandela Day: SAMA cares for the carers

SAMA thanks all doctors for their bravery, courage and commitment during the COVID-19 pandemic and the current crisis our country is facing.

"Healthcare workers across SA have worked against enormous odds to ensure continued quality care to patients. Many healthcare workers have also put their own lives and those of their families at risk, and many have worked long hours to ensure care for patients. We think of those fallen heroes who have lost their lives through their selfless sacrifice to others who needed their services. We want to pay tribute to them, especially. To acknowledge this, we commissioned a song to pay tribute to all healthcare workers," says Dr Angelique Coetzee, chairperson of SAMA. The song, written, composed and produced by award-winning artist Lloyd Cele, is called "Thank you (Caring for the Carers)", and applauds healthcare workers for working tirelessly during the pandemic, as well as the recent riots, to fulfil their obligations to patients.

"Many healthcare workers are currently experiencing severe physical and mental exhaustion from working extremely long hours in difficult conditions. We believe that during the last year, each and every healthcare worker in the country has genuinely exemplified Mandela Day by diligently doing their jobs. We want to give credit for this through this song," says Dr Coetzee.

See <https://www.youtube.com/watch?v=JO6u1goCw2o>.



Understanding the POPI Act

Tony Behrman, *medicolegal consultant, Medical Protection Society*

The Protection of Personal Information Act No. 4 of 2013 (POPIA) came into operation on 1 July 2020, and into full force and effect on 1 July 2021. By the time you read this article, all healthcare organisations will be required to comply with POPIA.

An essential part of a healthcare professional's role is, with patient consent, to gather personal information about patients, and process and store this in accordance with the regulations of the Act and the HPCSA directives.

POPIA affects all healthcare service providers in both private and public sectors who process personal information such as names, addresses, email addresses, health information and employment history.

It does not replace the HPCSA's existing guidance on safeguarding confidential patient data as laid out in booklet 5, "Confidentiality: Protecting and providing information". Guideline 7 of the booklet sets out that a healthcare practitioner may share information with other practitioners within the healthcare team without the consent of the patient. It is important to make patients aware of this possibility, and of the fact that express consent is not needed to disclose the information to other healthcare practitioners.

For example, this applies if a patient has consented to a GP examining, diagnosing and treating a condition, if the GP then refers the patient to a specialist.

Collecting personal information

Under POPIA, personal information may only be collected for the specific purpose of providing various services to a patient. If another healthcare professional provides you with a patient's personal information, it is only in the patient's legitimate interests for you to hold this information if you are also providing your services to the patient.

Once such personal information has been collected from another source, you must take reasonable steps to inform the patient of this – either orally or in writing – together with the source of the information, and the purpose for which it has been collected.

Preserving personal information

Your practice must implement reasonable measures to ensure that any personal

information you hold is protected from loss, damage, unauthorised destruction and unlawful access.

The concept of reasonableness is relevant here, and the resources of your practice or organisation will be considered, as well as the nature of the information, when determining reasonable measures.

Two key areas where changes will need to be made are agreements with your employees and consent from new and old patients.

Employee agreements

Written agreements must be concluded with your employees ensuring that they understand the importance of keeping personal information strictly confidential. Teaching sessions must explain staff responsibilities and, while sessions do not need to be professionally facilitated, dates and staff attendance must be recorded and kept on file.

Employees should have individual passwords to access patient information, which are updated from time to time – generic passwords in a practice are not acceptable.

Patients and informed consent

New and old patients must be asked to sign a voluntary specific and informed consent granting you permission to process their personal information.

Operators and third-party access

Under the terms of POPIA, the arrangement around third-party access to patient personal information broadly matches the guidelines as set out in the HPCSA guidelines, which require patient consent in most instances.

All third-party agreements need to be in writing, with an undertaking to advise of any information and data breaches that have been experienced. Patients are to be made aware of third parties – for example, if data are stored off site.

Examples of third-party operators who you may need to reach agreements with include practice management software companies, billing bureaus and practice accountants.

These data operators process your patient's personal information, and contracts with them will help to protect you should they experience a data breach outside of your control.

Information leaks and data breaches

Apart from protecting your data against breaches and information leaks, you must know what is expected of you if or when – despite best intentions – you experience a data breach.

Any suspicion on reasonable grounds that personal information has been accessed or acquired by an unauthorised person must be reported to both the patient and the information regulator.

