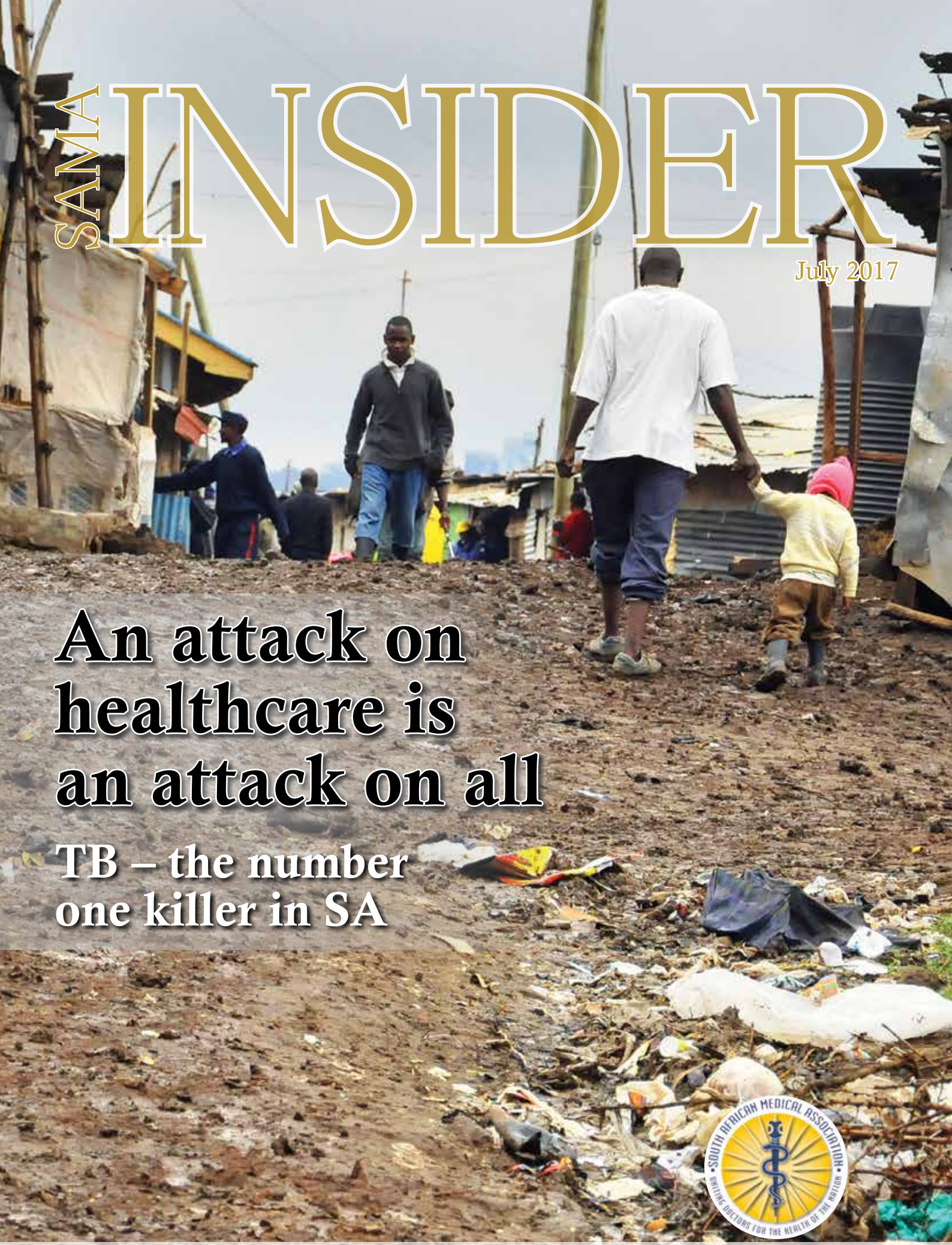

SAMA INSIDER

July 2017

An attack on healthcare is an attack on all

TB – the number one killer in SA

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

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LIVE BEYOND

CONTENTS

JULY 2017

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EDITOR'S NOTE

JULY 2017

Diane de Kock
Editor: *SAMA INSIDER*

A call for action

Dr Michael van Niekerk, JUDASA national secretary, was invited to attend the WHO 70th World Health Assembly in Geneva. High on the agenda was the global trend of attacks on healthcare.

In his article on page 5, Dr van Niekerk says attacks occur regularly in our communities as incidences of gang violence and soaring crime rates put SA at the forefront of attacks on healthcare workers.

"The problem of healthcare workers being attacked by patients becomes more acute in our country because we are such a violent nation," says Dr Grootboom, chairperson of SAMA.

