Health Focus

From left to right: Dr. Richard Peverini, a Senior Vice President of LLUH and Dr. Peter Landless, Director Emeritus, Adventist Health Ministries

Peter N. Landless – *Doctor of Humanitarian Service (DHS) Honorary Doctorate*

Presented to distinguished citizens and leaders in recognition of extraordinary achievement in such fields as science and technology, the arts and humanities, business and public service, or in recognition of outstanding contributions to the welfare and/or enrichment of the University, the state, the nation, or the world. Further, this honorary degree is awarded to bring recognition to the individual(s), to expose students and faculty to distinguished citizens and leaders, and to make an institutional statement as to Loma Linda University's values. The Doctor of Humanitarian Service (D.H.S.) is awarded for distinguished contribution to society.

Dr. Peter Landless

M.B.B.Ch. University of the Witwatersrand, South Africa 1974
M. Fam. Med. University of the Orange Free State, South Africa 1984
Internal Medicine Residency, Johannesburg General Hospital 1987-1990
Cardiology Residency, Johannesburg General Hospital 1990-1993
Fellow (Internal Medicine), College of Physicians

Crystal Angel Award, AdventHealth 2024
Seventh-day Adventist Education Award of Excellence, Adventist Education 2024
Global Impact Award, Loma Linda University Global Health Institute, 2024
Award of Excellence, Adventist Chaplaincy Ministries, 2024

Dr. Peter Landless trained in medicine in South Africa, his birthplace. During his first mission term, he specialised in Family Medicine and was ordained as a minister. He later focused on internal medicine and cardiology, practicing as a nuclear cardiologist. While advancing his academic career, he engaged in mission outreach and pastoral work. Serving in the military without weapons, he received the highest medal awarded to a national service officer in the South African Medical Services. His medical career included teaching, research, and aiding the underserved. He had the honor of serving as part of the health team of Nelson Mandela, an experience which reinforced an indelible and practical impression regarding the importance of forgiveness and grace from the Master Physician, Jesus Christ.

From 2002 through 2024, he worked for the Seventh-day Adventist Church in the General Conference department of Health Ministries, first as an associate director and then as director. He also serves as the president of the International Commission for the Prevention of Alcoholism and Drug Dependency (ICPA), a non-governmental organization with a UN Charter.
His roles in these various settings have provided opportunities to meet with numerous high-profile leaders, including kings, presidents, and prime ministers; speak to focus groups in the House of Commons, and to address leaders at the United Nations and the World Health Organization. This has, in a small way, facilitated the global health and humanitarian work of the Seventh-day Adventist Church he loves and has served for fifty years. He also served as a Trustee of Loma Linda University Health from 2013 – 2024.

In honor of his outstanding worldwide contributions to the welfare and health initiatives, in recognition of a life of achievement and service to humanity, and because of his exemplary modelling of the values of this institution, Loma Linda University is pleased to confer on Dr. Peter N. Landless the DOCTOR OF HUMANITARIAN SERVICE. This award was presented to him at the Conferring of Degrees for the School of Medicine on May 25, 2025.

On behalf of the Adventist Health Worker Family in South Africa, we want to congratulate you, Dr. Landless, for this prestigious Doctor of Humanitarian Service award. We salute you for your distinguished and continued contribution to the Health Ministry in South Africa.

Dr. Bets Breedt is a Director of Clinical Trial Educators, working at a global provider of clinical research services. Clinical Trial Educators help doctors working on clinical trials with ways to find suitable and willing volunteers to participate in clinical trials, they educate the staff on how to use devices, and how to follow Ethics Committee approved protocols diligently. This helps to keep patients safe and reduces the time needed to do the clinical trial, which leads to faster submission of a new medicine to Medicine Regulators like the FDA and (hopefully) faster availability to patients.

Dr. Bets Breedt

HOW DO CLINICAL TRIALS WORK?

INTRODUCTION

A clinical trial is a research study performed in a human population, aimed at evaluating a medical intervention. It is the primary way that researchers can find out whether a new treatment is safe and effective in people. A clinical trial can take up to 15 years to complete and is very expensive to do, it can cost up to $20 million per trial to complete all the various phases required.

