August 2025

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QualiCare

Newsletter

Update on OHSC Manuals, Registration, Inspectors and more.....

Developments pertaining to the 2 manuals released by the Office of Health Standards Compliance (OHSC) and the various workshops which OHSC has run with various organizations over the past 30 days require further discussion of the OHSC manuals.

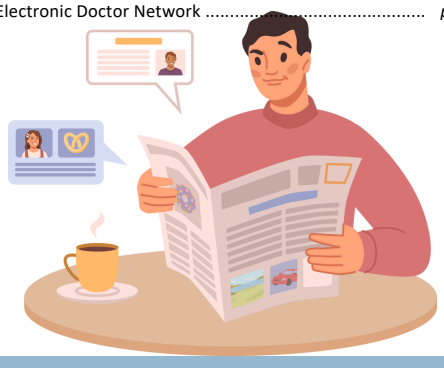
Readers may recall that I listed commonly asked questions, posed to our 5 Qualicare Consultants over the past 2 months, and now some of the answers have become more apparent, including the Department's position on:

- Prepackaging of medication and
- the requirement for O2 cylinders, and
- resuscitation trolleys and
- defibrillators.

The sudden announcement of 2 complicated manuals and a fixed short deadline for the implementation of their contained guidelines created mass panic throughout the private and public primary healthcare sectors, and as such, were greeted with pushbacks and even ridicule by the profession.

Recent developments with OHSC .....continue to page 3

Inside this issue



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To be quite clear, we support General National Quality Standards and have long recognized their need at all points of entry and continuity of the healthcare cycle, including State institutions such as Clinics, Day Hospitals, Secondary and Tertiary hospitals as well as all private practices, day clinics, and private hospitals.

There is a definite need for us to embrace change and adopt Quality Standards & guidelines.

In fact, we as General Practitioners should be at the forefront of adopting a collectively constructive attitude towards Quality and Outcomes.

The OHSC requirements may be unnecessarily complicating a rollout of self-initiated quality assurance, health standards, and excellent outcomes of our own volition.

The following recurring questions have been noted by our 5 Qualicare consultants during the months of June and July 2025:

RECURRING QUESTIONS ASKED:

1. When do the inspections begin?
2. What happens if I fail an inspection?
3. Will I still be able to see my patients if I fail an inspection?
4. What period of time do I have to become compliant following a failed inspection?
5. Will the medical aids be informed that they should not reimburse me if I fail an inspection?
6. Do I have to have an OHSC compliance certificate to continue in practice?
7. Is an OHSC practice compliance certificate only necessary to see a future National Health Insurance patient?
8. Can I elect not to see National Health Insurance patients if I am in possession of an OHSC compliance certificate?
9. How long does a compliance certificate last?

Recent developments with OHSC .....continue to page 5

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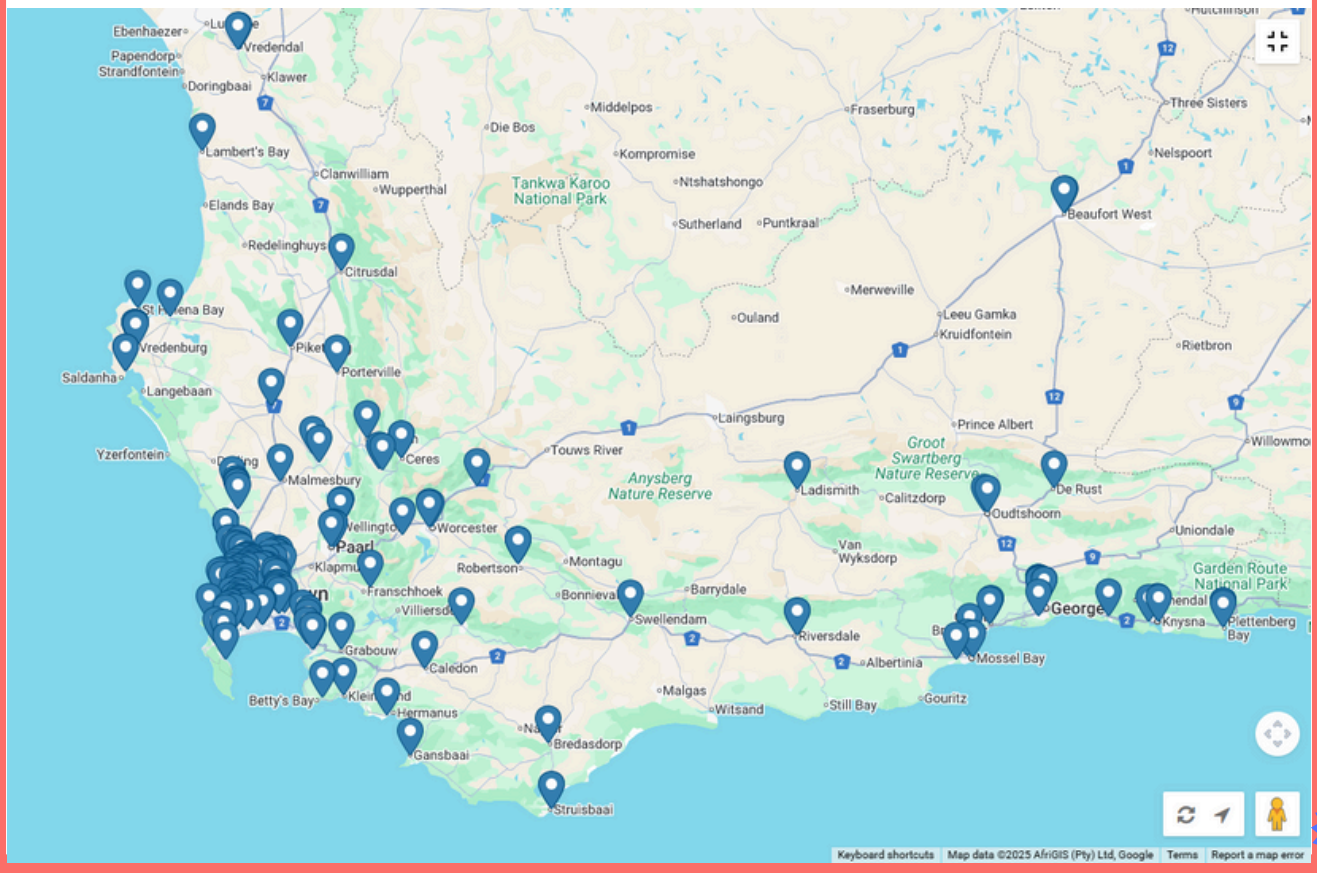

ANSWERS:

1. When do inspections begin?

According to the OHSC, the deadline for compliance with the 2 documents was the 31st of July 2025. At our telecons with them, we explained that this was unrealistic and unachievable; however, they remained and still remain insistent that this date will be enforced! We will nevertheless look at this pragmatically later in this article .....

Q 2 to Q5:

- What happens if I fail an inspection?
- Will I still be able to see my patients if I fail an inspection?
- What period do I have to become compliant following a failed inspection?
- Will the medical aids be informed that they should not reimburse me if I fail an inspection?

It has been explained to IPA leaders, as we discussed this at the highest level, that there is no "pass or fail". Inspectors will merely generate a list of recommendations for practice improvements that need to be attended to within an achievable time frame, estimated at approximately 1 year, whereafter the next inspection will fall due.

If, however, you are in gross violation of public health regulations and are outside of legal requirements, which could place a patient or your staff in danger, then immediate intervention can follow.

Outside of this scenario, it will be decided whether your practice meets the OHSC requirements, and will be encouraged. A further deadline will be offered during which time you may continue to see your normal patients.

This will also not be reported to funders to disqualify you from servicing their network's patients.

Q6 to Q10:

- Do I need an OHSC compliance certificate to continue in practice?
- Is an OHSC practice compliance certificate only necessary to see a future National Health Insurance patient?
- Can I elect not to see National Health Insurance patients if I am in possession of an OHSC compliance certificate?
- Do I need to buy a defibrillator and an Oxygen Cylinder?
- May I continue to prepackage and dispense medication?

You will have a period of at least one year following the first inspection by an OHSC official to introduce the changes which have been recommended at the initial inspection.

A follow-up inspection will be scheduled before at least one year later at which stage, if you are still not fully compliant, you will receive certain suggestions which will assist you in achieving compliance at the next inspection, which would then be scheduled sooner than one year.

Recent developments with OHSC .....continue to page 7

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It has, however, clearly been pointed out to us that the practitioner will not be prevented from practicing after having endured an initial inspection, but we'll be reinspected for progress approximately 12 months later. The officials that we have spoken to emphasize that they cannot afford to lose private general practitioners and, at all costs, will attempt to retain them within the health care delivery system and assist them with their compliance whenever possible.

The question of acquiring a defibrillator machine is still a requirement of the OHSC and we are currently engaging them on this matter as well as the need for an oxygen cylinder and an emergency resuscitation trolley. Please watch this space as discussions are ongoing on these topics.

Prepackaging of medication was discussed, and the Department of Health accepts that a dispensing practitioner, with a valid dispensing license, may prepackage medication for a 24-hour period, but may not prepare large supplies of prepackaged medication, as the manufacturer's specifications cannot be observed and maintained.

Regarding future NHI patients, this question is a long way down the line and depends on when and whether the primary practitioner section of NHI commences, as well as whether it is a financially viable offering or not?

