SAMA INSIDER

JUNE 2021

Vaccine hesitancy: The role of the medical fraternity

POPIA: Implications when using apps and operators

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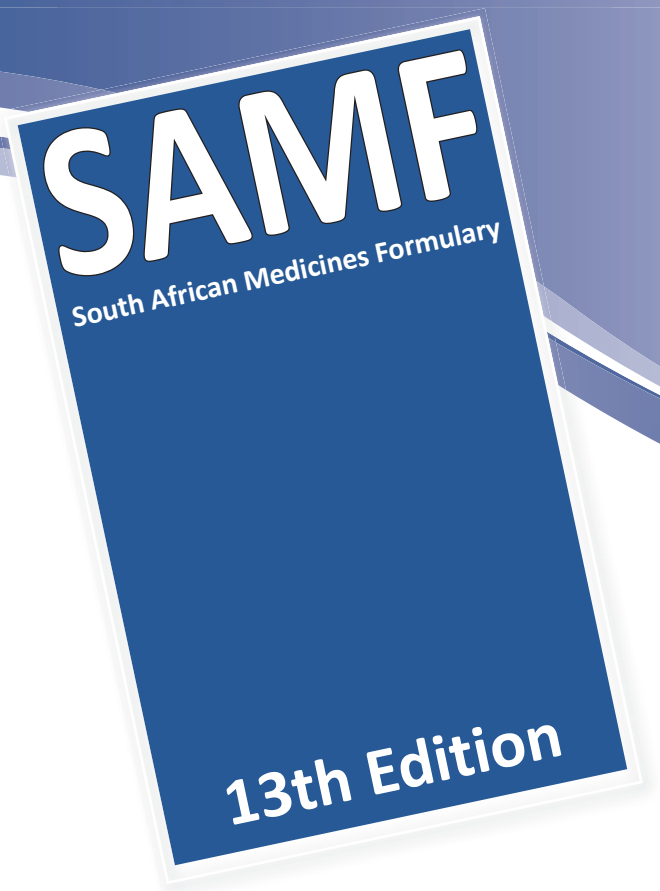

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EDITOR'S NOTE

JUNE 2021

Diane de Kock
Editor: *SAMA INSIDER*

Contributing internationally and nationally

Welcome to the June *SAMA Insider*. This month, we focus on SAMA's participation in the WMA council meeting held in April this year (page 5). SAMA continues to contribute to various working groups, as well as to developments on new and existing ethical and sociomedical issues needing attention at an international level.

The SA National Bioethics Committee of UNESCO recently hosted the first in a series of workshops on the fair, equitable and timely allocation of COVID-19 vaccines in SA (page 6). "A consolidated message must be sent out that as a continent, this gap is unacceptable, requires immediate action and must be remedied."

Vaccine hesitancy is a reality both internationally and nationally. SAGE, SAYAS and ASSAf confront the role of the medical fraternity in debunking vaccine myths (page 8). "Knowledge is best based on an appreciation of the contributions of the collective."

The POPIA Act becomes law this month; we look at its implications when using apps and operators to process information (page 9). "In the course of treating a patient, a healthcare practitioner may be required to share patient information with numerous parties, including treating and/or referral healthcare professionals, administrative departments and medical aid schemes for payments." We focus on three solutions than can enable POPIA compliance with regard to some of the processes in your practice.

This month, we introduce you to the Professional Association for Transgender Health, an area of healthcare that is still new to many health professionals. An international organisation exists, but members thought that there was a need for an SA professional network, which was established in October 2020 (page 12). "A focus on the health of transgender and gender-diverse (TGD) people is important, as this is a marginalised group that experiences significant health disparities." This is borne out by the article (page 13) on transgender youth being at the highest risk of suicide. "Young people who identify as transgender face an uphill battle for acceptance in the face of misunderstanding and misinformation, stigma, discrimination and bullying, putting their mental health and even their lives at risk."

In branch news, we feature Sandra Ferrone, who has worked for the Tygerberg branch for 45 years and will be stepping down this year. KZN Midlands' branch secretary Mandy Hattingh chats to recipients of Lifetime Membership Awards, and SAMA head office host a wellness day for employees.

We hope you enjoy the read.

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Published by the South African Medical Association
Block F, Castle Walk Corporate Park, Nossob Street
Erasmuskloof Ext. 3, Pretoria

Email: publishing@samedical.org | www.samainsider.org.za | Tel. 012 481 2069
Printed by Tandym Print (Pty) Ltd

Nurture young doctors – critical for future healthcare

Prof. Risenga Chauke, SAMA President

June is generally known as Youth Month in SA, in commemoration of Youth Day. The day of June 16th in 1976 marked one of the pivotal events that facilitated change in the sociopolitical landscape of our country, spearheaded by the youth of the day.

The youth remain an integral part of any society, and particularly so in Africa, the youngest continent – and SA specifically, which has a median age of 27.6 years. Indeed, young doctors play a significant role in service delivery, and are critical for safeguarding our capacity to deliver services in the future. We have an ageing population of medical practitioners, and this is especially the case in the specialist categories, where a significant proportion of practitioners are above the age of 60 years. It is important to determine whether this cadre is being replaced by able and capable youth.

What do statistics tell us?

The global population of people aged over 60 has doubled in size since the 1980s. The aged population also constitutes an important part of the labour force, and this fact is not given adequate attention. Africa's ageing population is expected to grow faster than that of any other region in the world, according to the UN 2017 report on population ageing: in fact, the ageing population in Africa is expected to triple between 2020 and 2050.

Older people are living longer and postponing their retirement, thus feeding into the narrative that senior and influential positions that could be occupied by the youth are blocked by the ageing. Various factors contribute to older people delaying retirement. Some of these are due to the legacy of apartheid and consequent lack of financial independence, especially among doctors of colour. This may also be compounded by what is known to some people as "black tax", among other financial challenges, which may result in delayed retirement and hence increased competition for senior roles.

There is no doubt that we need to be intentional in capacitating young professionals, and providing them with mentorship and platforms to attain various skills in the profession. This is easier said than done, especially if we lack an understanding of the challenges they face in medical education, training and practice. Some of these are discussed below.

Extended training time

To qualify as an independent medical doctor requires an investment of 9 years in SA today. This period might be extended due to the employment gap during internship and community service, which is beyond newly qualified professionals' control. A fully fledged specialist requires a training period of between 13 and 15 years, which includes a minimum of 4 years of specialist training. The majority of the youth are possibly not prepared to invest this amount of time in the necessary training.

Financial constraints

Some medical students struggle to fund their studies, especially the "missing middle" who do not qualify for National Student Financial Aid Scheme (NSFAS) support. Some students, on completion of their studies, have to immediately attend to their family's socioeconomic needs, as well as service the debt accumulated during their training. These new and urgent financial demands may delay or even deter newly qualified professionals from pursuing specialist training.

Lack of mentorship

The passing on of knowledge from senior to junior cadres in the profession is sometimes imperfectly done. Junior professionals often have to learn by what they see, and thus develop their own way of navigating through the medical field.

Litigation

The community in general is becoming more litigious, sometimes enabled by the law, and often encouraged by colleagues in the legal field. This can be discouraging to youth who may have liked to join the medical profession.

The Workload Indicators of Staffing Need (WISN) method, as approved by the WHO, determines and/or guides staffing requirements in terms of health professionals. However, this method is not yet fully utilised in SA, due to challenges in keeping satisfactory records of medical staff and the population. On average, SA has a doctor-to-population ratio of about 15 per 100 000. The ideal would be 100 doctors for a population of 100 000, which is 1 doctor per 1 000 people. The need for more doctors will only increase as people continue to live longer, while the challenges faced by young professionals and the attrition rate threaten the achievement of this target.

What can SAMA do?

The human resources for health requirements are known, and the pandemic has highlighted the importance of addressing this critical issue. The question, therefore, is why intern doctors should struggle to find placements in a human resource-constrained environment. Undoubtedly, the government has a huge role to play in ensuring that funding is made available to absorb new graduates and avoid the situation of doctors sitting at home uncertain about their future. The HPCSA, as the regulatory body, has an obligation to increase the accreditation of intern training sites to absorb these cadres into the system. As SAMA, we remain resolute in our determination to agitate for our doctors to be able to serve our country, and advocate for improvements in the treatment of our cadres.

There is a need for a review of medical training, and for improving the working conditions of doctors. We need to engage with the issue of the curriculum. Is it possible to reduce the curriculum, and therefore the training time for doctors? Is it necessary for first-year medical students to continue to study physics and chemistry post matric?

Can the living and working conditions for doctors be improved? Can the "military-like" training of doctors be relaxed?

Financial literacy for medical professionals should be included as part of the curriculum. This may mitigate against flawed financial decision-making by some young doctors. For example, is it important to purchase an expensive new car as soon as one completes training, or can that be deferred to a later date?

Having role models is essential. The seniors in the profession should be encouraged to mentor and become role models for the young professionals.

The regulatory bodies and government could play a bigger role in reducing the appetite for litigation in the medical profession. SAMA as an organisation is prepared to defend the profession in this area, without of course condoning wrongdoing.

As an organisation that advocates for the rights of doctors, we remain committed to working with the government, regulators and other stakeholders to improve these conditions for our members.

SAMA at the WMA April 2021 council meeting

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

The World Medical Association (WMA), of which SAMA is an active member, held its 217th annual council meeting as an online event from 20 to 24 April 2021.

Originally planned to take place in Seoul, South Korea, the council meeting had to be moved to an online event as a result of the ongoing COVID-19 pandemic. Fortunately the online format allowed SAMA the opportunity to participate despite travel restrictions.

About the WMA

We have written about the WMA and SAMA's participation in it previously (see *SAMA Insider* December/January 2021).

The WMA is an international organisation representing physicians. The organisation was created to ensure the independence of physicians, and to work for the highest possible standards of ethical behaviour and care by physicians at all times.

SAMA has been a member of the WMA since its inception, and has also been involved in the development of many ethical and sociomedical affairs guidelines, as well occupying key leadership positions within the association in the past.

SAMA's inputs to the declarations, statements and resolutions of the WMA are generally prepared with input from the SAMA Health Policy and Human Rights, Law and Ethics Committees (HPC and HRLE), with additional input from content experts where this is required.

SAMA also participates actively in a number of WMA working groups that have been established to examine certain issues in detail.

Public consultation

As approved for circulation at the April council meeting, the draft of a revised version of the International Code of Medical Ethics (ICoME) is now open for public consultation, and may be downloaded from the WMA website.

SAMA participated as part of the working group that has driven the revision of the ICoME and worked in inputs to the existing document since 2017.

The ICoME was adopted by the WMA in 1949 as a complement to the Declaration of Geneva: The Physician's Pledge. The ICoME outlines the guidelines, norms and central duties of the medical profession.

The code has been amended three times, most recently in 2006. Now, in a major revision, new clauses have been added dealing with physicians' potential conflicts of interest, advertising, telemedicine and duties towards the environment.