REGULATION OF CLINICAL TRIALS

Due to unethical medical experimentation on people in the past e.g., in Nazi Germany, USA and Japan, there are now very strict ethical and operational regulations on how medical research must be done. An international harmonising council developed guidelines called ICH GCP[1], which is an ethical and scientific quality standard for designing, conducting, recording, and reporting trials that involve the participation of human participants.

Compliance with ICH GCP provides public assurance that the rights, safety, and well-being of trial participants are protected, consistent with the principles of the Declaration of Helsinki[2], and that the clinical trial data is credible. South Africa also strictly adheres to these regulations, and even added a few extra stricter rules to protect our population. All clinical trial activities are monitored and audited, and if a clinical trial is not complying with ICH GCP requirements, data will not be accepted, and regulatory authorities[3] (RA) will not approve the medication.

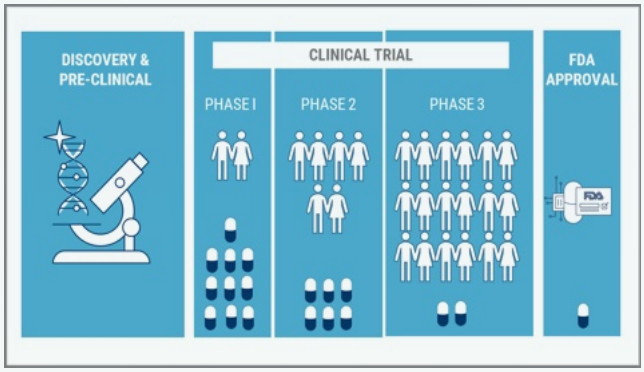
PHASES OF A CLINICAL TRIAL

There are three phases to complete in the clinical trial process before a pharmaceutical company (also called sponsor) can submit their medication to regulatory authorities (RA) for approval to sell it to the public. It is then followed by a fourth stage which monitors side effects after the medication is registered and available in pharmacies. Each stage of a clinical trial has its own purpose in ensuring that a treatment is safe and effective for use by the public.

In the **pre-clinical phase,** medicines are tested in the lab, on cell cultures or animals to find out whether it has the potential to cause serious harm (toxicity). If there are no serious side-effects or toxicity, the sponsor can start with a phase 1 trial.

Phase 1 trials are done to ensure that the treatment is **safe** in humans and to determine how and where it distributes within the body. This testing normally takes place with a small group of healthy volunteers (<50 normally). The trial sponsor monitors these participants very closely for potential "serious adverse events"— that is, any toxic, undesirable, or unwanted effect that causes death or danger to health, like a disability or permanent damage, birth defect, heart attack, or other serious medical condition.

At the end of Phase 1, the results are collected, analysed, and submitted to the regulatory authorities (RA) for permission to proceed to Phase 2 clinical trials.



However, if the results show that the treatment was associated with one or more serious adverse events, the RA will not approve the trial to proceed, and the treatment is discontinued. If the trial meets the pre-determined requirements, then the RA permits the treatment to proceed to Phase 2 clinical trials.

Phase 2 trials determine **the right dosage and effectiveness** in treating a particular disease. This testing normally takes place with a larger number of volunteers (a few hundred) who have the targeted disease. Participants are assigned to different treatment groups, where each group can receive different doses or delivery of the treatment. Normally, there is a "control group" that receives either the current available treatment, or a "placebo" (inactive) treatment.

The health of the group(s) of participants who received the different types of treatment is compared to the control groups. However, if the results show that the treatment did not work better than the current available treatment, or caused worsening of the disease, or caused other unexpected serious adverse events, the RA do not allow proceeding to Phase 3 and the treatment is discontinued.

Phase 3 clinical trials involves a much larger group of volunteers (thousands) and primarily focuses on determining whether the treatment would be **safe and effective** for a wide variety of people. It involves assigning participants to treatment or control groups. There can be more than one treatment group, especially if the treatment involves a combination of drugs or different components. Again, there is a control group that receives either the current available treatment or a placebo treatment.

After completion of phase 3, the health of the participants who received the different types of treatment are compared to the control groups. If the results show that the treatment did not work better than the current available treatment or the disease worsened or it caused unexpected serious adverse events, the RA do not approve the application for a New Drug Application (NDA).

