

SAMA INSIDER

MARCH 2020



**Shaping SAMA
for the future –
a strategic
framework**

**Nanomedicine and
its promise for TB
treatment**



PUBLISHED AS A SERVICE TO ALL MEMBERS OF
THE SOUTH AFRICAN MEDICAL ASSOCIATION (SAMA)

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Diane de Kock
Editor: *SAMA INSIDER*

March is TB Awareness Month

This month, the world, and in particular healthcare professionals, will be reading a lot more about TB in the media than usual, as World TB Day is observed on 24 March. For the whole month the focus will be on increased awareness.

In SA, TB is still the leading cause of natural deaths, and presents a significant health challenge. In their article on page 8, Jolene Hattingh and Shelley McGee say: "SA has one of the world's highest burdens of latent TB infection ... with reported rates of infection ranging from 26% up to 89%."

Providing perhaps a little light is Prof. Admire Dube's article (page 9) on nanomedicine and its promise for TB treatment. "Research and development is ongoing in SA ... to reduce toxic side-effects."

"The proof-of-principle data on the benefits of nanomedicine in the treatment of TB are convincing," says Prof. Dube, who believes nanomedicine promises good future prospects for the treatment of TB.

On page 5, Acting General Manager Dr Vusumuzi Nhlapho unpacks SAMA's newly created "Strategic Framework 2020 - 2024". "Essentially, this document is a roadmap for SAMA into the future," says Dr Nhlapho of the document, which was adopted by the SAMA board of directors towards the end of 2019.

Codeine has been in the news recently, following the SA Health Products Regulatory Authority's announcement in January this year that they are considering clamping down on the over-the-counter sales of codeine-containing products, and collecting data on products containing meprobamate. "SAMA will continue to contribute to and monitor discussions regarding scheduling and registration status," says Shelley McGee in her article on page 13.

This is just a small sample of what you can expect from our March edition. Please email your feedback, suggestions and ideas to the editor, Dianed@samedical.org. We look forward to hearing from you.

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Impact of outbreaks on economy and health



Dr Sizeka Maweya, SAMA President

In epidemiology, an outbreak is a sudden increase in occurrences of a disease in a particular time and place. Outbreaks include epidemics, which term usually is only used for infectious diseases, as well as diseases with an environmental origin, such as water- or foodborne disease. An outbreak of infection is defined as an incident in which two or more people experiencing a similar illness are linked in time or place, or a higher-than-expected incidence of infection compared with the usual background rate for a particular location occurs, or, for certain rare diseases, a single case.

A sizable outbreak can overwhelm the health system, limiting the capacity to deal with routine health issues, and compounding the problem. Beyond shocks to the health sector, epidemics force both the ill and their caretakers to miss work or be less effective at their jobs, disrupting and driving down and productivity. The World Bank has become the first financial institution to downgrade SA's 2020 economic growth forecast from 1.5% to 0.9%. SA will not survive if the trend does not change shortly. What will happen if the outbreaks happening around the world hit our country, given our low economic growth? With the emergence of the new coronavirus in Wuhan, China, and the threat from Ebola in the Democratic Republic of the Congo, if an outbreak reaches our shores, our economy will plummet. It is our duty as healthcare professionals to spearhead the

health of the nation in order to grow our economy by keeping our workforce healthy.

According to CNN Business in London, China has become an indispensable part of global business since the time of the 2003 severe acute respiratory syndrome (SARS) outbreak. It has grown into the world's factory, churning out products such as the iPhone and driving demand for commodities such as oil and copper. China's economy accounted for roughly 4% of world's GDP in 2003; it now makes up 16% of global output. The whole world is dependent in China for the global economy, based on the stats above. Despite the products belonging to other countries' brands, China produces them for the world. The new coronavirus, which originated in the central Chinese city of Wuhan, has already killed more than 700 people, and infected over 34 400 across 25 countries and territories. In SA, the erratic share price movements on the Johannesburg Stock Exchange (JSE) and on world markets in general, have been a stark reminder to investors of how integrated the global economy has become. The business report plainly stated that the outbreak of a new strain of the coronavirus (2019-nCoV, or Wuhan Flu) in China has caused share prices on the JSE to move down sharply.

Our continent will not be ready for a disease outbreak

This global connectedness is a harsh reminder that the lack of proper readiness to respond to outbreaks in our country will have a devastating effect on our industrial workforce. Healthcare professionals must advocate for the economic growth of our country by demanding proper response plans from our health departments.

The region of Wuhan is China's leading manufacturing hub, and thus effectively that of the world. Everything from batteries to toys to fibre cable to locomotives (to name a few) is manufactured in this region. Market participants fear that the lockdown of this region will impact manufacturing, and therefore global trade in general. SA's economy is reliant on tourism, which

contributes 9% to our GDP. The country has signed a 2-year marketing agreement with China's biggest online platform to promote SA to Chinese tourists. If China is closed to the world, SA stands to lose in its ailing economy, and trading commodities such as iron ore, steel, manganese, chrome ore, tobacco, wool, granite, gold, copper, aluminium and motor vehicle spares.

Responding to the coronavirus outbreak

In a statement released by the WHO on 7 February 2020, they asked whether, since the health systems in many African countries are already struggling with the existing workload, they can deal with another outbreak of a highly infectious disease? There are only two laboratories to test for the disease in the whole of Africa – one in Senegal, and one in SA. Our continent will not be ready for a disease outbreak any time soon. SA, with its ailing health system and shortage of health workers, will at least be able to respond, but the response will not be optimal. SA will also need to help other countries in our region, especially neighbouring countries. The SA GDP will drop drastically. Our resources will not be sufficient to cater for the Southern African Development Community (SADC) region, let alone the whole of Africa. According to BBC News on 6 February 2020, for manufacturers selling goods abroad, there may be issues with buyers becoming more reluctant to buy from China. If we too experience an outbreak, SA export goods will not be attractive to China and the world at large, and this will plummet us into the worst disaster ever experienced.

More than 60 000 Africans are currently studying in China. If they come back home, there is no sign that we will cope. In SA, some parents have been pursuing the government to assist them in bringing their children studying in China back home. These students will need to be quarantined on their return for 14 days, while being tested to exclude the infection. There is no information as to how many seclusion beds we have. What is our state of readiness to respond to this outbreak? Our economy is not growing – do we even have sufficient emergency funds to cater for the coronavirus outbreak? There are more questions than answers. The obvious answer is that we are not ready – hence the silence.

Shaping SAMA for the future – a strategic framework

SAMA Communications Department

In 2019, SAMA senior management developed guidelines for the association's future. What was produced was SAMA's "Strategic Framework 2020 - 2024", a working document aimed at enhancing the output of the association, as well as aligning the activities of all departments and staff toward a common goal.

"Essentially, this document is a roadmap for SAMA into the future. It will be used to develop the organisation, and ensure that everything we do is in line with international best practices. What is important, we believe, is that this framework considers the unique dynamics of the medical profession in SA. This is key, because while it looks at what has worked best internationally, it also has a local flavour," explains Dr Vusumuzi Nhlapho, Acting General Manager of SAMA.

The strategic framework was adopted by the SAMA board of directors toward the end of 2019, and presented to staff in early December. Ensuring that staff understand the elements of the framework, as well as the roles they will play in implementing its provisions, is key; the successful application of the framework ultimately rests on their, and management's, shoulders.

"This document is a roadmap for SAMA into the future"

According to Dr Nhlapho, the process of developing the strategic framework considered a number of different factors. An important overarching element was understanding the current state of SAMA: its strengths and weaknesses, and the opportunities that exist both for itself as an organisation, and for its members.

Vision and mission

"Our current vision and mission provided a good starting point and a guiding light for our deliberations, as they provide important reminders to each of us as to our purpose as an association. They remind us of where we want to be, and how we need to get there," says Dr Nhlapho.

He says that SAMA's vision is to continue to be the leading and preferred membership organisation advocating for and supporting medical practitioners in SA. In conjunction with this, SAMA's mission – in other words, how it defines itself as an organisation, and the reason for its existence – is to continue to be the custodian of a growing advocacy platform that unites, guides and supports members for the health of the nation.

"It may seem clichéd to some, but these two elements are really key to our functioning, now and for the future. Through the process of developing the strategic framework, we consulted the vision and mission constantly because they conceptualise and refine who we are as an association, what we do, and why and how we do it. They also set a course for where we want to go," he explains.

SAMA values

Along with the vision and mission, Dr Nhlapho says it is essential to focus on SAMA's values. These act as the foundation and anchor for SAMA, and serve as a golden thread throughout all the organisation's operations. SAMA has three main values. These are that it is member-driven, that it performs influential advocacy and, critically, that it has operational excellence in everything it does.

"In terms of being membership-driven, we must have focused engagement, and be empathetic and collaborative. These are important qualities through which we interact with our members. We underscore this value as being at the centre of all our interactions with our members," Dr Nhlapho emphasises.