The current revision can be downloaded from https://www.wma.net/what-we-do/medical-ethics/declaration-of-geneva/public-consultation-on-a-draft-revised-version-of-the-icome/.

2021 WMA council elections

In line with the WMA articles and bylaws, new council officers were elected as part of the 2021 council meeting, for a 2-year term. Dr Frank Ulrich Montgomery (Germany), was elected as chair of the WMA council, and Dr Kenji Matsubara from the Japanese Medical Association elected as vice-chair. Dr Ravindra Sitaram Wankhedkar from India was elected as treasurer.

In addition, each of the three council committees elected their chairperson for the next 3 years. Dr Marit Hermansen of Norway was elected chair of the medical ethics committee (MEC), Dr Osahon Enabulele of Nigeria chair of the sociomedical affairs committee and Dr Jung-Yul Park of Korea as chair of the finance and planning committee. SAMA is looking forward to contributing to the work to be done by these committees over the next 3 years.

Key discussions

While references to learning and experiences during the COVID-19 pandemic shaped a good deal of the updates and concerns raised during the council meeting, there were also important developments in other areas worth noting.

Three urgent council resolutions were passed after debate. The first, entitled "Resolution in support of the countries worst affected by the COVID-19 crisis", calls for the international community and governments to urgently prioritise support and aid to the worst-affected nations, for the sake of all.

The second resolution addresses the continuing actions of the current police and Myanmar security forces, including arbitrary arrests and detention of health personnel and other citizens, attacks against physicians and other health personnel and facilities and continuing harassment and intimidation of protesters, human rights defenders and journalists.

The third resolution notes the critical health condition of the Russian opposition activist Alexei Navalny, detained in Moscow since January 2021. Navalny was on a hunger strike from 31 March, and was transferred to a prison hospital, where it was reported that he was facing denial of adequate medical care and threatened with force-feeding by the prison authorities. The WMA referenced its Declaration of Malta on Hunger Strikers, laying down the medical ethical principles governing hunger strikes, in particular respect for the individual's autonomy and dignity. Force-feeding and any other forms of coercion constitute a form of torture, and are contrary to medical ethics.

In addition to those addressed urgently, several other statements and policy positions were debated and finalised.

SAMA had submitted a proposal to include e-cigarettes in the existing WMA resolution on the plain packaging of cigarettes. The WMA resolution had already recognised the need for governments to introduce mechanisms such as plain packaging to reduce brand recognition and the promotion of tobacco products. SAMA's arguments for the inclusion of e-cigarettes in this resolution centred around the increasing use of e-cigarettes, and the mounting evidence from several countries that e-cigarette use predicts initiation of use of traditional tobacco products among non-smokers and young people. Currently, 83 countries now regulate e-cigarettes as tobacco products, while 27 countries, including 4 in Africa (Gambia, Mauritius, Seychelles and Uganda) have banned the sale of e-cigarettes.

SAMA continues to contribute to various WMA working groups

The newly revised resolution on plain packaging is already available on the WMA Policy Portal at https://www.wma.net/policies-post/wma-resolution-on-plain-packaging-of-cigarettes/.

In addition, two policy statements that had been in need of revision were submitted by SAMA for review by the MEC: the WMA "Statement on access of women and children to health care", and the WMA "Statement on women's rights to health care and how that relates to the prevention of mother-to-child HIV infection". Both statements were accepted (with some minor amendments) by the WMA MEC, and will be submitted further for approval by the WMA general assembly when it meets in October 2021.

Of additional importance to SA was the revised Declaration on Principles of Health Care for Sports Medicine. While this declaration has previously dealt with issues of doping and other performance enhancement methods in sports medicine, the updated declaration includes the WMA's objection to World Athletics Regulations that require that female athletes with differences in sex development must take drugs to suppress and control their natural blood testosterone levels in order to compete. The revised declaration states that the mere presence of a condition induced by a difference in sex development, in a person who has not shown an intention to change that condition, is not a medical reason for treatment – it is unethical to use medical treatment simply to alter athletic performance. Doctors specialising in sports medicine have a responsibility and an obligation to observe and comply with the basic principles of the WMA's Declaration of Geneva, which states that "the health and wellbeing of my patient will be my first consideration."

SAMA first brought the WMA's attention to the World Athletics Regulations in 2019 when they were published, and at that point the WMA issued a statement rejecting them. We are pleased that this rejection will finally be carried into the existing declaration, once it is approved by the general assembly at the end of the year.

It is unethical to use medical treatment simply to alter athletic performance

SAMA continues to contribute to various working groups this year, as well as to develop new and existing ethical and sociomedical issues needing attention at an international level.

All the approved policy documents are available on the WMA website: https://www.wma.net/policy/current-policies/.

References and full WMA declarations and statements available on request.

Vaccine equity: Fair, timely allocation of COVID vaccines in Africa

Phinith Chanthalangsy, *programme specialist for social and human sciences, UNESCO Regional Office for Southern Africa,* **Safia Mahomed,** *associate professor, School of Law, UNISA*

On Wednesday 14 April 2021, the SA National Bioethics Committee of UNESCO, together with the UNESCO regional office of Southern Africa hosted the first in a series of community engagement and experience-sharing workshops on the fair, equitable and timely allocation of COVID-19 vaccines in Africa. The workshop involved participation by a number of stakeholders: the SA Medical Research Council (SAMRC); Africa Centres for Disease Control and Prevention (Africa CDC); UNESCO; the SA National Commission for UNESCO; the Coalition for National African Medical Associations; and the WHO.

The two normative frameworks that prompted the series of workshops, as published in early 2021, are the "Framework for fair, equitable and timely allocation of COVID-19 vaccines in Africa", issued and co-developed by Africa CDC and the SAMRC, with the input of over 1 300 policy-makers, community advocates, ethicists and public health experts, and the "UNESCO ethics commissions' call for global vaccines equity and solidarity", a joint statement by UNESCO's International Bioethics Committee (IBC) and the World Commission on the Ethics of Scientific Knowledge and Technology (COMEST).

Both frameworks share one common goal – ensuring that a COVID-19 vaccine is considered a "global public good" that is accessible to everyone, irrespective of ethnicity, nationality, gender, sexual orientation, race or religion.

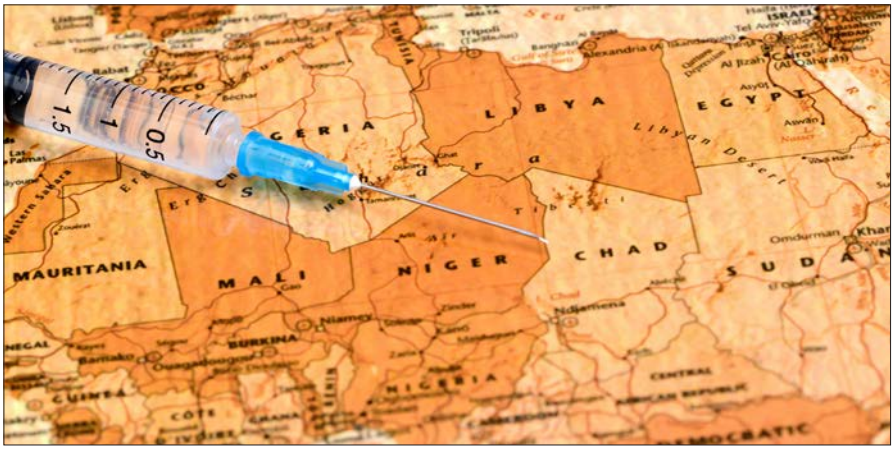
Outcomes

The robust webinar programme was presented and chaired by experts in the various disciplines. Four themes emerged from the presentations and the energetic input from the delegates.

Firstly, in the face of major crises, shall we give priority to action over ethical reflection? The answer is no! The COVID-19 pandemic, as

well as its related cultural and socioeconomic consequences, and now immunisation campaigns, are characterised by uncertainty, complexity and urgency. Science and policies still ignore many aspects of the causes of the pandemic, as well as of the short- and long-term effects of the vaccines. The preventive and curative measures, which at least we know and control, are difficult to put in place and complex in terms of co-ordination and operationalisation, including, for instance, the closure of borders, the shutdown of economies and the logistics around vaccine manufacturing and distribution. Yet governments and scientists are urged, every day, to decide and act rapidly in containing the virus, and save the global economy. This can be achieved by restating the core values and principles that hold our societies together, and by taking decisions and actions that are measured against them. Public deliberation must be fostered, and our collective intelligence needs to be shared. This is why the UNESCO call for COVID-19 vaccines to be a global public good and Africa CDC's framework for equitable and timely access to vaccines based on African values and *ubuntu* principles are of vital importance. These need to be viewed as vital landmarks to guide actions.

Secondly, can states act? The response is yes! In the face of vaccine inequality that is increasing by the day as countries – rich and poor – rally for vaccines for their populations, states have the power to remedy the impediments to access from intellectual property rights. The situation currently is that 80% of the world's population in low-resource settings will not receive a vaccine this year. One of the major impediments is that some pharmaceutical companies had patented vaccines even prior to proving their efficacy. This is in complete disregard of the concept of a people's vaccine, which must be free of charge to all. Big pharma is reluctant to contribute towards the COVID-19 technology access pool (CTAP) and the agreement on trade-related aspects of intellectual property rights (TRIPS) application submitted to the World Trade Organization (WTO) by India and SA. Aimed at temporarily suspending intellectual property rights to allow equal access for all, and to help countries override monopolies until herd immunity is reached, and while supported by more than 100 countries, it has been blocked by countries mainly in the global north – in some instances, by those same countries who have purchased vaccines in excess of their population's supply. TRIPS can be waivered by virtue of the WTO Doha Declaration that



defines its scope by stating that WTO members cannot be prevented from "taking measures to protect public health" and "to promote access to medicines for all" (paras 4 - 6). Therefore, we are not doomed to vaccine inequality or nationalism – approving a waiver for the COVID-19 vaccines is a matter of political will. It was also highlighted that Africa as a continent should not be defined by the participation of its population groups in clinical trials. Africa needs to build on her capabilities as a continent, and must include a long-term manufacturing vision. Africa CDC's announcement of the formation of a partnership for African vaccine manufacturing (PAVM) brings renewed hope for Africa.

Thirdly, can citizens and individuals act? The response is yes! The knowledge society that we live in today offers unique possibilities in communication, and we all make use of information technology, and the traditional media as well as social and new media. Civil society organisations need to demand transparency and accountability from their states and pharmaceutical companies, and engage with communities. Citizens can and must exercise their rights to enquire on both technical and political questions, because each one of us can voice our concerns, demand accountability and look for information. Despite the complexity of the issues, which lead to a general feeling of powerlessness and fatality, this is the time for individuals to build coalitions for change.

