SAMA INSIDER

AUGUST 2022

Ethically managing data transfers for research – a way forward

Cape Flats doctor brings care to the people

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EDITOR'S NOTE

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Diane de Kock
Editor: *SAMA INSIDER*

Driving research innovation

Welcome to the August *SAMA Insider*, an issue which shines a light on the importance of research in Africa, and particularly SA.

SAMA president Prof. Risenga Chauke's article (page 5) unpacks research history, definition, scope and impact on societies. "Besides adding knowledge to the scientific community, it plays a significant role in guiding policy-makers when research output is used to inform their decisions and planning. It may also influence policy implementation."

A recent webinar focused on the open science movement encouraging data sharing and collaboration across borders for research. However, the POPIA Act "has prompted discussion and debate around the use of research participants' personal information and transfers of their data outside of SA," says Prof. Safia Mahomed in the her article (page 8), which talks to "the limited consideration of the wider issues related to the use of personal information for research in SA with regard to ethical values and universal principles that underpin the research landscape, namely equity, reciprocity, justice and solidarity."

Continuing on this theme, *The Lancet* recently announced that it will "continue to reject papers with data from Africa that fail to acknowledge African collaborators, in the interests of building African research and of promoting integrity, equity and fairness" (page 15).

Sean Davidson, a right to die activist, was recently released after 3 years of house arrest, an event that has once again highlighted "the ethical tensions between arguments against and for active forms of euthanasia – one of the most contested ethical subjects in the world" (page 7).

Bringing medicine to the people is a passion for Dr Randall Ortel from Manenberg on the Cape Flats, from bringing vaccines to the community in a Vaxi Taxi, chatting to local seniors about their health, to the challenges of loadshedding for residents with medical problems (page 11).

We also look at the spread of monkeypox (page 16), SAMA's welcoming of the recent Certificate of Need judgment (page 14) and coping with power outages (page 17).

Dedicating 42 years of your life to SAMA brings knowledge, experience, insight and affection. Sadly, in July, the Western Cape Branch bid farewell to Emily Nel, a regular contributor to *SAMA Insider* and often the focus of articles. We wish her well.

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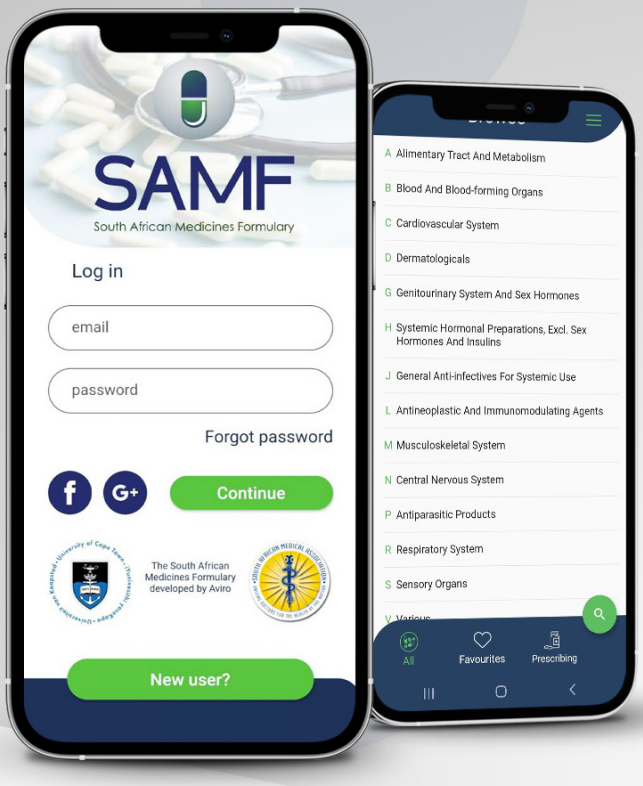

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23 June 2022: SAMA recommends vigilance in the monkeypox case in SA

SAMA recommends vigilance among its members and the public after the discovery of the first monkeypox case in SA. The case has been confirmed in Gauteng. However, members in other provinces should be on the lookout for this virus.

According to the NICD, the case involves a 30-year-old male with no recent travel history. The virus is transmitted through person-to-person close, direct contact with infected person(s) or contaminated materials (e.g. bed linen, clothes and other household items).

The virus is said not to be highly transmissible. The symptoms to look out for are acute illness typified by fever and general flu-like symptoms, followed by blister-like rash on the skin and/or swelling of the lymph nodes. The disease is rarely fatal; cases can resolve within 2 - 4 weeks. Isolation is recommended to limit the spread of infection.

SAMA is in support of the adoption of contact tracing and monitoring of cases as per the guidance of the WHO and the NICD, who do not recommend embarking on a vaccination programme for monkeypox. However, the NICD has published a contact tracing procedure for monkeypox: https://www.nicd.ac.za/wp-content/uploads/2022/06/Standard-Operating-Procedure-for-Monkeypox-contact-tracing.pdf.

23 June 2022: SAMA urges continued observation of COVID-19 rules in healthcare settings

SAMA welcomes the repeal of the COVID-19 regulations by the Minister of Health Dr Joe Phaahla on 22 June 2022, and recognises that there has been a decline in hospitalisations and reported cases of COVID-19 in SA.

SAMA welcomes the removal of the regulations pertaining to the wearing of masks indoors, the number of people at gatherings and international travel entry, but notes that the virus is still present, though not as prevalent. SAMA members remain in the forefront of the health system, and faced with patients who may or may not present symptoms of COVID and other viral diseases.

The WHO recommends a "no regret policy" when it comes to measures to protect patients and healthcare professionals during COVID-19. The Occupational Health Act of 2003 requires the employer to bring about and maintain, as far as practicable, a work environment that is safe and without risk to the health of workers in the delivery of health services.

Due to the close proximity between healthcare workers, patients and/or patient biological materials, SAMA urges its members to continue to observe non-pharmaceutical COVID-19 measures in all healthcare settings. This includes the continued wearing of face masks and implementation of sanitisation measures for patients and healthcare professionals in medical settings. SAMA maintains that vaccination is still the most powerful weapon that society has against COVID-19. Only 32% of the population (18.9 million) are fully vaccinated against COVID-19. Therefore increased vaccination and observing of COVID-19 regulations in healthcare settings is necessary.

30 June 2022: SAMA calls for a review of the ICSP application portal process

SAMA calls for a review of the Internship and Community Service Programme (ICSP) application portal process, and recommends that the National Department of Health (NDoH) convenes stakeholder engagements with key role-players, SAMA being one of them, to perform an in-depth review of how the ICSP application process has been undertaken over the years, identifying current shortfalls and coming up with recommendations of how the process can be enhanced.

With this due diligence process undertaken, other players could be tasked with running the portal, and SAMA is willing to play a leading role in this process. The process should be in line with applicable legislation and frameworks to ensure that doctors are not disadvantaged, as in the current process. As it is, the process is not assisting doctors or organisations such as SAMA in ensuring that doctors are safely and properly placed.

While the suggested process is being considered by the NDoH, SAMA also requires a response from the department regarding the legal notice dated 24 June 2022 pertaining to a written undertaking that SAMA members will not be prejudiced or disadvantaged as a result of the delayed opening of the ICSP portal.

5 July 2022: New SAMA board members announced

SAMA wishes to announce that three new board members have joined the organisation. The board members are Drs S Z Nzama, L J Mphatswe and S N Harbor.

Dr S Z Nzama is a general practitioner (medical officer) employed by the Department of Health in KwaZulu-Natal (KZN). Dr Nzama has served in the SAMA National Council, JUDASA and the Constitutional Matters Committee from 2018. In 2021 he served on the board, and is once again joining SAMA as a board member.

Dr L J Mphatswe is a general practitioner (medical officer) working at the King Edward VIII Hospital in Durban, KZN. He has served on the Audit and Risk Committee, the National Council, the Executive Committee and the General Practitioner Private Practice committee from 2016, where he is also the SAMACAPE director.

Dr S N Harbor is a registrar in anatomical pathology at Tygerberg Hospital in the Western Cape. He has been a branch member from 2018 and a member of the SA Registrars Association from 2019, and has served on the National Council since 2020.

We look forward to the new board members enjoying a successful tenure as we continue championing for the health of the nation.

15 July 2022: SAMA urges compliance with RWOPS

SAMA urges compliance with the RWOPS programme, which is meant to strengthen the clinical skills and enrich the experiences of public service doctors and other health professionals.

SAMA has been at the forefront of ensuring that public service doctors are not left behind in equipping themselves with skills and technology that they can bring from private practice. Public service doctors' remuneration is not competitive, therefore this programme was intended to ensure that skilled doctors improve their earnings by continuing to provide a service in public health without exiting the public service for private practice.

However, recent media reports have highlighted the issue of the abuse of this programme, something that SAMA cautioned about many years ago – that there was a lack of control on the granting of RWOPS. This abuse points to, among other issues, the lack of control by management of public sector doctors, and unethical behaviour on the part of those doctors who abuse this programme. Without proper controls and implementation of this programme, SAMA believes that it will be open for widespread abuse.

SAMA reiterates that the programme has clear rules and regulations that must be adhered to by doctors and monitored by public service management. SAMA urges health professionals to comply with the rules of the programme, and calls on the National Department of Health to exercise managerial control of this programme for the health of the nation.

Research as a differentiator

Prof. Risenga Chauke, SAMA president

Research is defined in the Oxford dictionary as the systemic investigation into and study of materials and sources in order to establish facts and reach new conclusions. Significant headway has been made from the dark days of medical research, where people of colour were used as guinea pigs, to the present day, where guinea pigs are treated with dignity, after the introduction of good clinical practice and research ethics. Health sciences research includes basic, clinical and applied science on human health and wellbeing, as well as the determinants, prevention, detection, treatment and management of diseases. Research also gives individuals, communities, institutions, organisations, and countries a competitive advantage.

Medical research is about scoping problems and/or questions to be asked to improve care and its delivery, explore phenomena and discover new therapies, and, of course, it adds to the body of knowledge in our scientific community. Besides adding knowledge to the scientific community, it plays a significant role in guiding policy-makers when research output is used to inform their decisions and planning. It may also influence policy implementation.

Francis Collins said "I think history would say that medical research has, throughout many changes of parties, remained as one of the shining lights of bipartisan agreement, that people are concerned about health for themselves, their families and their constituents."

Research-informed policies benefit humanity and economies. It is a significant contributor to the realisation of "One Health" (an endeavour to obtain optimal health for people, animals and the environment), as defined by the One Health Initiative Task Force.

Carl Sagan says, "Somewhere, something incredible is waiting to be known." Indeed, this is a challenge for health sciences institutions and others to cultivate a culture of curiosity, and equip students at all levels with research skills.

Medical problems and diseases occur in communities, hence the importance of acknowledging and elevating the social determinants of health. Research is the primary catalyst of advances in medicine, and there is a great need for research that explores the relationship between society, culture and health in our context.