He says the role of SAMA in performing influential advocacy is critical to the strategic framework, noting, "We must lead the intellectual conversations as they relate to all matters affecting the health profession".

To this end, Dr Nhlapho says SAMA must inform and educate, and it must be the thought leader in society with regard to every aspect of the medical profession and its associated activities. A key element of the strategic framework is that SAMA must be resourceful, and use all available means at its disposal in the promotion of its values, and in pursuance of the ideals of the medical profession.



Dr Vusumuzi Nhlapho

"To get to all of this requires an organisation working optimally, at its best. Operational excellence requires that we offer quality service in everything we do, and with everyone we interact with," says Dr Nhlapho. He stresses that operational excellence also means that staff and departments within SAMA are accountable to each other, and to those they do business with.

"Operational excellence extends beyond just doing a good job; we define this as also being agile and responsive to the demands of the organisation and our members," he says.

Four strategic pillars

Underpinning the entire strategic framework are four strategic pillars which, Dr Nhlapho says, lay the foundation for achieving the goals and objectives set out in the roadmap, and act as important levers to deliver on the strategic objectives.

"These pillars are important because they focus our attention on what needs to be done to ensure that we implement the strategic framework correctly. The four pillars are: membership growth; brand amplification; enhanced member value; and strategic partnerships," he says.

Dr Nhlapho explains that through membership growth, SAMA will be able to extend its influence, in the medical profession specifically and in society in general. Increased member advocacy and targeting specific

segments in the medical profession are key to this pillar.

“We are looking at a number of initiatives here, including increasing our conversion rates of students to members, hosting more university and medical school events and increasing the number of doctors recruited at SAMA events and through special interest groups,” explains Dr Nhlapho.

He says that to ensure brand amplification, SAMA will embark on awareness campaigns, as well as use its position as the largest and oldest medical association in SA to further entrench its position as a thought leader in the healthcare field.

“We will continue ... to give our members real value”

In terms of enhanced member benefits and strategic partnerships, Dr Nhlapho says SAMA will increase its offerings relating to professional development, and support and assist members with specialised services. He also says the growth of sustainable and successful SAMA subsidiaries will ensure stronger partnerships can be formed.

Dr Nhlapho says that the values, along with the organisation’s vision and mission supported by the four strategic pillars, provide a substantial platform for SAMA to achieve its goals.

“We have crystallised our way forward in a practical and pragmatic document that will drive us into the future. I am confident that our teams across the organisation have encapsulated the essence of what we are all about in such a way that we will continue not only to be an authority in our field, but that also allows us to give our members real value, and which shapes the medical profession for the future and the health of nation,” Dr Nhlapho concludes.

Moeti reappointed head of WHO’s Africa region

SAMA Communications Department

The WHO executive board has appointed Botswana national but SA-born Dr Matshidiso Moeti for a second 5-year term at the helm of the organisation’s Africa region. Moeti pledged to work on accelerating regional efforts towards the attainment of universal health coverage.

At the start of her first term in 2015, Moeti set up the regional universal health coverage flagship programme, aimed at promoting concrete country actions to ensure that everyone can access the care they need without financial hardship. In February 2019, at the annual summit in Addis Ababa, African heads of state launched an initiative to increase investment in health to achieve universal health coverage.

Africa continues to face significant health challenges, but progress is being made, for example, in strengthening health systems, combating diseases and improving people’s health. Policies to tackle tobacco use, provide vaccines for cervical cancer, prevent malaria and create joint initiatives to procure medicines affordably are among the recent efforts by member states to lighten the disease burden.

During her first term, Moeti promised to champion the transformation of the regional office to improve accountability and efficiency. She has since won recognition for improving the financial accountability of the WHO in the region. Moeti has vowed to ensure that the WHO in the African region continues to be accountable by deploying the right staff with



Dr Matshidiso Moeti

the capacities and competencies to support member states.

In addition, she will focus on increasing investment in innovation, including encouraging digital health initiatives, as well as doing more to ensure that communities have better access to life-saving interventions such as immunisation, and backing the efforts of member states to tackle difficult health challenges.

Moeti is a public health veteran with more than 35 years of national and international experience. She joined the WHO Regional Office for Africa in 1999, where she has served as deputy regional director, assistant regional director, director of non-communicable

diseases, WHO representative for Malawi, co-ordinator of the inter-country support team for the southern and East African countries and regional advisor for HIV/Aids.

She is renowned for having led the WHO 3-by-5 Initiative in the African region at the height of the Aids epidemic, resulting in a significant increase in access to antiretroviral drugs for people living with HIV. Through her leadership, the African region has now gone for more than 3 years without a wild poliovirus case, and Moeti is determined to ensure that the region is certified free of wild polio by the end of June 2020.

Source: Medical Brief, 6 February 2020.

SAMA Doctor's Pledge adapted for SA community

SAMA Human Rights, Law and Ethics Committee

On 2 August 2019, the Human Rights, Ethics and Law (HRLE) Committee formally adopted the SAMA Doctor's Pledge. The pledge is based on the Declaration of Geneva, and adapted for the SA context. While identical in meaning and significance, it varies from the Declaration of Geneva in that it is specifically adapted for the SA community and broader African communities. This is the first known medical pledge to incorporate African values. The SAMA Doctor's Pledge integrates the general principles of both the Hippocratic Oath and the Declaration of Geneva, including a promise not to use medical knowledge to violate human rights, and to practise medicine without bias or prejudice.

History of the Hippocratic Oath

The Hippocratic Oath is one of the most ancient and widely known ethical codes. The original text is attributed to Hippocrates, a Greek physician who is widely credited with founding the practice of medicine as a rational science. The oath embodies the highest aspirations of the doctor.

The ancient Hippocratic Oath, as with current codes of medical ethics, included a promise to practise medicine to the best of one's ability and judgment, and to submit to the expertise of other qualified doctors where possible. The oath also included the guarantee of patient confidentiality.

At the time that it was written, the Hippocratic Oath was considered very modern, as there are few references to the text between its initial appearance around 400 BCE, and the Middle Ages. It was not until the 1700s, when the text was translated into English, that Western medical schools started to integrate the oath in convocations on a regular basis.

There are many revised versions of the Hippocratic Oath, and it is these versions, rather than Hippocrates', that medical students commonly swear upon graduation. The Declaration of Geneva is a widely known modern version, first adopted in 1948 by the WMA and revised from time to time.

SAMA Doctor's Pledge adaptations

There are three key adaptations from the Declaration of Geneva that feature in the SAMA Doctor's Pledge:

The Declaration of Geneva states:

- The health and wellbeing of my patient will be my first consideration;
- I will respect the autonomy and dignity of my patient;
- I will give to my teachers, colleagues, and students the respect and gratitude that is their due.

The SAMA Doctor's Pledge adds:

- The health and wellbeing of my patient, community and my broader African communities will be my key considerations;
- I will respect the autonomy and confidentiality of my patients and not divulge what ought not to be divulged;
- I will give to my family, teachers, colleagues, and students the respect and gratitude that is their due.

The three key adaptations are based on African values – the notion of ubuntu, encompassing humanity, togetherness and harmony. There is a need to seek ways to restore the dignity of the people of Africa, whose values, beliefs and cultures were denigrated in the past. One way is for African doctors to begin to apply indigenous African philosophy, thought and values in their practice. The SAMA Doctor's Pledge is based on the values of community, respect for persons, non-maleficence, beneficence, human rights, autonomy, tolerance, confidentiality, justice and most importantly, ubuntu.

The HRLE committee expressed concerns that the medical schools in SA offer variations of the Hippocratic Oath. The variations stem from modifications of the original oath and the Declaration of Geneva, as well as the creation of new oaths. While these variations do not take away the meaning and significance of either, the HRLE committee, encouraged by the SAMA chairperson, Dr Angelique Coetzee, felt that it was important for SAMA to have an oath specifically for its doctors. The committee also felt that the SAMA Doctor's Pledge could be offered to the medical schools for their own use, as it would be morally appropriate for SA to have one oath that all medical students took upon graduation.

SAMA, therefore, encourages all SA medical schools, their Deans, the National Department of Health, the HPCSA and all other relevant stakeholders to adopt the SAMA Doctor's Pledge.

References available on request.

SAMA Doctor's Pledge

As a member of the South African Medical Association (SAMA):

I solemnly pledge to dedicate my life to the service of humanity;

I will practise my profession with conscience and dignity and in accordance with good medical practice;

The health and wellbeing of my patient, my community and my broader African communities will be my key considerations;

I will respect the dignity of my patient;

I will respect the autonomy and confidentiality of my patient, and not divulge what ought not to be divulged;

I will foster and honour the noble traditions of the medical profession;

I will give to my family, teachers, colleagues, and students the respect and gratitude that is their due;

I will share my medical knowledge for the benefit of the patient and the advancement of healthcare;

I will attend to my own health, wellbeing, safety and security, and abilities in order to provide care of the highest standard;

I will maintain the utmost respect for human life;

I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I will not use my medical knowledge to violate human rights and civil liberties, even under threat;

I make these promises solemnly, freely, and upon my honour.