Notification must be in writing, and must provide sufficient information to allow the patient to understand:

- the possible consequences of the unauthorised disclosure for the person
- a description of the measures you intend to take to protect their interests
- the identity of the individual who made the unauthorised access, if this is known.

Your policy for responding to a data breach

It is important that your practice has a policy for responding to data breaches, which must be set out in writing, as well as being easily understood and accessible by staff.

Your data breach response policy should explain:

- the urgency of the response required to a data breach
- how to determine what security was breached, and what data was compromised
- the people to whom a breach must be reported internally, i.e. the information officer
- whose responsibility it is to report to the regulator
- whose responsibility it is to notify patients, and how patients will be notified
- who is responsible for taking immediate steps to secure the data from further compromise
- how a breach will be assessed
- what future preventative measures will be implemented.

Aligning your old PAIA manual with your POPIA folder

Various new templates for the Promotion of Access to Information Act No. 2 of 2000 (PAIA) may still be forthcoming, but until these are received it is a good idea to use the previous

headings from the old PAIA to identify aspects of documentation that your practice should have available and that can be incorporated into your new POPIA folder, which should reside at your practice and be shown to an inspector in the event of a compliance audit. You do not need to submit the POPIA folder to the regulator.

Your POPIA folder, once compiled, must list:

- the name of your information officer (IO) (note: the need to register your IO with the regulator has been suspended temporarily, and a notice will be published as to when you have to comply with such registration)
- the name and details of your information regulator
- the purpose for which personal information is processed
- the type of personal information that will be processed (use the categories of the PAIA manual to assist you with examples of headings)
- to whom the personal information will be provided for processing (i.e. the names of the operators)
- the security measures in your practice
- whether personal information will be transferred out of SA, indicating where it

will be sent and what security measures are in place.

Not complying with the provisions of the POPI Act can potentially lead to:

- a complaint lodged with the information regulator
- a civil claim for payment of damages
- criminal prosecution with a fine of up to ZAR10 million or a prison sentence, or even both but these are probably only relevant in serial offenders or gross violations of the Act.

Final message

Now that POPIA is in full force and effect, healthcare professionals should be especially mindful that patient information may only be used for the purpose for which it was originally collected. Thereafter, it must be deleted or destroyed. The time frame for doing so depends on the HPCSA recommendations on the length of maintaining records after considering the patient's legitimate interests in holding this information for provision of future services. As a rule of thumb, you must retain documentation of an adult for 6 years after the last interaction with the patient (HPCSA guidelines), but you may not retain documentation for a longer period than 6 years (POPIA) unless you can justify why you

have done so (e.g. for complicated cases with prolonged prescriptions).

There is nothing unusual about the provisions of POPIA, and it now brings SA's privacy laws into line with those of other jurisdictions, including the UK and Europe's General Data Protection Regulations (GDPR) and the USA's Health Information Portability and Accountability Act (HIPAA).

In many respects, healthcare professionals are at an advantage over other professions. You are already trusted by your patients on a daily basis to safeguard not only their wellbeing but also their privacy. For the majority of healthcare professionals, your existing good practice in protecting patients' privacy will stand you in good stead in complying with POPIA. The laws now in effect should merely codify and reinforce the good practice already being followed by the vast majority of healthcare professionals.

For more information, you can review the Medical Protection Society (MPS)'s POPIA factsheet: www.medicalprotection.org/southafrica/casebook-and-resources/factsheets/factsheets/sa-protection-of-personal-information.

An MPS webinar on this topic is available for members on our online learning platform: www.prism.medical.org.

Dr Rossouw appointed Frere Hospital CEO

Dr Stacy Rossouw, vice chairperson of the SAMA Border Coastal branch, has been appointed as acting CEO of Frere Hospital in East London.

Dr Rossouw is a dedicated medical specialist and academic actively involved in the establishment and evaluation of integrated healthcare systems, with a specific focus on stroke care management in a rural setting, as well as international outreach experience.

She was the acting head of clinical unit: Division of Neurology at Frere Hospital, appointed in 2014 with the task to develop, establish and implement neurological services within the hospital, and immediately became aware of the high stroke burden.

She has a particular interest in the establishment and development of integrated stroke care services and the development of such services in an under-resourced setting. In particular, her research focus has been around the further development of a model of stroke unit care in the absence of resources (staff

and infrastructure (dedicated stroke beds), and how telemedicine can be used to bridge the gap.

"I have a deep desire to see our country prosper through a healthy society in which everyone has an equal opportunity to discover and realise their fullest potential: improving access to a patient-centred, efficient, cost-effective health service, and at the same time, promoting social cohesion and building social solidarity through an inclusive leadership style," says Dr Rossouw about her ethos.