The NDA contains all the information gathered at every stage of the process (starting from the drug discovery through to the results of the Phase 3 clinical trials), and is submitted to the RA for their consideration to approve the sale of the treatment on the market.

Phase 4 of clinical trials is the ongoing monitoring of side effects caused over time by a new treatment after approval and marketing. If new negative trends are noticed, the medication may be discontinued from the market or get a "black box warning" which highlights potential risks to doctors.

ETHICAL CONSIDERATIONS

To find out if a new drug or treatment is safe and/or effective, it needs to be tested on participant volunteers. However, by placing some people at risk of harm for the good of others, clinical research has the potential to exploit participant volunteers. The purpose of ethical guidelines is both to protect participant volunteers and to preserve the integrity of the science.

Seven main principles have been described as guiding the conduct of ethical research:

- Social and clinical value: Only if society will gain useful knowledge — which requires sharing results, both negative and positive — can exposing human participants to the risk and burden of research be justified.
- Scientific validity: A study should lead to an understandable answer to a valid and valuable research question. The research methods must be valid and feasible, and use accepted principles, methods, and reliable practices.
- Fair subject selection: Participants should not be asked to participate in research without a good scientific reason. Individuals who accept the risks and burdens of research should be able to enjoy its benefits, and those who may benefit should share some of the risks and burden.
- Favourable risk-benefit ratio: The risks and inconvenience to research participants must be minimised, the potential benefits maximised, and the potential benefits to individuals and society must be proportionate to, or outweigh, the risks.

- Independent review: An independent review panel (Ethics committee) with no vested interest in the clinical trial should review the protocol and monitor the results of a study while ongoing.
- Informed consent: Individuals must be fully informed of the purpose, methods, risks, benefits, and alternatives to the research, understand this information and how it relates to their own clinical situation or interests, and make a voluntary decision with written consent about whether to participate.
- Respect for potential and enrolled participants:

    1. Respecting their privacy and keeping their private information confidential.
    2. Respecting their right to change their mind, and to withdraw without penalty.
    3. Informing them of new information that might emerge during research, which might change their assessment of the risks and benefits of participating.
    4. Monitoring their welfare and, if they experience side-effects, ensuring appropriate treatment or removal from the study.
    5. Informing them about the final outcome of the research.

MONITORING AND OVERSIGHT OF CLINICAL TRIALS

The process of clinical trial monitoring involves verifying the informed consent process by reviewing the associated documents and source notes, and overseeing the progress of a clinical trial, to ensure that it is conducted, recorded, and reported in accordance with the protocol, standard operating procedures, the Principles of ICH GCP, and the Medicines for Human Use (Clinical Trails) Regulations. Monitoring is performed on a regular basis by trained clinical trial associate professionals throughout the enrolment, treatment, and follow-up periods. It is usually done ± every 6 weeks.

An audit of a clinical trial is independent of, and separate from, monitoring and quality control activities. Its purpose is to evaluate trial conduct and compliance with the protocol, standard operating procedures, GCP, and the applicable regulatory requirements. Audits can be done by the FDA or EMA, local regulatory authorities, ethics committees, sponsors, and clinical research organisations.

WHAT HAPPENS TO THE DATA GATHERED DURING A CLINICAL TRIAL?

The data gathered during the clinical trial process is used to prove that the medication is safe and effective to be registered for use by the public. The data is also used in the package insert of a medicine, which includes details and directions that health care providers need to prescribe a drug properly, approved uses for the drug, contraindications, potential adverse reactions, available formulations, dosage, and how to administer the drug.