Adapted from the WMA Declaration of Geneva October 2017.

Keeping ahead of latent TB infection

Jolene Hattingh, Shelley McGee, SAMA Knowledge Management, Research and Ethics Department

This month is TB Awareness Month, with World TB Day observed on 24 March. Despite significant improvements in the fight against TB, roughly 10 million new cases were reported globally during 2018, with an estimated 1.2 million deaths. Although the period between 2000 and 2018 has seen a global reduction of 2% in the TB incidence rate, the majority of countries are still behind the 2020 milestones of the End TB Strategy. In SA, TB remains a significant health challenge, and is still the disease responsible for the most deaths in the country.

In addition, SA has one of the world's highest burdens of latent TB infection (LTBI), especially in high-risk populations such as young children, adolescents, household contacts of TB patients, people living with HIV, miners, prison inmates, immunocompromised individuals, people suffering from silicosis and healthcare workers (HCWs), with reported rates of infection ranging from 26% up to 89%.

In November 2019, SAMA submitted comments to the National Department of Health (NDoH)'s TB Control and Management Cluster, on the draft revised guidelines for the treatment of LTBI (10 October 2019). These national guidelines, once finalised, will lay out new treatment options for LTBI, including isoniazid, rifapentine and rifampicin, which could be provided for 3, 6 and 12 months, in various combinations, depending on the type of patient and his/her circumstances and vulnerability.

The addition of new short-course treatment regimens is a significant step forward for the management of LTBI in SA, and we believe will assist in managing identified cases, and ensuring adherence to treatment.

However, the body of SAMA's comments examined specific aspects of LTBI in healthcare personnel, which were not addressed in the draft guidelines.

Although we have had assurances from the NDoH that HCWs' needs will be addressed in a different and subsequent guideline, the issues facing them are pressing, and SAMA has submitted that these be addressed with urgency.

HCWs represent a high-risk, and often forgotten, population for LTBI. Being responsible for providing healthcare does not make HCW immune from contracting TB. HCWs are also likely to spread the disease to

other uninfected patients within a healthcare facility. The 2016 *Global TB Report* estimated that 10 000 HCWs contracted the disease that year, with China leading at 30% of the group, followed by SA at 21%. That is more than 2 000 of our HCWs developing a potentially fatal condition in a single year.

A systematic review of the literature on LTBI in HCWs in low- and middle-income countries (LMICs) found that there is an urgent need for infection control measures to be implemented, as the risk of acquiring it remains extremely high.

Screening and precautionary treatment

The treatment of LTBI is a crucial yet neglected component of global TB control. The diagnosis relies on the measuring of the immunological response to *Mycobacterium* TB antigens through tuberculin skin testing (TST) or interferon-gamma release assays (IGRAs). However, both tests only infer infection, rather than proving it.

The findings of 26 LTBI studies in LMICs found annual incidence rates of LTBI of a mean 17% in positive TST, and mean 18% positive IGRA. Both prevalence and incidence were associated with work location, number of years of work, and TB contact and job category.

According to global reports, less than 1.5 million eligible persons received treatment for LTBI in 2017. This needs to increase to at least 6 million by 2022 for the UN high-level meeting targets to be reached. HCWs should test for TB at least once a year, as they are among the key populations susceptible to the disease.

Treatment options for LTBI fall into four options: a weekly dose of rifapentine and isoniazid for 3 months; a daily dose of rifampicin plus isoniazid for 3 months; a daily dose of rifampicin for 3–4 months; and a daily dose of isoniazid for at least 6 months.

The bacillus Calmette-Guérin vaccine is the only licensed TB vaccine currently available. Developed nearly 100 years ago, this vaccine only prevents severe forms of TB in children, but not in adults, either pre- or post-exposure. However, the phase II trial of the M72/AS01E candidate is showing some promise.

The Sustainable Development Goals and the global End TB Strategy targets set for 2030

cannot be met without intensified research and development in prevention, treatment and cure. Priorities in these spheres include a vaccine to lower adult risk of infection, medication and treatment to reduce the risk of TB in those with LTBI, and rapid diagnostics at the point of care. The number of new TB infections and TB-related deaths can also be decreased by the reduction of health-related risk factors for TB, e.g. smoking, diabetes and HIV infection.

There is also an identifiable need for guidelines and standards to be implemented for HCWs who are at risk for LTBI, supported by the necessary funding to account for protective wear, and training on both themselves and on patient safety.

International and local control policies recommend that the following be implemented on a health facility level for all HCWs as a high-risk group:

- baseline preplacement screening and testing
- post-exposure screening and testing
- serial screening and testing for HCWs without LTBI
- evaluation and treatment of HCWs with positive test results
- prioritisation based on identified risk factors and location (e.g. epidemiology, resource availability).

TB infection control measures should include:

- TB infection control policy, planning, assessment and surveillance
- patient triage and management
- screening of HCWs who have contact with multi-drug resistant TB patients
- sputum management
- staff protection (personal respiratory protection): special attention should be paid to ensuring that the correct equipment is available – an N95 mask is essential, as the bacterium is extremely small and can penetrate a normal surgical mask
- environmental controls
- annual follow-ups for LTBI in HCWs (TST or IGRA) who serve patients with TB, particularly HCWs working in the following areas:
 - pulmonology, TB, infection clinic
 - respiratory, TB ward
 - emergency department
 - medical ICU

- bronchoscopy suite
- sputum induction room
- spirometry room
- laboratory (TB-related work)
- aerosol-producing room (e.g. nebuliser)
- professional practice model (PPM) nursing, counselling nursing.

Conclusion

With SA on track to achieving the 2020 End TB milestones for both incidence and

death, screening and preventive measures need to be improved. There is a growing urgency, globally, to act on the commitments by governments set in the global 2020 milestones of the End TB Strategy to scale up access to prevention and treatment, build accountability, ensure sufficient and sustainable financing (including for research), promote an end to stigma and discrimination, and promote an equitable, rights-based and people-centred TB response.

HCWs are specifically vulnerable to contracting TB, and a significant effort needs to be made by the NDoH, provincial DoHs and facilities themselves to assist our doctors and other HCWs to protect and maintain their health. The availability of protective measures, active surveillance and treatment availability will all be imperative to address the problem in this vulnerable population.

References available on request.

Nanomedicine and its promise for TB treatment

Prof. Admire Dube, School of Pharmacy, UWC



The field of nanomedicine offers promise in addressing some of the major challenges encountered in the chemotherapy of TB. Nanomedicine is a branch of nanotechnology, which is grounded in the science known as nanoscience. Nanoscience refers to the study of small structures, whose size typically ranges from 1 – 100 nanometres. To provide an idea of the size of these particles, imagine you are holding a strand of human hair – you would need to shrink the diameter of that strand of hair 100 000 times to obtain a nanometre. Scientists are engineering nanoparticles, and applying these particles in fields such as electronics, engineering and health, where nanoparticles are used to deliver drugs into the body or to diagnose a disease (i.e. nanomedicine).

With regard to nanomedicine and drug delivery, drug molecules are encapsulated within nanoparticles, and through this approach, one can improve the bioavailability of the drug and its pharmacokinetic properties in blood and/or tissues.

Nanoparticles therefore typically function as Trojan horses in delivering and distributing drugs in the body. The particulate nature of a nanomedicine allows these systems to take advantage of unique pathophysiological characteristics occurring at disease sites, and in some cancers, nanoparticles preferentially accumulate in tumours through what is known as the enhanced permeability and retention effect. The release of the drug from the nanoparticle can be controlled, enabling therapeutic drug concentrations to be sustained for longer time periods – leading to reduced dosing frequency. Coating the nanoparticles with select polymers imparts stealth properties to the nanoparticles, reducing opsonisation and extending the time to clearance of the nanoparticles by cells of the mononuclear phagocyte system – thereby extending the residence time of the drug-loaded nanoparticles in blood. Furthermore, the surfaces of nanoparticles can be functionalised with ligands specific to receptors located on target cells, and this affords nanoparticles the ability to actively target or localise drugs at the site of disease.

There are several types of nanoparticles in the nanomedicine toolbox. These include liposomes, polymeric nanoparticles, solid lipid nanoparticles and dendrimers, and these particles are synthesised using biocompatible and biodegradable materials. Nanoparticles are also versatile, in that they can be administered via various routes, including intravenous, subcutaneous, oral, topical, ocular and pulmonary.

Nanomedicine has already reached patients. The US Food and Drug Administration (FDA) currently lists over 50 nano-

medicines approved for use in humans, and some of these are available in SA. Most nanomedicines currently available are indicated for the treatment of various cancers, and have provided significant benefits to patients, including faster reduction in tumour mass and reduced toxic side-effects. One of the earliest nanomedicines to be approved by the FDA was a liposome formulation of doxorubicin (Doxil) for cancer, in 1995. Chemotherapy using doxorubicin is limited by cardiomyopathy, which may lead to congestive heart failure and death. However, the liposome formulation of doxorubicin has provided a reduction in the incidence of cardiomyopathy through preferential accumulation of the drug in tumours, and away from the heart. Several other nanomedicines are currently undergoing clinical trials by pharmaceutical companies in Europe and the USA.