Once there is more clarity on this, you will be in a better position to decide if it makes financial sense to see NHI patients or not.

The final question as to whether you can elect to opt out of seeing NHI patients and only see privately insured patients has not yet been answered.

In the long run, every private practice will need a compliance certificate from the OHSC to remain in practice, but this will be an evolutionary process, and not a short-term shotgun approach, and will be spread over a year or more.

Registration with the OHSC:

In our last newsletter, we mentioned that there was no huge rush to register with the OHSC as no deadline has been announced. Our reasoning was that there were various parts of the website registration which needed further refinement and attention. In amplification of this, it was possible for a non-medical person to register on the site, as there was not a request for an MP number on the website. This was raised by an attorney colleague of ours with the OHSC.

Recent developments with OHSC.....continue to page 8

They replied that they want as many people to register as possible and that they would then weed out incorrect registrations!!

So, it's really up to you to register now and get it over with, or to wait a while until their website is perfected. We will, of course, inform you as soon as a deadline is announced.

We, however, remind you of the launch of the POPI Website, where the early registrations ran into a multitude of problems.

About Inspectors and more:
??Is it Inspector Clouseau, Inspector Carr, or Inspector Morse??

Over the past two to three months, we have been made aware of a plethora of inspectors coming into general practice establishments, usually unannounced and demanding to conduct a random inspection.

The vast majority have not made an appointment to see the doctor or to take up his time and insist on being seen when they arrive, despite the waiting room having sick patients who too are waiting for medical assistance.

A common thread is the arrogance, and often rudeness of the inspectors, who carry little or no identification, often bear no name badge, carry no letter of appointment, Do not clarify which branch of the law they represent, and frequently become involved in a cross section of items to inspect including medical records, stock files, toilet facilities, general cleanliness, compliance with POPI, compliance with IPWIS, compliance with labor regulations, to mention but a few.

Add to these possible inspections by OHS representatives, and we can attest to how harassed the profession is currently by Inspectors.

Recent developments with OHSC .....continue to page 10

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What are your rights when approached by any inspector:

Should the inspector present you with an official document or a Magistrate's letter demanding an immediate inspection, you must comply.

Failing this, maintain politeness and a professional approach at all times, and

- Request them to return with a set appointment, possibly within the next 48 hours.
- Request them to bring with them a letter of appointment, showing for whom they work, quoting the law which empowers them to inspect your premises as well as a written reason for the inspection, and the modalities that will need to be inspected.
- The inspector is confined to the mandate on his inspection letter.
- Should they be insistent, then agree to the inspection and inform them that next time they should take heed of what the law states.
- At no time become involved in an altercation with the inspector, but remain firm that your patients must be treated as a priority and routine, Inspections must be by way of a pre-existing confirmed appointment and be accompanied by a written reason for the inspection and the modalities which that inspector has been tasked to inspect.

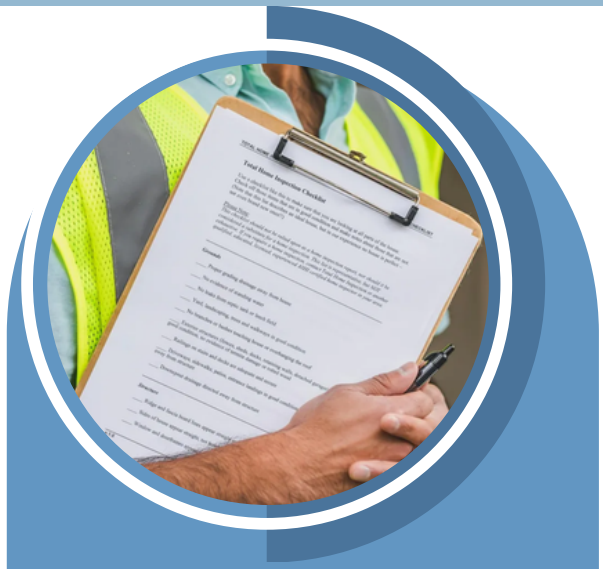
Please inform your Qualicare Consultant should this occur, and obtain the contact details of the inspector for us to take this up with his superiors.

OHSC Inspectors: The logistics. When will you be inspected?

With approx. 60 inspectors for the entire country. They currently have to inspect all State health facilities, including Clinics, Day Hospitals, Secondary and Tertiary hospitals, as well as all private day clinics and private hospitals and private practices and ensure that they are informed of their shortcomings.

They will then need to re-inspect institutions that did not make the cut one year later, unless there is a gross violation of patient safety, when a reinspection can be ordered within days or weeks!

The average time taken for an inspector to investigate a facility using the complex and intricate OHSC manuals, which have been made available, has been estimated at approximately 2 days, as a minimum.



From a General Family Practitioner scenario and applying this information:

IF

Using all 60 inspectors, each inspector would need to complete 142 inspections. Each inspection would take approx. 2 days, so 142 inspections will take 284 days. Assuming 5 working days in the week, this will equate to 57 working weeks, not allowing for holidays or leave.

Any practice that fails an inspection will need to be re-inspected after an agreed period of time, usually 1 year. At that inspection, provided that it can be seen that you are making an effort to apply, it is unlikely that action will be taken against you but rather you will get even a further extension followed by another reinspection. The Department of Health has emphasized that we need every general practitioner that we have for the delivery of quality healthcare for all.

Recent developments with OHSC .....continue to page 11

Knowing that up to now, only 16% of state facilities have passed their first inspection, let's be optimistic that our private GPs will have a minimum of a 50% pass rate!

Even so, OHSC is left with over 4000 GP practices which did not pass and need to be re-inspected at the end of the first years round of inspections.

This would take approx. 30 more working weeks to perform the re-inspections (although a re-inspection may take a shorter time than the first inspection).

So, just for the General Practitioners, OHSC are utilizing the full 100% of their inspectors for the first year and 50% of the inspectors for half of the second year.

Remember however, that the inspectors have to cover all of the state hospitals, private hospitals, clinics, specialty clinics etcetera, as well as the private GP population.

So bottom line is that it is highly unlikely that inspectors will be out there inspecting General Practitioners in an organized fashion and will possibly rely on tip-offs and hot leads.

This further makes the ultra-short deadline recently announced by the OHSC look rather esoteric, unnecessarily autocratic, and top-down! Cut out the table below for ease of reference. It will help you organize your approach to the OHSC requirements.

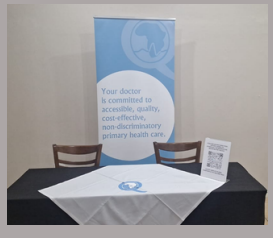
It was with this in mind that I simplified the 2 OHSC manuals and requested that all of our Qualicare doctors use them to:

- ✓ Carefully analyze their own practices and measure themselves against the OHSC criteria, taking care to ascertain and achieve what they can do with ease, then next,
- ✓ Plan what they will need extra CapEx for, and set up a plan with a time frame to do this and
- ✓ Finally, leave what is totally unaffordable by your practices, to the IPAs and our involvement with the Department of Health to come out with a final position.

The motto of Qualicare is: To provide Quality, Affordable, Sustainable, Equitable, Non-discriminatory Primary Healthcare to the patients of the Western Cape, through empowering our doctors, dentists and other medical and allied practitioners with clinical, business and ethical knowledge, as well as up-to-date practice information and assistance.

Remember that your Qualicare IPA, your 5 Qualicare consultants, as well as your General Manager, John Paul Valentyn, and I are at your service at a moment's notice.