Fourthly, does the globe have a choice? No! Since immunisation campaigns have started globally, Africa as a continent has received under 2% of vaccine doses, while its population is equivalent to 16.7% of the world. High-income countries (HICs) have vaccinated 163 times more people than lower-middle-income countries (LMICs). Yet equitable administration of vaccines, as opposed to a distribution limited to HICs, could cut the number of global deaths in half. With increasing inequality, tensions resulting in conflicts and wars could result. International co-operation is key to dissolving the dramatic rhetoric around the divides between the HICs and LMICs. COVAX is an example of such an international collaboration, and its aspirational goals should not be undermined by HICs. Furthermore, it could be used to redistribute the excessive amounts of unused vaccines that have been bought up by these countries.

Conclusion

Some key take-home messages include that the number of ethical questions that have arisen during the progression of COVID-19 and vaccine rollout and distribution in Africa are immense and intense. African populations have been sidelined through the rollout process. A timeline taking Africa into 2023 was described as unethical. It was reiterated that African countries need to invest in their own structures and stop relying on colonial structures that do not serve us optimally. The current disproportionate rollout in Africa needs to be changed, and vaccine hesitancy must be addressed, as there is a moral obligation to safeguard our population through equal distribution. This not only makes moral and ethical sense but also scientific and economic sense, as a slow rollout in Africa will impact the rest of the world. The world cannot wait for the worst before it reacts. Global responsibility extends to all mankind, and co-operation and international solidarity are key to the rollout process in all regions of the world. While intense pressure is exerted on HICs to release their excess doses to COVAX, the question to be considered is whether this will be enough to make a meaningful impact. A consolidated message must be sent out that as a continent, this gap is unacceptable, requires immediate action and must be remedied.

Vaccine hesitancy: The role of the medical fraternity in debunking vaccine myths

Dr Keagan Pokpas, *NanoChemistry and Electroanalytical Sensor Technologies, SensorLab, UWC,* **Dr Sershen Naidoo,** *Institute of Natural Resources NPC,* **Prof. Pradeep Kumar,** *Wits Advanced Drug Delivery Platform Research Unit,* **Prof. Jerome Amir Singh,** *Howard College School of Law, UKZN, and Dalla Lana School of Public Health, University of Toronto*

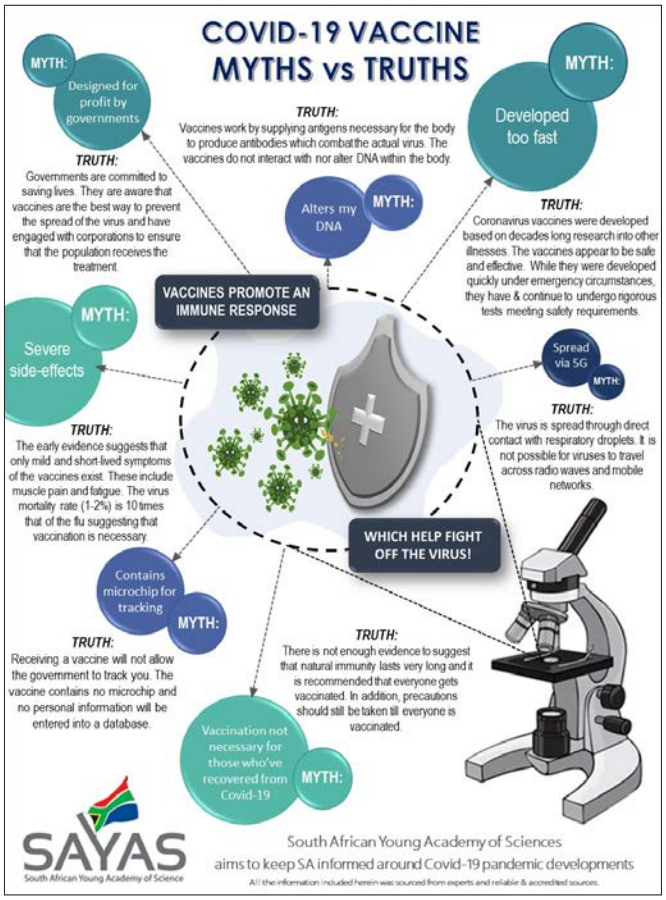
Considered one of the greatest achievements of public health, vaccines have been crucial in helping to eradicate or control infectious diseases such as smallpox, polio and measles. Despite these achievements, vaccine hesitancy remains high in many settings. In 2019, the WHO declared vaccine hesitancy and distrust as one of the 10 greatest challenges facing public health. To underscore this fact, despite the dire public health threat that COVID-19 poses, and notwithstanding several COVID-19 vaccines being granted emergency use approval in settings globally, an ever-growing COVID-19 anti-vaccine movement is gaining traction on various social media platforms, centred on an array of myths. Not surprisingly, therefore, a recent survey conducted by the University of Johannesburg found that less than two-thirds of South Africans said they would agree to be vaccinated. This figure is significantly lower than most of the other 14 other countries surveyed in an Ipsos survey. If SA's COVID-19 public vaccination campaign is to be successful, policy-makers, clinicians and proponents of vaccines will have to rapidly develop strategies to counter COVID-19 vaccine hesitancy in the country.

Raising awareness of COVID-19 vaccine myths and how to counter them

For SA to attain vaccine-induced herd immunity, vaccine deployment will have to occur rapidly and seamlessly, and uptake will have to be high. To facilitate the attainment of these goals, policy-makers and clinicians will have to be able to explain COVID-19 vaccines to members of the public in layman's terms, and be aware of some of the myths surrounding the SARS-CoV-2 virus and COVID-19 vaccines so that these can be countered. The SA Young Academy of Sciences (SAYAS) regards public awareness around the benefits of vaccines as critical to countering COVID-19 vaccine hesitancy. To facilitate COVID-19 vaccine uptake, SAYAS has developed a printable and digitally shareable infographic, intended for use by clinicians and policy-makers, aimed at addressing vaccine hesitancy.

Understanding vaccine hesitancy

Countering vaccine hesitancy requires an understanding of how such hesitancy arises. A deep distrust of and lack of confidence in health officials in SA's overburdened public health system is one of the primary sources of concern among communities across the country, according to the Ipsos survey. Mismanagement of the public health system, a lack of access to adequate medical facilities and scepticism over the sourcing of the vaccines have all contributed to this hesitancy. A history of inequality in the country has also given rise to fears that inequitable distribution of vaccines to the wealthy will occur, leaving the poor behind to fend for themselves. Furthermore, cultural factors stemming from a distrust of Western medicines, among other things, need to be addressed. Added to this, scepticism surrounding the safety of the vaccines, the relatively low reported death rate in Africa when compared with more developed nations,



Infographic prepared by SAYAS to assist in debunking some of the common myths around COVID-19 vaccines and their use

and general misinformation have done little to allay people's fears. On this note, misinformation in the media, including fake news, conspiracy theories and false reporting continue to propagate these fears, and are responsible for much of the mistrust and suspicion surrounding the COVID-19 vaccines. Some of the more common myths circulating on social media are that: (*i*) the virus was purposefully created and spread; (*ii*) severe side-effects are commonly associated with vaccine use; (*iii*) vaccinated patients will be tracked; and (*iv*) people in Africa are being used as guinea pigs. A summary of some of the common myths and the facts associated with COVID-19 vaccine use is given in the infographic. We encourage those in the medical fraternity to share this graphic with patients and the public in general. A digital version can be accessed at https://www.sayas.org.za/wp-content/uploads/2021/04/SAYAS-Coronavirus-Vaccine-Myth-Poster-2021.pdf.

In addition to the information featured in the infographic, it is worth mentioning to patients that injection-site swelling, pain,

redness and an itchy rash are normal and relatively common side-effects of vaccine administration. Moreover, COVID-19 vaccinees may experience mild side-effects such as fatigue, mild headache, muscle pain, chills, fever and nausea. To date, documented serious side-effects, such as unusual blood clots with low blood platelets, are very rare. Patients and the public may also look toward members of the medical fraternity to answer questions regarding whether the vaccination is mandatory. At this stage, COVID-19 vaccination is voluntary in SA, and there is no indication yet to suggest that the SA government will mandate COVID-19 vaccinations in the country. However, some employers may require their staff to be vaccinated. Clinicians should also stress to patients that vaccines do not contain microchips capable of tracking vaccinees. Furthermore, while the names of vaccinated individuals will be recorded, this information is private and confidential.

Combatting vaccine hesitancy

The WHO suggests multiple ways for combing through the vast amount of resources available to identify mis-information and disinformation. Accessing the sources and identifying the author's credentials and credibility are the best ways to curb the influx of incorrect information. As far as possible, the medical fraternity should try to rely on credible and reputable sources to gather the most accurate information possible. Secondly, checking the publication date is now more crucial than ever. The COVID-19 pandemic is rapidly evolving. Scientific findings and evidence-based recommendations are continuously changing. Clinicians are urged to apprise themselves of new developments in the field so that they can counter vaccine myths. This will entail verifying the credibility of sources. Credible scientific publications are peer-reviewed and will include information that can be corroborated by other credible sources. Moreover, we must acknowledge that our personal biases and backgrounds frame the way we view some information. However, personal bias should not influence our decision-making around the information we share. Finally, those involved in raising awareness must engage in discussions with experts and the broader public as a whole. Engage, learn, argue and, most importantly, listen to the varying views that exist. Knowledge is best based on an appreciation of the contributions of the collective.

The authors are members of the Scientific Advisory Group on Emergencies (SAGE), SA Young Academy of Sciences of South Africa (SAYAS) and Academy of Sciences of SA (ASSAf), Pretoria. SAGE is supported by the National Research Foundation of SA, the Canadian International Development Research Centre (IDRC), Swedish International Development Co-operation Agency (SIDA), the UK Department for International Development (DFID), UK Research and Innovation (UKRI) through the Newton Fund, SA's Department of Science and Innovation (DSI) and Fonds de Recherche du Québec (FRQ).

References available at http://samainsider.org.za/public/sup/2021-05-vaccine.pdf.

POPIA and its implications when using apps and operators to process patient information

Kim-Lisa Gad, *compliance manager, Vula Mobile,* **Dr Peta-Anne Browne,** *founder, Wardworx,* **Andrew Davies,** *CEO, Signapps,* **Dr Biano Hobson,** *senior account and clinical manager, Signapps*

Over the past few years, technologies, apps, IT services and improved connectivity have made the healthcare and health-tech industries more effective, and are driving efficiencies, mitigating risks and ultimately ensuring better outcomes for patients. At the same time, the speed of change is such that keeping up with regulations and compliance mandates, such as the Protection of Personal Information Act No. 4 of 2013 (POPIA) is becoming more complex. With the POPIA deadline approaching on 1 July 2021, healthcare practitioners must become more aware of how this affects them as they make use of software solutions when processing, collecting, storing and sharing patient information.

A few important terms are defined here from POPIA, taken from popia.co.za (and accompanying explanations in the setting of patient information).

"Data subject" means the person to whom personal information relates (in this case, the patient).

When it comes to personal information: if you collect it, then respect it and protect it

"Responsible party" means a public or private body, or any other person, which, alone or in conjunction with others, determines the purpose of and means for processing personal information (in this case, the healthcare practitioner or practice).