"My entire career path has prepared me for the challenges and demands that lie ahead, beginning with the acquisition of the necessary academic and technical background, the obtaining of practical hands-on experience in both rural and urban health environments within the Eastern Cape Province, the successful integration of health systems and processes, and the training and development of diverse personnel within both clinical and non-clinical service delivery clusters for the



Dr Stacy Rossouw

overall improvement of health services in the Eastern Cape Department of Health.

"The above activities would ultimately set me on a path of becoming a transformational leader, fostering collaboration between people, collaboration between systems and processes and ultimately collaboration between people and the system. This would ultimately become my life's work," comments Dr Rossouw on her appointment.

Our congratulations and best wishes for the road ahead.

KZN Coastal promote SAMA at festive outdoor event

On Youth Day, 16 June, doctors at the Ngwelezana Hospital in Richards Bay, Empangeni, led by Dr Jackson Myeni, organised a celebration for all the hospital employees.

The festive environment, created by the SAMA KZN Coastal branch, was a perfect backdrop to the many sporting events on the day. A team of doctors recruited by SAMA competed in the soccer competition and were ultimately declared the champions. SAMA's Dr Akhtar Hussain and Dr Jackson presented the trophies and medals to the winning teams.

SAMA KZN Coastal branch took the opportunity to support the event by sponsoring



Promoting SAMA on Youth Day, from left; Hlengiwe Kheswa, Dr Ogonnaya Harbor, Dr Akhtar Hussain, Phumzile Gwala and Dr Jackson Myeni

T-shirts, drinks, juice, banners and promotional material for the doctors. COVID-19 has made it difficult for the branch to visit hospitals, meet members and recruit new members. "It was a great experience and opportunity to promote SAMA," said chairperson of the Employed Doctors Forum, Dr Hussain. "We need to do more open-air activities in this COVID-19 pandemic."

Phumzile Gwala and Hlengiwe Kheswa from the SAMA KZN Coastal branch recruited many new members, and were able to assist in solving labour and workplace challenges.



Dr Hussain (left) presents the trophy to members of the winning team, from left, Dr M E Zulu, Dr S Mthombeni (team captain) and Dr A Ncunjana

Congratulations Prof. Hagemeister

The Free State branch council recently congratulated the chair of their branch, Prof. Dirk Hagemeister, on his appointment as associate professor in family medicine at the University of the Free State.

Prof. Dirk Thomas Hagemeister qualified as a medical practitioner at the Universität Ulm in Germany, and went on to specialise in family medicine. As postgraduate qualifications, he completed Master's degrees in public health and in bioethics, a Doctor of Medicine as well as a PhD in health professions education.

Prof. Hagemeister has also obtained the following additional qualifications:

- emergency medicine (Germany)
- sports medicine and diving medicine (Germany)
- diploma in HIV management (SA)
- diploma in anaesthetics (SA)
- postgraduate diploma in internal research ethics
- Bachelor of arts degree in history.

Prof. Hagemeister has worked in Germany and the UK, and for the past 15 years in SA. Over the years, he has accumulated a wealth of experience in such diverse areas as primary healthcare, occupational health, diving and aviation medicine and district hospital inpatient care.



Prof. Dirk Hagemeister receives a gift from SAMA Free State honorary secretary, Dr Chantelle van der Bijl while Dr Nyakallo Makatsa (councillor representative for SARA), and Dr Tanzey Konso (branch councillor) look on

He works full time in the public health sector in Bloemfontein, as head of clinical unit in family medicine at the National District Hospital, where he is involved in government priority programmes such as maternal and child health and HIV and TB care.

Prof. Hagemeister's research interests focus on emergency care training. He is a master trainer in ESMOE (essential steps in the management of obstetric emergencies) and instructor trainer for basic and advanced cardiovascular life support (BLS and ACLS) under the RCSA (Resuscitation Council of Southern Africa).

His hobbies include family life, swimming, jogging, scuba diving, reading, travelling, languages and cooking.

Farewell June

The Free State branch recently presented branch secretary June du Toit with a long-service award and retirement gift, as a token of appreciation and in recognition her 20 years of dedication and commitment to SAMA.

Dr Frik Bester, Free State branch treasurer, thanked June on behalf of the SAMA Free State councillors, and wished her the best of luck in her retirement.



June Du Toit receiving a gift from SAMA Free State Treasurer, Dr Frik Bester



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