Africa, and indeed SA, trails behind the world as far as research and researchers are concerned

Established researchers need to support and mentor others early to impart their knowledge to young, enthusiastic, committed and diligent medical researchers. In so doing, the art of research and its many benefits are preserved.

The COVID-19 pandemic highlighted the significant role of research, from understanding why individuals chose not to get vaccinated to discovering new therapeutics.

The WHO has an approach called "Health in all policies". Researchers (or medical and social scientists) should also have a mantra of "Research in all policies."

Wenham *et al*. write in their article "Measuring health science research and development in Africa: Mapping the available data", that "efforts to understand health science research capacity are limited to output metrics of journal citations and publications, failing to reflect the complexity of the health sciences research landscape in many settings". Medical research's value should go beyond citations and knowledge acquisition. It ought to enhance our ability to reduce poverty and improve the social welfare of communities.

It can be said that societies that excel in research and innovation also excel in their economies

Communities need to be educated about the value of research and the role people themselves can play in medical research. Researchers also need to communicate their findings using multiple media platforms and simple language.

Communities need to recognise the enormous contribution that they can make to research. This should not be about the monetary value they can derive from being involved in the research. It should also be about the long-term legacy they can leave for their children and their children's children. It is about the improvement and quality of life that are the direct fruits of research. Scientists then have a duty to educate communities about the spin-offs derived. This warrants the development of community research education.

Africa, and indeed SA, trails behind the world as far as research and researchers are concerned. Flowing from community research education is a need for education and career development in medical research. It can be said that societies that excel in research and innovation also excel in their economies.

This will go a long way toward developing the next generation of health sciences researchers and, therefore, drive innovation.

Africa gears to host major climate change summit

Bernard Mutsago, *SAMA health policy researcher*

The zest is palpable on the African continent, as global environmental stakeholders will be gathering for a 27th Congress of the Parties (COP 27) annual summit in Egypt in November this year. The summit will take place from 7 to 18 November 2022. It is a rare opportunity for an African country to host such a high-level meeting. The only time an African country has hosted a COP summit was in 2011, when SA hosted COP 17 in Durban. COP 27 should draw an unprecedented number of delegates from the African continent itself.

The Congress of the Parties is the supreme decision-making body of the UN Framework Convention on Climate Change (UNFCCC), an international treaty that compels its signatories to develop national programmes to reduce their emissions of greenhouse gases. SA is a signatory to the UNFCCC, the Kyoto Protocol and the Paris Agreement. COPs are convened every year at a chosen global location. The first COP (COP 1) was held in 1995 in Berlin, Germany.

COP 27 being held on African soil is an opportunity to interrogate climate change through an African lens, and to articulate priorities in an African voice. The irony at the core of climate change discourse is that Africa accounts for the smallest share of global greenhouse gas emissions – only 3.8% – yet is particularly vulnerable to climate change perils. Africa contains vast rural communities that depend on natural resources for their livelihoods. The continent's household subsistence and national economies are significantly dependent on agriculture, which is highly climate-sensitive and severely impacted by rising temperatures, changing rainfall patterns, water pollution and droughts. Other parts of Africa are beset by locust invasion and floods. Many Africans have sadly been rendered climate change refugees. All these adverse events have an impact on livelihoods, food security, water availability and the health of individuals and families.

From a health perspective, African health systems have the weakest resilience and capacity to adequately respond to challenges posed by climate change. Climate change is an existential threat, and a social determinant of health. The 2018 *Lancet* Countdown Report on health and climate change designated climate change as the biggest global health threat of the 21st century. It is recognised that climate change may increasingly threaten the achievement of universal health coverage. Hence the WHO, WMA and SAMA recognise climate change as a threat to individual and population health, acknowledge the environmental footprint of the global healthcare sector and are acting to reduce waste and prevent environmental and air pollution to ensure healthcare sustainability. The health impacts of climate change range from rising mortality to mental health challenges, injuries, respiratory illnesses and disrupted health services and infrastructure, among many others. Climate change is expected to cause approximately 250 000 additional deaths per year from malnutrition, malaria, diarrhoea and heat stress between 2030 and 2050.

Globally, climate-related disasters killed thousands of people, affected nearly 100 million more, and had a financial cost of USD310 billion in 2019 alone. SA has witnessed catastrophic manifestations of climate change, including unseasonal snows, veld fires, droughts and floods. In 2022, KwaZulu-Natal experienced two climate-related disasters within a 6-week period, killing nearly 500 people, displacing tens of thousands and costing the province nearly USD2 billion.

Discussion at COP 27 will focus on mitigation, adaptation and climate finance. It will be the first COP to receive updates on targets expressed by countries in their nationally determined contributions (NDCs). The initial agreement was for NDCs to be reported every 5 years, but the last COP reduced the reporting period to annually, beginning this year. SA is among the African countries that have completed their updated NDC documents. One of the key outcomes expected from COP 27 is a stronger commitment on providing adaptation finance for the benefit of the African continent, given that developed countries failed to meet the goal of delivering USD100 billion a year by 2020 to developing countries. In its submission on the draft SA Climate Change Bill in May 2022, SAMA noted that both adaptation and mitigation efforts are important targets. SAMA noted that while the health sector mainly falls on the adaptation side in terms of climate change actions, there is a need for the sector to actively support mitigation efforts and a low-carbon and climate-resilient economy in SA, as it also causes significant emissions into the atmosphere. Further, mitigation has well-demonstrated health co-benefits. A mitigation campaign will entail exerting pressure on the SA and other African governments to fulfil their national commitments to international agreements on cutting carbon emissions.

Egypt prepares to host COP 27

SAMA, as the leading organisation for medical doctors in Africa, sees the professional and moral need to leverage COP 27 to have an engagement with national, SADC region, African and global stakeholders on the necessity for interdisciplinary climate change interventions that should be taken by the global healthcare sector to ensure sustainable health systems.

SAMA is an active climate change policy influencer, and holds membership in the WHO Civil Society Working Group on Climate Change, the WMA Environmental Caucus, the (SA) National Climate Change and Health Steering Committee, the Public Health Association of SA and, formerly, the Climate Change Committee of COSATU.

The nexus between climate change and development cannot be overemphasised. As we go into COP 27, a developmental mindset is required. The already small GDPs of many African countries are forecast to suffer a further decline due to climate change, in addition to the impact of COVID-19. Citizens in countries with strong economies and low poverty levels have better resilience and coping mechanisms against the adverse impacts of climate change. The converse is also true, and Africa is worst off.

References available on request.

The right to die: Unpacking an ethical dilemma in SA

Chris Jones, *chief researcher, Department of Systematic Theology and Ecclesiology, head of Unit for Moral Leadership, Stellenbosch University*

Sean Davison, the euthanasia activist and co-founder of DignitySA, recently completed a sentence of house arrest in SA for his role in the deaths of three people. He said he had not committed a crime or murder, but had helped these people because they were desperate to die. Anrich Burger, Justin Varian and Richard Holland were suffering unbearably with no hope of recovery, and unable to end their own lives.

The late SA emeritus Archbishop Desmond Tutu, in whose honour Davison wants to fight to change the laws around assisted suicide, once wrote that he would want the option of an assisted death. Tutu argued that dying people should have the right to decide how and when they wanted to leave this life.

Legislation in Canada and a number of US states and European countries, for example, allows assisted suicide. But there are still billions of people around the world, as in SA, who do not have this right.

The question of whether this is a right is a debate that has been raging for years in medical ethics and within religious groups.

This article is not about the religious or strictly legal aspects of the debate. It grapples with the ethical tension between arguments against and for active forms of euthanasia – one of the most contested ethical subjects in the world.

Arguments against active euthanasia

There are, broadly, three arguments against active forms of euthanasia:

- Only God has the authority to dispose over life and death.
- It is the role of medical doctors to preserve life and not to cause death.
- A doctor could abuse his or her position to take the lives of vulnerable patients, or patients might be killed against their wishes.

Although these arguments must be considered, I prefer to put forward the arguments in support of the active forms of euthanasia.

But let's first look for the sake of clarity at two forms of active euthanasia.

Two kinds of active euthanasia

The first is known as voluntary active euthanasia. This is when death is intentionally brought about in the life of a patient who is competent to make such a decision, and where death is reasonably believed to be in the interest of and based on an informed request by the patient. The doctor's act is the proximate cause of death.

The second form of active euthanasia is where a doctor assists a patient in suicide, called "physician-assisted suicide". The doctor intentionally provides the means to a competent individual who then takes his or her own life.

In SA, both these forms of euthanasia are illegal.

Constitutional and other supportive perspectives

In a constitutional democracy, active euthanasia should not be dealt with primarily as a theological issue. Of course, people of faith may express their beliefs about it, but they should not expect to dictate the law. There are many citizens who do not share religious values.

Although legislation in SA prohibits active forms of euthanasia, I believe that it is not against the Constitution. The Bill of Rights includes three relevant rights:

- human dignity (article 10)
- freedom and security of the person, including the right not to be treated or punished in a cruel, inhuman or degrading way (article 12(1))
- bodily and psychological integrity, including the right to security in and control over one's body (article 12(2)).

There is another point in favour of active euthanasia. The development of medical science means that people have more control over death and life than ever before. Although life has high value, it is not absolute.

People make decisions throughout their lives about their health. But when they are terminally ill, often in unbearable pain and suffering – and sometimes even losing their dignity – they are not allowed to decide when they want to die.

If someone is terminally ill and suffers badly, can a strong moral case not be made that such a person – within prescribed medical-ethical parameters, evaluating the patient's suffering, prognosis, mental competence, informed decision-making and clear communication – be assisted with the dying process?

In support of active euthanasia

Three arguments have been put forward in support of active euthanasia.

Right to die activist Sean Davison (Brenton Geach/Gallo Images via Getty Images)

Personal autonomy should be respected: this implies that a competent person has a moral right to make his or her own choice.

Unbearable suffering should be prevented: nobody should be forced to endure suffering – often at high medical cost.

When life is no longer good, and death is no longer bad, and when death is therefore preferred to continuing life, the role of medicine could change from healing and preserving life to helping someone die in a way that is compassionate, kind, gentle and respectful.

I believe everyone should be allowed to choose his or her "moment". For me, active forms of euthanasia are not so much the termination of life, but rather the shortening of suffering and the dying process.

Moral equivalence: physician-assisted suicide is like other practices that are already morally acceptable – such as passive euthanasia.

To withhold treatment is viewed as an omission, while physician-assisted suicide and voluntary active euthanasia are regarded as acts. But people are morally and legally responsible for both acts and omissions.

SA is a country where people hold different opinions. This diversity of opinions must always be considered, according to the Constitution. South Africans did it with the termination of pregnancy (which was legalised) and the death penalty (which was scrapped).