A call for action is urgently needed – it is vitally important that we treat each other with respect, and to quote Dr van Niekerk: "A united stance will have to be taken by government, the healthcare workforce and the community."

TB remains the number one killer disease in SA, a challenge discussed by Bernard Mutsago in his article on page 6. A following article from the TB Alliance adds weight to the issue by discussing drug developments and the alliance's belief that their research has the potential to turn this epidemic around.

In light of the recent Paris Agreement on climate change, we are delighted to report that SAMA's environmental and climate change task team, represented by Bernard Musago and Shailendra Sham, is now a stakeholder in the SA National Climate Change Committee – see page 9.

This month we are pleased to publish a range of news from our branches – we congratulate the newly elected branch council members for 2017 - 2020, cover successful CPD meetings and report on building positive relationships between SAMA and medical students.

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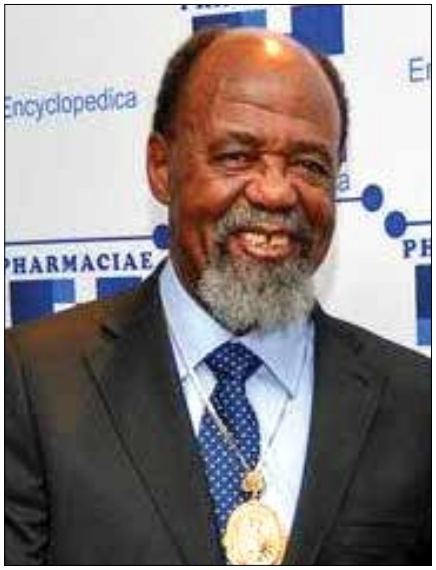
Cannabis – a remarkable journey



Prof. Dan Ncayiyana, *SAMA president*

This article may come across as a "victory lap" on my part. It isn't, although I must admit to feeling somewhat vindicated by the recent developments in relation to the status of cannabis here in SA. Almost 17 years ago, in the September 2001 issue of the *SAMJ*, I wrote an editorial entitled "Time to decriminalise marijuana", in which I advocated for the decriminalisation of the recreational use of dagga, to be regulated in much the same way as tobacco and liquor. I argued that "legislation will serve to pull the rug from under the (drug) dealers, free our justice system infrastructure to concentrate on tackling truly harmful drugs, assure religious freedom for Rastafarians, and bring some order to the production of dagga – an important sector of our (underground) rural economy." The editorial received much mostly friendly attention from the media, although I was pilloried from some quarters.

Dagga policing does not come cheap. Considerable human resources are devoted to tracking down dagga that could be more profitably employed in combatting the serious crime that is so prevalent in our country today. In addition to these opportunity costs, experts have estimated that the cost to the state for arresting, prosecuting and applying correctional sanctions in respect of each marijuana offender stood somewhere around R240 000. And while it is true that the perverse use of marijuana – like anything else – can lead to undesirable outcomes, no disease condition or mortality has been attributed to its recreational use by responsible adults.

Two recent developments have radically changed the status of cannabis in the SA legal system. In a landmark ruling, the Western Cape High Court has declared that it is an infringement of privacy guaranteed by our constitution to ban the use of dagga by adults in private homes, and has allowed for the possession, cultivation and private use of dagga at home. It directed Parliament to amend the relevant sections of the Drug Trafficking Act, as well as the Medicines Control Act, within 24 months to give effect to this ruling. Remarkably, the state failed miserably during the court hearing to demonstrate that dagga had uniquely harmful effects sufficient to justify wholesale criminalisation, with the court finding the evidence to be "singularly unimpressive".

This decision will no doubt remain provisional until it is confirmed by the Constitutional Court. Simultaneously, the SA Medicines Control Council has accepted the use of cannabis products for medicinal purposes, and has submitted to Parliament a 32-page document containing proposed guidelines for regulating the cultivation of cannabis, and for the extraction and manufacture of cannabis-based medicines.

Cannabis has a history of medicinal use dating back thousands of years, across many cultures, although latter-day legal restrictions have hampered a more thorough research of cannabinoids using modern methodologies. But anecdotal evidence points to its effective use in HIV/AIDS patients, preventing nausea more effectively in chemotherapy, reducing chronic pain and muscle spasms, and controlling the symptoms of multiple sclerosis, among other actions.