"Operator" means a person who processes personal information for a responsible party in terms of a contract or mandate, without coming under the direct authority of that party (in this case, the third-party software service provider).

As the first POPIA principle states, accountability by all parties processing personal information is of the greatest importance. The information regulator requires all entities to take responsibility for the personal information they collect, process, store and share, and to understand not only what personal information they collect, but also how they collect it, why they collect and process it, where they store it, who they share

it with and who has access to it, in order to ensure they are doing so lawfully, fairly and transparently.

As a responsible party, if you are not fully aware of where and how all personal information in your practice is processed, stored and made accessible, you cannot take the necessary steps to implement the correct physical and administrative processes to protect that personal information. Nor can you ascertain whether more suitable products or solutions may be required to reduce the risks associated when digitally collecting, processing, storing and sharing personal information.

The seventh POPIA principle, security safeguards, places importance on the way in which personal information is protected. Software systems should be built with privacy by design and security by default at the forefront of their architecture. Privacy by design is the principle that any action undertaken that involves the processing of personal information must be done with data protection and privacy in mind at every step. In any software solution, the strictest privacy principles should apply by default, without any manual input required from the user. Security by design in software means that the default configuration settings, particularly for users, are the most secure settings, and that the principle of least privilege when accessing personal information is always applied first to a user account until authorised approval has been given by a system administrator to access more confidential information.

When selecting an appropriate solution and service provider (operator), the following points should be taken into consideration:

- choose an operator that understands POPIA, is compliant with the Act within their own organisation and will help you meet your its obligations
- check if the solution has security by default and privacy by design at the forefront of its architecture, and check that there are adequate security controls in place such as strong access control and encryption protocols
- choose an operator that hosts their solution in a well-established data centre that has robust physical security and environmental controls in place
- check that the operator is able to explain how, within their own organisation, the personal information you are processing within their system will be kept secure and confidential, will not be accessed by unauthorised individuals and how such restrictions will be ensured
- choose an operator that is open about what information they collect, how they protect it and what steps they will take in the event of a data breach or in the event that a data subject has requests about their data – this information should be available publicly on their website, and is normally referred to as the privacy policy or privacy notice.

Unfortunately, installing a software solution or using a cloud service solution is not going to automatically make you or your practice POPIA compliant, in the same way that having a filing cabinet to lock patient files in to keep them safe does not guarantee the security of those files. You still need to have processes in place, and have trained administrative staff to put patient files into the filing cabinet and lock it, for example. Software solutions processing patient health and personal information are much the same. They also require administrative processes to be in place within the practice to enable security and confidentiality of the information. For example, similar to the filing cabinet scenario, you need to train users to log out of the system, or lock workstations or mobile devices when not in use.

There needs to be a practice-wide understanding of the importance of keeping patient information confidential, and physical, administrative and technical measures need to be in place to protect it throughout every business process. In short, when it comes to personal information: if you collect it, then respect it and protect it.

In the course of treating a patient, a healthcare practitioner may be required to share patient information with numerous parties, including treating and/or referral healthcare professionals, administrative departments and medical aid schemes for payments. Here we spotlight three solutions that can enable your POPIA compliance with regard to some of the processes in your practice.

Signapps

Signapps Care is a suite of mobile and web applications that provide POPI- and General Data Protection Regulation (GDPR)-secured, user-friendly channels for healthcare professionals to communicate securely with one another around the care of patients in real time from any location. Signapps Care integrates into healthcare systems and helps care teams improve workflow efficiency and reduce risk.

Communicate and collaborate in your team of healthcare professionals using messaging and structured data. Enrich the conversation among a patient's treating team by sharing images, custom forms and checklists, and documents in message threads, or send a private message to another healthcare professional.

What makes the Signapps solution unique is the simplicity with which our workflow tools integrate with Signapps Messenger to enable you to both capture and collaborate around the valuable data generated by your care team's workflows.

You can find more information about Signapps Care at: https://www.getsignapps.com or download the application for iOS via the App Store and Android via the Google Play Store.

Wardwork

Wardworx is a free task management app, designed to simplify the daily tasks of healthcare practitioners working in a hospital setting. It facilitates the creation of patient lists, structuring these patients according to their ward and bed location. Wardworx facilitates the creation, prioritisation and completion of on-the-go tasks centred around each patient for each day of the week.

Wardworx enables secure, POPIA compliant sharing of this information through cloud-based team collaboration, allowing everyone to be on the same page – from intern to consultant.

Wardworx prides itself in being an app created for doctors, by doctors – with an understanding of the unique SA setting, and an ingrained respect for patient privacy and confidentiality.

For more information or to try Wardworx for free visit https://wardworx.app. Available on IOS via the App Store and on Android via the Google Play Store.

Vula

Vula believes that everyone deserves the best possible healthcare. To achieve this vision, we connect healthcare practitioners to one another through a protected platform. Here they can discuss patients, get advice, make referrals, share images and co-ordinate urgent transfers.

Vula has been in operation since 2014, and was voted best health solution in SA by MTN in 2019. The platform is currently used in 6 provinces by 83 types of healthcare professionals, including 53 specialties. On average, a "Vula" is sent every minute.

We place great importance on the privacy and security of all information we are entrusted with. We comply with POPIA, have obtained our Cyber Essentials Plus certification, and are HIPAA (the US Health Insurance Portability and Accountability Act) verified. Our platform is a cloud service solution hosted in an HIPAA compliant and ISO27001 certified Amazon web services data centre in Europe.

Download the Vula App from your app store, or please contact us at www.vulamobile.com or support@vulamobile.com.

Should doctors treat family members?

Brandon Ferlito, *bioethics researcher, SAMA Knowledge Management, Research and Ethics Department*

According to the Canadian Medical Protective Association, "the practice of medicine is based on a [doctor]-patient relationship and requires acting in the best interests of patients. Knowing who a [doctor] can or should treat, and under what circumstances, are valid questions in light of a [doctor's] obligations. The integrity of a professional relationship, which is the basis of quality care, can be compromised if there is an emotional, familial, or personal affiliation."

Many benefits come with having a doctor in the family: visits crammed around packed schedules as personal gifts, a noticeable lack of financial pressure and the opportunity to understand both medical options and healthcare programmes. In a health crisis, however, family and professional positions may collide.

When the patient is a member of the doctor's immediate family, the doctor's emotions can have an undue impact on his or her professional medical decision. "The physician may fail to probe sensitive areas when taking the medical history, or to perform intimate parts of the physical examination." Despite their discomfort, doctors may feel compelled to provide care for family members. They may also be inclined to treat issues that are beyond their scope of knowledge or experience.

Patients can also be apprehensive about seeking treatment from a doctor who is a family member. When a doctor is a close relative, a patient may feel unable to reveal intimate details. This frustration is compounded when the patient is a minor child who may not feel free to refuse treatment if the doctor is also the parent.

Ethical considerations

According to Kling, "treating a family member is a classic example of a dual relationship: a relationship that occurs when a doctor treats

someone with whom he or she has another, non-patient-doctor, relationship."

The doctor is trustworthy and can take good care of the individual because of the bond that remains between them and the experience that the doctor has of the patient, according to the arguments in favour of treating family members. However, there are arguments not in favour of treating a family member. One is that the doctor's failure to be truly impartial can have a detrimental impact on the patient's level of care and/or recovery. If a treatment results in a problem, or an adverse effect arises because of a diagnosis or treatment delay, this may have a detrimental impact on the relationship, causing significant damage. In the event of complications, there could be legal ramifications. These are just some of the arguments for and against a doctor treating family members.

What do the guidelines say?

Several noteworthy medical associations have published ethics statements discouraging doctors from treating family members. According to the ethical guidelines of the American Medical Association, doctors should not treat members of their immediate family.[3] Further, according to the American College of Physicians, doctors should avoid having a doctor-family member relationship.

In its booklet on ethical standards for the health professions, the HPCSA does not explicitly address this topic. According to the SAMA website:

Most ethical guidelines warn doctors not to treat family members

"Medical practitioners who wish to treat their own family members should note that the Medical and Dental Professions Board resolved in October 2007 at a board meeting that it was permissible for a practitioner to treat his or her immediate dependants. It was not, however, permissible for a practitioner to render accounts for services rendered to such dependants, except in the case of laboratory fees and material for which it would be permissible to render an account. The expression 'material' as referred to above could be interpreted to include 'dispensing of pharmaceuticals'. Immediate family refers to dependent family members only."

Most ethical guidelines warn doctors not to treat family members unless they have minor complications or are in an emergency situation.

Proposed WMA statement

SAMA proposed a statement to the WMA regarding physicians (doctors) treating relatives. The statement outlines the possible ethical dilemmas involved in doctors treating family members, and provides recommendations for doctors on how to deal with or avoid such ethical dilemmas. The proposed statement is currently out in circulation for comment by other national medical associations.

Concluding remarks

Doctors should reflect on their own situation and decide for themselves what they are prepared to do in any given situation regarding treatment of family members, while considering the professional guidelines and codes that exist.

References available at http://samainsider.org.za/public/sup/2021-05-appendix.pdf.

Introducing the Professional Association for Transgender Health

SAMA Communications Department

Professional Association for PATHSA Transgender Health South Africa

Transgender health is a growing area of healthcare that is still new to many health professionals. A focus on the health of transgender and gender-diverse (TGD) people is important, as this is a marginalised group that experiences significant health disparities. Internationally, the World Professional Association for Transgender Health provides guidance on best care. The need for a SA professional network was recognised, leading to a group of founding members coming together in September 2020 to discuss a draft constitution and constitute an initial board. The Professional Association for Transgender Health South Africa (PATHSA) came into existence as a voluntary association on 7 October 2020, when the constitution was adopted.

PATHSA is an interdisciplinary health professional organisation working to promote the health, wellbeing and self-actualisation of TGD people. The objectives include:

- to facilitate networks and foster supportive environments for health professionals working with and for TGD people
- to develop, advocate for and promote best practices and clinical resources for gender-affirming healthcare
- to encourage, promote, conduct and disseminate research that is done in a respectful way towards the community, to expand knowledge and deepen understanding about trans and gender diversity.
- to advocate for institutional, policy and legislative change by utilising our collective knowledge and expertise
- to provide education on holistic gender-affirming healthcare promoting the health and wellbeing and supporting the self-actualisation of TGD people
- to develop leadership skills among TGD health professionals, and promote community perspectives
- to disseminate awareness around the power dynamics that are typically inherent to all healthcare seeker/provider interactions involving people who are part of the TGD communities, to acknowledge the damage that has been done by such dynamics and to insist that gender-affirming clinicians take steps to dismantle these typical power hierarchies.

In line with the principle of "nothing about us without us", which was first used in disability studies, the founding members are a diverse group, and the composition of the board was

carefully considered to include TGD health professionals.