Source: The Conversation, *29 June 2022. https://theconversation.com/the-right-to-die-unpacking-an-ethical-dilemma-in-south-africa-185788.*

Ethically managing data transfers for research – a way forward for SA

Safia Mahomed, *School of Law, University of South Africa*

The open science movement encourages data sharing and collaboration across borders. In SA, the Draft National Open Science Policy and the Draft National Data and Cloud Policy promote the ideology of open data in line with international best practice. Health research is currently regulated by the National Health Act No. 61 of 2003, its Chapter 8 regulations, the 2018 SA Materials Transfer Agreement template and the 2015 Department of Health Ethics in Health Research guidelines. However, the Protection of Personal Information Act No. 4 of 2013 (POPIA), which came into effect in 2021, has prompted discussion and debate around the use of research participants' personal information and transfers of their data outside of SA. Although most of these discussions have focused on consent and the protection of privacy within this context, there has been limited consideration of the wider issues related to the use of personal information for research in SA with regard to ethical values and universal principles that underpin the research landscape, namely equity, reciprocity, justice and solidarity. While POPIA offers a regulatory framework on how to process data in a manner that protects the research participant and provides mechanisms by which data can be transferred outside of SA, it does not consider the other rights and interests that are at stake in the sharing of data for research purposes. In the rush to ensure compliance with POPIA for access, use and sharing of personal information, there is the risk that other rights and ethical interests are overlooked. A data transfer agreement (DTA) with an integrated bioethics approach to the use of personal data can guard against this by situating the protection of personal data among the relevant ethical principles, rights and interests at stake. Currently, there is no uniform guidance on this.

The Department of Science and Innovation (DSI) and the SA Medical Research Council (SAMRC) hosted the first webinar in a series of stakeholder activities to kickstart the process around data-sharing safeguards, with a view to developing a national DTA template to assist with the ethicolegal management of data transfers for research purposes in SA. The objectives of the webinar included: examining the need for and potential challenges associated with data sharing for research; reflecting on community concerns, perceptions and expectations when their data is shared; debating the use of a DTA as a tool for the ethical management of data; and exploring international perspectives in this regard. The full webinar programme can be accessed at https://www.samrc.ac.za/sites/default/files/attachments/2022-07-04/Data%20Transfer%20Webinar%20Programme.pdf. The full webinar is available at https://youtu.be/HD4Lg34bSCk. A synopsis of the webinar follows below.

Prof. Ames Dhai, chair of the SAMRC Bioethics Advisory Panel (BAP), and Prof. Melodie Labuschaigne, chair of the BAP's Genome Working Group, co-chaired the first session, which focused on understanding the context of data transfers in research. They stressed that this was the beginning of a set of activities towards a national DTA. Prof. Glenda Gray, president and CEO of the SAMRC, and Ms Glaudina Loots, director of health innovation at the DSI, officially opened the proceedings, highlighting the importance of taking the open science movement into practice to the advantage of participants and researchers in the Global South, and to pave a way forward for equitable data sharing to ensure that African scientists also benefit from the process. They emphasised that the need for a participatory process with collective involvement from all relevant role-players.

Dr Rizwana Mia, senior programme manager at the SAMRC, explained how the 0.2% difference in our genomes has revolutionised medicine. A single genome sequence gives rise to approximately 100GB of data, with more than 3 - 4 million genomic variants found. A major challenge for SA is that we have not generated enough big population-level data sets, nor do we have a large pipeline to analyse data – thus we rely on data generated outside the country, and collaborations, to develop concrete inferences. Logging data in a recognised archive is stringent, and SA lacks a national repository system.

Ms Nomampondo Barnabas, head of recruitment and retention at the Clinical HIV Research Unit, discussed various community perspectives and expectations, and highlighted questions that the community requires answers to when data are transferred. For example: what is the meaning of data transfer? What are the benefits and risks? Who owns the data – SA as a country, or the participants? How can we ensure that scientists do not overstep boundaries? How can we really know that data are being transferred within the confines of the informed consent form? Regarding withdrawal, how can this be guaranteed? There needs to be more communication from researchers in terms of feedback to participants. Communities do not always trust the research process, and we need to dispel the myths and mistrust from the process.

Dr Bonginkosi Shozi, a research scholar from the Institute for Practical Ethics at the University of California, San Diego, presented on the multidimensional legal nature of human genomic data, indicating that a bundle of rights is applicable in this context, including property, personality and/or intellectual property, depending on the type of data in question. It is important to differentiate between samples and the various stages/types of data, as these distinctions elicit unique rights that then have implications for ownership and intellectual property. A legally mandated form of contract is not the only means to ensure that important provisions are included. Another way would be a statutory instrument or regulation that outlines the provisions to possibly be included within a DTA.

The second session, which focused on the current regulatory management of data transfers in SA, while including perspectives from Italy and Canada, was co-chaired by Prof. Safia Mahomed from the School of Law at the University of South Africa, and Dr Ciara Staunton, a senior researcher at the Institute for Biomedicine, Eurac Research (Italy). They highlighted that there was a need to analyse how competing rights and interests are dealt with in other jurisdictions, while being mindful of the context in SA.

Ms Eleni Flack-Davison, head of the Research Integrity Office and data protection officer at the University of the Witwatersrand, provided an overview of POPIA and an update on the ASSAf Code of Conduct for Research. Data subjects need to know details around the processing of their information. Transferring special personal information or personal information of a child to a foreign country without adequate data protection laws in place would require prior authorisation and a DTA. The Code of Conduct for Research that applies to industry and academia is currently being developed by ASSAf, which would then alleviate the need to apply for prior authorisation.

Dr Deborah Mascalzoni, senior researcher at the Centre for Research Ethics and Bioethics at Uppsala University (Sweden) and the Institute for Biomedicine, Eurac Research (Italy), provided perspectives from Italy. She pointed out that data mean different things to different people, and explained that their practices were developed through the Co-operative Health Research in South Tyrol study (which began in 2011 and will continue for 25 to 30 years), where dynamic consent was used as a legal basis for collecting research data. Policies had to be developed to hold onto participants' trust in the process. There was a need for comprehensive and transparent governance with public oversight mechanisms in place for the flow of data.

Public and private partnerships are crucial and need to be transparent

Prof. Ma'n H Zawati, executive director at the Centre for Genomics and Policy at McGill University in Canada, shared their practical experiences during the COVID-19 pandemic. The use of data is a scientific and ethical imperative, and a number of principles need to be considered when developing a governance framework. The importance of continuous public engagement to increase public trust was also emphasised.

During discussion, the importance of community engagement was underscored. Creating local core capabilities from an infrastructure perspective was recommended, being mindful of the fact that SA still needs to create the skill set to become sustainable in its research efforts. The importance of guidance on the management of data in international collaborations and the significance of scientists working together was emphasised. Since data transfers occur from the Global South to the Global North and vice versa, we need to ensure not only that our standards or a higher standard is met for outside transfers, but that we can also comply with relevant standards for inward transfers. Public and private partnerships are crucial and need to be transparent. Having a template in place that outlines access, security measures and other safeguards is extremely helpful to foster trust.

Dr Mantoa Mokhachane (BAP member and director of the Undergraduate Medical Education Unit at the University of the Witwatersrand), who did the closure, highlighted the strengths and weaknesses in our context of data sharing, the lack of partnerships between SA scientists and ethicists as a weakness and the real need for vigorous community engagement for us as a country to move forward. Overall, the need for a regulatory mechanism that incorporates ethical principles and values, with a balance between open science and the protections of participants, was welcomed. Should a national DTA template be implemented, it should not impede ethical research, specifically in the context of international collaborative research.

Prof. Dhai emphasised that much work needs to be done if the development of a national DTA is taken forward. She encouraged all interested individuals and parties to email her (ames.dhai@wits.ac.za) on aspects that they would want to contribute towards as the DSI and SAMRC continue activities in this regard, as an inclusive, transparent and collaborative process is required.

Access to safe abortion critical for health of women and girls: WHO

World Health Organization

The WHO released new guidelines on abortion on 9 March 2022, in a bid to protect the health of women and girls and help prevent over 25 million unsafe abortions that currently occur each year.

"Being able to obtain safe abortion is a crucial part of healthcare," said Craig Lissner, acting Director for Sexual and Reproductive Health and Research at the WHO. "Nearly every death and injury that results from unsafe abortion is entirely preventable. That's why we recommend that women and girls can access abortion and family planning services when they need them."

Based on the latest scientific evidence, these consolidated guidelines bring together over 50 recommendations spanning clinical practice, health service delivery and legal and policy interventions to support quality abortion care.

New recommendations to improve access to high-quality, person-centred services

When abortion is carried out using a method recommended by the WHO, appropriate to the duration of the pregnancy and assisted by someone with the necessary information or skills, it is a simple and extremely safe procedure.

Tragically, however, only around half of all abortions take place under such conditions, with unsafe abortions causing around 39 000 deaths every year and resulting in millions more women hospitalised with complications. Most of these deaths are concentrated in lower-income countries – with over 60% in Africa and 30% in Asia – and among those living in the most vulnerable situations.

The guideline includes recommendations on many simple primary-care level interventions that improve the quality of abortion care provided to women and girls. These include task sharing by a wider range of health workers, ensuring access to medical abortion pills, which mean that more women can obtain safe abortion services, and making sure that accurate information on care is available to all those who need it.

For the first time, the guidelines also include recommendations for use where appropriate of telemedicine, which helped support access to abortion and family planning services during the COVID-19 pandemic.

Removing unnecessary policy barriers facilitates safe abortion access

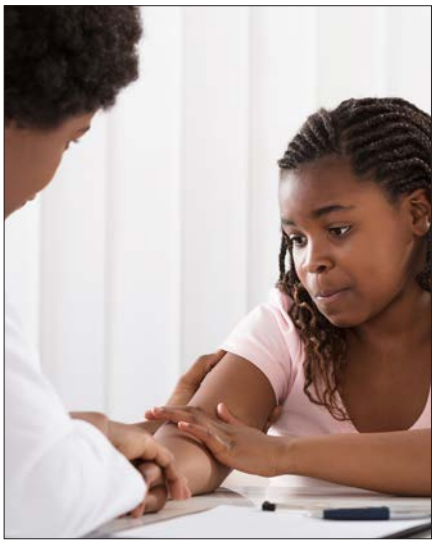
Alongside the clinical and service delivery recommendations, the guidelines recommend removing medically unnecessary policy barriers to safe abortion, such as criminalisation, mandatory waiting times, the requirement that approval must be given by other people (e.g. partners or family members) or institutions, and limits on when during pregnancy an abortion can take place. Such barriers can lead to critical delays in accessing treatment and put women and girls at greater risk of unsafe abortion, stigmatisation and health complications, while increasing disruptions to education and their ability to work.

While most countries permit abortion under specified circumstances, about 20 countries provide no legal grounds for abortion. More than 3 in 4 countries have legal penalties for abortion, which can include lengthy prison sentences or heavy fines for people having or assisting with the procedure.

"It's vital that an abortion is safe in medical terms," said Dr Bela Ganatra, head of the WHO's Prevention of Unsafe Abortion Unit. "But that's not enough on its own. As with any other health services, abortion care needs to respect the decisions and needs of women and girls, ensuring that they are treated with dignity and without stigma or judgement. No one should be exposed to abuse or harms like being reported to the police or put in jail because they have sought or provided abortion care."