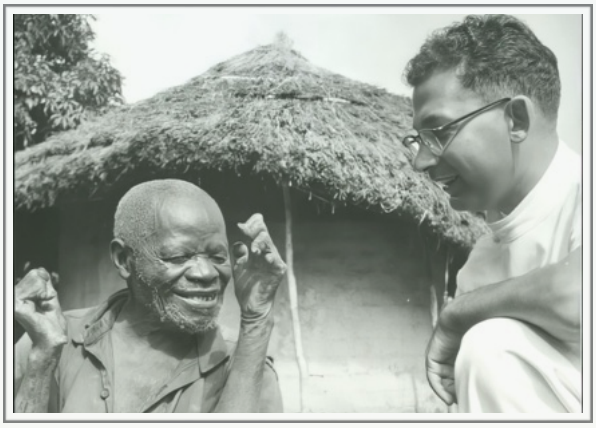
REFERENCES:

1. ICH GCP: https://database.ich.org/sites/default/files/E6_R2_Addendum.pdf
2. Declaration of Helsinki: https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-participants/#:~:text=The%20World%20Medical%20Association%20(WMA,identifiable%20human%20material%20and%20data.
3. https://sironclinical.com/role-of-agencies-in-clinical-trials/

Clinical trials are one of the quiet heroes of modern healthcare — the careful, step-by-step process that makes sure new treatments are safe, effective, and truly help the people who need them. They're built on rigorous science, strong ethics, and a deep respect for the volunteers who make them possible. Thank you Dr. Breedt for shedding light on how this process works, turning a complex subject into something we can all understand and trust.

THE DEVELOPMENT OF THE ADVENTIST HEALTH MINISTRY IN SOUTH AFRICA

In the previous edition of Health Focus we took a brief look at events that led to the further development of the Adventist Health Ministry in South Africa during the period 1912-1920. In this edition we are going to follow the Medical Mission Expansion that took place from 1920.



Mwami Leper Colony - Dr. K. Seligmann speaking to Alfred Phiri

Adventist medical mission work in South Africa and Basutoland did not include leper work like the northern territories. Instead the first medical mission in South Africa was established at Cancele with other specialised work. Dr. Huse joined mission director J.N. de Beer and with the prospects of a large medical mission field, a hospital-dispensary was built by African Division builder O.R. Shreve. The doctor soon specialised with many chest conditions, such as influenza, pneumonia and tuberculosis.

Unfortunately Dr. Huse barely started at Cancele when he was transferred to Kanye, and Dr. J.J. Bell succeeded him in 1929. Dr. Bell, assisted byMiss Strydom, continued his work until the end of 1930, when the South African Union Conference, under the leadership of N.C. Wilson from Nyasaland, took an action to release him from mission employment in view of the lack of response to the medical work. Dr. Bell enjoyed his medical work at Cancele, so he proposed to stay at the mission on a self-supporting basis and combine his work with that of farm manager. The leaders approved of his proposal, but the medical mission venture at Cancele never really rallied, it lingered through the thirties until it was closed as a medical without a mission and doctor.

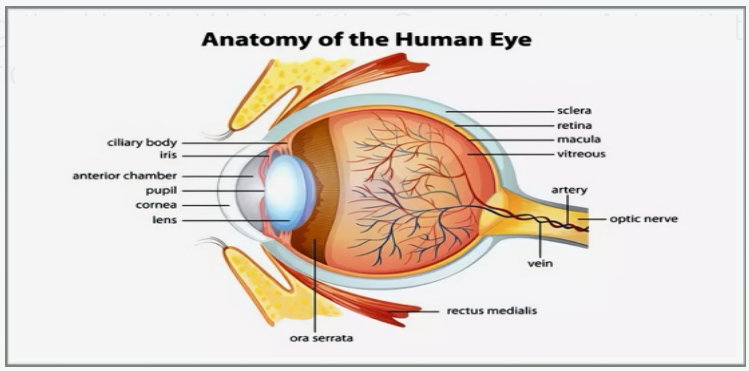
The initial drive for medical missions, after Kanye and Malamulo were established, resulted in Mwami, Songa, Bongo and Cancele being established with hospital dispensaries.The final stage of the drive came in 1931 when the African Division approved a combination hospital-dispensary plan with a double ward in the rear, submitted by Division Medical Secretary Dr. Tonge. It was decided to use this building plan at Ngoma and Lower Gwelo.

Accordingly within a decade six medical missions originated and two were planned for the thirties. Indeed the twenties was an era of medical mission expansion for the Adventists. No other decade from 1920 to 1960 compared with it for the founding of new medical missions.