Dr Tony Behrman CEO, and the Qualicare team



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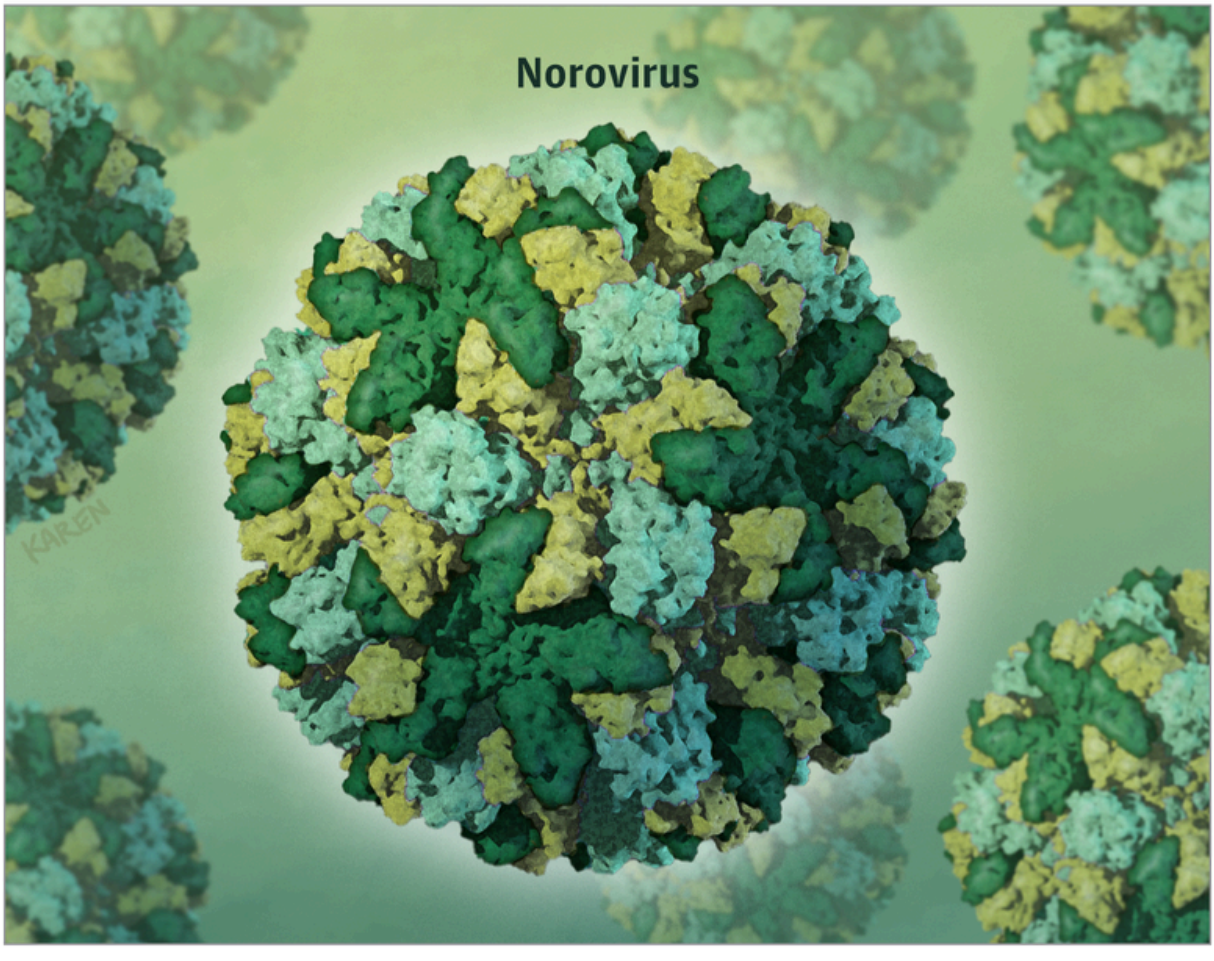
IS THERE A NOROVIRUS VACCINE ON THE HORIZON?

This past winter, cases of norovirus, a highly contagious stomach bug characterized by sudden vomiting and diarrhea, surged in the US. Nicknamed the “Ferrari of viruses” for how fast it spreads, it’s also known for racing through cruise ships, long-term care facilities, and school cafeterias. But, according to those who study it, the virus hasn’t gotten the attention it deserves.



The virus is a leading cause of acute gastroenteritis worldwide. In the US, it causes more than 50% of all foodborne illnesses. And each year it accounts for nearly half a million emergency department visits, mostly for young children, and roughly 900 deaths, predominantly in older adults, according to the US Centers for Disease Control and Prevention.

Is There a Norovirus Vaccine .....continue to page 15

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In well-resourced regions, norovirus symptoms commonly pass after a few extremely unpleasant days, but "there are other places on the planet where diarrhea really does threaten the health of populations, especially those already suffering from malnutrition, chronic starvation, or dehydration," said C. Buddy Creech, MD, MPH, director of the Vanderbilt Vaccine Research Program at Vanderbilt University Medical Center. "It's a significant driver of mortality around the globe."

Norovirus contributes to nearly 1 in 5 episodes of diarrheal disease worldwide and causes about 200 000 deaths annually. The most vulnerable populations include children younger than 5 years, older adults, and people who are immunocompromised. In developing countries, deaths from norovirus are common among children—who make up more than a third of the global death toll.

Preventive measures like improved water, sanitation, and hygiene have not proved effective enough to control the notably transmissible virus, which incurs a $60 billion cost to society—including $4.2 billion in health care costs—globally every year. It's for these reasons that the World Health Organization called developing a vaccine for it a priority in 2016. Since then, vaccine developers have struggled to create a safe and effective option. Currently, a handful of candidates are in various stages of clinical trials, including one that would be offered in the form of an oral tablet—a promising approach for a virus with such a devastating grip on resource-limited nations.

"No one is developing a norovirus vaccine in order to avoid the occasional cruise ship outbreak," said Creech, who is also the Edie Carell Johnson chair and professor of pediatric infectious diseases at Vanderbilt. "We're doing it so we can protect the world's most vulnerable from potentially devastating illness."

Why Norovirus Is So Tricky

What makes the norovirus "incredibly tricky" to manage is, in part, how it's spread, said William Schaffner, MD, a professor of preventive medicine and infectious diseases at the Vanderbilt University Medical Center. "It's not just touching and then ingesting from contaminated surfaces," he said. "It can also spread through the air. You can actually inhale the virus, and just a trace of it is enough." Not only that, people who have recovered from the infection can continue to shed the virus for weeks, and it can live on surfaces for even longer.

Is There a Norovirus Vaccine .....continue to page 17

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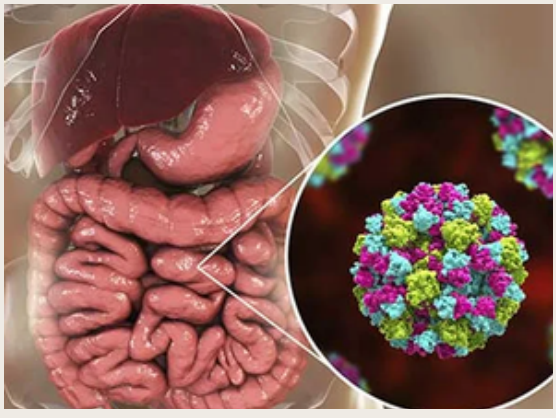

In addition to its most noteworthy adverse effects, norovirus infection can also cause fever and headaches, which is why Schaffner said it's often referred to as a stomach flu despite being unrelated to influenza.

Variability in the severity of norovirus illness adds to the complexity. As Creech noted, the "disease burden is a U-shaped curve" in terms of demographic risk.

"Most people recover, but the very young and those older, frail people are the ones who run into trouble and end up in the hospital to get rehydrated," Schaffner said.

These factors make norovirus a "perfect pathogen," noted Lisa Lindesmith, MS, a senior scientist who is studying the virus at the University of North Carolina at Chapel Hill. "It's highly infectious, it's very environmentally stable, and there's a tremendous amount of diversity within the family."

But a perfect pathogen makes for a challenging task, rife with scientific barriers, for vaccine developers.

Based on genetic differences, researchers have divided noroviruses into nearly 50 genotypes split into 10 groups. Five of these groups are known to infect people, with genotype I (GI) and GII being most common. Similar to influenza virus, dominant norovirus strains change and evade immune systems. GII.17 caused most of the norovirus cases in the US this past winter, when there were 2630 outbreaks—nearly double those of the previous year. Meanwhile, GII.4, known as Sydney, has been the most prevalent strain for more than a decade and the one associated with the most severe illness.

"These GII.4 viruses are the ones that cause pandemic levels of disease and cyclical patterns over time," Lindesmith said. "They are particularly good at changing themselves, which leads to evasion of the immunity that you've already developed. When you think about young children who have the most severe disease, it's easy to see what a challenge this is. We've got an immature immune system that's going to need to build through repeat exposure, yet we have a virus that's continually changing."

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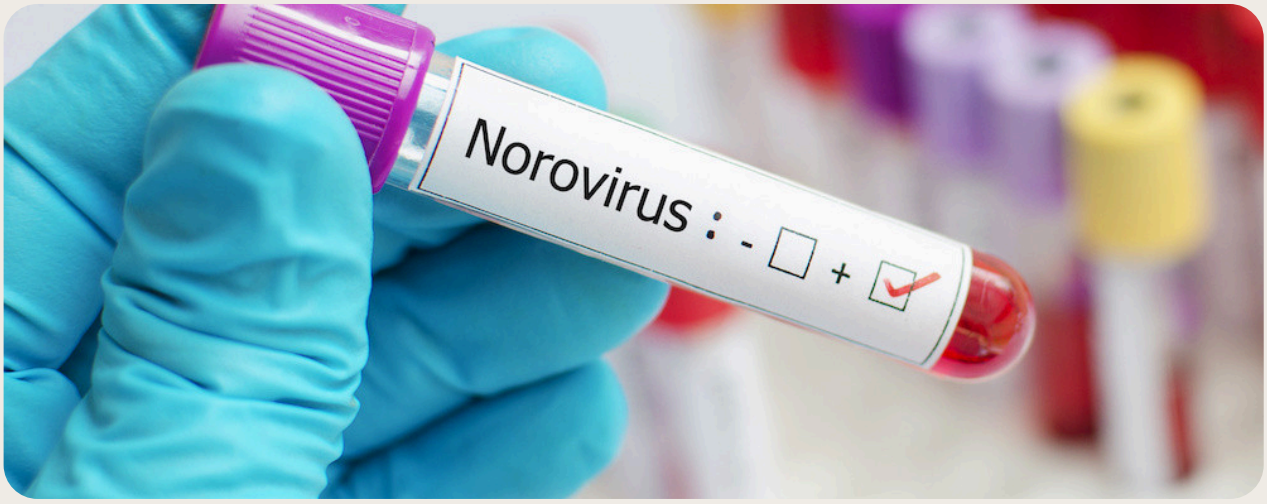
On top of that, researchers don't know how long immunity lasts after a norovirus infection—depending on the study, estimates range from several months to up to 9 years. And human norovirus cultivation has not been possible until recently: "It's rather difficult to grow it in laboratory conditions, so that's caused delays in development as well," Schaffner said of vaccine research.