Evidence shows that restricting access to abortions does not reduce the number of abortions that take place. In fact, restrictions are more likely to drive women and girls towards unsafe procedures. In countries where abortion is most restricted, only 1 in 4 abortions are safe, compared to nearly 9 in 10 in countries where the procedure is broadly legal.

"The evidence is clear – if you want to prevent unintended pregnancies and unsafe



abortions, you need to provide women and girls with a comprehensive package of sexuality education, accurate family planning information and services, and access to quality abortion care," Dr Ganatra added.

Following the launch of the guidelines, the WHO will support interested countries to implement these new guidelines and strengthen national policies and programmes related to contraception, family planning and abortion services, helping them provide the highest standard of care for women and girls.

Notes

Quality abortion care is care that is effective – delivered by health workers with the right skills, resources and information; safe; accessible to all those that need it; timely; and respectful of women and girls' needs and rights.

The WHO abortion care guideline updates the former edition, released in 2012, and consolidates existing and new recommendations. The digital version is available at https://srhr.org/abortioncare.

An interactive online database containing comprehensive information on the abortion laws, policies, health standards and guidelines for all countries is available at https://abortion-policies.srhr.org.

Cape Flats doctor brings care to the people

SAMA Communications

Dr Randall Ortel is not a 9-to-5 doctor. Instead, this medical practitioner from Manenberg on the Cape Flats is invested in making the lives of people in his community better all the time. He does this by actively being involved in – and starting – many campaigns and initiatives designed to bring medical knowledge and care to the people.

In December last year, for instance, Dr Ortel ran a 3-day programme called the Manenberg Vaxi Taxi Vaccine Outreach with a team of other healthcare providers, using a converted ambulance.

"We assessed the situation and knew there were many people who simply couldn't access vaccination sites, so we decided that if they couldn't get there because they were in wheelchairs or unable to move, we'd bring the sites to them," he says.

During this programme, people started queueing at least 2 hours before the arrival of the Vaxi Taxi, with Dr Ortel and the team administering almost 200 vaccinations a day.

But Dr Ortel's involvement doesn't stop there. At the Manenberg Swimming Pool in January, Dr Ortel spoke at Manenberg's annual seniors' lunch organised by the Manenberg Senior Committee.

"During my talk I covered issues on diabetes, high blood pressure and cholesterol, and stressed the importance of adhering to the medication regimens prescribed by doctors. I also spoke about end-of-life issues, urging them to think about their health wishes if such a scenario arose," explains Dr Ortel.

During this visit, Dr Ortel also encouraged the seniors to get proxies or powers of attorney before the onset of dementia, because these proxies can sign documents on their behalf, and this would alleviate a lot of stress.

For many, having these discussions can seem daunting, but for Dr Ortel it's all part of playing an active role in his community.

"It's absolutely necessary because many people don't have access to this kind of treatment. I do a lot of house visits to chronically ill patients and give advice on palliative care, something many aren't aware of. I come from this area and it's vital that I give something back, and this is one way I can do it," he says.

Dr Ortel also realised that many residents of the area have medical problems during loadshedding, and decided to do something about it.

Dr Randall Ortel's Manenberg Vaxi Taxi Vaccine Outreach programme was a huge success

Chatting to seniors in the community

"There are patients who are on peritoneal dialysis for kidney failure, which means they are totally dependent on clean warm water. These patients usually have a high infection risk, and we encourage them to boil (sterilise) the water when washing their hands or cleaning around the port in their abdomen."

"I put a call out on my WhatsApp status and Facebook page to ask if there were people who needed help during these times, and I was overwhelmed with the response. People try to be innovative by filling flasks with warm water before loadshedding, or even ironing blankets before the time to keep their peritoneal dialysis fluid bags in the blankets to keep them warm before they start putting this fluid into their abdomen to start the dialysis process at home. One cannot microwave or boil the peritoneal dialysis fluids before using them, so the fluid needs to be warmed to body temperature by ambient means. But I urged them to be more proactive and to try to get their dialyses done before these blackouts, if possible," he says.

Dr Ortel also visits patients on 24/7 oxygen for irreversible lung problems. During loadshedding oxygen machines don't work, and most patients are reliant on oxygen tanks to continue their oxygen treatment during loadshedding.

"Now, with the anxiety of the oxygen running out of the tank, these patients usually use a lower flow of oxygen, which is inadequate and makes them feel sick. I home visit to educate these patients and families as to what to do during loadshedding, and make sure they understand how to use the equipment and what the danger signs are to look out for," he says.

Social media is a major tool for Dr Ortel in his interactions with the Manenberg community. Recently he took to TikTok to talk about termination of pregnancies, and was flooded with comments and requests.

"It's a totally polarising topic, to be sure, but it's necessary that people understand the law and how it affects them. After my initial TikToks I did a TikTok live session where I explained the law, and the procedures involved. Afterwards I had calls from girls asking for advice, and that is where the benefit of being involved in the community is really visible," he says.

Dr Ortel is on a mission to improve healthcare delivery in his community, and he is doing it one programme and one talk at a time.

"People are struggling financially and emotionally, and as a healthcare worker I have a duty to support them in any way I can, and in a way I was trained to. I do have an obligation to my community, but it's also rewarding to play such a role and to see how my involvement is changing and improving people's lives."

Let's talk disciplinary warning

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

In labour law, the main purpose of issuing warnings is to remind employees of the employer's standards of conduct and work performance, and to give them a chance to improve. The following will assist in shedding light on the use of warnings as a means of improving an employee's conduct and performance without infringing the employee's rights.

What is a disciplinary "warning"?

A disciplinary warning is an oral or written statement made by an employer informing the employee that his/her conduct or performance level is not acceptable, and that any further failure to meet the required standards will result in stronger measures being taken. In this sense, a warning is not a punishment – instead it is a notification that further corrective measures could follow.

When is the giving of a warning appropriate?

When it has been established that a less than serious offence (one with relatively mild potential consequences) is committed, it is most often appropriate to issue a warning to the employee. The level of warning (oral, written or final written warning) to be used depends of the level of seriousness of the transgression and on whether previous valid warnings have been given.

When is a warning inappropriate?

Where the offence is very mild, a counselling session may be better than a warning. For example, if an employee is 5 minutes late for work for the first time, the Disciplinary Code and Procedures for the Public Service suggests that a mild rebuke or counselling session will suffice. Where an offence is very serious or a final written warning has already been given, then in some cases, a warning is unlikely to have the desired effect, and stronger discipline may be appropriate.

Can warnings be cancelled?

The disciplinary policy of the public service does allow employees to appeal against warnings. Even where this is not so, the employee concerned is entitled to refer the warning to the bargaining council. If the arbitrator finds the warning to have been unfair, (s)he is empowered to remove the warning.

Is the employer entitled to combine a warning with other measures?

The Labour Relations Act No. 66 of 1995 is silent on this question. It would be unfair to punish an employee twice for the same offence, but there are instances where the chairperson of an enquiry might issue a sanction of a final written warning plus 3 months' suspension without pay, short of dismissing an employee. This often happens when the charges are quite serious

in nature, and when the presiding officer wants to send an unequivocal message to other employees that such transgressions will not be tolerated.

Can an employee be dismissed for a repeat offence after having received a final written warning for a similar offence?

The answer to the question is "yes", provided that:

- there is no reasonable alternative corrective action to the dismissal; and
- the final written warning is valid.

Remember, the SAMA Legal Affairs Department is only a phone call away! Contact us on 012 481 2000 or labour@samedical.org.

Inequality kills: How race, money and power affect who survives COVID

Waasila Jassat, Cheryl Cohen, Nicholas Crisp, *for Bhekisisa Centre for Health Journalism*

In SA, COVID-19 has, for instance, shown us that the country's history of racial inequalities, even after almost 30 years of democracy, still affects who lives or dies, who gets an intensive care unit (ICU) bed, or who has access to lifesaving oxygen or ventilation when they end up in hospital.

We know this from analysing the data of almost 440 000 patients – collected between March 2020 and January 2022 – from DATCOV, a system that was created during the pandemic, and which allowed for public and private COVID-19 hospital admissions to be recorded in the same database.

We looked at demographic information such as age, sex and race, and risk factors for falling seriously ill with COVID, such as age, obesity, diabetes and hypertension, and compared the data with the type of treatment someone received and the outcome thereof.

As researchers, we wanted to answer the question: "Why are black Africans, coloured and Indian people seemingly being disproportionately affected by COVID-19?"

This is what we found:

- People of colour (black Africans, Indian and coloured people) had a higher risk of dying of COVID-19 than whites.
- People admitted to public hospitals were more likely to die of COVID-19 than those with beds in private hospitals.
- Black Africans admitted to public hospitals had a lower chance than white people of getting an ICU bed or being ventilated – despite having a higher risk of dying.
- Black African, coloured and Indian private hospital patients had a higher chance of being treated in ICU or ventilated.
- Of patients who died of COVID-19 in hospital, 10% in the public sector were treated in ICU, compared with 60% in the private sector.

What do these results mean and tell us about SA?

Our findings tell SA's story of inequality and the consequences thereof on health outcomes.

We argue that a legacy of long-standing inequalities has resulted in structural discrimination and exclusion to healthcare based on race.

There is little conclusive evidence that genetic or biological reasons alone can explain the racial and ethnic differences in people's likelihood of getting infected with SARS-CoV-2 (the virus that causes COVID-19) or dying of it. In fact, attributing poor clinical outcomes in vulnerable race groups solely to genetics and biological differences has historically been responsible for marginalising their health needs.

Rather, we need to look at the impact of structural inequalities such as unemployment, poor housing, low household income, food insecurity and environmental hazards, as well as social factors such as racism and oppression, to find the answers.

SA is the country with the highest level of income inequality in the world. Black Africans, people without jobs, those who are less educated and female-headed households are the poorest people in the country. Our study showed that people of colour and people with lower incomes (we used the type of health facility used as a proxy for someone's income) had a higher risk of dying of COVID-19 and a lower chance of being treated in an ICU or being intubated.

Why?

Because how much money you earn influences the quality of health services that you have access to, whether you can afford transport to a health facility, whether you live in a crowded or spacious place, how much food you have and how likely you are to live with another condition, such as diabetes, obesity, hypertension, HIV or TB, that make you more likely to get very sick with COVID-19. Your salary is, of course, also closely related to the type of job you do, which in turn determines how exposed you are to contracting an airborne virus such as SARS-CoV-2.

Our data show that most COVID-19 hospital admissions were among black African, coloured and Indian people of working age.

How inequality makes black people more likely to get infected with SARS-CoV-2

SA blood service data show that SARS-CoV-2 infection is consistently higher among black African individuals than the rest of the population. This is because their socioeconomic status makes them more likely to be exposed to the virus: poorer people tend to use public transport (as opposed to private cars with only a few passengers), they often live in multigenerational households with little space for social distancing and have manual labour jobs that make it impossible for them to work from home during periods when infection rates are high.

But what happens after someone gets infected, in other words, how likely they're able to access quality healthcare to treat their infection, also plays a crucial role in their survival.