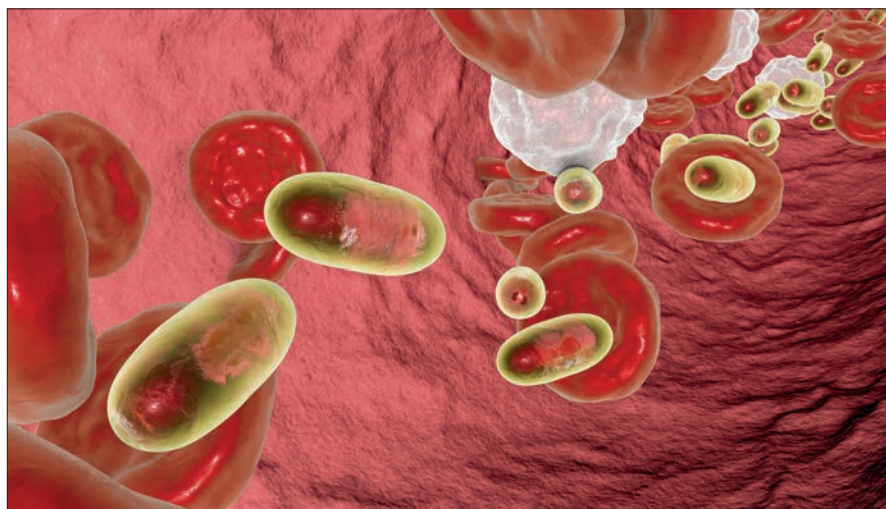
Nanomedicine ... promises good future prospects for the treatment of TB

One of the diseases requiring attention from a drug delivery perspective is TB, caused by *Mycobacterium tuberculosis*. TB is a global public health concern, and is responsible for significant morbidity and mortality in SA. Although curable with antibiotics, there are challenges associated with the treatment regimens, which include high drug doses and

lengthy treatment duration, as well as toxic side-effects that negatively affect patient compliance. Poor patient compliance is a major contributing factor to the emergence of drug-resistant forms of TB.

Research and development is ongoing in SA and elsewhere in the world, to encapsulate anti-tubercular drugs in various types of nanoparticles in order to enhance drug bioavailability and pharmacokinetic profiles, deliver drugs across difficult-to-cross biological barriers such as the central nervous system and achieve localised treatment in the lungs, to reduce toxic side-effects. Research is also ongoing into using nanoparticles to deliver immune-modulating compounds to the host cells of *M. tuberculosis*, with the aim of developing host-directed therapies/immunotherapies for TB, and thus circumvent issues of drug resistance.

At present, studies using animal models of TB have shown nanoparticles to favourably alter the absorption and pharmacokinetics of anti-tubercular drugs, and lead to enhanced ability to kill *M. tuberculosis*. Loading of the cocktail of first-line anti-tubercular drugs in nanoparticles has been achieved. Preferential and extended accumulation of TB drugs in the lungs has also been demonstrated. The immunostimulatory capability of nanoparticle formulations has been shown to induce death



of *M. tuberculosis* in cell and animal models of TB. The proof-of-principle data on the benefits of nanomedicine in the treatment of TB are convincing, and in the next stages of the development process, clinical trials will need to be performed to demonstrate efficacy and safety in humans. More collaborative efforts among clinicians, biologists, pharmaceutical scientists and industry are necessary in order to conduct these clinical studies and achieve translation of this technology to TB patients. Equally important in this process is input from patients, and support from governments.

Nanomedicine has already reached patients

In conclusion, nanomedicine is providing beneficial therapies for diseases such as cancer, and promises good future prospects for the treatment of TB.

References available on request.

WMA declare 2020 Year of the Nurse and Midwife

World Medical Association

A New Year message of support for nurses and midwives has come from the WMA to mark the 200th anniversary of the birth of Florence Nightingale.

The message follows the WHO's decision to designate 2020 as the Year of the Nurse and Midwife.

On 1 January, the WMA, representing millions of physicians across the world, issued a message of thanks to nurses and midwives for their co-operation and teamwork at all times, in all countries and in all conditions.

WMA president Dr Miguel Jorge said: "We are proud to work in multidisciplinary teams providing the best healthcare necessary.

"Our nursing colleagues are strong partners in helping patients and communities"

Our nursing colleagues are strong partners in helping patients and communities, and together we make a difference. Nurses and midwives are often the first health professionals to see a patient, and sometimes the only ones."

WMA chair Dr Frank Ulrich Montgomery added: "For healing patients and the best

care, for palliation and rehabilitation, for community care and prevention, nurses and midwives are an essential element in the chain to deliver healthcare.

"We hope that declaring 2020 as the Year of the Nurse and Midwife is more than just tokenism and lip service. There is a severe lack of nurses in many countries, and in most places nurses and midwives are undervalued and underpaid. Nurses are desperately needed to provide nursing care.

"We hope for and expect governments to take the necessary steps to improve the working and living conditions of nurses and midwives, so that they can provide the services for which they have been educated."

Growing petition support shows strength of feeling on doctor arrests

Medical Protection Society

In December 2019, two doctors were arrested on charges of culpable homicide, following the death of a young patient. The doctors were visibly handcuffed together in the presence of waiting media.

This generated an unprecedented level of debate and fear across the healthcare community, and a petition calling for charges to be dropped until a proper investigation has taken place has at the time of writing (11 February) been signed by more than 66 000 people.

Dr Graham Howarth, head of Medical Services, Africa at Medical Protection, said: "The recent arrest of two doctors on charges of culpable homicide has created real concern among healthcare professionals. It is not just the realisation of how vulnerable we are to charges of culpable homicide, which could result in a jail sentence, but also the way these arrests have been handled. The doctors concerned were charged with uncharacteristic haste, suffering the indignity of being handcuffed to one another and simultaneously exposed to the media.

"When things go wrong, doctors can face a loss of reputation, profession and income. In some cases they can also lose their liberty. We understand and share the strength of

feeling on this issue, and the support for the Change.org petition is testament to the sentiments of the profession.

"Criminal charges should be reserved for those who have been reckless"

"This was already a tragic case, with an apparently healthy young person dying after a routine procedure, and our thoughts are with the family at this extremely difficult time.

"Criminal charges should be reserved for those who have been reckless and where that recklessness is responsible for the patient's death, or for those very rare individuals who wilfully harm patients.

"MPS will be calling for a review into culpable homicide law and its application in a healthcare setting. As part of this, it is vital to learn from other jurisdictions – for example, in Scotland, where charges are only brought against doctors if an act is proved

About Medical Protection

Medical Protection is a trading name of The Medical Protection Society Limited (MPS). MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals. They protect and support the professional interests of more than 300 000 members around the world, including more than 30 000 healthcare professionals across SA.

to be intentional, reckless or grossly careless. This has to be a better way to determine the culpability of a doctor in a patient death.

"It is hard to see who benefits from a system that goes against these principles – a family loses a loved one through tragic circumstances, doctors risk losing their career and facing a jail sentence, and fear of personal recrimination becomes increasingly embedded across healthcare."

View the Change.org petition at www.change.org/p/south-african-department-of-justice-and-the-mpa-drop-it-and-wait-sa-doctor-s-profession-patient-care-under-threat.

SAMA response to warrants of arrest for two doctors

SAMA has noted the unprecedented warrants of arrest issued for two doctors accused of negligence, in December 2019. The association says that it sympathises with the families, and hopes for a speedy resolution to the case to provide closure for all those involved. The two are accused of negligence in the death of a child in October 2019.

"A proper investigation must be conducted to assess all the factors that may have played a role in the outcomes in the cases in which the doctors are accused of

negligence. It is also necessary that these factors are addressed at a systems level to ensure they are not repeated in future," says Dr Angelique Coetzee, SAMA chairperson.

Dr Coetzee says that the case should not be litigated in the media and become a political football, and that the families of those who have suffered should be respected while proper investigations are underway by the relevant authorities, such as the HPCSA.

"The inclusion of medical professionals in the investigation is critical, as these

professionals understand the nuances of what might have gone wrong, and that any investigation should be fair and transparent," Dr Coetzee notes.

She says that the accused doctors have rights, and are innocent until proven guilty.

"Medicine is inherently risky, and severe consequences are unfortunately not uncommon – even when there are no mistakes involved. Until an investigation is concluded, there are not yet enough facts to draw any medical conclusions," Dr Coetzee says.

Key ethical principles in clinical research

Adri van der Walt, SAMAREC officer

Research involving human participants must be done in an ethical manner. Failure to adhere to basic ethical principles not only challenges the scientific process, but may also affect the participants and the researcher adversely.