The Challenges Facing Norovirus Vaccine Makers

Scientists have taken several different approaches toward a norovirus vaccine, but all have progressed in fits and starts.

One of the most advanced vaccine candidates contains viruslike particles (VLPs), empty structures that imitate the size and shape of the pathogen but lack its genetic material. "It looks just like the virus to your immune system, so, in theory, you can make the appropriate response without being exposed to the replicating virus," Lindesmith said of this vaccine technology, which has so far been used to protect against human papillomaviruses and hepatitis B and E. Developers have posted positive efficacy and immunogenicity data for the investigational VLP norovirus vaccine in adults but the same candidate failed to protect infants in a trial, manufacturer HilleVax announced in July 2024.



Moderna, which has also been at the forefront of norovirus vaccine development with its single-dose messenger RNA–based candidate, mRNA-1403, had its own setback, the pharmaceutical company announced in February. The US Food and Drug Administration (FDA) put a temporary hold on a phase 3 clinical trial of mRNA-1403 following a single reported case of neurological disorder Guillain-Barré syndrome. The trial launched in September 2024 with a recruitment goal of 25 000 participants globally.

Moderna did not respond to a request by JAMA Medical News for comment, but noted in its press release that an investigation was under way and that it "does not expect an impact on the study's efficacy readout timeline."

Is There a Norovirus Vaccine .....continue to page 21

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Another platform, live-attenuated vaccines, has been successful for rotavirus and influenza, but Lindesmith said it's not currently possible to grow the norovirus at the scale necessary for this. Still, new discoveries may make this possible in the future. Over almost a decade of work, scientists have made significant advances in norovirus cultivation, and in January, researchers from Baylor College of Medicine in Houston showed that they were able to reliably grow the virus in a "mini gut," an organoid culture system that mimics human intestines.

Another novel approach involves piggybacking on the highly effective vaccines for rotavirus, an unrelated pathogen that also causes diarrhea. Researchers engineered an experimental combination vaccine by adding a key protein from norovirus to a harmless strain of rotavirus, and it induced the production of neutralizing antibodies against both. The results, while encouraging, were from preclinical studies of mice—which are not representative of human norovirus infection—and the researchers still need to demonstrate that the immunized animals are less likely to get sick from norovirus before it can move forward as a solution for broad-spectrum protection.

The Potential for a Norovirus Pill

Most recently, a biotech company has sought to bring a norovirus vaccine to market with a pill. Administered orally in a coated tablet form, Vaxart's delivery platform is an adenovirus vector vaccine designed to stimulate mucosal immunity, which could be the key to preventing norovirus infections at

their starting point, said Becca Flitter, PhD, MPH, director of immunology at Vaxart, which also has an oral influenza vaccine in development.

*I*n May, researchers published promising data on the pill from a trial during which participants were intentionally exposed to the virus.

"Unlike a large trial with 30 000 people where we only see who gets disease and who doesn't, a challenge study like this one allows scientists to get blood samples and even stool samples in the hours or days before symptoms occur, so they get to know a lot more about the actual cadence and rhythm of the response to the vaccine," Creech said.

Half of the nearly 150 participants, aged 18 to 49 years, received the oral vaccine, and a month later, all participants ingested the GI.1 strain of norovirus in a liquid dose "hard enough" to ensure people got infected, Flitter noted.

Is There a Norovirus Vaccine .....continue to page 23

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By the following week, 82% of the placebo group was infected compared with 57% of the vaccinated group, a 30% relative reduction. Additionally, Flitter and her coauthors found that those who received the vaccine shed less virus in their stool and vomit than those who got the placebo, suggesting the vaccine could slow the spread of the virus.

The reduction in the severity of disease symptoms, however, was not statistically significant. Flitter said this may be due, in part, to the fact that participants received higher amounts of virus than they'd encounter in real-world settings.

This phase 2 proof-of-concept study, which appeared in Science Translational Medicine, followed previous analyses that found the tablet induced mucosal immunity in older adults and broadly neutralizing antibodies against norovirus. In a press release, Vaxart also announced results of a trial focused on breastfeeding mothers: it showed an increase in norovirus antibodies in their breastmilk, which suggests the potential for passive transfer to infants.

Lindesmith, who coauthored two of the studies on the oral pill with Flitter, acknowledged that the strain they tested, GI.1, isn't responsible for the bulk of global infections. "We really have the epidemiological data to support this need for GII.4 to be the target as a matter of public health," she said.

In June, Vaxart reported in a press release that a second-generation version of the vaccine protected against both GI and GII viruses in a phase 1 trial and, according to Flitter, the candidate has "greater potency and enhanced immunogenicity in humans."

Flitter said she's excited about the possibility of "forging a new path" with the tablet format. "With a pill, you don't need the infrastructure you need with a needle," she said. "You don't need trained professionals who know how to inject. You can keep it at room temperature, so bags of pills could be shipped to wherever there's a need, with no medical waste."

This will work well with the at-risk older adult population, but not the other side of that U curve, Creech noted. "My anticipation is that we start with an oral tablet and move into a liquid formulation, like we do with oral rotavirus vaccine, that can be given to [infants and] younger children," he said, adding that this will take time. "Hopefully through vaccinating adults first, we can start to reduce the likelihood of transmission to those who are most vulnerable who cannot yet be vaccinated."

Of course, without an approved vaccine, these considerations are still a long way off. Vaxart has yet to begin a phase 3 trial of its oral pill. Flitter is currently prepping phase 2b trials for the second-generation version.

Lindesmith acknowledges the challenges that still lie ahead. She said the field is "not just solving for the GII.4 of today but also the GII.4 of tomorrow" and estimates the earliest possible approval for any norovirus vaccine is still years away. Creech predicts that an application to the FDA is 5 years out. Even then, most experts predict that, due to norovirus's rapid evolution, a vaccine will function much like flu shots and require regular boosters. But "something is better than nothing," Schaffner said. "If it's not preventing the virus altogether, we want to see the disease blunted at the very least," said Creech, who suggested administering it in anticipation of an outbreak or in advance of travel. "Driving down the burden of this illness has tremendous societal benefit."

Article Information
Published Online: July 25, 2025. doi:10.1001/jama.2025.10673

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Poor hygiene, staff shortage contributes to hospital infections

SA Medical Association urges Gauteng health department to treat the situation with urgency, it demands

Overcrowding, staff shortages, lack of cleaning materials, and inconsistent infection control practices are some of the contributing factors that could have increased the hospital-acquired infections in Gauteng last year.

According to Gauteng health MEC Nomantu Nkomo-Ralehoko's response to the DA at the legislature recently, 7,743 patients out of 217,490 got infections while in hospitals last year — a huge jump from the previous year's 2,034 infections.

Poor hygiene, staff shortage .....continue to page 29

CNS

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Clobazam

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References: 1. CLOZABAM ADCO 10 & 20 mg tablets Professional Information, 27 June 2023. 2. Faulkner MA. Comprehensive overview: efficacy, tolerability, and cost-effectiveness of clobazam in Lennox-Gastaut syndrome. *Ther and Clin Risk Manage* 2015;11:905-914. 3. Generics dictionary. http://www.generic.co.za/frontend/generics?utf8=%E2%9C%93&q%5Bactive_ingredient_name_eq%5D=CLOBAZAM (Accessed: 03 October 2023).

For full prescribing information please refer to the Professional Information approved by SAHPRA (South African Health Products Regulatory Authority).

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Dr Angelique Coetzee from the Unity Forum of Family Practitioners said most public hospitals were under resourced and overcrowded, which makes them susceptible to infections. "The 7,743 hospital-acquired infections is really a significant number, and it points to systemic challenges that require urgent attention.

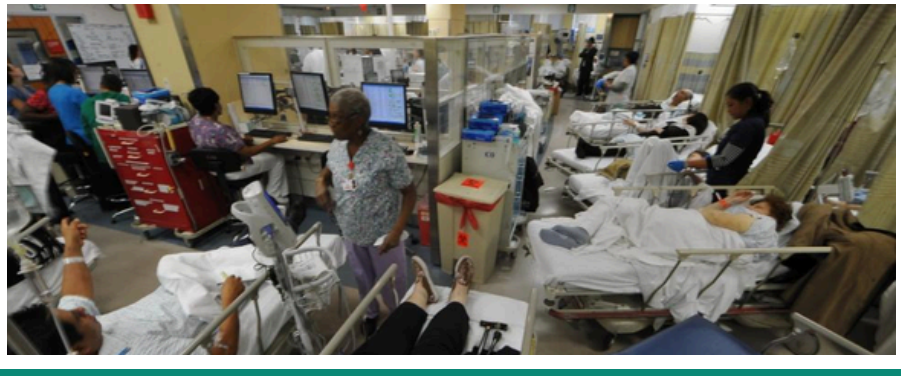
"The most common contributing factors in your public hospitals include overcrowding, staff shortages, stuff like aging infrastructure, inconsistent infection control practices, and the rising antibiotic resistance. Your ICU and high-care wards are particularly vulnerable due to the nature of invasive procedures and high patient acuity. Also, these infections not only increase patient suffering and length of stay, but also place, unfortunately, an additional strain on our already limited public health resources," Coetzee explained.