SA has a two-tiered health system where in 2019, 40% of all spending on healthcare in the country was in the private healthcare system, which only serves 27% of the population. Higher spending buys more medical expertise, specialised hospitals, sophisticated technology and equipment and advanced and expensive medication.

Only 1 out of 10 black Africans belong to a medical aid

But in SA, only just over 15% of the population can afford medical insurance, while the rest have to rely on under-resourced state hospitals and clinics, or pay for private healthcare in cash. Our study showed that black Africans were less likely to be admitted to private hospitals – and that Indian and white people had a higher chance of accessing a private hospital bed. They therefore also had a higher chance of survival, as our results reveal that public patients were more at risk of dying from COVID-19 than private patients.

When we look at the race breakdown of medical aid coverage in the country, it's clear why black Africans were less likely to end up in private health facilities: most can't afford medical insurance, which you need to cover the cost of such care. A 2018 general household survey conducted by Statistics South Africa showed that 10% of black Africans have medical aid, 17% of coloureds, 52% of Indians and 73% of whites. It was therefore not surprising that in the private sector, people of colour were not deprived of being treated in ICU or ventilated. But of concern was that in the public sector, black people were less likely to be treated in ICU or ventilated, compared

with whites. The inequality could be due to black patients more likely accessing care in rural district hospitals that had few ICU beds or ventilators available.

A study in Brazil also revealed that whites were more likely to be admitted to ICU than people of colour. In SA, 47% of individuals in the 2018 general household survey reported facing challenges in access to health services. Black South Africans, rural residents, the less educated, the unemployed and the poor were most likely to report such difficulties, and struggled with issues of long travel times to the nearest healthcare facilities or inconvenient operating hours.

What now?

Our study shows how important it is to collect data on socioeconomic status and race, alongside age and sex, to identify the groups of people in a population most likely to get infected and fall ill with COVID-19. Without doing this, we won't know how to design interventions that work best for vulnerable populations.

But our study also confirms how crucial it is for health resources between the public and private healthcare systems to be redistributed so that access to healthcare is more equal in the country. Healthcare is a human right built into our Constitution, and the quality of care that you receive shouldn't have to depend on how much money you can pay for it. The country's proposed National Health Insurance scheme is one way of addressing this – but it will only work if access to quality healthcare is at the heart of its planning.

Source: Bhekisisa, *10 June 2022. https://bhekisisa.org/article/2022-06-10-inequality-kills-how-race-money-and-power-affect-who-survives-covid/.*

SAMA welcomes the recent Certificate of Need judgment and suggests alternatives

SAMA Communications

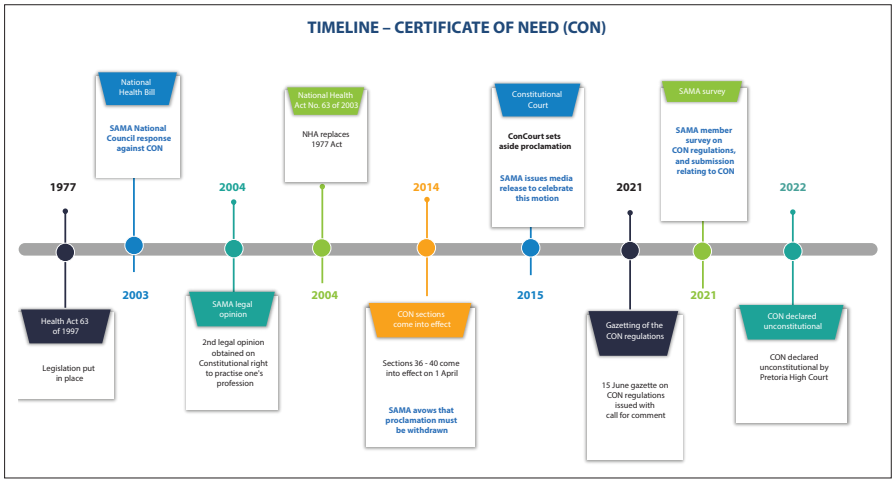
SAMA suggests alternatives to the certificate of need (CON). As the timeline in the figure illustrates, the CON has been a long battle in the provisions of the National Health Act(s).

SAMA has been vocal for many years on the Constitutional right to practise one's profession, and reiterates the need for co-operation and finding lasting solutions to the issue. The organisation presented alternatives in a submission to the National Department of Health (NDoH) in August 2021. These are:

Incentive model: SAMA proposed that the government should invest more in "carrot" solutions in place of the current "stick" approach. This would be in the form of proper remuneration and incentives for medical doctors to work or set up practices in underserviced areas, and ensure favourable geographic distribution of health services today.

Licence model: A licensing regimen can be considered, and be made more transparent. This involves publishing statistics on the number of beds, operating theatres and intensive and high care units that are available across the country for capacity considerations. This responsibility should be led by the government, with input from relevant stakeholders. In addition, these data need to be overlayed with accurate and credible demographic information and other information (needs assessment) to make CON decisions. Data on disease profiles and patterns in all areas must be accurate and credible in order to be taken into account when deciding on whether or not to grant a CON.

In addition, the government must undertake a thorough investigation around the failures of the CON process in other countries so as to limit a repeat of the same problems in SA.



With the Gauteng High Court ruling declaring these provisions unconstitutional, SAMA believes that it is high time the department invested in support infrastructure to make any of these alternatives a possibility. These include developing adequate infrastructure in deprived and rural areas, such as equipment infrastructure, backup support, infrastructural requirements, cost of equipment, etc.

The scathing ruling is a major set-back for the NDoH's plans to implement the proposed NHI model. With the health policy stakes so high, it is perplexing that the NDoH did not oppose the application. Acting Judge Thembi Bokako said the respondents had "unaccountably refused to participate in the matter … despite without a shadow of a doubt being aware of the proceedings". It has been reported that the department will seek a recission of the judgment, or challenge the ruling in the Constitutional Court.

The impugned sections will now go to the Constitutional Court, for their fate to be finally decided.

Clearly, a rethink is required. Shoddily drafted legislation and regulations that introduce yet more bureaucracy and severely infringe on the Constitutional rights of healthcare practitioners would do more harm than good. Less restrictive means should be explored to increase access to healthcare in our underserved populations.

SAMA believes that all the relevant stakeholders who have been involved in this process should work together to find a lasting solution to delivering on the health needs in this country.

Renowned journal rejects papers that exclude African researchers

Maina Waruru *for University World News, 3 June 2022*

Respected global medical journal *The Lancet* will continue to reject papers with data from Africa that fail to acknowledge African collaborators, in the interest of building African research and of promoting integrity, equity and fairness in research collaboration, according to senior executive editor Dr Sabine Kleinert.

The journal made the decision after coming across manuscripts submitted by researchers from outside Africa and with data collected from the continent, but with no mention or acknowledgement of a single African collaborator, she told the 7th World Conference on Research Integrity (WCRI 2022) held in Cape Town from 29 May to 1 June.

"We are now rejecting such papers because when you bring us such a paper you probably had a local researcher collecting data for you or you 'helicoptered' to Africa, but you chose not to recognise them, which is not acceptable."

Kleinert – one of the co-chairs of the conference, hosted by the University of Cape Town – noted that failure to disclose or appreciate work done by others amounted to a breach of integrity, something that every publisher had a duty to look out for.

She was responding to a question during a session on "Implementation of the Hong Kong Principles in an African context". The Hong Kong Principles for assessing researchers were formulated and endorsed at the 6th WCRI held in June 2019 in Hong Kong. Their purpose is to help research institutions that adopt them to minimise questionable research practices

Quality, equity and diversity

The Lancet, said Kleinert, was strictly focused on the quality of work done when assessing manuscripts, but recognised that equity and diversity play a role when it comes to research conducted in different regions of the world.

The publisher recognised that pricing can be prohibitive, and is a major factor in considering the choice of a publisher for many researchers from low- and middle-income countries. It is for this reason that *The Lancet* now charges different prices for different regions.

The Hong Kong Principles on research integrity were important to academia in addressing challenges around academic awards, the assessment of research and the ethical conduct of research. They emphasised the importance of research integrity as a measure in rating universities, said Kleinert.

In addition, they addressed a range of issues including career progression, research funding and the questions of quality over quantity, team versus individual, and long-term v. short-term impacts of research. Overall, the framework was meant to "foster research integrity and improve its conduct".

Research networks

Prof. Ntobeko Ntusi, chair of medicine in the Faculty of Health Sciences at the University of Cape Town, said Africa was loudly crying out for equitable collaborations between African researchers and those from outside the continent, in order for there to be a semblance of responsible conduct of research.

African science, he observed, faced many challenges, including inadequate funding, lack of requisite infrastructure, a shortage of supervisors in universities and a lack of mentorship. To tackle these challenges, it was necessary to strengthen and streamline research administration, funding and regulatory bodies.

"We also need to build institutional research networks and create more partnerships between universities to allow them to leverage available resources," Ntusi said.

Examples of such networks and partnerships include organisations such as the African Research Universities Alliance, which has fostered collaborative research between member institutions across the continent.

Under such networks it was possible to engage institutions to start programmes on research integrity, and set up disciplinary societies such as the Ethics Institute of SA.

Ntusi said the time had come to alter the reward system in universities with regard to academic progression, to ensure that the system valued quality right through supervision, mentorship, scholarship, research culture and "academic citizenship".

He made a case for open science, noting that it could play a role in entrenching ethical research conduct by freely availing data to researchers.

"Africa needs a lot of support for open science by providing necessary infrastructure, skills and money," he argued. "Open access is costly, but it is what Africa needs."

Many African researchers required support in the form of discipline-specific training, in the use of public databases and in research methodologies. These, he observed, would contribute to entrenching ethical research conduct and to building a culture of integrity.

Above all, individual commitment to research integrity was necessary, and institutions and countries needed to sign on to the Hong Kong Principles, the Leiden Manifesto for Research Metrics and the Declaration on Research Assessment (DORA).

The role of institutions in enforcing integrity would be greatly enhanced if universities adhered to the DORA and Hong Kong Principles on assessing research, since the two emphasised fairness and rewarded excellence.

Source: University World News, 3 June 2022. https://www.universityworldnews.com/post.php?story=20220603115640789.

WHO concerned about monkeypox spreading among children

Kerry Cullinan *for Health Policy Watch*

Monkeypox appears to be establishing itself as a prominent danger to high-risk populations such as children, immune-compromised people and pregnant women, WHO Director-General Dr Tedros Adhanom Ghebreyesus has warned.

Already, the WHO said authorities had confirmed cases involving two children in the UK and a child each in Spain, France and the Netherlands.

At the end of June, Tedros defended the decision by a WHO emergency committee not to declare monkeypox as a public health emergency of international concern (PHEIC). Only 3 of the 14-person emergency committee felt the outbreak should be declared an emergency, Tedros told a media briefing.

"While the emergency committee did not advise that the current outbreak represents a PHEIC, they acknowledged the emergency nature of the event and that controlling the further spread requires intense response efforts," he said. "They advised that I should reconvene them quickly based on the evolving situation, which I will do."