It is therefore necessary to submit any and all planned human research to an ethics committee for review to ensure that the planned research is done ethically, and complies with local legislation.

The key ethical principles to keep in mind in clinical research, as described in the National Department of Health (NDoH)'s *Ethics in Health Research – Principles, Processes and Structures 2015* can be summarised as seen in the figure.

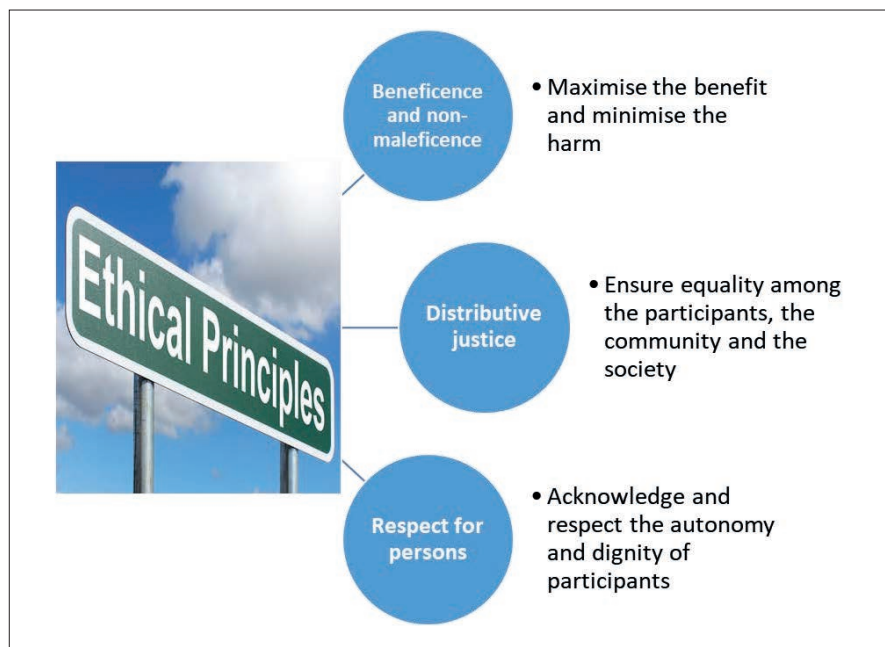
These principles seem quite straightforward, and should already be part of daily practice.

However, when it comes to clinical research, depending on the type of study, we are essentially dealing with an experiment – testing, comparing or administering treatment – all with our fellow human beings as subjects.

The onus of ensuring that ethical principles are upheld falls on the researcher.

With that in mind, ask yourself the following questions when planning your study:

- Is the research I am doing relevant to the SA population? In other words, will my work be of value to current or future participants in my own country? Keep in mind the population group, current practices, accessibility and the practicality of treatment – not just during the study, but afterwards as well.
- Is the science sound? Careful consideration should be paid to the research methodology and overall design, as this will directly influence the integrity of the research. Using incorrect methodology may lead to inaccurate results, thus wasting time and resources. Use the most current and up-to-date information available, and also a variety of known and respected resources.
- Is there any foreseen harm to the participants? In general, clinical research follows the principle of ensuring that the benefits thereof outweigh the risks. However, risks (however minor) may be a reality, and must be acknowledged, anticipated and declared. Depending on the nature of the



study, these risks may not be immediately obvious within the confines of the research itself. Who will my participants be? The research question will determine who the study population will be. In clinical research, we generally focus on patients with an existing underlying disease entity. Inclusion and exclusion criteria must carefully be assessed so as to comply with section 8 of the SA Constitution. As per the Constitution, the following may be seen as grounds for discrimination: "race, age, sex, sexual orientation, disability, education, religious belief, pregnancy, marital status, ethnic or social origin, conscience, belief or language". The NDoH has reiterated this by adding: "similarly, persons should not be unfairly targeted for research merely on the basis of one or other of these grounds," in their guidelines.

- Will I obtain the appropriate informed consent/assent? The participants must be clearly informed of all aspects of the study. The use of medical terminology or jargon is discouraged. The informed consent must also be obtained before study-related activities commence.
- Are my participants protected throughout the study? Clinical research may at times involve sensitive medical information about the patient. Ensuring that measures are in place (for example, keeping patient

files anonymous) is essential to ensure that privacy and confidentiality are maintained throughout the study.

- Am I addressing an area within my field of expertise? For any clinical research, the researcher should preferentially be an expert in their field. Expertise levels will be evident from experience, past research done and formal training in the specific field.

The ethics committee reviewing your proposed study will keep all of these points in mind, and will expect you to address them in your protocol. The review process will also act as a guide as to ensure that ethical principles are maintained.

Once you have compiled your information, you can get started on preparing the submission to the ethics committee. The general required documents will be addressed in a follow-up article on ethics committees in a future issue of *SAMA Insider*.

SAMA has their own independent research ethics committee, SAMAREC, to review studies to be done in the private sector.

Should you have any queries, please contact the SAMAREC Secretariat: Adri van der Walt on 012 481 2046, or samarec@samedical.org.

You can also access the SAMAREC standard operating procedure and terms of reference at <https://www.samedical.org/cpd-hpcs/research>.

SAHPRA reconsiders the scheduling status of codeine- and meprobamate-containing medicines

Shelley McGee, health policy analyst, SAMA Knowledge Management, Research and Ethics Department

In January 2020, the SA Health Products Regulatory Authority (SAHPRA) announced again that it is considering clamping down on the over-the-counter (OTC) sales of codeine-containing products, and that it is also collecting data on products containing meprobamate.

SAHPRA is not the only regulatory authority faced with these decisions, and there have been moves in a number of other jurisdictions to address the control and use of both these substances.

Codeine

There is growing concern internationally about the rising use of opioid prescription and non-prescription medications, including morphine, fentanyl, oxycodone, tramadol and codeine.

Codeine has historically been a widely used analgesic, and was available for sale OTC in pharmacies in a number of countries, including the UK, SA, Ireland, France and Australia. In the countries with OTC codeine sales there have been emerging concerns about misuse of and dependence on codeine-containing combination analgesics, with increasing numbers of people presenting for help with codeine dependence at primary care and addiction treatment services.

This has led to many countries, including SA, reviewing the availability of codeine in available OTC preparations, and considering possible measures to reduce harms from misuse of OTC codeine-containing combination analgesics.

Early in 2018, the Australian Therapeutic Goods Administration (TGA) made all codeine-containing products available only on a doctor's prescription. Subsequently, a TGA analysis of pharmaceutical industry sales data found that the total number of codeine-containing products supplied in Australia had halved in 2018, compared with the previous 4 years.

In SA, there is still limited data available on levels of prescribing of codeine, consumption levels and prevalence rates of codeine use, misuse and dependence. There is also inadequate information on how medical professionals screen, detect or treat codeine misuse in primary care.

In 2013, the Codeine Care Initiative (CCI) was formed to help promote safe, responsible self-medication. It proposed a system that requires the name and details of a person buying codeine to be registered by a pharmacist, in an attempt to help regulate the sale and distribution of medicines that contain this active substance. A number of pharmacies and pharmacy groups indicated support for this approach.

The CCI has experienced a number of challenges, from an inability to monitor sales from points not connected electronically to a central database, to potential breaches of the Protection of Personal Information Act No. 4 of 2013.

In addition, SAHPRA reports that codeine cough medications registered and available OTC in SA are finding their way, illicitly, onto the market in neighbouring countries, despite restrictions on exports.

Early in 2015, the then-SA Medicines Control Council advised that it had changed the scheduling status of acetyldihydrocodeine, codeine, dihydrocodeine and norcodeine.

The maximum quantity of codeine or dihydrocodeine allowed in a single dosing unit for a schedule 2 medicine was reduced from 20 mg to 10 mg, with a maximum daily dose of 80 mg, and packs containing only sufficient dosage units for 5 days of use.

Codeine in higher doses and combination dosage forms was made schedule 3, and single-component codeine in higher doses was retained as schedule 6.

This seems to have done little to address the challenges posed by the OTC use of codeine, and SAHPRA has now announced that it is again in the process of reviewing the scheduling status of codeine and codeine-containing medicines.

SAHPRA recognises that up-scheduling codeine products is likely to be inadequate to address the abuse problems, nor will it fully address the problem of diversion of products to other countries.

The regulator has therefore requested inputs from suppliers and professional associations to submit proposals for the amendment and strengthening of the intervention, and to make legally enforceable proposals regarding alternatives to the idea

of up-scheduling codeine to prescription-only status.

In terms of section 19(2) of the Medicines and Related Substances Act No. 101 of 1965, SAHPRA has requested that all manufacturers of codeine-containing products for domestic use, import or export supply it with sales data on these products, so that it can examine further regulatory steps to be taken.

Meprobamate

Perhaps of more interest to doctors, meprobamate, a carbamate anxiolytic, which has been a long-time component of several polycomponent analgesic preparations, is also under review.