The South African Medical Association (Sama) spokesperson, Vezi Silwanyana, pointed out that doctors working in the public sector had routinely raised concerns about the dire state of hygiene in the hospitals. "Many healthcare professionals have to work without access to essential infection prevention control (IPC) materials, or in environments where wards are cleaned irregularly due to overwhelmed cleaning staff."

The most common contributing factors in your public hospitals include overcrowding, staff shortages, stuff like aging infrastructure, inconsistent infection control practices, and the rising antibiotic resistance.

Dr Angelique Coetzee

She said in post-operative wards, delayed detection of early signs of infection, due to staff shortages or inadequate monitoring, can result in outbreaks affecting entire units, including vulnerable populations such as neonates.
Silwanyana said, in some cases, regular IPC monitoring procedures such as routine surface swabs or cleaning audits are not consistently carried out. Waste segregation is often not followed, further increasing cross-contamination risks.



Poor hygiene, staff shortage .....continue to page 30

Sama is urging the Gauteng health department to treat this situation with the urgency it demands. According to Nkomo-Ralehoko's responses to DA spokesperson for health Jack Bloom, by far the worst hospital is Charlotte Maxeke Johannesburg Academic Hospital, where 1,473 out of 12,940 patients got nosocomial infections — meaning one in every 10 patients were infected.

At the Chris Hani Baragwanath Academic Hospital, there was 1,796 infections from 31,950 admissions. Bloom said these new infections include antibiotic-resistant ones, which are difficult to treat and could be life-threatening. "These are known as nosocomial infections, which develop during a hospital stay when patients get an infection other than what they were admitted for. Nosocomial infections are more likely in the higher-level hospitals because they have more complex cases with long hospital stays, do more invasive procedures, and use more antibiotics."

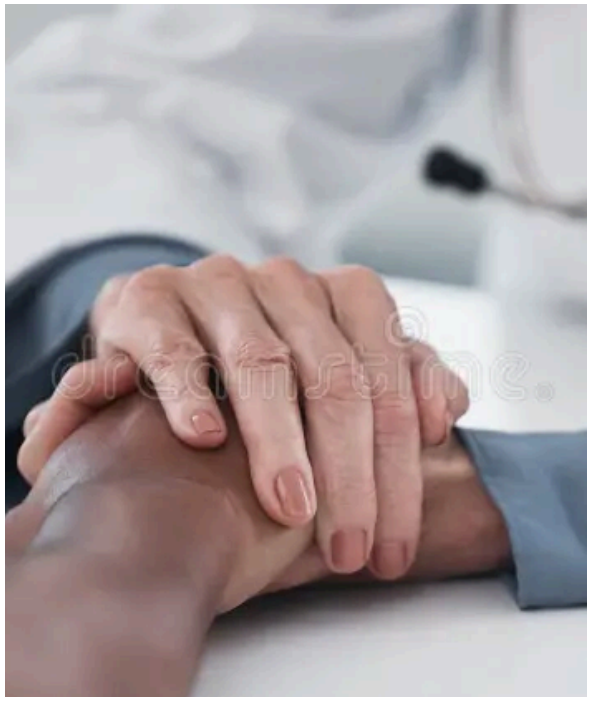
He said the department blamed staff shortages, overcrowding, inadequate hand hygiene facilities, broken equipment and frequent stock-outs of essential cleaning materials such as soaps and disposable paper towels. Linen shortages are also blamed as it forces patients to reuse bedding and pyjamas for long periods, and surgical patients are at extra risk due to inability to provide clean linen pre-and post-operatively.

Bloom further said he was concerned many patients were getting infections that can easily be avoided with basic improvements like decent cleaning and adequate linen.

Other hospitals with a concerning number of hospital-acquired infections include:

- Tembisa Hospital — 596 from 13,116 admissions
- Kalafong Hospital — 554 from 8,952 admissions
- Edenvale Hospital — 407 from 5,166 admissions
- Leratong Hospital — 365 from 1,026 admissions
- Pholosong Hospital — 249 from 5796 admissions

THE ROLE OF EMPATHY IN MEDICINE: A MEDICAL STUDENT'S PERSPECTIVE



Throughout medical school, my instructors stressed the importance of empathy, generally defined as the understanding of and identification with another person's emotional state. Sympathy and empathy, commonly confused with each other, are not the same. Sympathy is a statement of emotional concern while empathy is a reflection of emotional understanding. The applications of empathy are widespread [1,2], and are especially relevant in fields such as medicine, where the successful treatment of patients depends on effective patient-physician interactions. This article explores the concept of empathy and examines its utility in medicine from the perspective of a medical student.

What is Empathy?

Empathy is an emotional experience between an observer and a subject in which the observer, based on visual and auditory cues, identifies and transiently experiences the subject's emotional state [3]. In order to be perceived as empathic, the observer must convey this understanding to the subject. During the initial phase of the process, the observer must not only identify but also understand the basis of the subject's feelings. For example, a physician may encounter a patient who appears depressed, expresses feelings of sadness and informs the physician that a close relative has recently passed away. This may cause the physician to recall subconsciously his emotional state during a similar situation in which a close relative died. Alternatively, he may not have experienced death in his family but may understand the emotional response to death in the patient's culture. In both of these situations, he may be able to respond empathically because he understands and can relate to the patient's current grief. In a different situation, the physician may have a dissimilar cultural background in which death is not associated with sadness but with joy and celebration of the deceased's life.

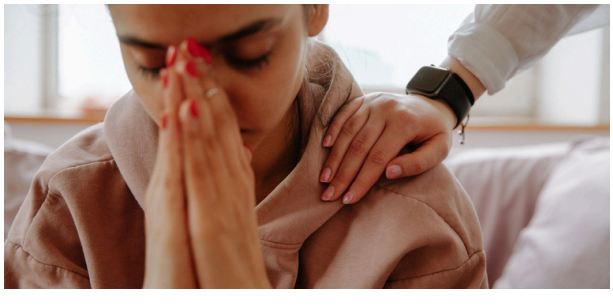
The Role of Empathy in Medicine .....continue to page 32

Due to the conflicting associations with death, the physician may feel confused because he does not understand the basis of the patient's sorrow. Without understanding the nature and circumstances of the patient's emotional state, it may be difficult for the physician to generate an empathic response.

There is more to empathic understanding than simply knowing and evaluating objective information about a patient, however. Researchers have found that male friends have higher empathic accuracy than male strangers [4]. While this is not surprising, it is interesting to note that the greater accuracy was correlated with a higher quality of shared information rather than a greater quantity of information.

This result is especially relevant for practicing physicians, for it indicates that it is not enough to know a large amount of factual information about a patient. The physician who understands each patient on a personal level stands a far better chance of experiencing and conveying empathy and treating the patient and illness effectively than the physician who does not have that level of understanding.

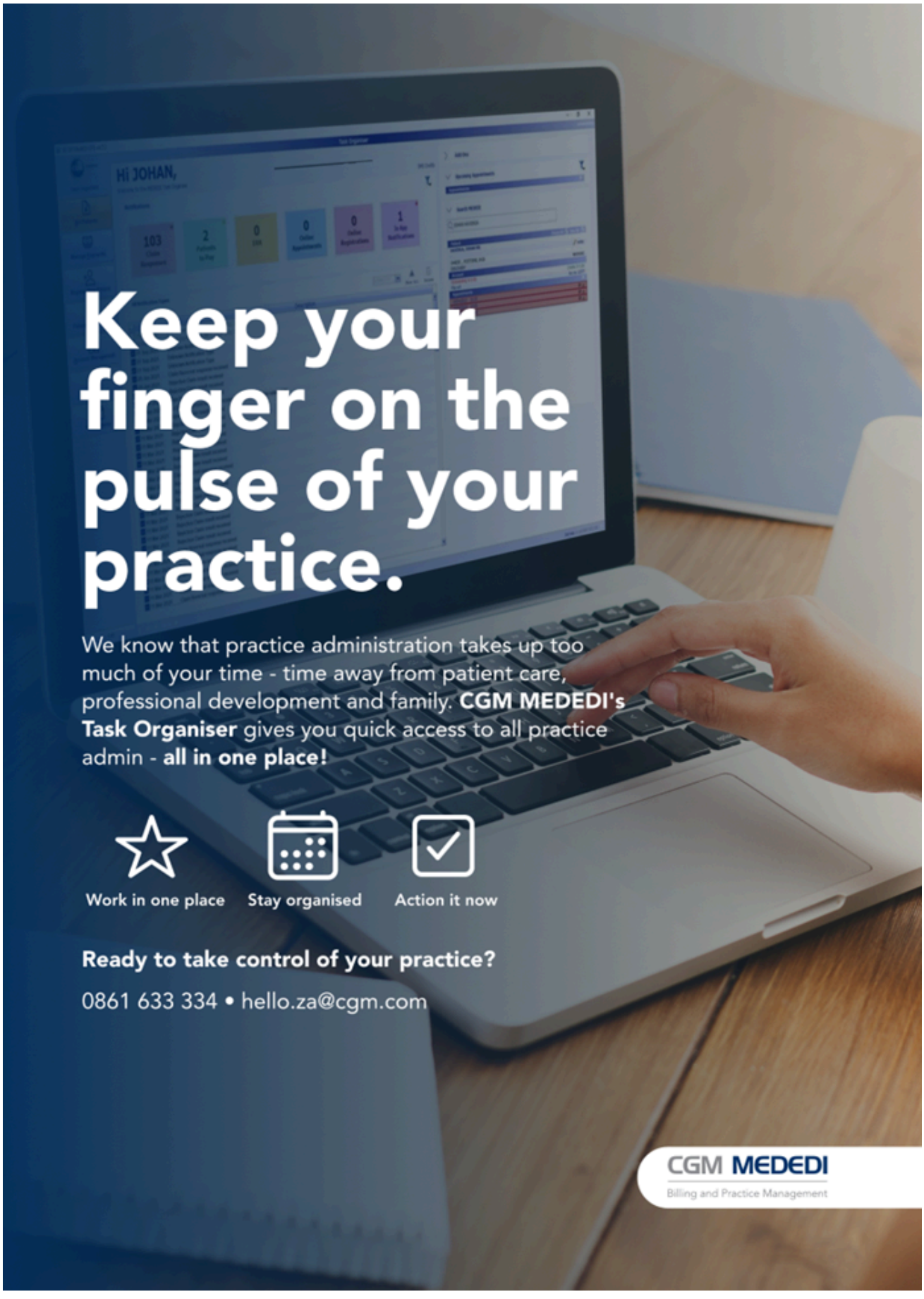
It is also important that the physician possess sufficient communication skills to convey the feeling she is experiencing to the patient. In everyday life, people who are poor communicators and cannot adequately express their feelings are misunderstood by people around them. Thus, it is possible for a physician to be perceived as nonempathic when in actuality, she feels empathy but is unable to express it. Conversely, a physician who may not actually feel empathy may still be able to generate an appropriate response because she understands how she should respond in the situation and possesses excellent communication skills [5]. As these examples illustrate, many factors influence the generation, expression and perception of an empathic response.