In contrast, the US Centers for Disease Control and Prevention (CDC) activated its Emergency Operations Center to ensure "an aggressive public health response" to the outbreak.

The WHO reported that there were 3 413 laboratory-confirmed cases of monkeypox and 1 death from the virus reported from among 50 countries, with 86% of the new cases occurring in Europe. The highest numbers of cases were reported in Germany, Spain and the UK.

In Africa, one death was reported in Nigeria. Though it has been hit with an outbreak since 2017, the nation reported more cases than usual this year.

Vaccine shortage

Amid the public health crisis, the world has been grappling with a global shortage of vaccines that are effective against monkeypox. The nations that have them generally have limited supplies to fight a smallpox outbreak.

The only one that is licensed for use by adults against both monkeypox and smallpox – Bavarian Nordic's Jynneos vaccine – is in particularly short supply, and there are limited clinical data about its efficacy, as the only evidence is from animal studies.

WHO Director-General Dr Tedros Adhanom Ghebreyesus

While more supply of Emergent BioSolutions' ACAM2000 vaccine is available, it is only licensed for smallpox, has more side-effects and cannot be used by immunocompromised people – including people with uncontrolled HIV.

Another vaccine called LC16m8 is licensed for smallpox – but only in Japan.

The USA and Canada have made doses of the Jynneos vaccine available to health clinics for people with known exposure to the virus and those who are considered to be at "high risk," which is currently defined as men who have sex with men with multiple recent sexual partners living in areas where there has been high transmission among this particular population.

The US CDC announced that it had 56 000 doses available immediately, but that a further 240 000 would be available in coming weeks and 750 000 more by the end of August.

There remains some concern, however, just as there has been with COVID-19 vaccines, that the monkeypox vaccines will be monopolised by wealthy countries that can afford them, who will corner the market.

Even Spain, which is facing the biggest outbreak in the world at present, has only been able to give 71 vaccines to close contacts, according to *La Vanguardia*. These were made available to Spain from the European Union's smallpox response stockpile.

However, Dr Mike Ryan, the WHO's executive director of health emergencies,

Update

With a 77% increase in new monkeypox cases in the first week of July, the WHO's Emergency Committee is increasingly likely to declare the outbreak a public health emergency of international concern. A total of 59 countries have reported monkeypox cases, with Spain (1 804 cases), the UK (1 351), Germany (1 304) and the USA (605) recording the highest caseloads.

However, 10 countries have not reported new cases for over 21 days, which is the maximum duration of the incubation period of the disease, according to the WHO's latest report. At the time of writing SA reported 3 cases.

So far, there have been 6 027 laboratory-confirmed cases of monkeypox and 3 deaths, but most countries are unable to test for the virus.

However, the European Centre for Disease Prevention and Control (ECDC) reported that 5 949 cases had been identified in 33 European countries alone through international health regulation mechanisms and public records.

The vast majority of cases (99%) were male and aged between 31 and 40 years (42%).

told the media briefing that countries such as the USA that have vaccine stockpiles in case of smallpox have agreed to share these with other countries in need.

"But again, we must remember that these products have been licensed in the main for the use of smallpox," Ryan cautioned. "In one case, they've been licensed for monkeypox but based on animal models, and, I believe, immuno-bridging data from the smallpox side of things."

He called for more clinical data to be collected at the same time that vaccine use is expanded, as has been the case during the Ebola outbreaks. In particular, he says, there has been no evidence of the vaccine's effectiveness in treating high-risk groups.

Four-step approach

Tedros also called on all countries facing monkeypox outbreaks to take a series of public health steps.

First, he said, surveillance of the virus must be increased through much more testing. The next step, he said, is to follow WHO best-practice guidance in managing their responses.

Third is to actively engage communities such as LGBTQI groups to educate people about how to protect themselves, he said. And the fourth step, he said, is "to provide equitable access to countermeasures, like vaccines and antivirals."

Dr Ibrahima Socé Fall, the WHO's assistant director-general for emergencies response, said monkeypox already is a "multi-country, multi-regional emergency," with Europeans facing the high risk. He said WHO regions can activate emergency measures to address it.

Source: Health Policy Watch, *29 June 2022*. *https://healthpolicy-watch.news/who-concerned-about-monkeypox-spreading-among-children/*.

Coping with power outages – advice for healthcare professionals

Dr Tony Behrman, *Medical Protection Society*

By now, the experience of power outages, or loadshedding, will be very familiar to readers. So, too, is the experience of having to put contingency plans in place immediately to ensure that treatment continues and patient safety is not compromised.

While measures are in place to increase supply, the ever-present challenge of the power outage will not be going away any time soon.

Power outages are challenging enough for any business or household. For healthcare professionals – who have a clear duty of care – the challenges are compounded.

I have written about the guidance that healthcare practitioners should refer to when facing power outages. Given the continued prevalence of loadshedding and the concurrent demands of winter temperatures and continuing spread of COVID-19, it is timely to revisit the issue.

The law and power outages

The Occupational Health and Safety Act No. 85 of 1993 and its regulations form the basis of risk assessments regarding power outages, among other risks. Under the Act and regulations, the 16.1 and 16.2 appointee (the CEO and their designated appointee), with their risk-control staff, have the final decision as to whether a hospital is safe to proceed with surgical cases, provided the risk can be mitigated.

The employer must provide a work environment that is safe. Such an obligation includes routine maintenance to eliminate, mitigate and reduce the risk of danger to external healthcare providers, employees and patients.

The SA National Standards (SANS) electrical guideline 10142 is the only appropriate guideline to follow, and contains a section on minimum power requirements for medical facilities. The guideline refers to a power supply from a "safe source" such as a generator, which shall be energised if the usual source of power fails.

Minimum response times for replacement power

There are three response times specified in the SANS 10142 regulations:

(*i*) Uninterrupted power supply (UPS): the response time for an alternative power source in the event of a power failure needs to be faster than 0.5 seconds for all medical equipment in intensive care units (ICUs), theatres and recovery areas, where there are high-risk patients. This requirement can only be met using a UPS. Unfortunately, most UPSes only function for a limited time before they need re-energising, and as a result, hospitals are required to invest in UPS battery back-up equipment, which must deliver power for a regulated 20 minutes, as per SANS 10142. This power source is only a temporary bridge that ensures enough time for an alternative source of power from a generator to supply the hospital.

(*ii*) Critical generator supply: a response within 30 seconds is required of the critical emergency generators that supply critical elements in the hospital for the continuation of critical services such as emergency lights, life-support equipment in theatres, ICUs and wards, medical gas compressors, pharmacy fridges, certain lifts and support to recharge drained UPSes. These generators must be able to function for at least 24 hours, or for a minimum of 3 hours to complete surgery and evacuate the building, and the day theatres, if required. The recent huge increase in the need for ventilators during the COVID-19 pandemic has placed hospital back-up power again firmly in the spotlight, and resulted in considerable extra strain on already overstretched hospital resources.

This will affect the types of cases surgeons will be able to perform in that facility, as there is no legal requirement for an alternative power source over the requirement for a critical emergency generator. It is important that practitioners working in such a facility are aware of which generator backup system or systems are in place, to understand their and the patient's risk exposure in the event of a power failure or loadshedding.

Due to the 30-second start-up time of critical generators to accept the load, a

UPS is deployed to supply the equipment within 0.5 seconds and carry it through the 30-second power break until the critical generator takes over.

Based on this supply of power, a surgeon may need to cancel further operations after completion of the current case, until the full risk is mitigated. For this reason, many large hospitals have dual redundancies on generators, such as two or more separate generators supplying power to the hospital if required, the essential and the "non-essential" generators, inclusive of a UPS bridge.

When power outages are threatened or deemed likely, surgeons are encouraged to find out whether there are additional mobile generators, and whether there is sufficient fuel on site before starting surgery.

(*iii*) Baseload generator supply: these will supply a response after an interruption longer than 30 seconds. They are for non-essential supplies, and are only needed when a hospital provides a replacement ongoing baseload supply as backup.

When such a generator is present, the surgeon may carry on with activities as if the normal power supply is present, and until this fails, resulting in only the critical load generator being functional. At this point surgeons should finish their cases as described above, and not consider starting any new cases. The decision to install and utilise these baseload generators is ultimately one that balances clinical and commercial factors. Managers will consider the cost of total downtime to a hospital v. the return on investment of keeping the hospital up and running. With these facilities, doctors are safe to start new cases as long as all systems remain functional.

While many private hospitals have voluntarily invested in large baseload generators, which can run for many days, it is important to remember that in times of severe power outages there may be severe rationing of diesel, which may result in fuel being diverted to other facilities, according to the state's priorities.

Final advice for clinicians

Clinical teams who are working in a facility where power outages are likely to occur should have a contingency plan in place. They are encouraged to confer with the general manager of the facility, and carefully consider their advice and explanation of the risks of losing backup power supply. Should facility managers advise not to proceed with new cases, this advice should be taken extremely seriously. A doctor who ignores this advice could put a patient's safety at risk and in doing so, could leave themselves vulnerable to claims of clinical negligence, an inquest and even a possible criminal charge.

If healthcare professionals are in doubt about clinical decision-making in the face of potential power outages, they should contact their medical defence organisation for advice.

Letters to the Editor

The *Letters to the Editor* page aims to give members the opportunity to comment on, query, complain or compliment on any matter, topic, incident, event or issue in their particular field or with regard to general healthcare, which you feel should be shared with your colleagues and fellow readers.

Please note that letters:

- should be no longer than 500 words
- can be published anonymously, but writer details must be submitted to the editor in confidence
- must be on subjects pertinent to healthcare delivery
- should be submitted before the 6th of the month in order to be published in the next issue of *SAMA Insider.*

Please email contributions to: Diane de Kock, dianed@samedical.org.

Farewell Emily, you will be missed

SAMA Communications

For more than 42 years, branch administrator Emily Nel has been one of the friendly voices at the SAMA Cape Western branch (CWB), a lady know and loved by SAMA members making contact with the branch in Pinelands.

CWB said a sad farewell to Emily Nel in July after 42 years in service to SAMA. Emily joined MASA (the Medical Association of SA) in 1979 when their offices were in Wale Street, and comprised at least four floors. The association began in 1884. The Wale Street building was sold and demolished in 1984, and the offices moved to Pinelands. While in Pinelands, Emily started a locum agency for doctors, which was very successful. She was then approached by the then GM of MASA, Dr Derek Hanekom, to also start recruiting doctors as members.

"When MASA changed to SAMA, the recruitment department grew exponentially, and I was having to travel to all the towns in the Western Cape," says Emily. "Many members joined SAMA because of the personal contact – I attended every intern orientation at the various hospitals in the Western Cape, from Hermanus to Paarl, Caledon and even Swellendam (a 2-and-a-half-hour drive)."

"When Helen Strong was appointed by head office to oversee the membership department, she asked that I travel to the Transkei for a week to recruit. I visited all the hospitals and clinics in the area, which was quite successful. I think it is very important to personally visit the hospitals and private practices when doctors are available."