Little did the founding members know how quickly PATHSA would have to raise its voice. In late October 2020, PATHSA became aware of claims that a healthcare professional had motivated for a type of conversion/reparative therapy specifically with reference to TGD children and adolescents. It was critical to release evidence-based position statements on both reparative therapy and gender-affirming healthcare (GAHC) for TGD children and adolescents, to support the outcry from trans activists and parents. PATHSA takes a gender-affirming position when it comes to TGD children and adolescents, in concert with many international professional healthcare bodies and associations. PATHSA regards gender affirmation of TGD children and adolescents as evidence based, internationally recognised and in the best interest of the child and adolescent. PATHSA strongly opposes any form of so-called "conversion therapy" or "reparative therapy" imposed on TGD children and adolescents, where the aim is to convince the child that their gender identity experience, which does not match their gender assigned at birth, is a pathology, and the child is counselled to accept their gender assigned at birth. The full position statements with references can be read at https://pathsa.org.za/pathsa-position-statement-reparative-therapy/ and https://pathsa.org.za/pathsa-position-statement-children/.

PATHSA released a statement in January 2021 in response to the very disappointing outcome of the Bells v Tavistock case in the UK, which caused a significant setback with regard to GAHC for adolescents needing to access puberty pausing and gender-affirming hormone treatment. The PATHSA statement expresses disagreement with the ruling, with evidence-based challenges to the findings of the judgement. It can be read at https://pathsa.org.za/pathsa-response-to-the-bell-vs-tavistock-judgement/.

There is currently a process by the SA Department of Home Affairs (DHA) to review the Official Identity Management Policy. It is an administrative minefield for transgender persons to change their gender marker on their ID document. Even though there is an Act governing this, namely the Alteration of Sex Description and Sex Status Act No. 49 of 2003, the Act is interpreted in different ways by home affairs officials. One of the PATHSA founding members recently received confirmation of the change of their gender marker only after 14 months, and that only after threatening the DHA with legal action. These delays have a huge impact on the ability of transgender persons to apply for work, register their vehicles or travel, among other things. PATHSA made a submission to the DHA on the Official Identity Management Policy, stating that a solution must be found that is inclusive of transgender, non-binary and intersex persons, and that does not discriminate. Of the options provided by the department for the new policy, PATHSA supports the proposal of a random number that does not have specific digits as a gender marker, as that will be the least discriminatory policy. PATHSA supports the approach taken by Malta and Argentina that allows for the legal gender recognition of persons based on self-determination. The current process of requiring letters from two health professionals for a change of gender marker, as indicated in the Alteration of Sex Description and Sex Status Act, is regarded as unnecessary and not in line with the medical ethical principle of autonomy. PATHSA prefers a process of self-determination without the requirement of letters from health professionals.

A key objective of PATHSA is to provide education on GAHC. The monthly CPD meetings are recorded and made available on YouTube, at https://www.youtube.com/channel/UCzyFyySONOZGYciRS7TRCzA. There was an informative online workshop on GAHC of TGD children and adolescents in April 2021, and a workshop on gender-affirming surgery is planned for July 2021. As GAHC is not a significant part of undergraduate curricula as yet, there is a huge need for empowering health professionals with the knowledge needed to provide care to this vulnerable group.

Because GAHC ideally needs to be provided by a team, PATHSA is an interdisciplinary health professional organisation with a membership consisting of doctors, psychologists, social workers, counsellors, speech therapists, occupational therapists and other health professionals. Lively discussions take place at the monthly meetings, with wisdom shared from diverse professionals who have a common goal in mind – the best care we can provide to TGD patients and their families. More information is available at https://pathsa.org.za/.

Transgender youth at highest risk of suicide

SAMA Communications Department

Despite growing global attention on and acknowledgement of gender diversity, young people who identify as transgender face an uphill battle for acceptance in the face of misunderstanding and misinformation, stigma, discrimination and bullying, putting their mental health and even their lives at risk.

Transgender individuals are at an increased risk of mental health conditions such as depression, anxiety and substance abuse, with almost half of transgender adults having suicidal thoughts, and nearly a third attempting suicide. Similarly, transgender youth – already facing the physical changes and emotional turmoil of adolescence – are at high risk for mental illness and life-threatening behaviours. Studies have shown that more than a third of transgender youth have a history of self-injuring behaviours, and a third report at least one suicide attempt. While almost 1 in 10 teenage deaths in SA per year are the result of suicide, the risk of suicide is even greater among transgender youth who don't receive the support they need.

"It is important to understand that identifying as transgender is not a mental illness or disorder. However, gender dysphoria – a state of intense distress that can arise from the sense of a mismatch between one's sex assigned at birth and one's lived gender identity – is a real condition that can benefit from treatment such as gender-affirming counselling or psychotherapy.

"Additionally, youth identifying as transgender may experience anxiety and depression, increasing their risk of self-harm, due to stigma, lack of acceptance, a feeling that they have to hide their true selves, low self-esteem, social isolation and, at its

worst, bullying, harassment and abuse," Prof. Gerhard Grobler, psychiatrist and past president of the SA Society of Psychiatrists (SASOP), said.

He said these risks have been widely shown to reduce significantly when youth receive social and psychological support in "being the gender they identify with and feel is their authentic self".

While the percentage of youth who identify as transgender is small (a study in the USA estimated 0.7% of teenagers aged 13 - 17, and 0.6% of adults), the spotlight has been turned on transgender teens in recent years through increased public and media visibility of transgender people, and heated social media debates among high-profile figures.

People identifying as transgender are, however, "not a new phenomenon", Prof. Grobler said, as gender non-conforming people have been documented in the histories of cultures across the globe, including in Africa.

Prof. Grobler explained that "transgender" is an umbrella term encompassing various expressions in which people's birth-assigned sex differs from their experienced gender identity.

Sex is assigned at birth as either male or female, and has to do with physical, biological attributes, he said, while gender is a social construct of expected attributes, behaviours, roles and activity (including dress) assigned to males or females, and can vary in different cultures. He said it was increasingly accepted by healthcare professionals that gender identity operates on a spectrum rather than being a fixed, binary "either/or" state.

He emphasised that gender identity and sexual orientation were not the same: "Gender identity refers to one's internal sense of gender, of being male or female or non-binary. Sexual orientation refers to one's physical, romantic and/or emotional attraction to others, and is not defined by gender identity. Transgender people can be straight, gay, bisexual or asexual, just as non-transgender people can be."

For parents whose children display gender non-confirming attributes and behaviours, or state that they wish to transition to their preferred gender, Prof. Grobler said it was vital to understand and accept that this was not "just a phase".

"Adolescents in particular are grappling with separation and independence, forming their own identities and autonomy. No one decides on or just chooses a gender identity overnight – appreciate that they have likely spent significant time contemplating this, and it has taken courage to share it with you." "While some children may later shift their gender identity again, rather than labelling it as a passing phase, treat it as real and accept their identity in the here and now," he advised.

Identifying as transgender is not a mental illness or disorder

Supporting a child or young person who identifies as transgender takes patience, understanding and being willing to advocate on behalf of your child, Prof. Grobler said.

He highlighted some pointers for parents, families and friends of youth who identify as transgender and choose to transition:

- Understand that every person's transition and how they choose to live in their gender identity differs. The process of transitioning is complex, and takes many steps. While this can include medical treatment and surgical procedures, this is not always the case, and usually occurs much later in the process.
- Engage with schools and other institutions to address your child's situation and particular needs, with their consent.
- Respect your child's privacy and don't "out" them before they are ready.
- Don't force them to act, dress, etc. in a more gender-conforming way.
- Seek support from a mental health professional who specialises in children and adolescents and is competent in working with gender diverse and non-conforming young people. And also help your child to find peer groups and support networks for trans youth.
- Respect their choice of name and pronouns. Don't misgender or "dead name" (use their old name) a person – to them, it is like denying their existence.
- Don't make assumptions about how your child would like to dress, what sport they want to play and other gendered stereotypes – let them take the lead in their own individuality and show you what their gender means to them.
- Don't make assumptions about their sexual orientation.
- Educate yourself on transgender terms, issues and rights so that you can advocate for your child.
- Parents and loved ones of a person transitioning need support too – seek help from mental health professionals and support groups for parents of transgender youth.

Prof. Grobler warned that there was no scientific evidence to support so-called conversion or reparative "therapy" aimed at changing a person's sexual orientation or gender identity, and that the evidence in fact showed that these discredited practices were more likely to be harmful and destructive.

"SASOP opposes any forms of such treatment," he said.

"However, a transition in gender identity can be extremely stressful, and psychotherapy can play a vital supporting role in helping a person come to self-fulfilling acceptance and self-actualisation, as well as developing the life skills to cope with prejudice, discrimination and rejection," he said.

References available on request.

Resources and organisations that can provide further information and support

- Groote Schuur Hospital Transgender Clinic – counselling, mental health support, gender-affirming care, information on support groups: http://www.psychiatry.uct.ac.za/psych/clinical-services/groote-schuur-hospital. Tel: 021 404 2151 or email GSH.PsychOPD@westerncape.gov.za,
- Matimba – emotional and psychological support for transgender youth and their families: https://www.matimba.org.za/page-about-us.html. Tel: 074 084 5237 or email info@matimba.org.za.
- OUT – counselling, health services, advocacy: https://out.org.za. Tel: 012 430 3272 or email hello@out.org.za.
- Gender Dynamix – trans and diverse gender resources and information portal: https://www.genderdynamix.org.za/. Tel 021 447 4797 or email info@genderdynamix.co.za.
- Triangle Project – counselling, healthcare, support groups: https://triangle.org.za/. Helpline: 021 712 6699 or email info@triangle.org.za.
- American Psychological Association information and resources: https://www.apa.org/topics/lgbtq/sexual-orientation/

Electronic signatures and issuing of prescriptions

Wendy Massaingaie, *legal advisor, SAMA Legal Department*

This article will detail the legal requirements for completing medical prescriptions, and the role of electronic signatures in doing so.

Wet signature v. electronic signature

It is common knowledge, and part of our common law, that the purpose of a signature is to identify the person making the signature, to confirm that the information accompanying the signature was intended by the signatory and to state that the information is approved by the signatory. There are two types of signatures recognised in SA: the normal "wet" signature, and the electronic signature. Both are legally binding if they fulfil the requirements of a signature as stated.

The Electronic Communications and Transactions Act No. 25 of 2002 defines an electronic signature as "data attached to, incorporated in, or logically associated with other data and which is intended by the user to serve as a signature". Section 13 of the Act speaks of acceptable electronic signatures, and provides:

"13. (1) Where the signature of a person is required by law and such law does not specify the type of signature, that requirement in relation to a data message is met only if an advanced electronic signature is used.

(2) Subject to subsection (1), an electronic signature is not without legal force and effect merely on the grounds that it is in electronic form […]

(4) Where an advanced electronic signature has been used, such signature is regarded as being a valid electronic signature and to have been applied properly, unless the contrary is proved."

In addition to the above, section 14 of the Act states that an electronic signature qualifies as an original signature, and certifies that there have been no changes made to the information displayed. The section reads:

"14. (1) Where a law requires information to be presented or retained in its original form, that requirement is met by a data message if –

(a) the integrity of the information from the time when it was first generated in its final form as a data message or otherwise has passed assessment in terms of subsection (2); and

(b) that information is capable of being displayed or produced to the person to whom it is to be presented.