Clinical Empathy

Researchers have long examined and discussed the utility of empathy in medicine and have found differing results. Some argue that it is not possible for a physician to genuinely empathize with every patient—to do so would be emotionally draining and difficult under modern time constraints [6]. These researchers paint a picture of a physician who is best able to care for his or her patients by remaining "clinically detached" [7]. By not becoming emotionally involved with patients, the argument goes, the detached physician is able to make objective decisions concerning their care.

The Role of Empathy in Medicine .....continue to page 34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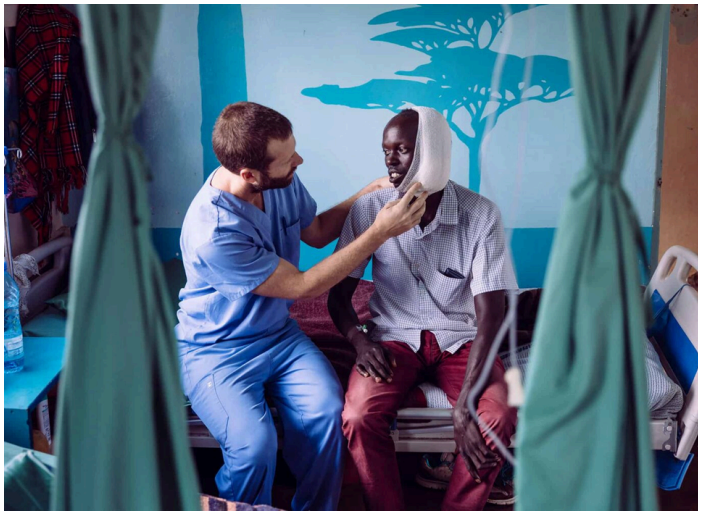
Yet there is increasing evidence that, when choosing a physician, patients value affective concern as much as, if not more than, technical competence [6]. As a medical student, I often heard descriptions of the characteristics of a "good doctor" from patients, instructors and even my family members. The one attribute that was always mentioned as necessary to being a good physician was being a good listener. Each patient wants to be treated as a person, not as an illness, and wants to be reassured that the doctor understands the nonmedical aspects of his or her condition. A doctor may be listening carefully to a patient, but the only way for the patient to know that is for the doctor to reflect that he understands the patient's concerns; i.e., to respond empathically. If it is a goal of medicine to treat the patient—to alleviate suffering and not simply cure disease—then empathy is a necessary clinical skill. It seems, then, that the physician must perform a difficult internal balancing act: by becoming too emotionally involved with the patient, she may lose objectivity; by not becoming involved enough, she may be unable to relate as a human being.

Research has shown that empathy is also useful on other levels; it has been found to be directly therapeutic by reducing anxiety in patients [7]. When a patient feels that a physician understands his condition and apprehensions, he may feel more comfortable confiding in the physician. This process of telling one's story can be therapeutic [8] and may also help facilitate the healing process. Moreover, patients often do not explicitly state their psychosocial concerns [9], which may manifest as physical illnesses (somatization). The prevalence of somatoform disorders has been estimated to be as high as 30 percent [10], and can only be diagnosed by a physician who is carefully attuned to the patient [11]. And, finally, empathy is beneficial to physicians; it has been demonstrated that doctors who are more attuned to the psychosocial needs of their patients are less likely to experience burnout [12].

Teaching and Learning Empathy

Although there is not a consensus on the best method of doing so, many researchers currently think that it is possible to teach and learn empathy [13-15]. When considering ways to develop the ability to be empathic, it is important to consider that empathic responses result from the interaction between behavioral and emotional factors. Thus, it is possible that increasing one's sensitivity to either of these factors will improve one's capacity for empathic response. For example, enhancing observation skills should make it easier to detect a patient's emotional state, while improving communication skills should help a physician convey his feelings to the patient.

The Role of Empathy in Medicine .....continue to page 35



The actual emotional process of empathy may be aided by exercises such as self-reflective writing, which helps an observer become more aware of her own emotions and subsequently improve her ability to be empathetic towards another [14]. Cultural education and a wide range of interests should give physicians a greater frame of reference with which to understand and relate to a patient, thus making an empathic response more likely. Finally, it has recently been suggested that physicians who act empathically may be perceived by patients as being genuinely empathic [5]. Physicians who practice this "deep acting" technique may, over time, learn to be genuinely empathic; thus, teaching acting may be a method of teaching empathy [5].

Conclusion

During the first two years of our medical education, my classmates and I were instructed in empathy and medical professionalism in a course that also entailed cultural awareness and the patient-physician relationship. Course methods included lessons in cultural awareness, ethics discussions and role-playing, in which we acted the parts of physician, patient and other members of the care team. During a typical session we attended a lecture and then met in groups of 24 to explore the current topic with our faculty mentors. Several sessions were devoted to each topic, after which we were required to complete a written self-reflection form.

Initially, it was somewhat difficult for me to understand the importance of these sessions. I appreciated our instructor's intentions but often felt that the material could have been more effectively presented. In retrospect, I was probably one of the milder critics of the course; a large number of students did not take the curriculum seriously, seeing it as a waste of time that could have been better spent studying. Possibly this reflects the views of many people in the medical community who see cultural education and professionalism training as being "soft." Another possibility is that medical students, who have been trained throughout their academic careers to value objective performance, simply do not want to spend their time with a subject that cannot be measured objectively.

The turning point for me came while I was working on this essay. After several months of research and discussion with my mentors, I began to understand that our professionalism course was building a base of knowledge and experience for us to use when relating to patients. A computer can read a list of signs and symptoms and give a diagnosis, but it does not have a range of experiences and cultural knowledge to draw on that would enable it to treat the person, as well as the illness. The empathic component of medicine is what makes a physician special; without it we are, in essence, highly trained computers.

The challenge for medical educators is to present the information in a format that makes it relevant and actively engages the students. Although students may not immediately see the value of this type of education, it is to our benefit that my generation of physicians is specifically instructed in empathy and professionalism. Programs such as these build a strong foundation for empathic interaction and give us the tools to be both effective communicators and skilled physicians.

The Role of Empathy in Medicine .....continue to page 37

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ED – erectile dysfunction; EF – erectile function

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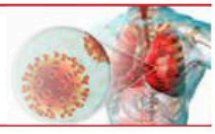
XPERT MTB/XDR TESTING



PathCare introduces Xpert MTB/XDR testing as a reflex test for rapid molecular drug susceptibility testing of rifampicin-resistant Mycobacterium tuberculosis (RR-TB) positive clinical samples

South Africa remains one of the top 30 high-burden countries for multidrug-resistant/rifampicin-resistant *Mycobacterium tuberculosis* (MDR-TB/RR-TB) (WHO, 2022). The National Department of Health (NDOH) has published updated guidelines for the management of RR-TB which recommends early access to a bedaquiline, pretomanid, linezolid and levofloxacin (BPaL-L) treatment regimen and early detection of second-line drug resistance, especially fluoroquinolone (FLQ) resistance, for optimal therapy (NDOH, 2023). Subsequently, reflex testing on direct RR-TB positive samples, within the public sector, has been implemented. Whilst the private sector has been constrained with re-imbursement challenges, it remains important to comply with guidelines, and to provide standard of care as we acknowledge that current conventional methods to detect second-line resistance, utilizing line probe assays on culture isolates, can cause severe delays and this practice has been phased out in the public sector.