Emily is held in very high regard by the CWB, playing a privotal role in the lives of many doctors. "SAMA has been my whole world for many years," says Emily, who has enjoyed recruiting and meeting doctors and seeing their careers develop over the years. "I am really going to miss all the many contacts I have made in over 40 years with MASA/SAMA – the association has been very important in my life." A common comment when visiting doctors was: "Are you still here? I am so happy to hear that." Emily was always willing to go the extra mile for members, often working after hours. She will be sorely missed.

Over the years and while visiting hospitals to canvass new members at intern orientations, Emily became aware of the need for knitted goods in local hospitals and her community. She has been an avid knitter for years, initially making booties and hats for premature babies. Later she knitted and crochetted for the Saartjie Baartmen Centre for Women and Children, a one-stop centre for woman and children who are survivors of abuse. "I like to do something in the background," says Emily, a sentiment that led her to start knitting teddy bears for the Tygerbear Foundation at Tygerberg Hospital. "The children undergo counselling and they receive a bear that they can call their own. It is soft so that it can be cuddled."

Dr Mohammed Abbas, a previous chairperson and now branch council member, comments: "I met Emily in 1997 when I joined MASA, and she always assisted us unconditionally with our transition to SAMA and throughout my years as branch councillor and member of the CWB executive. Emily always went the extra mile for everyone. We will miss her kindness and humility greatly. Long years of dedicated service to the branch will be a difficult position to fill in her absence."

Emily intends to remain involved in her community, visiting the elderly and a dog shelter, and occasionally crocheting blankets for a home for babies in Goodwood. She also enjoys reading and spending time with her family.

"I wish SAMA only the best, and that it goes from strength to strength."

Emily (right) with retired chairperson Prof. John Terblanche and colleague Chenienne Gericke at a presidential dinner in the early 2000s

MASA staff outside the new Pinelands offices in 1984

Informed decision-making: A practical perspective

JP Ellis, *head of legal, EthiQal*

Situations frequently arise in clinical negligence cases where the outcome of a case hinges on the informed consent process. Good patient education during the consent process is the doctor's chance to make sure that the patient's expectations are realistic. A proper understanding of the informed consent process is probably the most effective way to manage one's risk. Other than building the doctor-patient relationship, it ensures that patients do not encounter unpleasant surprises on their care journey that may result in unnecessary anger and blame.

Informed consent is both a legal and an ethical requirement. The National Health Act No. 61 of 2003 gives patients the right to be informed of the various treatment options available, and the benefits, risks and costs of each treatment option. It also gives patients the right to participate in decisions regarding their treatment, and the right to consent before any treatment is given, unless it is an emergency and they are not able to consent. From an ethical perspective, informed consent has two main objectives: firstly, to respect and promote patients' autonomy, and secondly, to protect patients from potential harm. Medical intervention with a patient's body is potentially an infringement of the Constitutional right to bodily integrity, and is legally wrongful unless there is a ground of justification. One such ground of justification is patient consent.

There are three basic requirements that need to exist in order for a patient to have consented, and all three are required – for example, consent can be vitiated if a patient is not given sufficient information to enable them to provide consent:

- patients must be given sufficient information (knowledge)
- in a way that they can understand (capacity/appreciation)
- to enable them to exercise their right to make informed decisions about their care (voluntariness/acquiescence).

Informed consent is therefore a process in which you provide information sufficient to enable the patient to make an informed decision regarding their healthcare. This is an ongoing process. Although the signature of a consent form often constitutes completion of the consent process, a signature without a balanced discussion does not constitute informed consent. Therefore, this process is best described as "informed decision-making".

From a practical point of view, the following is a suggested outline in ensuring that patients exercise their ability to make an informed decision regarding their treatment, and doctors are protected from allegations of wrongful conduct.

Basics

- Knowing your patient will help focus the discussion during the informed consent process.
- In explaining your patient's condition, use simple language.
- Assess your patient's capacity to understand the information.
- Avoid technical medical terminology (or include a glossary to the consent form).

Explain the procedure and material risks

- Discuss the various options available to the patient for treatment, including non-operative care and no treatment, together with the potential benefits and risks of each option.
- Make use of anatomical drawings.
- Discuss recognised and material complications that have a reasonable likelihood of occurring and/or that are likely to be of importance to your patient, considering personal circumstances – for example, an abnormal sense of touch after carpal tunnel syndrome surgery may affect a practising dentist more significantly than a retired librarian.
- Ensure that your consent form documents that no guarantees or promises have been made regarding the outcomes of the procedure, and that the patient has a right to refuse the procedure.
- Discuss potential follow-up treatment.
- Allow an opportunity for questions and answers.
- Provide further sources of patient information, such as patient education leaflets.
- Invite the patient to contact you if additional questions arise prior to the planned procedure.

Financial consent

Discuss the patient's responsibility to pay, their medical aid coverage, including any out-of-pocket costs, and the costs of any complications.

Obtain written consent

Ensure that your consent form is specific for each procedure, and contains the following minimum information:

- full name of your patient
- your name and contact details
- details of your patient's condition
- list of treatment options discussed
- list of material and recognised complications
- record of procedure that the patient has consented to
- record of the proposed date and time of procedure, if available
- reference to any information/resources/anatomical drawings, which must be attached to the form
- an affirmation that the patient understands the information and has had the opportunity to ask questions
- an affirmation that the patient has consented to the procedure
- financial consent
- highlighting of the use of anaesthesia
- highlighting of the use of blood products.

Consider giving the patient an opportunity to take the form home and return it later, if possible. Ensure that the patient initials and signs the document, and enters the correct date.

Sign the declaration at the end of the form as the treating doctor, and allow the patient to take a copy and keep one copy for the practice.

If a patient has specified that they would rather a procedure did not go ahead in the event of certain clinical findings, the patient's decision must be recorded and respected.

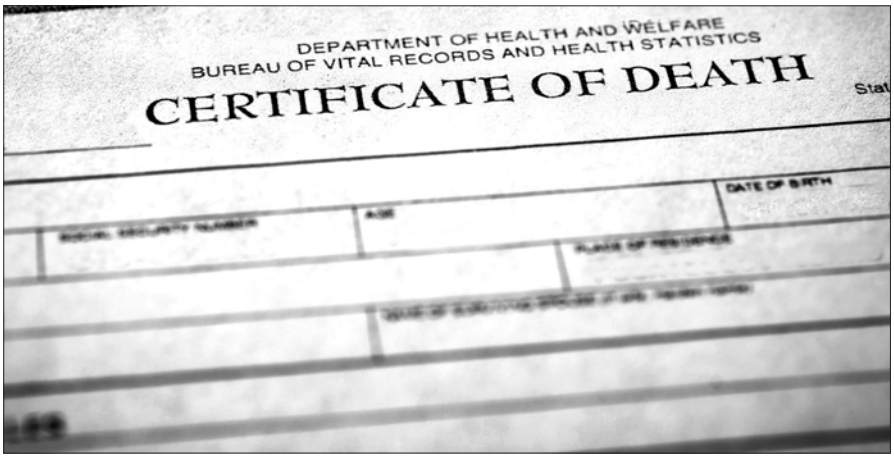
How long does consent last?

Consent remains valid until it is withdrawn by the patient, or until their circumstances change in a meaningful way. However, if significant time has passed since the original consent was obtained, you may need to update and document your discussion with the patient. Additions or corrections to the consent form must be dated, and initialled by both parties.

Doctors – do you have to examine a body before issuing a Notice of Death?

Johan Jooste, *MacRobert Attorneys*

"In this world, nothing is certain except death and taxes," according to Benjamin Franklin. While we all have to face the latter on a regular basis, doctors deal with the former on a more frequent basis than the rest of the population. Most medical practitioners will, at some point during their career, be required to complete an official Notice of Death/Still Birth form in terms of the Births and Deaths Registration Act No. 51 of 1992. This form DHA-1663 is an important document recording and reporting the death of an individual. It contains information such as the name, age, date of death and cause of death. For this discussion, I will focus on the cause of death aspect.



Section B of the DHA-1663 form ("the form") is titled the "Certificate by Attending Medical Practitioner/Professional Nurse". Its purpose is to record whether or not a medical practitioner believes that the deceased died solely and exclusively as a result of natural causes. The person completing the form has the option of either certifying that the deceased "died solely and exclusively due to natural causes" (section B 22.1) or that he or she "is not in a position to certify that the deceased died exclusively due to natural causes" (section B 22.2). Rather ominously, the medical practitioner, when signing this portion of the certificate, agrees that, if the chosen option in paragraph 22 is not true, "I shall be guilty of an offence and on conviction liable to a fine or to imprisonment for a period not exceeding 5 years or to both."

Section C of the DHA-1663 form deals with certificates issued after a medicolegal investigation of death, and is completed by a medical practitioner or forensic pathologist. A medicolegal investigation will need to be performed where, for example, the patient died during, or shortly after a surgical procedure, or where a practitioner has indicated in section B that (s)he is not in a position to certify that the deceased died exclusively due to natural causes. In the latter instance, whether or not the body was examined by the practitioner filling in section B may not be a contentious issue, given that the body will, in any event, be examined by the practitioner who completes section C of the form after a postmortem examination.

There is some uncertainty, and therefore a divide within the medical community, as to whether a medical practitioner is required to examine the body of a deceased patient after their death before recording whether or not the death was due to natural causes.

Not all scenarios are cut and dried. For example, you are a GP who has been treating an elderly patient at your practice for many years. Earlier in the week, the patient consulted you complaining of occasional chest pain. You performed various examinations and requested certain blood tests, but no particular explanation for the symptoms was noted. A few days later you receive a call from the patient's daughter advising you that the patient has passed away, in bed, during the night. The daughter advises that the paramedics who were called to the scene suspected myocardial infarction as the cause of death. The daughter then requests that you complete the form. In such circumstances, do you need to examine the body before completing the Notice of Death?

Based on a reading of the DHA-1663 form itself, the answer to the above question appears to be yes. Section A of this form, which deals with the particulars of the deceased, states that this section "is to be filled out by authorised medical practitioner … who is responsible for *examining the body to determine the cause of death*" (my italics). Section B, which is the certificate stating whether the death was due to natural causes, in turn, states that this section is "to be filled out by the same medical practitioner … who completed section A". Finally, section G, which is the medical certificate of cause of death, requires completion by the medical practitioner who has determined the cause of death (i.e. the practitioner who filled out section B or C). From the aforementioned, it appears that a medical practitioner is expected to examine a body before completing a Notice of Death form. This seems to be a logical position to take, given that it is arguably not possible for a medical practitioner to assess whether a death was due to natural causes without personally having examined the body for defensive wounds or any other signs of possible foul play. But why, then, does there seem to be uncertainty in the medical community?