Meprobamate has dependence potential, and has been superseded by benzodiazepines in the short-term management of anxiety. It is currently a schedule 5 medication in any concentration or dosage form, meaning it is already (at least in theory) only available with a prescription from a doctor.

SAHPRA has announced that it is concerned about the potential misuse and abuse of meprobamate-containing preparations in the country. SA is reported to have a high rate of usage of meprobamate in its pain indication, which SAHPRA attributes to irrational prescribing by medical doctors.

In 2012, the European Medicines Agency suspended all marketing authorisations of meprobamate-containing oral medications because of serious side-effects associated with them. The agency's Committee for Medicinal Products for Human Use (CHMP) noted that there was a risk of serious and potentially fatal side-effects, such as coma, in patients taking meprobamate-containing medicines under normal conditions of use.

The committee considered that these risks were increased due to the danger of unintentional overdose, as a result of the small difference between the treating dose and the dose that can harm patients, including elderly people. The CHMP also noted that some patients can become addicted to the medicine, leading to serious and sometimes fatal side-effects if they stop treatment abruptly after using it for a long time.

As with codeine products, SAHPRA has requested that all manufacturers of

meprobamate-containing products for domestic use, import or export supply it with sales data on these products, so that it can examine further regulatory steps.

SAMA will continue to contribute to and monitor discussions regarding scheduling and registration status. If

codeine does become a prescription-only medication, there may be more frequent requests from patients to practitioners to prescribe codeine-containing products, sometimes inappropriately, and SAMA may have to issue advice in this regard. Should meprobamate-containing products be

removed from the market, the options for pain control medications will be reduced, but the benefits of this may well outweigh the harms. SA will, however, have difficulty demonstrating this.

References available on request.

Cataract surgery under pressure – 290 000 South Africans could lose their eyesight

SAMA Communications Department

An estimated 290 000 South Africans could become blind as a result of untreated cataracts, with government facilities in most provinces unable to meet the demand for eyesight-saving surgery, and waiting lists stretching well over a year.

The Right to Sight Trust, the philanthropic arm of the Ophthalmological Society of SA (OSSA), has contributed more than ZAR50 million in services over the past 3 years to vision-restoring operations, but has now run out of funds to cover the cost of vital surgical consumables such as intraocular lens (IOL) implants that restore vision.

Right to Sight Trust chairperson Dr Bayanda Mbambisa says that although they have been able to assist in improving access to high-quality eye care for those in need through the Second Sight Project, the organisation will struggle to accomplish its goals of ending preventable blindness in the target year of 2020.

The Right to Sight Trust and the Second Sight Project, and its forerunner Eyecare 2000, are OSSA's response to the WHO's call for all countries globally to eliminate avoidable blindness by 2020. The Second Sight Project enables cataract sufferers from low-income households who are unable to afford private medical care and have been on a public hospital waiting list for over a year to access sponsored cataract surgery.

"Our initiative partners with the private and public sectors in realising the WHO's VISION 2020 ask. In the past 3 years, we have helped 2 071 people in SA. Based on a conservative estimate that one cataract sufferer impacts the lives of six people, over 12 400 individuals have benefited indirectly through this partnership that restores patients' independence along with their sight," says Dr Mbambisa.



"Yet, as we enter 2020, the target year set by the WHO, funds are dwindling. It's devastating that the project is once more struggling to accomplish its mission," she said.

Mbambisa said SA's national cataract surgery rate lags far behind international norms, even for developing countries, with the number of surgeries performed declining since the mid-2000s as government focus and funding shifted towards higher-priority medical conditions.

Second Sight's partnership approach includes ophthalmologists in private practice and their anaesthetist colleagues, who donate their time and skills, private hospitals providing theatre time and funding partners and sponsors who provide IOLs and other consumables for cataract surgery.

Ophthalmologists who perform pro-bono surgeries are reimbursed for consumables used. In the annual Eye Care Awareness Month in October, medical device companies and other sponsors give ophthalmologists access to IOLs and other consumables.

Mbambisa said that in 2019, five medical device companies and three financial donors partnered on the project, with

85 ophthalmologists performing regular monthly surgeries as well as those during Eye Care Awareness Week.

"In 2019 alone we helped 646 people regain their sight," says Mbambisa. "While the bulk of the cost for the surgeries is borne by ophthalmologists and hospitals that provide free time and theatre space, there is an urgent need for funding to cover the consumables that are essential to surgery. Funding is the only obstacle that stands between this highly effective partnership model and our ability to provide sight-saving surgeries."

"Every donation restores the sight and dignity of one patient, and filters down to a better quality of life for family members and friends who have been caring for the blind or partially sighted individual – with significant positive impact on the economic and social health of families and communities. We urge those in a position to assist financially to support us in caring for those who have no other means."

To find out how you can support the Second Sight Project, contact Cindy Buské, National OSSA Right to Sight operations manager at cindy@righttosight.org or 082 600 5970.

SAMA supports SAHRC recommendations

SAMA Communications Department

SAMA says immediate action is needed to prevent further deaths in neonatal wards, particularly the over-crowding of the neonatal unit at Tembisa Hospital, where 10 babies have already died since November 2019.

This follows an outbreak of the carbapenem-resistant *Enterobacteriaceae* that spread through the neonatal ward in November and December last year.

The SA Human Rights Commission (SAHRC) visited the hospital on 27 January

and found more than 100 babies admitted to the unit, which only has a 40-bed nursery. The SAHRC also concluded that the hospital is understaffed, and said that it needs 57 nurses in the ward, 51 more than the current 6. It also said the current allocation of 1 cleaner per ward in the hospital is not enough.

SAMA wholly supports the position of the SAHRC that more trained paediatric and ICU nurses be deployed to the hospital immediately, and that urgent interventions

be put in place to contain what is already an outrageous situation.

SAMA views the situation at the hospital as a gross human rights violation. It is also concerned that a situation that led to the spread of the bacteria was allowed to occur in the first place.

The association also believes that it is not enough to recognise that a problem exists; action must be taken immediately to ensure that more deaths are prevented.

UCT appoints new health sciences dean

SAMA Communications Department

Prof. Lionel Green-Thompson has been appointed as the new dean of the Faculty of Health Sciences at UCT, effective from 15 March 2020.

Prof. Green-Thompson joins UCT from the Sefako Makgatho Health Sciences University in Gauteng, where he is currently dean in the School of Medicine.

He has held multiple roles at the University of the Witwatersrand (Wits), including being the assistant dean for teaching, learning and undergraduate affairs in the Faculty of Health Sciences. He was also the clinical co-ordinator for the MB BCH degree in the Wits Centre for Health Science Education from 2004, during which time he

engaged in numerous student development initiatives, including the supervision of MMed (Anaesthesia) students.

He graduated from Wits with an MB BCH in 1988. He is a Fellow of the College of Anaesthetists of the Colleges of Medicine of SA. He obtained his MMed (Anaesthesia) at Wits in 2011, and completed a 2-year Wits Carnegie Clinical PhD Fellowship.

He was national chairperson for the SA Association of Health Educationalists for the 2010 - 2013 triennium, and chaired the national conference held at Wits in 2010 titled "Making education matter".

Prof. Green-Thompson is an occasional reviewer for academic journals such as the SA

Journal of Surgery, SA Journal of Psychiatry, SA Journal of Anaesthesia and Analgesia, African Journal of Health Professions Education and, internationally, *Medical Teacher* and *BMC Medical Education*. He is a member of the Research Committee of the Association for Medical Education in Europe for the term 2018 - 2022.

He is currently the chair of the network for medical education in resource-constrained situations. In 2019 he was nominated to the board of directors of The Network: Towards Unity for Health.

He will take over from Prof. Carolyn Williamson, who has been the interim dean since October 2018.

Letters to the Editor

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

Please note that letters:

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

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



How to detect and dodge financial scams

Gert Viljoen, *V Professional Services (VPROF)*

Financial scams have always been around, but their scale in today's world is truly amazing – estimates of annual losses in the USA alone reach USD120 billion.

The good news is that there are positive steps you can take to protect yourself, and perhaps the first and most important of these is getting to grips with the different types of “con” and how they work.

The first question we need to ask ourselves, therefore, is what is a “quick con”, and what distinguishes it from a “long con”? Then – the really important bit – we look at the types of people who are most vulnerable to con artists. Make sure you aren't one of them!

Scammers usually target people who are financially vulnerable (they have lost their jobs, or their business has folded), and they take advantage of economic downturns where a large percentage of people experience financial hardship.