The Xpert MTB/XDR (Cepheid, USA) PCR assay is able to rapidly detect resistance-associated mutations to isoniazid (INH), ethionamide (ETH), fluoroquinolones (FLQ) including levofloxacin and moxifloxacin and second-line injectable agents (SLIDs) such as amikacin (AMK), kanamycin (KAN) and capreomycin (CAP) in confirmed MDR-TB/RR-TB positive specimens. The WHO has endorsed the use of this assay as a reflex test on positive RR-TB samples to identify resistance as a low-complexity test without the delay to wait for subsequent testing on positive culture isolates (WHO, 2021). The reported sensitivity for *Mycobacterium tuberculosis* (MTB) detection among sputum smear positive and smear negative samples is 99.5% and 94.7% respectively and an overall specificity of 100%. The sensitivity for detecting drug resistance mutations correlating to phenotypic DST is >90% for isoniazid (INH), fluoroquinolones (FLQ), amikacin, kanamycin and capreomycin. Lower sensitivity for ethionamide is apparent at 65.9% (Omar et al, 2024).

Following the incorporation of this reflex testing in the public sector as per NDOH guidelines, PathCare offers this test as a reflex on positive RR-TB samples. Following detection of RR-TB/MDR-TB on a clinical sample, reflex testing will be performed following discussion with the attending clinician and treated as an add-on request to the sample.

Patients with RR-TB qualify for a BPaL-L treatment regimen. Additional phenotypic susceptibility testing for bedaquiline and linezolid, will be performed on all positive culture isolates. In the presence of FLQ mutations, levofloxacin should be omitted from the regimen and where INH and FLQ resistance mutations are detected together, pretomanid susceptibility testing is required. The laboratory will reflex further phenotypic testing as per the national algorithm.

The cost of the reflex testing will be 1x PCR billing code and will not be repeated on positive culture isolates. For specimens testing MTB negative on initial PCR testing but subsequently becomes culture positive with RR-TB, routine second-line testing will continue as per norm.

For further discussion please contact your local Clinical Microbiologist.

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Compiled by Dr AW Dreyer, Clinical Microbiologist, PathCare
On behalf of the PathCare Mycobacteriology Expert Group

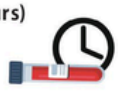
THE PATHCARE NEWS

IS IT HYPERKALAEMIA OR PSEUDOHYPERKALAEMIA?

Hyperkalaemia, defined as a potassium concentration greater than the reference interval, is a common electrolyte disorder that requires urgent attention. As both hyperkalaemia and hypokalaemia can have serious implications, it is imperative that the result obtained is a true reflection of the disease state.

Several factors can lead to a falsely elevated potassium concentration (pseudohyperkalaemia). These can be divided into factors associated with specimen collection and stability, and patient-related factors (associated with disease states). See table below.

NB: In patients with hypokalaemia, these factors may result in a falsely normal result.

FACTOR	MECHANISM	RECOMMENDATION
RELATED TO SAMPLE COLLECTION / STORAGE		
Delayed separation of serum from cells (> 4 hours) 	Potassium leaks from cells due to energy depletion	Samples should be centrifuged within 4 hours. Please contact the transport department as soon as the sample is collected.
Sample placed on ice or in a fridge 	Cold temperatures inhibit the Na/K pump, resulting in potassium leakage from cells	Please contact the transport department as soon as the sample is collected.
Haemolysis, due to e.g., fine gauged needle; high pressure on syringe, etc. 	Haemolysis, with release of intracellular potassium, results in significant increases in serum potassium, proportional to the degree of haemolysis	Vacuum tube systems, with correct needle gauge, creating minimal pressure on the draw are recommended
Tube additives, e.g., K-EDTA (purple top tube); NaF/K-Oxalate (grey top tube) 	Additives contain K salts and will result in significantly high K values (K >8), depending on the amount of contaminant present	Follow the recommended order of draw: blood culture tubes, sodium citrate, serum, heparin, EDTA, and sodium fluoride tube
Alcohol and povidone iodine 	Povidone has been shown to increase K by 1mmol/L (unknown mechanism). When ethanol antiseptics are not allowed to dry completely, cell disruption may result	Avoid phlebotomy in areas treated with povidone. Allow alcohol antiseptic to dry completely before phlebotomy
PATIENT-RELATED CAUSES		
Platelet count > **500** x10E9/L 	Leakage of potassium from platelets into serum during the clotting process (yellow top tube)	Use a plasma sample (green top tube), or do a blood gas
White blood cell count > **50** x10E9/L 	Leakage of potassium from white blood cells into serum. May be seen in patients with leukaemia (increased membrane fragility)	Do a blood gas

DOES GETTING FIT GUARD AGAINST COLORECTAL CANCER?

Evidence continues to mount that building cardiovascular fitness can help lower an individual's risk for colorectal cancer (CRC).

The latest study — a sweeping analysis of 643,583 individuals, with more than 8000 cases of CRC and 10 years follow-up — found a consistent, inverse, and graded association between cardiorespiratory fitness (CRF) and the risk for the development of CRC — a benefit similar for men and women and across races.

CRC risk was 9% lower for each 1-metabolic equivalent (MET) task increase in CRF, objectively measured by an exercise treadmill test.

When assessed across CRF categories, there was a progressive decline in CRC risk with higher CRF, Aamir Ali, MD, and colleagues with Veterans Affairs Medical Center, Washington, DC, found.

Compared with the least fit individuals (METs, 4.8), the CRC risk was 14% lower in those falling in the low-fit CRF category (METs, 7.3), 27% lower for moderately fit people (METs, 8.6), 41% lower for fit individuals (METs, 10.5), and 57% lower for high-fit individuals (METs, 13.6).

Moderate CRF is attainable by most middle-aged and older individuals, by engaging in moderate-intensity physical activity such as brisk walking, which aligns with current national guidelines, the authors said.

The study was published online on July 28 in Mayo Clinic Proceedings.

The results dovetail with earlier work.
For example, in the Cooper Center Longitudinal Study, men with high mid-life CRF had a 44% lower risk for CRC and a 32% lower risk of dying from cancer later in life men with low CRF.

A recent meta-analysis for the World Cancer Research Fund estimated a 16% lower risk for colon cancer in people with the highest levels of recreational physical activity relative to those with the lowest levels.

A recent UK Biobank analysis using accelerometers linked higher daily movement to a 26% reduction in risk across multiple cancers, including bowel cancer.

Does Fitness Protect Against Colorectal Cancer? .....continue to page 42

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Taken together, the data suggest that “the more you exercise, the better your overall health is going to be — not just your cardiac fitness but also your overall risk of cancer,” Joel Saltzman, MD, medical oncologist at Cleveland Clinic Taussig Cancer Center, Cleveland, noted in an interview with Medscape Medical News.

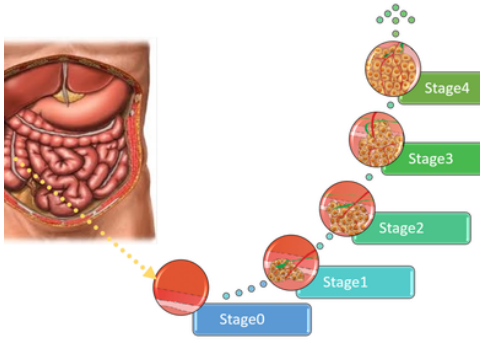
Can You Outrun CRC Risk?

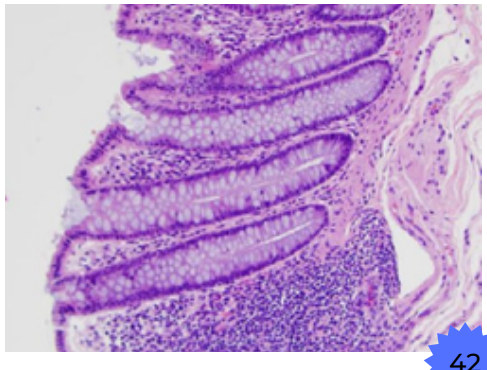
In the US, CRC is the second leading cause of cancer mortality, accounting for 51,896 deaths in 2019. The economic burden of CRC in the US is significant, topping $24 billion annually.

And while the incidence of colon cancer has decreased in older individuals during the past 3 decades, the incidence in younger adults has nearly doubled during the same period, “underscoring the limitations of screening programs and the critical need for risk factor modification,” Ali and colleagues wrote.

“There is good evidence that exercise and a healthy lifestyle/diet have significant benefits overall and as well for some potential risk reduction for colon cancer,” David Johnson, MD, professor of medicine and chief of gastroenterology, Eastern Virginia Medical School in Norfolk, Virginia, told Medscape Medical News.

“There are clearly suggestions of why this makes sense via the beneficial effects of exercise and physical activity in CRC pathways, including but not limited to regulation of inflammation and aberrant cell growth/cancer pathways,” Johnson said.





Does Fitness Protect Against Colorectal Cancer? .....continue to page 43

He emphasized, however, that exercise and lifestyle are not the best way to prevent CRC.

"Appropriate screening, in particular by colonoscopy (by skilled physicians who meet high-quality performance national benchmarks) to detect and remove precancerous polyps, is the best approach for prevention," Johnson said.

"At this point — albeit exercise is potentially helpful and a great general recommendation — my most current advice as an expert in the field, is that you cannot outrun CRC risk," Johnson said.

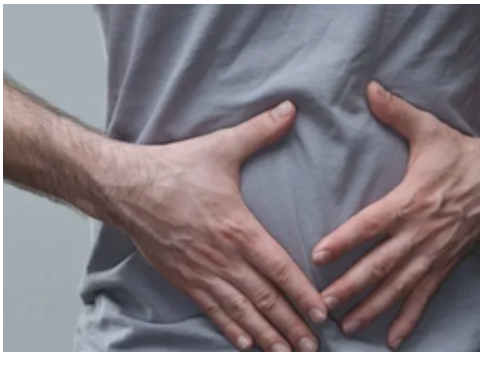
Can You Outrun CRC Recurrence?