The answer to this question lies in not only the enabling legislation, the Births and Deaths Registration Act No. 51 of 1992 ("the Act") and its regulations, but also, to some extent, in the form itself. Section 15(1) of the Act, as mentioned, states that "where a medical practitioner is satisfied that the death of any person who was attended to before his death by the medical practitioner was due to natural causes, he shall issue a prescribed certificate stating the cause of death". Section 15(2) states that "a medical practitioner who did not attend any person before his death but after the death of the person examined the corpse and is satisfied that the death was due to natural causes, may issue a prescribed certificate." Regulation 21(1)(a) of the regulations on the Registration of Births and Deaths (26 February 2014) states that a "notice of death must be given within 72 hours of the death by the informant – (a) on form DHA-1663 … where the cause of death certificate [section G of form

DHA-1663] contemplated in section 15(1) or (2) of the Act was issued by a medical practitioner" (my insertion).

The first point to note is that section 15(1) does not mention a requirement of examination, while section 15(2) does. It would appear from this that the legislator envisioned two situations: one in which a practitioner who had had previous dealings with the patient was not required to examine the body, and one in which a practitioner who did not know the deceased was required to do so. On this interpretation of section 15(1), provided the medical practitioner had attended to the person at some stage before their death and was satisfied that this was a result of natural causes, a certificate (section G of the form) could be completed without the practitioner having examined the deceased's body after death. Finally, to add to the uncertainty, section G.1 of the form specifically asks what method was used to ascertain the cause of death, and provides various options from which to choose. Two of these stated options include the opinion of the attending medical practitioner, and an interview with a family member. Not only is the requirement of examination not specified for either, but the options presented (including that of interviewing a family member), taken together, could be interpreted to mean that the body need not be personally examined by the certifying practitioner after the deceased's death.

The above presents some difficulties, the first of which is found in section A of the DHA-1663 form. This section, which is titled "Particulars of the deceased", must be completed by the medical practitioner "who is responsible for examining the body to determine the cause of death". This appears to contradict both section 15(1) of the Act and section G of the form. Section 15(1) requires that a practitioner must be "satisfied" that the death was due to natural causes. This is a subjective requirement and it may be difficult to determine, at the time, what is satisfactory in each situation. For example, based on the scenario above, can a practitioner be satisfied by having been informed of the paramedics' opinion by the deceased's daughter, coupled with his/her having seen the deceased 1 week before death? Again, section G of the form makes provision for a determination of death by various methods, not all including actual examination.

Based on the above, an argument can be made that a death notice can be completed without the practitioner concerned having examined the body (given that the Act seems to provide for this eventuality). However, it is far wiser for a practitioner rather to examine the body of a deceased person, regardless of whether (s)he has recently consulted with them or not. If a particular practitioner cannot examine the body, (s)he should approach a colleague to do so on his/her behalf.

Finally, practitioners must bear in mind that they may be called upon to substantiate their finding that death was brought about by natural causes. It is therefore important to document the basis and reasons for such a finding.

Legal proceedings instituted in foreign jurisdictions

Mark le Roux, *case manager, Medical Protection Society*

Dr H, a Medical Protection Society (MPS) member in SA, received a witness summons from the legal representative of an ex-patient (patient A)'s spouse. Dr H was instructed to produce clinical records at the Magistrate's Court of Western Australia on a specified date, in a dispute between patient A and her spouse. Failure to comply with the official summons could have led to his arrest and imprisonment, or him being fined by the court. The witness summons allowed AUD10 for his reasonable expenses in complying.

Dr H contacted MPS for assistance, since he could not contact his patient for her consent and did not know how to prepare the clinical records for reference by a foreign court.

How did MPS assist?

Due to the short time frame that was given to Dr H to comply with the witness summons, one of the MPS case managers, along with panel attorneys, assisted Dr H in timeously resolving the issue.

On our advice, Dr H did not comply with the witness summons, and we communicated this to the Australian legal representative acting on behalf of the spouse of patient A. It was held that the Magistrate's Court of Western Australia did not hold jurisdiction over Dr H and, further to that, if Dr H had acted on the witness summons without the documented consent of his patient, he would also be in violation of the National Health Act No. 61 of 2003 and the Protection of Personal Information Act No. 4 of 2013, which specifically deals with the transfer of personal information outside the Republic of SA.

As a MPS member, Dr H also had the advantage of being able to call on the support of MPS's Australia office, where we would have been able to instruct local attorneys if the matter had escalated.

Learning points

In this case, the universal aspect of consent was a key element in deciding whether to comply with foreign court orders and legal proceedings. It was also apparent that any processing of data should at all times be with the consent of the data subject, and that local legislation will always supersede the foreign legislation that might be attempted to be imposed.

Dr H, in this case, managed to make use of the medicolegal services available to him as soon as he became aware of the witness summons, and we were able to offer assistance promptly while dealing with the foreign legal representatives.

It should also be noted that Dr H complied with the HPCSA's recommendations on the duration of record keeping despite having prior knowledge of the fact that his patient and her family had emigrated to Australia.

Goldfields hold membership recruitment drive

On 24 June 2022, the Goldfields branch held a membership recruitment drive at Bongani Hospital in Welkom.

SAMA and non-SAMA members were welcomed with open arms. Information was exchanged by handing out a branch information pack and SAMA branded items to the doctors as a token of appreciation.

Moreover, the members checked and confirmed their membership status and details, and seven doctors signed up as SAMA members.

Sultana Hartzenberg (branch administrator) with Dr Pudumo Paseka, an intern at Bongani Hospital

KwaZulu Natal Coastal branch re-introduce CPD meetings

After almost 3 years of not having face-to-face CPD events during COVID, the KZN Coastal branch (KZNCB) held a meeting on Sunday 26 June 2022 at the Coastlands Umhlanga conference centre. It was well attended and a lot of interest was shown.

The topics focused on diabetes care and cardiovascular complications, mainly relating to family practices. Dr Aslam Amod, an endocrinologist, sent a video presentation, and Dr Sanjay Maharaj, a renowned cardiologist, gave us a very informative talk on cardiovascular complications during diabetes, and much-needed lifestyle changes.

Dr Abdool Cassim, branch chairperson, informed members about the restructuring of SAMA.

We ended with a talk by Dr Ismail Omar advising us on how to run a successful practice, and adapt our practices to the challenges faced by private family practitioners/physicians.

"We as the General Practitioners Practice Committee (GPPC) at the KZNCB intend to continue engagement and serve the ever-growing needs of our membership, and in line with this will try to make this a regular event on the branch calendar," said Dr Cassim. "Wishing all our members well."

Dr Abdool Cassim, chairperson of the KZN Coastal branch

Free State branch support SARZA event

The Free State branch contributed to the Search and Rescue South Africa Free State (SARZA) programme, in support of the 27th Annual Polar Bear swim, which took place on 25 June 2022 at the Willem Pretorius resort.

The public and swimmers from all over the country entered the water to swim a short distance in the middle of winter to raise funds for various charity organisations.

A team of four DHL lifesavers were present with private medical corporations to offer medical assistance if needed.

The event was successful and highly praised by the public, with no major incidents.

SARZA team members at the event

Welcome to SAMA

SAMA welcomes the following new members who joined our association in June.

Border Coastal branch
Jessica Mugambe

Cape Western branch
Zakiyya Abdurahman
Faybia Arendse
Nkhensani Dineo Baloyi
Jameela Harris

Eastern Highveld branch
Kyara Bergstrom Kruger
Sangeeta Arwin Bhoola
Aarti Komal Lakshmanan
Thabang Maphetho
Nabiela Ragooloo

Eastern Province branch
Thandelakhe Mabophe
Imtiaaz Mansoor
Solwethu Mose
Phahla Mthangayi
Nonelela Ndamase
Lwandile Nkosi
Emmanuel Nkosinathi Xego

Free State branch
Anre Anvari
Allison Angelique Bosman
Manuel Casal Perez
Kagisho Peace Jonas
Teboho Kgukutli
Pheello Alphons Manamathela
Moeti Motebang Moeti
Nkheseng Tracy Mokoena
Mikayla Mostert
Ramabole Rampeta
Emile Vorster

Gauteng branch
Daniel Benjamin
Zeenat Bismilla
Amy Feldman
Pnina Shani Herring
Tasneem Ooni
Gracia Opa
Eli Smith

Gauteng North branch
Inge Els
Michelle Human
Karen Nyota Kinqiela
Mfundo Kunene
Busang Malete
Paseka Donald Mello
Onthatile Boitshoko Moletsare
Bongeka Ndwandwe
Tholoana Ntai
Joseph Otieno Okello
Christelle Viljoen

Goldfields branch
Litha Bakumeni
Elizabeth Grace de Vries
Sello Enerst Makhetha
Pontsho Precious Modungwa
Paseka Piet Pudumo
Senamile Happiness Thabethe

Griqualand West branch
Keorapetse Bantsheng
Jacobus Johannes Schoeman
Malebo Abedneso Sebolai

KZN Coastal branch
Sherri-Leigh Hainswarth
Zahir Mahommed Jones
Matamba Jean Benoit Kabeya
Juhi Kiara Maharaj
Shivaangi Maharajh
Amanda Nono Mlambo
Kerusha Moodley
Keshini Munthree
Nomeshen Naidoo
Nondumiso Ndlovu
Ayanda Simphiwe Ndlovu
Devashya Ramdeo
Angelene Reddy
Caroleen Rudwelal
Gloria Mampho Selepe
Amil Singh
Talia Unice

KZN Midlands branch
Jessica Fryer
Licham Hlotshana
Marli Myburgh
Alicia Sivnarain

KZN Northern branch
Leticia Jade Iyer
Sphesihle Thokozani Mngoma
Maxine Lechelle Willis

Limpopo branch
Charmaine Mankwe Letsoalo
Khutjo David Mafifi
Kgaladi Mokgohloe Magooa
Miles Nyiko Tivane

Lowveld branch
Celia Aida Cumbi
Siphosomusa Andrew Masango
Gabriel Enough Phesane

Outeniqua branch
Tawie Wolvaardt

Transkei branch
Sibongeleni Alex Cele
Kanyisa Chumisa Fekisi
Siphosihle Msutu
Siphukuthula Mthethwa
Andisiwe Ethel Simakade
Sibeko Vatsha

Tygerberg Boland branch
Taryn Andrea Koopman
Nicolene Kruger
Ammaarah Mukaddam

Vaal River branch
Kamohelo Lesedi Sehapi

West Rand branch
Adams Brandon

Unattached
Sinakekelo Lukhele

SAMAREC

The South African Medical Association Research Ethics Committee (SAMAREC) has been a well-established Research Ethics Committee (REC) in South Africa since 1992.

As a registered REC with the National Health Research Ethics Council (NHREC), the Council reviews biomedical research proposals done in the Private Sector. Ethics review is done on any type of biomedical research, including full-scale clinical trials, observational and device studies, surveys and registers. If you are planning to publish your study or ensure that you comply with good clinical practice – SAMAREC will ensure your trial meets all the requirements. We offer a complete electronic submission process, and guarantee a quick turnaround time. SAMAREC has a designated Officer to keep you up to date with the progress of your application

For more information, please contact the
SAMAREC Officer | 012 481 2082 or **samarec@samedical.org**

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