(2) For the purposes of subsection 1(a), the integrity must be assessed –

(a) by considering whether the information has remained complete and unaltered, except for the addition of any endorsement and any change which arises in the normal course of communication, storage and display;

(b) in the light of the purpose for which the information was generated; and

(c) having regard to all other relevant circumstances."

Advanced electronic signatures

Section 1 of the Act defines advanced electronic signatures as "an electronic signature which results from a process which has been accredited by the Authority as provided for in section 37". It is important to note that the SA Accreditation Authority is tasked with accrediting, among other things, advanced electronic signatures, and there are currently only two authentication service providers in SA: the SA Post Office and LAWtrust. The benefit of advanced electronic signatures is that they go through a series of verification steps to ensure that each signature is that of the person it purports to be, and that no changes have been made to the document, which makes it safer to use than a standard electronic signature.

Signatures when issuing prescriptions

Booklet 2 of the Ethical Rules of Conduct for Practitioners registered under the Health Professions Act No. 56 of 1974 deals with issuing prescriptions under rule 17. It stipulates:

"Issuing of prescriptions

17. (1) A practitioner authorised in terms of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), to prescribe medicines shall issue typewritten, handwritten, computer-generated, pre-typed, pre-printed or standardised prescriptions for medicine scheduled in schedules 1, 2, 3 and 4 of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), subject thereto that such prescriptions may be issued only under his or her personal and original signature.

(2) A practitioner authorised in terms of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), to prescribe medicines shall issue handwritten prescriptions for medicine scheduled in schedules 5, 6, 7 and 8 of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), under his or her personal and original signature."

From the above, it is clear that a medical practitioner can issue electronic prescriptions for schedule 1, 2, 3 and 4 medicines. However, handwritten prescriptions are required for schedule 5, 6, 7 and 8 medicines.

Electronic record-keeping

Booklet 9 of the HPCSA, Guidelines on the Keeping of Patient Records, states that prescriptions issued to patients form part of the patient record, which must be retained by medical practitioners. Clause 4.1.6 stipulates: "Healthcare practitioners should enter and maintain at least the following information for each patient consulted … The medication and dosage prescribed." These records must be kept for a minimum of 6 years from the date they stop being utilised; where the records pertain to a minor who is mentally incompetent, records must be kept until said minor turns 21. This allows for 3 years after they reach the age of majority to lodge any claims. Mentally incompetent patient records must be kept for the duration of said patient's lifetime:

"9.4. In terms of the Occupational Health and Safety Act (Act No. 85 of 1993) health records must be kept for a period of 20 years after

treatment"; and "9.8. Where there are statutory obligations that prescribe the period for which patient records should be kept, a practitioner must comply with these obligations", as per clause 9 of Booklet 9.

Keeping record of issued prescriptions also protects the medical practitioner in instances in which patients submit the same or altered prescription, fraudulently, to various pharmacies, under the guise that the medical practitioner duly issued the prescriptions.

Conclusion

In light of the above, it is worth emphasising that the person appending their signature must be capable of being identified; they must intend to sign the document; and by doing so, they verify the information on said document. Electronic signatures can be used by medical practitioners, as they are as binding as "wet" signatures. However, standard electronic signatures cannot be used when completing prescriptions, as these lack security. Therefore, an advanced electronic signature must be used, if issued by an authentication service provider.

As discussed above, the ethical rules require that prescriptions for schedule 5, 6, 7 and 8 medicines must be made by hand, which would require that a "wet" signature should be appended, and bearing in mind that it would be redundant to handwrite a prescription only to append an electronic signature to it. Prescriptions for schedule 1, 2, 3 and 4 medicines may be done electronically, and while the "personal and original signature" may be an electronic one, it is preferable that an advanced electronic signature is used. Advanced electronic signatures ensure that the medical practitioner completing the prescription has safeguarded their signature against instances of fraud and theft. Should any medical practitioner be interested in SAMA engaging with LAWtrust for the purposes of obtaining an advanced electronic signature, kindly contact Karlien Pienaar: karlienp@samedical.org.

LatchOn! Breastmilk Drive for Tygerberg Hospital neonatal unit

SAMA Communications Department

There is a great need for donor breastmilk at Tygerberg Hospital's neonatal unit, especially for premature babies who may spend months at the hospital, and whose mothers often cannot provide enough breastmilk. The coronavirus pandemic has also provided its own set of challenges in the procurement of milk, as donors were not able to donate breastmilk.

To this end, the Tygerberg Hospital Children's Trust, in partnership with Tygerberg Hospital, has embarked on a breastmilk donation drive called the LatchOn! Breastmilk Drive. The purpose of the drive is to ensure that there is sufficient breastmilk to help all the babies, now and into the future.

Tameryn Rix, an occupational therapist who works in the neurology and neurosurgery unit at Tygerberg Hospital, is a breastmilk donor, and she had this to share: "I am one of those fortunate women who produces excess breastmilk. I started collecting and freezing milk over a period of time, and gradually built up a sizeable collection. I know that Tygerberg Hospital is always in need of breastmilk, especially for their premature babies, and knew that donating was the only way forward for these babies in need. It's a wonderful feeling to provide milk to babies in need and to give them the best nutritional start in life, and to impact positively on the lives of little people."

The Tygerberg Hospital Children's Trust, under the leadership of CEO Mr Jason Falken, is garnering all its resources in support of the initiative, and is appealing to mothers, individuals and companies alike to join them in support of the LatchOn! Breastmilk Drive. The appeal is for mothers to donate surplus breastmilk. Those wishing to donate will be screened, tested and counselled at the Tygerberg Breastmilk Training Room, 2nd floor, East Side entrance, Tygerberg Hospital. We are appealing to the general public to donate and drop off glass jars smaller than 250 mL at the same place.

"We would like to create a sustainable supply of breastmilk for the hospital to ensure that all our babies are provided with this important nutritional source," says Mr Jason Falken. "It's also important that we provide a clean, safe and welcoming space at the hospital where moms feel comfortable and safe while expressing milk, and also feel free to engage with each other in a socially supportive environment."

Tygerberg Hospital is the largest hospital in the Western Cape and cares for the greatest number of children within the province, including many from our rural communities. The hospital provides care for a substantial number of premature babies in SA, and is one of only a few functioning state breastmilk pasteurising facilities in the province.

It is well known that breastmilk is the most complete source of nutrition for babies from birth to 6 months, and beyond. Breastmilk provides a perfectly balanced source of nutrition for babies. It is easily digestible, contains everything a growing baby needs and provides important antibodies to fight infections and allergies. For a premature baby, daily access to breastmilk is vital for survival, and is especially important for brain development and ensuring a healthy immune system.

Together, we may be united for a healthy future.

For more information, follow the Tygerberg Hospital Children's Trust on www.tygerbergchildren.org.za; Facebook: @THCTRUST; Twitter: @HospitalTrust; Linkedin: https://www.linkedin.com/company/tygerberg-hospital-children-s-trust.

Relentlessly offering care and hope in South Sudan

Médecins Sans Frontières (MSF)

Dr Ebenezer Ngwakwe is an MSF doctor from Nigeria who worked in rural South Sudan for 11 months – an assignment that was filled with hope despite some devastating lows. Here he recollects the story of one HIV patient, and the challenges of ensuring care in a remote and unpredictable area.

She walked into the clinic quietly with her 5-month-old baby in her arms. I could see the overwhelming emotions she was trying so hard to conceal. Tears started streaming down her face. This was one of numerous similar encounters that would characterise my 11-month assignment with Doctors Without Borders (Médecins Sans Frontières; MSF) in Old Fangak, South Sudan.

Old Fangak is a region in the north of South Sudan. There are no telecommunication networks, no tarred roads and no cars, only boats. The community consists of about 30 000 people.

Nya-Cece (real name withheld) was in her early 20s, had her first child at age 14 and now had a new baby with a soldier husband who lives far away in another community. "I feel all alone, I have no-one," she said. "My father does not care about me because I had my first child outside marriage. He says I brought shame to his family. My mother remarried and left with her new husband. Now, I am HIV-positive with no money, no job and almost no food for my boys." Listening to her, I knew this was why I had joined MSF.

According to the latest UNAIDS reports, about 190 000 people are living with HIV in South Sudan. MSF provides a comprehensive HIV care package through a clinic that provides counselling and testing, inpatient management of opportunistic infections, viral load testing, prevention of mother-to-child transmission and community awareness campaigns.

With the help of the MSF HIV counsellor, we offered Nya-Cece medical care and psychosocial support and linked her to another organisation that provides food. Through this kind of work, we now have 120 patients enrolled in HIV treatment in Old Fangak, up from zero just 3 years ago.

Still, the HIV situation is very challenging. People have restricted access to healthcare, and sometimes patients walk for 72 hours just to get to our centre. HIV is also highly stigmatised in the community. The "hunger gap" season, when the food from one harvest is finished and the food from the next not yet ready, makes it difficult to get enough to eat – vital to maintaining a strong immune system and managing HIV. On top of this, people are frequently forced to move to escape ongoing insecurity and flooding, which makes it difficult to access healthcare, and make enough money or grow enough food.

A nurse's aide monitors a patient in the MSF hospital in Old Fangak town – the only hospital in the region where people can receive treatment for serious conditions (image: Tetiana Gaviuk/MSF)

The MSF Old Fangak Hospital

Dr Ebenezer Ngwakwe (image: Tetiana Gaviuk/MSF)

Despite the friendly nature of the people in Old Fangak, the incessant inter-clan armed clashes made the security situation very precarious, and negatively affected access to medical services. In May, our team was evacuated to New Fangak. On the morning of evacuation, we discharged stable patients and suspended all activities. The patients in unstable condition needed continued care, so they came with us to New Fangak.

In New Fangak, news of our arrival spread so fast that in no time people started coming for medical care. But I could not stop thinking about all the patients in Old Fangak who would now be denied access to healthcare. What about the patients with type 1 diabetes who depended on us for their daily insulin? What about the people living with HIV who would need their drugs? What about the women in labour who would need obstetric care? The list goes on and on.

As I look back, I realise this has been an impactful 11 months of offering care and hope relentlessly.

Precautionary suspension and employee's rights

Ruan Vlok, *employee relations advisor, SAMA Employee Relations Department*

The suspension of an employee can take place via one of two mechanisms: suspension on a precautionary basis; or suspension as a form of disciplinary action/sanction. This article will focus on the suspension of an employee on a precautionary basis pending disciplinary action, and the effect of such a suspension on an employee's remuneration within the public sector.

Item 7.2 of the Public Service Co-ordinating Bargaining Council (PSCBC)'s Resolution 1 of 2003, serving as the disciplinary code for the public sector, regulates the precautionary suspension of employees, and states as follows:

"a. The employer may suspend an employee on full pay or transfer the employee if –

i. the employee is alleged to have committed a serious offence; and

ii. the employer believes that the presence of an employee at the workplace might jeopardise any investigation into the alleged misconduct, or endanger the wellbeing or safety of any person or state property.

b. A suspension of this kind is a precautionary measure that does not constitute a judgment, and must be on full pay.

c. If an employee is suspended or transferred as a precautionary measure, the employer must hold a disciplinary hearing within a month or 60 days, depending on the complexity of the matter and the length of the investigation. The chair of the hearing must then decide on any further postponement."