The year 1925 was a critical year for three Adventist institutions: Bethel Training School, Spion Kop College and the Cape Sanitarium. The decisions made with regard to these institutions were to have a great influence on the future prosecution of missionary work in Southern Africa. The Cape Sanitarium and hospital, which was instituted in 1897, and later had its hey day, was lamentably on its "last legs" in the 1920's. Yetthe Sanitarium was ideally situated less than a quarter of a mile from the Plumstead railway station and about a hundred metres off the main motor car road. It was an attractive commodious building with forty three bedrooms and a wide verandah running the length of the front. Nevertheless the Cape Sanitarium which offered sunbaths in a well equipped solarium fitted out with ringsand horizontal bar for exercise, Turkish baths, hydrotherapy, and electrical treatment, could not attract sufficient “patronage".

Source: A word of gratitude is appropriate for Dr. Ronald Charles Lloyd Thompson for his dissertation, A History of the Growth and Development of the Seventh-Day Adventist Church in Southern Africa, 1920-1960. It is a source of valuable information regarding the Health Work of the Seventh-day Adventist Church in South Africa during this period.

"SUPERHERO OF THE EYES"



September 28th is WORLD RETINA DAY. As one of the most important parts within the eye, the retina has been called the "Superhero of the Eyes" and has earned its dedicated day due to its power in helping us experience our visual world.

The **retina** is the nerve layer at the back of the eye which captures light entering the eye and converts it into nerve signals which are sent via the optic nerve to the brain. The retina is a critical part of vision, turning visible light into something the brain can process and work with.

The "Superpowers" of the retina include the "Night Vision Ninja" which adjusts to low light allowing us to see stars in the night sky, the "Colour Connoisseur" which allows us to enjoy the full spectrum of vibrant colours, and the "Fast-Action Hero" which enables us to process images in milliseconds, helping us to react quickly to visual stimuli, such as catching a ball or dodging a falling object.

The **photoreceptor cells**, rods and cones, are the specialised cells within the retina that respond to light.

The **macula** is the area in the centre of the retina which is responsible for central vision and allows us to clearly see the specific aspects of visual images.

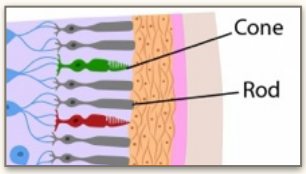
The **optic nerve** is a bundle of nerve fibres that transmits impulses from the eye to the brain for processing. The place on the retina where the optic nerve leaves the eye is the optic disc.

There are many challenges the retina can face, many conditions that can affect the retina, causing permanent damage and vision loss.

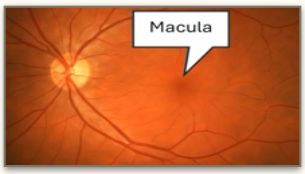
Follow a diet rich in vitamin A, lutein and omega-3 fatty acids, present in foods such as carrots, green leafy vegetables and salmon. Control blood pressure, blood sugar and cholesterol levels. Protect the eyes from harmful UV rays by wearing sunglasses. Know your family history and inform your optometrist of vision problems in the family as many retinal conditions have a genetic component. Most importantly, have your eyes examined regularly.

Take the opportunity during Retinal Awareness Week, 22nd to 28th September, to care for your retinal Superhero!

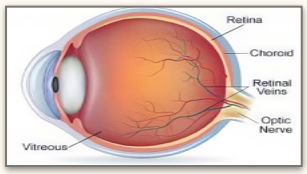
Shortened article used with permission from Mike Renou Optometrists