Prevention aside, the data thus far are even more supportive of risk reduction for patients who have had CRC and are targeting reduction of recurrence, Johnson said.

Perhaps the most compelling study was recently published in The New England Journal of Medicine.

The CHALLENGE trial enrolled patients with resected stage II or III colon cancer who had completed their adjuvant chemotherapy. Patients with recurrences within a year of diagnosis were excluded, as they were more likely to have highly aggressive, biologically active disease.

Participants were randomized to receive healthcare education materials alone or in conjunction with a structured exercise program over a 3-year follow-up period.



The focus of the exercise intervention was increasing recreational aerobic activity over baseline by at least 10 METs — essentially the equivalent of adding about 45-60 minutes of brisk walking or 25-30 minutes of jogging three to four times a week.

At a median follow-up of nearly 8 years, exercise reduced the relative risk for disease recurrence, new primary cancer, or death by 28% (P = .02).

"This benefit persisted — and even strengthened — over time, with disease-free survival increasing by 6.4 and 7.1 percentage points at 5 and 8 years, respectively," Johnson noted in a Medscape commentary.

The CHALLENGE results are "very compelling," Bishal Gyawali, MD, PhD, associate professor of oncology at Queen's University, Kingston, Ontario, Canada, noted in a separate Medscape commentary.

Does Fitness Protect Against Colorectal Cancer? .....continue to page 44

"If you compare these results with results from other trials, you'll see that this is a no-brainer. If this were a drug, you would want to use it today," Gyawali said.

Saltzman told Medscape Medical News patients often ask him what they can do to help prevent their cancer from coming back. "I would sort of say, 'Well, eat a healthy diet and exercise,' but I didn't have a lot of good evidence to support it." The CHALLENGE study provides "the proof in the pudding."

With these strong data, "it almost feels like I should be able to write a prescription for my patient to join an exercise program and that their insurance should cover it," Saltzman said.

Ali and Saltzman reported having no relevant disclosures. Johnson and Gyawali are regular contributors to Medscape Medical News.

Invitation to Dentists, Physiotherapists and Allied Health Care Professionals to become an Associate Member of CPC/QUALICARE

Dear Colleagues,

As we approach the new era of increased Government involvement in Health Care Delivery, we anticipate an increase in the speed of implementation of NHI Holding membership of the CPC/Qualicare Network, the largest and most widely representative Medical Network of Healthcare Providers in the Western Cape comprising Doctors, Dentist and Allied Health Care Professionals alike will, we believe, stand in good stead as Government looks to setting up the new Health Care Delivery system for South Africa.

Associate members of CPC/Qualicare offers you the following opportunities:

- Full access to our Monthly newsletter in electronic format.
- Free advertising in our monthly newsletter of your practice related information (max 200 words).
- Free advertising for a locum service, with no commission charges payable.
- Reduced fees to attend our CPC/Qualicare function, at Associate Member's rate.
  (Approximately 30% lower than Non-members rates)
- CPC/Qualicare is committed to providing our members and shareholders with all of their CPC requirements each year. Associate Members receive reduced cost of CPD offerings and other CME offerings compared to non-ember rates.
  (Approximately 30% lower than non-member rates).
- Free listing your practice as part of CPC/Qualicare's Western Cap Electronic Network, your practice will be listed as part of CPC/Qualicare at no charge. (Worth R6000.00 per annum)
- 2 Free stationary items worth R150.00 per month in the form of 1 Prescription pad - 100 leaves, 1 Sick certificate pad - 100 leaves and the ability to purchase further stationary at 30% below current market prices.
- Preferential rates on certain Practice management software systems depending on vendor.
- Inclusion into the CPC/Qualicare Mass email service to receive important health care updates.
- Certain personal banking offerings from commercial banks.
- NHI future possibilities for your practice...Watch this space as NHI starts to roll out!!
- Preferred wholesale and facilitation of opening new accounts with them.
- Assistance with registration of an Integrated Pollution and Waste Information System IPWIS off the Western Cape Government.
- Assist with late medical aid payments, claw-backs, and withholds, as well as advice on practice admin and responses to forensic investigations.

Cost of Associate Membership

- Dentist R332.00 VAT inclusive, per month
- Allied Health Care Professionals R332.00 VAT inclusive, per month

All fees payable by debit order only. Minimum membership period is 12 months with a 3-month notice period thereafter.

Please note that we also offer reduced membership fees for **first time Medical Practitioners** (GP's) in **private practice** for their first year of membership.

Should you be interested in this offering, please email Louna at pa@cpcqualicare.co.za and one of our 5 consultants will make contact with you shortly.

Warm regards,

Dr. Tony Behrman, CEO of CPC/Qualicare
Dr. Solly Lison, Chairman of CPC/Qualicare

Qualicare Electronic Doctor Network.

Free electronic listing (valued at R6,000.00 per year) of your practice, geographic location, special areas of interest and pictures of your practice can be featured on our Electronic Doctor Network which is only available to CPC/Qualicare Members and Shareholders!!

Our highly successful electronic doctors network see www.qualicaredoctors.co.za has rapidly expanded across the Western Cape Province, and to date has approximately 200 doctors.

As a Member or Shareholder you are still entitled, **at NO charge**, to list your practice on the "EDN" showing your name, practice name, GPS coordinates, areas of special interests, and any specific features which you would like to bring to the attention to prospective patients then please complete and return the form below at your earliest convenience should you be interested to join the growing network.

This is a limited offer open only to Shareholders and Members which is worth over R6,000.00 per year and is brought to you as a member or shareholder benefit at no charge.

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DOH Disp Lic Number (if applicable): _____

Areas of Special Interest and Focus: e.g. Paediatrics, Bariatrics, Occupational Health: _____

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Contact Details

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Practice Details

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Qualicare EDN ..... continue to page 47

Please also provide:

1. **Photo of yourself** - So that the patient can familiarize themselves with the Dr they are going to see.

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3. **A short bio – interests, hobbies & education** – This gives the patient some trust as they will feel they know you and will feel at home.

Please feel free to contact Annerè van Pletsen CPC/Qualicare Consultant at annere@cpcqualicare.co.za

I permit CPC/Qualicare to list my name, surname, the name of my practice, my practice details, and further details provided by me in this application, and my GPS Coordinates on the *"Electronic CPC/Qualicare Doctor Network"* at no cost to me or my practice (tick the appropriate block).

Yes I do agree to the above, in terms of POPIA Act 4 of 2013

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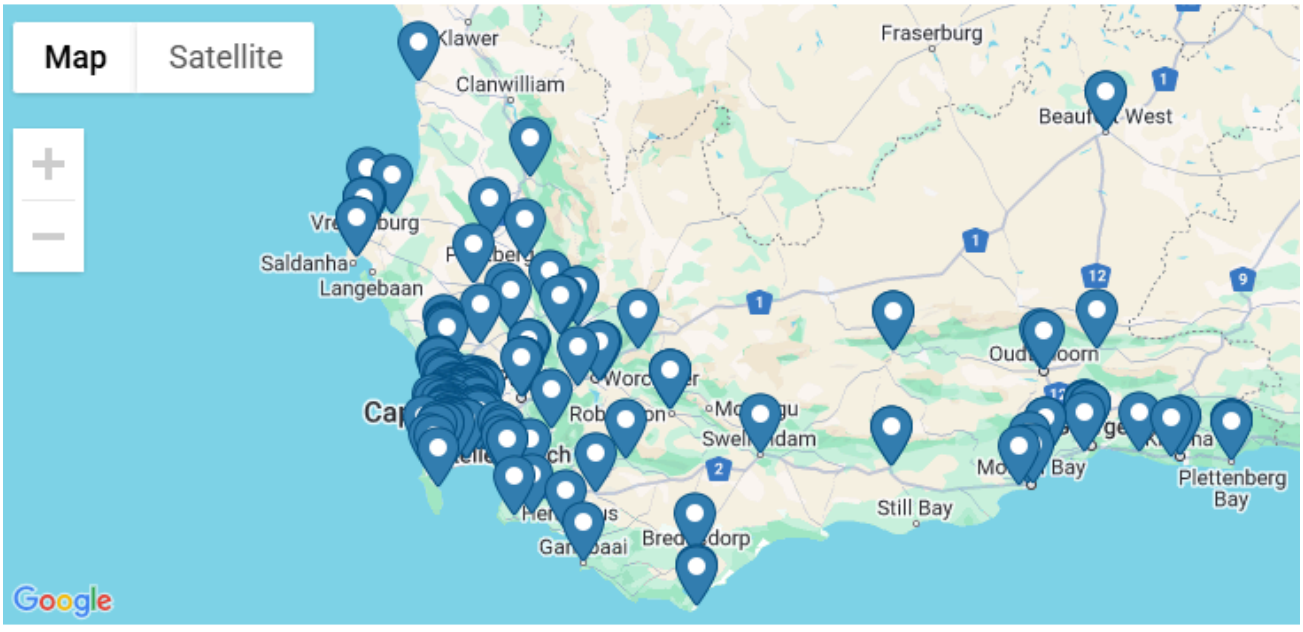

Disclaimer:

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Due to the fluency of the situation, information changes daily. Please visit our website for more updated information.

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