Case law

According to Judge Pillay in Sappi Forests (Pty) Ltd v CCMA & Others (2008) 3 BLLR 254 (LC), the position at common law has always been that an employer who suspends an employee without pay commits a breach of the contract of employment. An employer may suspend an employee without pay if the employee so agrees, or legislation or a collective agreement authorises the suspension.

In the case of Mabitsela v SAPS (2004, 8 BALR 969), the employee, a policeman, was suspended without pay pending a charge of murder. The SA Police Service (SAPS) regulations did allow for such suspensions without remuneration. However, Mabitsela at the bargaining council claimed that his suspension was unfair due to its length (5 months). The arbitrator found that the suspension itself was fair, but that it was unfair to implement the suspension without pay.

With reference to the above case law, one could conclude that any precautionary suspension should be on full pay. However, clarity should be provided on what is meant by the term "full pay" within the public sector.

As per the commuted overtime policies of the respective provincial governments, medical practitioners can claim for actual commuted overtime hours performed in excess of the core 40 hours per week, and depending on the commuted overtime group a medical practitioner participates in. All commuted overtime claimed must have been actually performed by the claimant, and cannot be performed by someone else on behalf of the complainant. Further to the aforementioned and in view of the fact that commuted overtime remuneration does not form part of the salary packages of medical personnel, and is only payable in instances where the individuals perform after-hours duties in excess of 40 hours per week, it is not payable to employees during any periods of suspension from duty with full remuneration. Since no commuted overtime will be performed during a suspension, no remuneration for commuted overtime can be claimed during this time.

Conclusion

Taking the above mentioned PSCBC resolution and case law into consideration, an employee cannot be suspended without pay, but this does not mean that such a suspension will be inclusive of all payments including commuted overtime. The state as the employer is well within their rights to pay an employee only his or her basic salary while on precautionary suspension. However, should the employer fail to pay any remuneration during an employee's suspension, this will constitute an unfair labour practice in terms of section 186(2)(b) of the Labour Relations Act No. 66 of 1995. It is also important for SAMA members to take note of the fact that should someone be suspended, (s)he is not allowed to take up his or her duties until the suspension is lifted, but must be available at a location acceptable to the employer for the purposes of its investigation.

Missed critical limb ischaemia

The Medical Protection Society share a case report from their files

Mr S was a 60-year-old truck driver. He was overweight and smoked, and could not walk far because he suffered from pain in his calves. During a long drive, he became aware of pain in his right calf and foot. This became so severe that he attended at the local emergency department (ED) that evening. The doctor at the ED measured both calves and found them to be the same. A history of forefoot pain but no calf tenderness was noted, and a deep vein thrombosis was excluded. He told Mr S that he likely had a problem with his circulation. Mr S was prescribed aspirin, and advised to consult with his own GP for further follow-up.

Mr S struggled to sleep for the next two nights because he had a burning sensation in his right foot and lower leg, which felt cold and numb. He had to get up and walk around to relieve the pain. He made an appointment with his own GP, Dr A, the next day. Dr A noted the history of numbness and rest pain. He documented that the right foot was pale and felt cold. He requested a non-urgent Doppler assessment because he could not detect any pulses in the right foot, and prescribed quinine sulphate.

Mr S's Doppler scan was arranged for the following week, but he rang his GP surgery 3 days later because the pain in his foot and lower leg was becoming more severe. He had to hang his foot over the edge of the bed to get relief. Dr A advised him to go straight to the ED. The ED doctor sent him home despite documenting limb pain at rest and a cool, pale right foot with weak pulses. The diagnosis of arterial insufficiency, rather than acute ischaemia, was made. Mr S was advised to stop smoking and to attend his Doppler assessment in 4 days' time.

Mr S was really worried about his leg despite being reassured in the ED. He rang his GP explaining that his leg was still very painful and was becoming swollen. Dr A reassured him because he had been discharged home from the ED, but arranged for him to have his Doppler scan the following day. When he attended the operator was unable to get a result due to swelling and pain, but noted that his foot pulses were difficult to detect. Mr S was given an appointment with Dr A the next day to discuss the results.

Dr A discussed the Doppler results and documented that his right foot was cold. He made the diagnosis of "worsening peripheral vascular disease" and arranged for Mr S to consult a specialist surgeon the following day.

Mr S was admitted urgently after the surgical consultation with a diagnosis of an acutely ischaemic right leg. On femoral angiography, he was found to have thrombus in the distal superficial femoral artery. He had a right femoral embolectomy, which was unsuccessful and converted to a right femoral popliteal bypass. Unfortunately his leg was still not viable following this procedure, and he went on to have an above-knee amputation. Mr S suffered with phantom limb pain, and despite undergoing rehabilitation he remained severely limited in his daily activities.

He was devastated, and made a claim of negligence against his GP. It was alleged that Dr A had not appropriately acted upon his symptoms of rest pain, or made the correct diagnosis of critical limb ischaemia. It was claimed that Dr A had failed to refer him for urgent surgical review, and that he had wrongly asked him to wait for a week for a Doppler scan.

Learning points

- Useful guidelines on the diagnosis and management of lower limb ischaemia have been published and are available to practitioners.
- Critical limb ischaemia is characterised by any of: rest pain, arterial ulceration or gangrene. It has a high risk of amputation. If a patient has rest pain, (s)he needs same-day surgical assessment.
- You should not be completely reassured by another doctor's assessment. In this case the GP had been reassured by the diagnosis in the ED, which was incorrect. Doctors should use their own clinical acumen.

Expert advice

The Medical Protection Society sought the advice of an expert GP. She felt that Dr A had performed below the acceptable standard of GP care. She considered that there was sufficient evidence of critical ischaemia in the description of rest pain at night coupled with an alteration in colour and temperature of the foot. She said that this required urgent same-day surgical assessment.

She felt that there was no clinical indication for quinine sulphate, and the decision to request a Doppler scan, which was clearly not performed with any degree of urgency, was insufficient in the light of the history and clinical findings.

The opinion of a professor in vascular surgery was also sought. He considered that Mr S's foot was obviously ischaemic when he presented to his GP. He thought that an amputation may well have been avoided if Mr S had been admitted earlier. The case was settled for a high amount against both the hospital and the GP.

Sandra Ferrone – branching out into a new life after 45 years

SAMA Communications Department

After 45 years as the branch secretary of the SAMA Tygerberg Boland branch, Mrs Sandra Ferrone will step down at the end of May. She leaves a deep mark in the branch she has dedicated most of her working life to, and she will be fondly remembered by the many hundreds of SAMA members, students and colleagues she has met along the way.

"At 69 it's time to move on, and I can now spend time getting used to not going to work, and enjoying longer holidays. I'll also be able to spend more time with my grandchildren. On demand, of course," says Sandra, who, after four-and-a-half decades with SAMA, will also get to spend more time gardening and cooking, specialising in Italian cuisine.

Sandra started working for the then Medical Association of SA in 1972, after a short stint with Cape Hotels. After 15 months with Cape Hotels, the company was taken over by the Southern Sun Group, and Sandra had to look for alternative employment. At that time, the now Tygerberg Boland branch was a division of Cape Western, but branched off on its own in 1978.

"I studied administration at what was then known as the Cape Technikon, and got a job almost immediately at Cape Hotels. But when that didn't work out, I had to look elsewhere, and eventually ended at the Medical Association. It obviously worked out well, because I've been here ever since," she says.

Sandra explains that her role as branch secretary is to act as a middleman for SAMA members in the branch and head office, and also to liaise between patients and doctors.

"Patients often phone in because they want someone to listen to them, and I do. We try and resolve their queries as best as we can, and in most instances we are able to do that. It's the same for the doctors; we resolve their queries and listen to their concerns. This is what we do, and I enjoy being that person who people come to for advice. I also loved being an ear for the students who often come in to talk," she says.

Tygerberg Hospital was completed in 1976, and shortly thereafter the medical school was opened. It was at that time that then-dean of the medical school allowed a MASA office to open on the premises. The hospital is attached to the Stellenbosch University medical school. Six years ago, the Tygerberg Boland branch moved to the Oude Westhof Medical Centre due to reorganisation at the medical school.

The Tygerberg Boland branch council in 1978/1979: Sandra is seated in the front row, third from the left

"Over the years, the deans of the medical school have all had a soft spot for SAMA, as they were invariably members of the association. Being in the same building as all the students and with many members coming to visit, I've always felt part of the faculty here, and that's really been a standout for me. I've always felt I belonged here, and I've been treated as one of the staff. That's honestly made my time here very special," says Sandra.

Sandra's daughter is a business strategist, and her son a financial planner. Both studied at the University of Cape Town. Having had two student children herself made it easier for Sandra to relate to other students on campus.

Another critical part of her relationship with SAMA, says Sandra, is that she was able to work a half-day and spend as much time as she could with her children.

"That was an absolutely crucial thing for me. I was able to see my kids grow, and be a big part of their lives. I'm doing the same with my grandchildren now and that's very important. Through the years I've seen my kids go to school and study at the University of Cape Town, and I've been present throughout. I'm very grateful for that," she says.

Over the years Sandra has seen many come and go but, she says, many of those who have passed through the medical school still drop in to say hello, or message her to tell her about their lives. It's one of the enduring memories she will have as she moves on to a more relaxing life after SAMA.

Sandra Ferrone

But before she departs, Sandra says there's one person she must single out. "I want to thank all the members who served on the branch council over the years who have allowed the branch to grow and be successful. But there's a special word for Dr Wynand Goosen, our chairperson the past 14 years: his dedication and commitment to the Tygerberg Boland branch has been exceptional. Without him, our branch wouldn't be where it is today," she says.

Before Sandra takes the next big step in her life, she says she can't leave without giving her successor a small bit of advice.

"Be professional and responsible and regard your branch council as experts, each with their own personality, experience and knowledge. They are your support system, and you must use them. Above all, though, do your best and strive for excellence," she says.

SAMA head office hosts wellness day

Lisa Reid, *SAMA CPD officer*

SAMA head office recently organised a wellness day, the first of what will become monthly events. The day aims to provide a caring environment where employees can actively engage with staff members in a socially distanced atmosphere. This allows staff and medical professionals within SAMA to gain support from various stakeholders and sponsors in the healthcare industry. A wellness day allows SAMA to provide information on relevant healthcare issues affecting the workplace and medical professionals.

The various benefits of hosting wellness days are to:

- improve employee health behaviours
- reduce elevated health risks
- reduce healthcare costs
- improve productivity
- decrease absenteeism.

While the importance of mental and physical health has always been recognised, the COVID-19 pandemic has highlighted how critical such initiatives are to employee wellbeing. SAMA would like to take this opportunity to thank all the sponsors involved.