Why cannabis was prohibited in the first place

The prohibition of marijuana has an interesting early history that has little or nothing to do with medical safety. Cannabis was in common usage among the indigenous peoples in the Cape and elsewhere in southern Africa well before the European occupation. The Basotho, for example, used it as a hypnotic painkiller in childbirth. The name dagga is derived from the Khoikhoi word *dacha*, as recorded by Jan van Riebeeck in 1652. Cannabis soon crept into Dutch settler recipes for tea and other foods. The Dutch East India Company tried to establish a monopoly on its cultivation and sale in order to use it as currency in trade with the Khoikhoi, but the "weed" was readily available in the wild, and so this ploy did not work. In the Colony of Natal, its use was prevalent among the indentured Indian labourers, but was subsequently banned under the Coolie Law Consolidation of 1870, on the basis that it "sapped the vitality of the workers". Meanwhile, in the Transvaal, it was sold openly by store-keepers to the miners. Much later, the use of cannabis raised concern for its disinhibitory effect which engendered "camaraderie which led some to lay aside race and other prejudices with regard to fellow users".

After the formation of the Union of SA in 1910, provincial dagga laws were superseded by national law. Although deeply rooted in the indigenous culture, dagga was not widely consumed in the white community; therefore, its prohibition was not likely to affect the ruling class. In the early 2000s, the Law Society of the Cape of Good Hope banned Gareth Prince, a qualified lawyer, from practising law on the basis that he smoked dagga as a Rastafarian. He sued the Law Society all the way to the Constitutional Court, and lost. However, Justice Albie Sachs dissented, noting in his minority report that at its original proclamation, the prohibition had been driven solely by political and moral prejudices of the time, and observed that "only in that year [1921] were there serious signs of moral panic focusing around dagga, when SA criminological thinking came to be obsessed with interracial sex, the provision of alcohol by whites to blacks and the reverse flow of dagga. Of particular concern was the 'camaraderie' which led some to lay aside race and other prejudices with regard to fellow (users)."

How did marijuana end up acquiring international classification as a highly dangerous drug? It was at SA's insistence that dagga was listed in the same class as opiates at the League of Nations Advisory Committee in Traffic on Opium and Other Dangerous Drugs in 1925. Now, after nearly a century of languishing in the legal abyss, *Cannabis sativa* appears to be well on its way back to where it started.

An attack on healthcare is an attack on all

Dr Michael van Niekerk, *JUDASA national secretary*

"Statistics of attacks on healthcare make a mockery of international humanitarian law." – Dr Margaret Chan, World Health Organization director general.

Acts of violence, including attacks, threats against and obstruction of the function of hospitals and health workers have sadly become more and more prevalent.

The 70th World Health Assembly of the World Health Organization (WHO) was held from 22 to 31 May 2017 in Geneva. Attacks on healthcare were discussed with earnest intent, particularly considering the adoption of United Nations Security Council (UNSC) resolution 2286, 1 year ago.

According to a recent WHO report, nearly 600 violent incidents against health facilities in 19 countries took place in 2014 and 2015. In the first three-quarters of 2016, 198 such incidents against healthcare were reported. Apart from the death of many civilians and medical personnel, the secondary loss of life and the additional suffering caused by such violence deprive the affected population of basic health services.

Police escort an ambulance into the gang-ridden area of Mannenberg in the Western Cape

Another sad reality is that these attacks do not only occur in areas of war, but also in local communities with gang violence and soaring crime rates.

SA is unfortunately a strong example of this. Multiple cases of attacks on ambulances and pre-hospital emergency workers have been reported. Just last month, a young doctor was attacked and stabbed repeatedly on his way home at night after a shift in the emergency department. A week before, one of the porters working at a community health centre in Cape Town was stabbed and killed on hospital grounds.

Every attack on healthcare workers is one attack too many. At a global level, especially in war-stricken areas, the UNSC resolution 2286 demands an end to impunity for those responsible. It also calls for respect for international law on the part of all parties to armed conflict, and urges states and other parties to develop effective measures to prevent and address acts of violence against the delivery of medical care in armed conflict.

In SA particularly, the call must be made loud and clear for these same measures. A united stance will have to be taken by government, the healthcare workforce and the community. We remain resolute: we want a healthy community ensured by a healthy and safe health workforce. An attack on healthcare is an attack on all.

A surge of attacks on ambulance workers has led to parts of Cape Town being declared danger zones

The devastating aftermath of an attack on healthcare facilities

Why does a curable disease continue to be the number one killer in SA?

Bernard Mutsago, *SAMA health policy researcher*

This was the grand question a group of TB stakeholders grappled with at a recent *Mail & Guardian* event titled "Game changers to end TB as a public health threat in SA". The event was held at the Birchwood hotel in Boksburg, Gauteng, on 23 March 2017, ahead of the commemoration of World TB Day and concurrent launch of SA's National Strategic Plan (NSP) 2017 - 2022. I participated in this thought-provoking dialogue representing SAMA, a pivotal party of the anti-TB and HIV/AIDS machinery in SA. Beginning this year, SAMA has been trusted with secretariatship of the SA National AIDS Council's health professionals sector.