Photoreceptors



Macula



Retina

DELICIOUS LENTIL SOUP

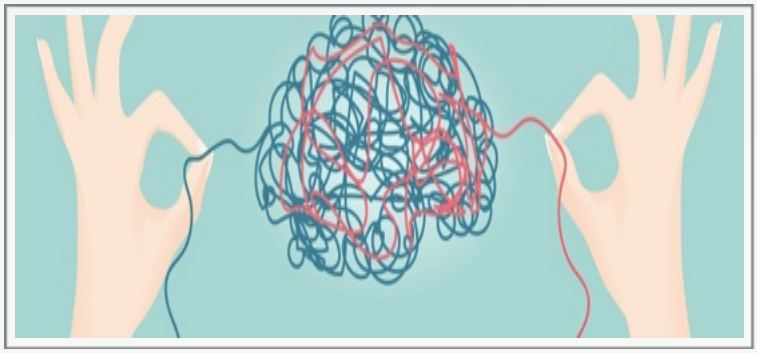
Stovetop Instructions

1. Heat the oil in a large pot or Dutch oven over medium heat. Add the onion, celery, and carrots and cook until the vegetables start to soften, about 8 minutes.
2. Stir in the kale stems, garlic, and cumin, followed by the vinegar, tomatoes, broth, thyme, lentils, salt, and pepper. Bring to a boil, reduce the heat, and simmer for 30 minutes, or until the lentils and vegetables are tender.
3. Add the kale leaves and cook for 5 minutes more, or until wilted. Add a pinch of red pepper flakes and season to taste with salt and pepper. Garnish with the parsley and Parmesan cheese, if desired.

Ingredients (Serves 6)

- 2 tablespoons extra-virgin olive oil
- 1 medium yellow onion, chopped
- 2 celery stalks, chopped
- 2 cups chopped carrots, about 4 medium
- 6 kale leaves, stems finely diced, leaves chopped
- 4 garlic cloves, grated
- 1 can diced fire-roasted tomatoes
- ¾ cup uncooked green lentils
- 2 tablespoons white wine vinegar
- 12 fresh thyme sprigs, bundled
- 1½ teaspoons sea salt
- Heaping ½ teaspoon ground cumin
- Freshly ground black pepper
- 6 cups vegetable broth
- Red pepper flakes
- ½ cup chopped fresh parsley, for garnish
- Grated Parmesan, for serving, optional
- Crusty bread, for serving

Normal forgetfulness or dementia?



Understand the important differences between everyday memory loss and serious cognitive decline.

"Watching my father slowly lose his mind was both heartbreaking and worrying," says Gale, 57. "It started with him leaving home at night, thinking he needed to get to the airport for a work trip, even though he'd been retired for years. It ended with him having no idea who or where he was."

"Thankfully, we had a carer to help, but it was agonising to know he was no longer able to bathe, feed, or dress himself. Every now and then, he'd have a flash of recognition and would grab my hand. But then it would pass, and he would get agitated and sometimes lash out at me."

Having watched her father's deterioration, Gale is now concerned that she might have early-onset dementia. "Every time I forget a word or don't remember about an appointment, I'm convinced I too will no longer remember my adult son in a few years' time. The idea keeps me awake at night."

Knowing the difference

Everyone experiences moments of forgetfulness – whether it's misplacing keys, forgetting someone's name, or walking into a room and wondering why we're there.

Like Gale, these lapses might make you think: "Is this normal forgetfulness, or could it be a sign of dementia?"

Understanding the distinction between these two conditions can give you peace of mind or encourage you to seek a medical opinion.

"Dementia is an umbrella term used to describe a range of neurological conditions that progress over time," says Dr Katie Hamilton, a neuropsychologist at Mediclinic Morningside. "People with dementia slowly lose the ability to remember, rationalise, and even communicate to the point that it affects their daily life and activities."

Alzheimer's disease is the most common form of dementia, but there are many other types, including vascular dementia, which can happen after a stroke or long-term heart disease, and frontotemporal (FTD) disorders.

Normal age-related forgetfulness

As we age, our brains naturally undergo changes that can affect memory. "Normal forgetfulness might mean you slip up with appointments occasionally or struggle to recall a particular word or name that's on the tip of your tongue," says Dr Hamilton.

Generally, that information comes back to you once you've moved on to another task or topic.

You also might forget specific details. For example, after reading a book, you might not recall details of the plot or characters. "Although these lapses in memory can be frustrating, they don't impact how you work or look after yourself," Dr Hamilton says.

Understanding dementia

Dementia, by contrast, is not a normal part of ageing. "People with dementia might find it hard to dress themselves, forget to maintain proper hygiene, and experience extreme mood swings," says Dr Hamilton. "They might also show strange behaviour, such as oral obsessions and hoarding, getting lost in familiar places, or becoming suspicious of people they previously trusted."