To be a part of future wellness days, please contact lisar@samedical.org.

Dr William Oosthuizen presents a raffle prize

Thanks to the sponsors, head office was able to present prizes to staff

Head office employees at the wellness day

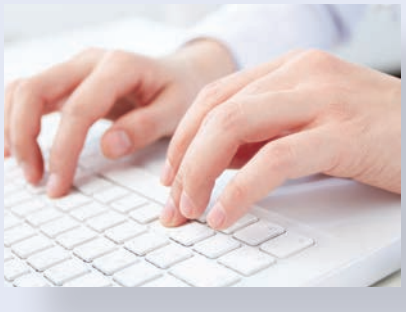
Lisa Reid thanks SAMA chairperson, Dr Angelique Coetzee, for her COVID-19 reporting

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.

KZN Midlands presents Lifetime Membership Awards

SAMA Communications Department

Congratulations to KZN branch members Dr Mike Smit and Dr Mahomed Iqbal Ismail Moola, who recently received their framed Lifetime Membership Awards from branch secretary Mandy Hattingh.

Mandy asked them to reflect on their years as SAMA members.

Dr Mike Smit

I have been a SAMA member I would think all my medical life, since I qualified. I can't say that I was an active, involved member, and of course when it was MASA, there were many moments of doubt.

However, looking back, I think that SAMA has been the most effective association that I have been involved with in terms of supporting doctors and effecting positive change and outcomes medically, ethically and legally. As a GP I belonged to a number of Independent Practice Associations, but globally they could not meet the support and advice that I received from SAMA through the years.

"If you can't do great things, then do small things in a great way" Martin Luther King

I never considered it a union, although that would appear to be what it has partly become for some members.

The FPD has, to my mind, also proved to be a winner, and the management course I did in about 2000 under the auspices of Manchester University really helped with a number of medical businesses that I was involved with, as well as my own practice management.

I wish SAMA all the best in the years ahead. With that I also wish all my colleagues who are still actively working in these troubled times all the best.

This is clearly a new type of medicine in a new type of world.

Perhaps a message to my colleagues is to remember that we are one big family, and we must look after one another as such. As we know, families and their members can be a pain, but we still love them.

I have never knowingly charged a colleague or a dependent family member, and this is something that I think should be a core feature of the way we practise our medicine. A state of gratitude will lead to a state of grace.

Dr Mike Smit

Dr Mahomed Iqbal Ismail Moola

Dr Mahomed Moola

I have been a member of SAMA for just over 40 years, and have seen the evolution of this association from the days of the Medical Association of SA (MASA) to the SA Medical Association.

I am proud to be both a member and branch councillor of SAMA. SAMA has always been at the forefront for medical practitioners both in the public and private healthcare sectors. They have contributed immensely to continuing medical education.

SAMA has a proven track record in resolving the issues that medical practitioners are constantly faced with in this forever-changing healthcare environment.

Free State welcomes new branch secretary

The Free State branch council has recently announced the appointment of Sultana Hartzenberg as the new branch secretary.

Sultana has been with SAMA for 4 years, and currently works as secretary to the Griqualand West branch in the Northern Cape. She will now be overseeing both branches.

She has recently obtained her qualification in labour law from the University of Johannesburg, and can be contacted at samafsb@samedical.org.

Sultana Hartzenberg

LocumBase: Simplifying the Locum booking process

Zulé Vuuren, LocumBase CEO and founder

LocumBase is an independent online booking, payment and management platform that provides real-time availability of and access to verified Locum medical professionals for pharmacies, medical practices, hospitals and clinics, at a fraction of the time and financial cost of traditional recruitment methods.

We are proudly South African, with a vision and mission to simplify the Locum booking process without any fee-heavy implications for practices and Locums. We ensure secure record-keeping and an "open-market" model that helps a practice to effectively grow its business, and ultimately assists healthcare professionals to utilise their skilled hours.

At LocumBase we believe that Locums need to be fairly compensated for their skilled hours against their experience. We do not charge a Locum to gain access to bookings via our platform, and you can sign up for free today at www.locumbase.com.

SAMA members who have their own practice receive a 1-year premium package for free from the date of sign up. This gives you access to the full LocumBase dashboard experience, and includes unlimited bookings at a discounted 10% facilitation fee. All of this great value because you are a registered SAMA member!

We see you

LocumBase empowers Locum medical professionals (independent contractors) to earn their worth in a flexible way. The LocumBase platform automates all admin, enabling confirmation, payments and reviews of a practice, and a Locum's service, at the click of a button. Not only a technical platform, LocumBase is a supportive ecosystem, a growing community on a mission to uplift the quality of healthcare in SA, while optimising pharmacy, practice and hospital businesses and enabling flexible earning opportunities for medical professionals nationwide.

Leading the Locum revolution

LocumBase is the first marketplace platform in SA that empowers both medical practices and medical practitioners, from optometrists and pharmacists to GPs and nurses. Your practice is a business that needs to keep caring for your patients while you take that much-needed break or attend a conference. We want you to empower you with the best solution possible, whatever your needs are.

Showcasing success stories

With the focus on empowering medical professionals, primary practitioners and practice owners to do their best work in an environment of flexibility and taking the time they need to revive and recharge, LocumBase has helped practice owners and Locums in various ways.

Recently, an optometry practice owner was in a state of panic as she desperately required a Locum to take care of her practice while she focused on her traditional and modern wedding ceremonies and honeymoon for 2 weeks. She had been building her practice for over 2 years without taking any time off, and definitely deserved a break. She selected a Locum via the LocumBase platform, knowing that she could enjoy this very special time of her life without worry.

The medical space is all about people, and helping medical professionals live their best lives means that better care can be provided. With over 4 000 Locums (across professions) and over 600 practices on our system, the demand is there to work smarter with tools of the trade that weren't available only a few short years ago.

With the events in healthcare over the last year, we have seen the demand for continuous access to flexible healthcare rise. LocumBase is positioned to meet this need, with tools that empower both medical professionals and practices through a supportive ecosystem that brings various elements in the healthcare industry together to help you live your best balanced life.

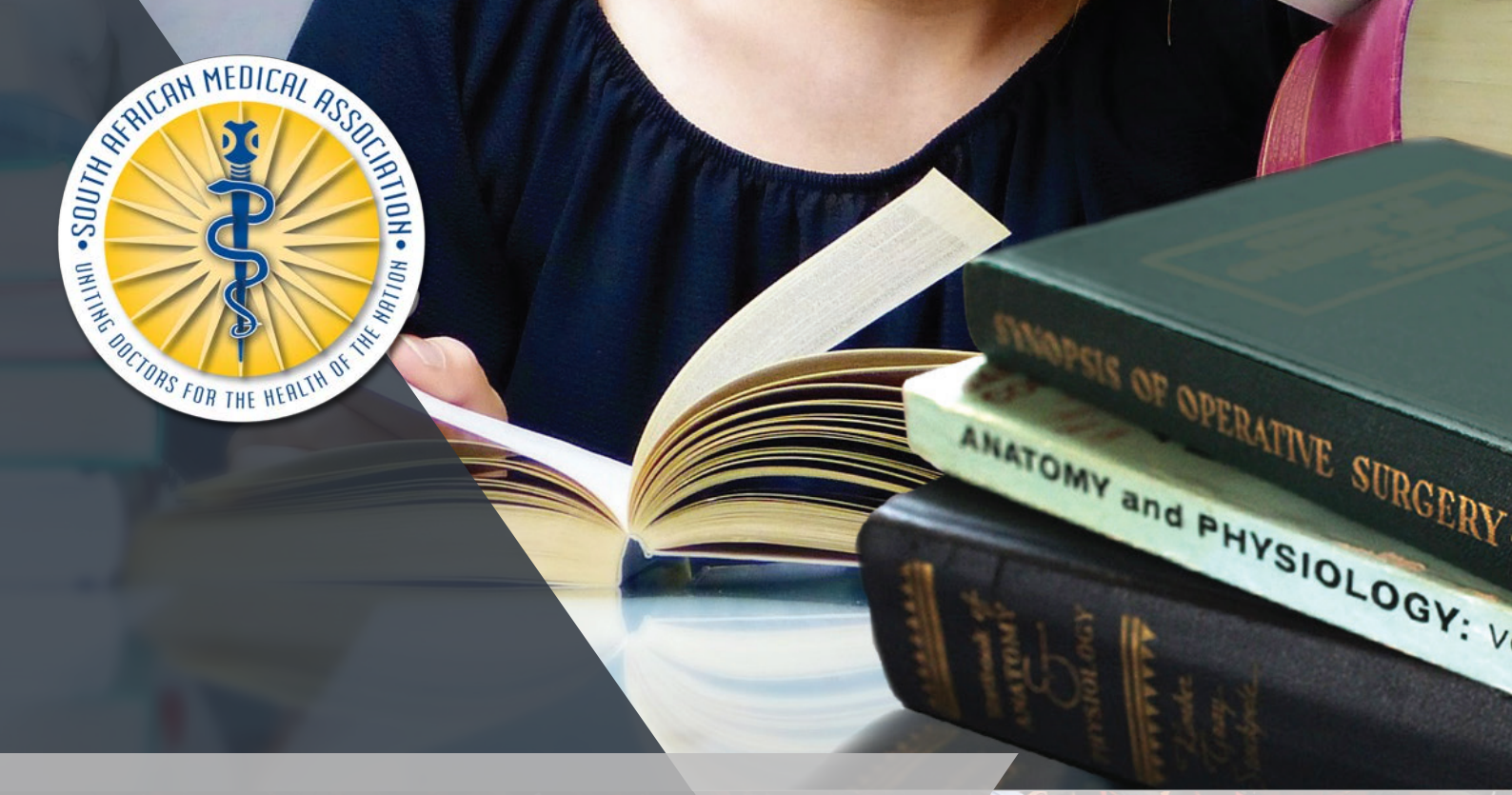
The future of your business

The future looks bright, with LocumBase.

Our team is agile and able to continually improve the Locum booking process with the help of your review inputs, which are highly valued.

We look forward to welcoming you to the LocumBase family, and are happy to help with any questions you may have. Contact us at hello@locumbase.com or give us a call on 021 201 7390.

Our founder and CEO, Zulé Vuuren, says: "We are striving towards a healthcare sector where continuous quality care can be ensured by distributing the necessary healthcare skills to where and when they are needed most." You can find out more about LocumBase by visiting us on LinkedIn: https://www.linkedin.com/company/locumbase.



CPD

For further information please contact the CPD Officer on

012 481 2000

cpd@samedical.org

WHAT ARE WE ABOUT

Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association is one of the institutions that have been appointed by the Medical and Dental Professions Board of the Health Professions Council of SA to review and approve CPD applications.

SERVICES AVAILABLE

- South African Medical Association Continued Professional Development Accreditation

- **Our Mission**
  - Empowering Doctors to bring health to the nation
  - Excellent Service
  - Quick Turnaround
  - Efficiency