The quick con

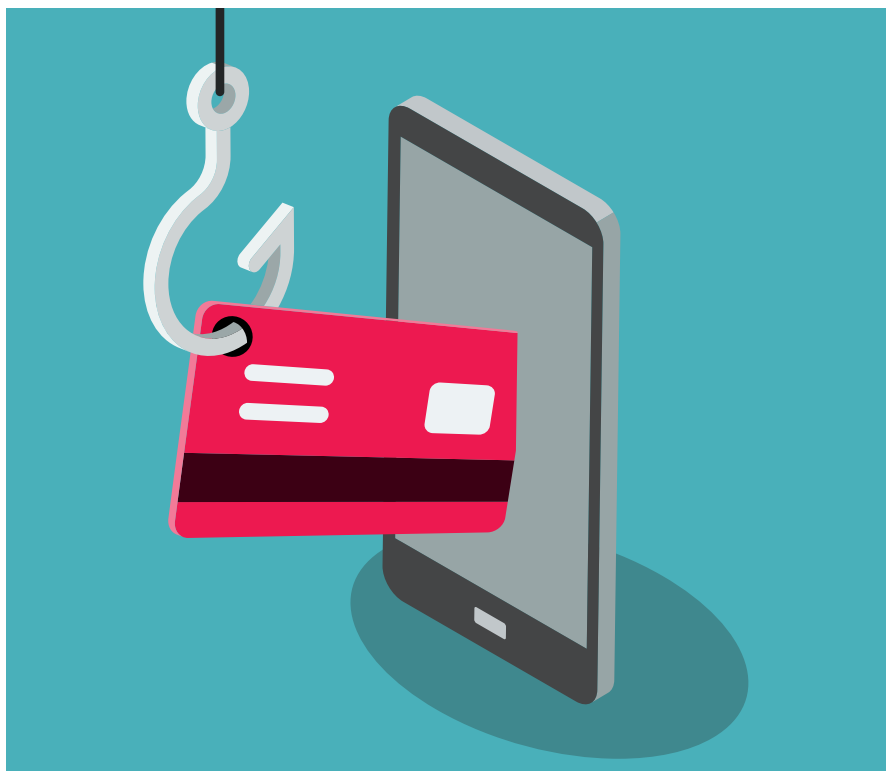
Typically, it is difficult to fully get to grips with the scheme being sold to you, as its workings are hard to fully understand. But the con artist will tell you that the real issue is that you will get astronomical returns, and they will show you for example pictures of yachts cruising in the Mediterranean – messaging to you that this is the life you will lead once you have made your quick fortune.

Because they prey on the financially vulnerable, con artists spin conspiracy theories – the reason you have fallen on hard times is that the system has crushed you, and this scheme of theirs bypasses all the financial regulation nonsense, and the like.

Conmen are also hard salesmen, and they will pressurise you into making this “investment”.

The long con

You need to be really careful of these, as you are up against some sophisticated operators. The main principle is to provide assurance from people in your social circle that the scammer or the scheme is credible and achieves high returns (these people are wittingly or unwittingly part of the con). In addition, the scammers can point you to well-known financial experts who will vouch for the scheme (they typically are part of the con).



It is usually a Ponzi scheme, which will operate successfully until no new funds come into the scheme. It then unravels very quickly, and the vast bulk of investors lose their investments.

Be careful of investments that are too good to be true

A third type of scam is known as “pump and dump”, where salesmen extol a little-known share, and this drives the price up. These salesmen make aggressive pitches to unsuspecting victims who get carried away by the upward momentum of the share. Once the share has gone way over its value, the conmen sell it short (the dump of the scheme) and the share price collapses.

Who is vulnerable to these scammers?

Strangely enough, it is often well-to-do people (usually men) who are experiencing financial stress and are happy to take on risk

who are the most vulnerable. These people are well educated and financially literate.

The combination of factors that makes them gullible (apart from being under financial stress) is:

- They are put under pressure (they need to get in “before it’s too late”, and their friends “are making a killing”).
- The scheme can be complex or opaque, and so they rely on their intuition.
- Most of these people are decent and trusting, so they tend to believe the conmen, and don’t want to let them down (no doubt the scammers are aware of this vulnerability).
- They are emotional. Greed is a very powerful emotion, and can lead you to impulsive decisions that you will regret later.

Sir Isaac Newton was an acknowledged genius, but he lost all his money in the South Sea Bubble scam in the 1720s.

So before you get caught up in a scam, step back and think rationally. You should also analyse yourself, and if you have any of the above traits, then be very careful of any investments that are too good to be true.

Your rights when taking parental, adoption or surrogacy leave

Modisane Lelaka, *SAMA employee relations advisor*

This article looks at amendments to the Basic Conditions of Employment Act No. 75 of 1977 (BCEA) regarding leave of absence relating to adoption, surrogacy and parental leave. The amendments to the provisions on leave were published on 23 December 2019 in Government Gazette 42925, and came into effect from 1 January 2020.

Section 28 of the SA Constitution stipulates that a child has the right to family or parental care. Furthermore, section 28(2) of the Children's Act No. 38 of 2005 provides additional protection by stating that the child's interests are paramount in every matter concerning the child. It is therefore a child's right to receive family or parental care. The BCEA previously made provision only for maternity leave, thus catering only for women.

Prior to President Cyril Ramaphosa signing the Labour Relations Amendment Act No. 8 of 2018 into law, fathers were entitled

to 3 days of family responsibility leave in terms of section 27 of the BCEA. This section has now been replaced by 25A(1) and 2. An employee not covered by maternity leave is now entitled to at least 10 consecutive days of parental leave. The amendments also include 10 consecutive weeks of adoption leave if the child is under the age of 2 years, and commissioning parental or surrogacy leave. A single adoptive parent is entitled to these 10 weeks' leave; if there are two parents, only one will be entitled to the adoption leave. The parents may decide who takes the adoption and who the parental leave. In the case of commissioning parental or surrogacy leave, the commissioning parents can also decide who takes the 10 weeks' and who takes the normal parental leave. The leave can commence on the date of the birth of the child for adoption and surrogacy leave.

An employee who takes parental, adoption or surrogacy leave may claim

the unemployment insurance benefit (UIF) from the Department of Employment and Labour.

However, it is not yet known in the public service whether fully paid leave will be granted, or if the employee will need to claim UIF. Within the public service, the amendments have not yet been implemented; the minister of public service and administration is yet to issue a sectorial determination in the form of directives for leave of absence within the public service. This therefore means that in the interim, employees must continue to use only the 3 days of family responsibility leave, until this determination has been issued.

The matter has, however, been tabled by the unions at the Public Service Co-ordinating Bargaining Council, with a demand for implementation. The matter is currently under discussion. Members will be informed when the determination has been issued.

Moms' maternal health is important for children too

South African Society of Psychiatrists

As many as one in five new mothers will experience depression just before or after giving birth, at risk to their own health and to the growth and development of their newborns.

And while it was previously thought that psychiatric medication was harmful to the unborn child, there is growing scientific evidence of the safety of antidepressants in pregnancy, and also showing that stopping medication may in fact cause more harm to both mother and baby.

"The risks posed to a fetus from antidepressants are consistently overestimated, while the risks of untreated depression are consistently underestimated because of the pervasive stigma against mental illness," warns specialist psychiatrist Dr Bavi Vythilingum, member of the South African Society of Psychiatrists.

Depression in pregnancy is often undiagnosed and goes untreated (as the focus is primarily on the physical health of mother and baby), but it can lead to premature labour, low birthweights and developmental delays, she says.

Postnatal mental illness, which mainly occurs as depression and anxiety, is second only to malnutrition as the greatest risk factor for poor development in newborns and young children, which in turn impacts on their own mental and physical health, intellectual abilities and future potential.

Dr Vythilingum said life changes around pregnancy make women vulnerable to mental illness, and women who have been diagnosed with depression before or during pregnancy are at higher risk of developing postnatal depression.

"Depression and anxiety cause significant suffering and disability – leading to a

higher risk of substance abuse and suicide, hampering the mother's ability to bond with and care for her child, and disrupting family and partner relationships," she said.

Maternal mental health is considered a major public health challenge, both locally and globally. SA's National Department of Health has maternal and child health as one of its key priorities for the health of the nation, while reducing maternal and infant mortality are the leading targets of the UN Sustainable Development Goal 3: to "ensure healthy lives and promote wellbeing for all, at all ages".

Dr Vythilingum said virtually all women are at risk of developing mental disorders during pregnancy and in the first year after delivery, but pre-existing mental illness, alcohol or substance abuse, a lack of social support, poverty and unwanted pregnancies put them at greater risk, along with exposure to

extreme stress or domestic, sexual or gender-based violence.

She said that pregnant women or new mothers experiencing symptoms of depression – including sleeping difficulties, feelings of inadequacy, helplessness or panic, lack of motivation, or feeling like crying for no reason – should consult their doctor, obstetrician or psychiatrist to develop an individual treatment plan.

“While these are all common symptoms of depression, women and their partners should also look out for [the mother’s] feelings of detachment from the baby, feeling like she doesn’t love the child as she should, and thoughts of harming herself or the baby,” she said.

Regarding treatment, she said that psychotherapy was always the first line of treatment, along with mobilising family support, especially from the father or significant partner, and using community resources such as antenatal and baby clinics.