It's also common for them to struggle with simple routines, such as following a recipe, paying their bills, or finding their way to familiar places. Not being able to name or identify everyday objects can also occur, often starting with difficulty with names, but can progress to using incorrect words. "Big shifts in personality, increased anxiety, depression, paranoia, or inappropriate behaviours are further signs of cognitive decline," Dr Hamilton adds.

When to seek medical help

Normal forgetfulness is annoying but doesn't prevent you from living independently. If you – or a loved one – have memory issues that interfere with work, socialising, and personal hygiene, you should talk to your doctor.

"Human error is on a spectrum, and when your occasional lapses start to interfere with your daily functioning or quality of life, it's time to explore what could be behind them."

"Everyone occasionally makes mistakes, but people with dementia show a pattern of making poor decisions," says Dr Hamilton.

Your GP can refer you to a neuropsychologist, neurologist, or geriatric specialist who will take a detailed history and conduct psychiatric evaluations and neurological exams. They might recommend a CT or MRI scan to check that your symptoms aren't due to a brain condition other than dementia, or to help differentiate the various types of dementia.

The only way to treat dementia is to manage the condition through ongoing medical care. If you're diagnosed early, your doctor could prescribe medication that may improve your quality of life, giving you and your family more time to plan for the future.

Once diagnosed, treatment should focus on slowing down the disease. Your doctors will likely use medicines to help manage symptoms, therapy sessions, physical exercises guided by a physiotherapist, and help from neuropsychologists. All these treatments work together to help keep your cognitive abilities, physical movement, and wellbeing as healthy as possible for longer.

Social workers can also help by advising you on ways to protect yourself, helping your family understand how to support you, and finding ways to improve your quality of life.

If you are concerned about your – or a family member's – brain health, find a doctor who can help.

The Power of Healing

Dr Dave & Cheryl Glass

Factors that impede healing - 3

We have been discussing various impediments to healing. This week we will look at the impact of foreign bodies. Wounds caused by thorns or splinters, shrapnel, glass, or wounds contaminated with gravel or dirt, may delay in healing until the foreign material has been removed. It is not uncommon for small shards of glass, or small gravel bits to eventually be discharged months or years after the initial injury. Often there is pain and discharge from the wound on and off in the interim.

The foreign body provides hiding places for bacteria to live, protected from the immune system's efforts to remove them. Even some sterile surgical implants, like artificial joints, may become a nidus for infection. I remember an elderly church member in KZN who required a knee replacement. Unfortunately, infection intervened, and after more than 20 operations, she eventually required an above-knee amputation before the infection was controlled. Obviously other factors like diabetes, obesity, poor blood supply can also impact the outcome.

There are many factors that can impact our spiritual healing: Unwillingness to come to the healer, thinking that we can do it ourselves; not partaking a healthful spiritual diet that provides enough spiritual nutrients (spending time in personal Bible study and reflection, and conversational prayer); lack of spiritual exercise (reaching out to those around us in positive ways to share God's grace and love): and finding restorative spiritual rest by personally experiencing and believing God's deep love and care for us.

But perhaps one of the most problematic "foreign bodies" is bearing grudges, an unwillingness to forgive those who have offended us. This attitude can profoundly affect our spiritual growth, and our ability to move on. By harbouring this resentment, we are not hurting the person who hurt us, but in fact hurting ourselves and our spiritual health- even to the point of mental imbalance at times.

It is no wonder that Jesus warned that it is impossible for God to forgive us our sins, if we are unwilling to forgive those who have offended us.

"In prayer there is a connection between what God does and what you do. You can't get forgiveness from God, for instance, without also forgiving others. If you refuse to do your part, you cut yourself off from God's part." Matthew 6:14,15. The Message (emphasis supplied).

If healing is not taking place, it may be necessary to check if there is a hidden foreign body - both in the physical as well as the spiritual realm.

This is Health Byte 7 written by Dr Dave Glass for Helderberg Church Health Ministries - used with permission.

"WELLNESS IS THE COMPLETE INTEGRATION OF BODY, MIND, AND SPIRIT - THE REALISATION THAT EVERYTHING WE DO, THINK, FEEL, AND BELIEVE HAS AN EFFECT ON OUR STATE OF WELL-BEING"

- Greg Anderson

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PLEASE send your submission (news, pictures, articles, etc.)

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