Medication such as antidepressants can be prescribed, depending on the nature and severity of the condition, and after weighing up the risks and benefits of medication for both mother and baby.

“Clinicians should weigh the growing evidence of detrimental and prolonged effects in children due to untreated antenatal depression and depressive symptoms during pregnancy, against the known and emerging

studies on the safety of in-utero exposure to antidepressants,” she said.

Dr Vythilingum advised women who fall pregnant while taking antidepressants not to stop taking the medication, but rather to consult with their doctor or psychiatrist, who can determine whether the specific medication should be continued, changed or stopped.

She said the selective serotonin reuptake inhibitors (SSRI) class of antidepressants were the most well-researched and safest for use in pregnancy, at relatively low risk to the unborn baby, but stressed that any decisions on medication should be made in consultation with the patient’s psychiatrist and her obstetrician.

References available on request.

Fifteen years of urinary tract infections – what’s the cause?

The Medical Protection Society shares a case report from their files

Mrs Q underwent a kidney transplant and, after surgery, re-presented with urinary tract infections on a number of occasions over a 15-year period. It was later found that Mrs Q had a retained ureteric stent from her transplant, and she brought a claim against Dr X, the genitourinary specialist who had provided follow-up care.

Dr X contacted the Medical Protection Society (MPS) and requested assistance. When discussing the case with our medicolegal consultant, he explained that imaging of Mrs Q’s urinary system was not clinically indicated during the periods of urinary symptoms because there was no indication of a structural or obstructive abnormality that would warrant imaging studies. He also said that Mrs Q was predisposed to urinary tract symptoms and infections because of her history of kidney transplant and chronic immunosuppression, her gender and age, and the menopause.

Expert opinion

The expert instructed by MPS was supportive of Dr X’s approach, including his decision to prescribe prophylactic antibiotics instead of ordering an ultrasound scan during the second cluster of urinary symptoms.

In addition, the expert also highlighted the fact that Mrs Q failed to attend various



follow-up consultations and was often non-compliant with the medical therapy for her chronic kidney disease, hyperlipidaemia, gout and arthritis, which may have contributed to the symptoms she complained of. In particular, Mrs Q’s non-compliance with

allopurinol treatment may have caused more frequent flares of her gouty arthritis, and failure to follow up with gynaecology caused persistence of her vaginal symptoms.

MPS successfully defended the claim, and it was discontinued by Mrs Q.

Learning points

The experts who we instruct will examine a case carefully to understand and reconstruct the information that was reasonably available to the treating doctor at the relevant time. For example, in this case, there was no reason for Dr X to suspect a retained ureteric stent, as the operating surgeon had made no record of stent insertion.

Experts also analyse and comment on the impact of a patient’s non-compliance with treatment and non-attendance at follow-up appointments, and provide an opinion on the consequences for the patient’s clinical course and symptoms.

Sleep symposium successfully hosted by GWB

Griqualand West branch hosted a CPD symposium on 25 January 2020 at the Lenmed Royal Hospital in Kimberley. The topics discussed at the symposium, which was presented by Dr H Swanepoel, Mr P J S Vermaak, Dr Z Motlekar and Dr I Abdoola were investigation of sleep disorders, adult and paediatric sleep disorders, sleep matters, surgical management of obstructive sleep apnoea and ethics and biomaterials used in maxillofacial and oral surgery.

Dr Hendrè Swanepoel, a specialist clinical pathologist, started his career in pathology in 2011, and later relocated to Groote Schuur Hospital as a clinical assistant. In 2017 and 2018 he worked as a consultant for the National Health Laboratory Service in George, and currently works full-time in the private sector in SA.

Mr Peet Vermaak studied medicine (MB ChB) at the University of the Orange Free State during 1989, and switched to clinical technology at the Central University of Technology in 1990. He specialised in neurophysiology at the then H F Verwoerd Hospital in 1991, later obtaining his BTech degree in clinical technology (neurophysiology) from Tshwane University of Technology in 2006. Together with Dr Marina Greyling (a neurologist), he started the first privately owned sleep and neurophysiology laboratory in Pretoria, at the Muelmed Private Hospital in 1994. Peet, together with Mr Jaco



Mr Peet Vermaak (neurophysiologist), Dr Hendrè Swanepoel (clinical pathologist) and Dr Zaaheera Motlekar (specialist physician), speakers at the CPD symposium

Smith and Dr Donovan Schultz, started the Clinical Neurophysiology Society of SA in 2008, and he is currently the president of the society.

Dr Zaaheera Motlekar completed her MB ChB and went on to qualify as a specialist physician at the University of the Witwatersrand. She is currently in full-time private practice in Kimberley, SA. Her clinical interests include multidrug-resistant TB, and sleep disorders.

Dr Irshaad Abdoola qualified as a dentist at the University of Pretoria, and went



At the Lenmed Royal Hospital, left to right: Hanria Erasmus (representing the sponsor, van Rensburg Lancet), Dr Mbesi Joseph Ngundu (council chair), Sultana Hartzenberg (branch secretary) and Dr Jimmy Amsini (branch councillor)

on to qualify as a maxillofacial and oral surgeon. He is currently in full-time private practice in Kimberley. His clinical interests include orthognathic surgery, facial pain, temporomandibular joint conditions and aesthetic surgery.

Great presentations and outstanding catering, with attractive decorations made this CPD symposium a success for all who attended.

Intern orientation signs 26 new members

West Rand branch held a successful intern orientation on 2 January 2020 at Leratong Hospital.

Twenty-six interns attended, and all filled in new membership applications. SAMA West Rand branch sponsors the breakfast at the orientation, and also gives the interns a goodie bag that includes a shopping bag, a pen and a gift from head office.



Intern doctors who attended the intern orientation, with representatives from West Rand branch

Border Coastal attend rural doctors' retreat

The Rural Doctors Association of SA held a retreat in the Eastern Cape on 8 February, which was attended by 20 doctors and two facilitators from the East London region, including Maclear, Butterworth, Mqanduli and King William's Town.

Dr Tshepile Tlali, JUDASA vice-chair, did a short presentation on behalf of the SAMA Border Coastal branch, who handed out SAMA application forms and welcomed five new members.



The SAMA stand at the event



Dr Ndiphiwe Bakumeni and Dr Tshepile Tlali, JUDASA vice-chair

84% of doctors join SAMA at intern function

Griqualand West branch hosted a very successful and well-attended intern orientation event at the Ambassador Lodge in Kimberley on 18 January 2020. More than 84% of the intern doctors present joined SAMA.

Dr Athi Kema, Northern Cape JUDASA chairman, delivered a presentation on SAMA member benefits and spoke about the importance of joining SAMA, and Dr Arun Nair, a specialist family physician, enlightened the intern doctors on the new internship programme, and what is to be expected.

Modisane Lelaka, SAMA industrial relations officer, gave an informative presentation on labour relations matters, and informed the intern doctors what to do when they encounter problems at their places of work.



Labour relations officer Modisane Lelaka engaging with the intern doctors at the function



Stephan Vermeulen (Insist Risk Management Global) presenting to the intern doctors



Northern Cape JUDASA chairman Dr Athi Kema introduces SAMA to the intern doctors at the orientation function



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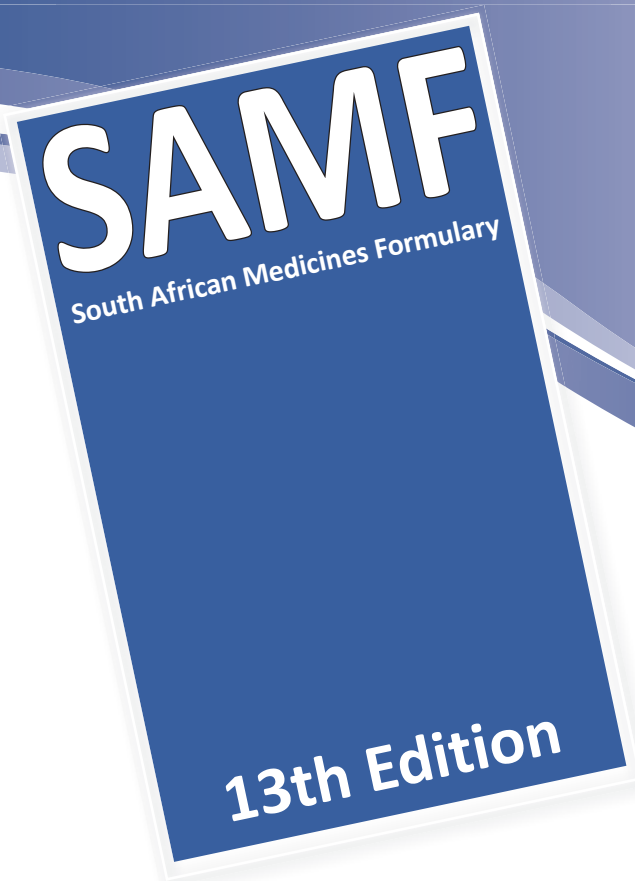
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