The diversity of panellists symbolised a reassertion of the requisite multi-stakeholder approach for acceleration of the national response to TB and its close allies – AIDS and sexually transmitted infections (STIs). Despite the absence of non-health panellists, concomitant with the multi-sectorial partnership approach embodied in the new NSP, there was at least the attendance of the National Department of Health (Yogan Pillay), SA National AIDS Council (Steve Letsike), University Research Company (Refiloe Matji), USAID (Paul Mahana), Desmond Tutu TB Centre (Pren Naido), a GP (Ausie Nki), the National Religious Association for Social Development (Richard Menatsi) and of course the event organiser, the *Mail & Guardian*, represented by the director Mia Malan and team. In the audience there was also a variety of participants from different quarters.

TB is not only curable but preventable, and yet it is the leading cause of death in SA, representing 8.4% of all deaths in the country. Panellists noted that SA is high on the WHO list of the 22 high-burden countries for TB. This is undesirable, and SA must come off that list. Of the 10.4 million TB cases in the world, 454 000 are in SA, and only 300 000 of these have been found and are undergoing treatment. The grand mission is to find the approximately 150 000 "missing cases". A total of about 33 000 people in the country died of TB in 2015. TB/HIV co-infection rate is at an estimated 60 - 73%, and about 3.5 million people are on antiretroviral treatment in the SA public sector, and 250 000 in the private sector.

This solid reality is frightening, and government has some difficult questions to answer. All delegates agreed that SA is facing a health catastrophe which will worsen if we continue business as usual. Radical game-changing strategies and action are desperately needed. And none of the possible solutions will be effective without a proper diagnosis of the current drivers of the TB epidemic, as well as a thorough understanding of the serious "gaps" in TB care.

Much of the TB epidemic in SA is on the back of some "fault lines" in our societal and health-system arrangements. However, this is not to be dismissive of SA's significant progress to date, namely, a decline in new TB infections, better TB cure rates, and fewer TB-related deaths. So, where are we getting it wrong? Firstly, as highlighted by Dr Pillay, we are talking and doing less about prevention as stakeholders and as a nation. It is discernible that, as a society, we are still largely slack on counter-TB practices and policies. For example, unabated smoking and smoke exposure continue to exacerbate TB risk, while the dangerous situations of closed windows in crowded spaces, such as commuter taxis, trains and prisons, continue to fuel TB transmission.

Secondly, patients endure long treatment periods, frequent clinic visits, horrible-tasting drugs, and terrible side-effects; consequently, some patients may – quite expectedly – opt for the pain of TB rather than that of the drugs. All these system- and patient-side factors can be blamed for low cure rates and poor medication compliance by patients. Science has clearly failed to meet the needs of patients. Can't scientific innovation solve this?

Thirdly, delegates were unanimous that as a system we are putting people on treatment too late. Fourthly, there has been a lack of new, improved drugs for too long: until 2013, no new TB drugs had come into the market to meet the stubborn bug in 50 years. Fifthly, a lot of South Africans who could save themselves from TB are preventing from doing so by ignorance; there is poor TB literacy in the general population and among patients. Sixthly, there is a need for the organisation of an effective "army" of healthcare workers against TB, which is a source of untapped potential.

The panellists and delegates collectively engaged in hard thinking and idea-sharing on possible impactful approaches required for SA to turn the tide on TB. A comprehensive package of interventions, including resourcing, was deliberated on. None of the suggested interventions appeared any more sophisticated or novel than those that are already being made. What was palpable, though, was an "enough is enough" aura, and a dogged resolve to take the TB battle to a higher level, especially under the impetus of the new and innovative NSP, which is regarded as one of the most potent versions in the history of NSPs in SA.

One of the key identified game-changers was for more effective and palatable TB medicines to be developed and made available to patients. Surely science must have the means to eliminate unsavoury TB drugs, especially for children. Therefore, more investment in research and development for better and user-friendly drugs is needed. A new, shorter (9 month) treatment regimen for multi-drug-resistant TB was launched in the country in March this year.

Another identified key game-changer was more effort towards prevention, both primary and secondary. The dialogue highlighted strong support for the current NSP's "focus on location" approach, whereby special preventative and treatment attention is given to TB/HIV/STI hotspots such as mining areas, metros and truck routes. Some donors similarly use this geographic targeting. For example,

PEPFAR (the US President's Emergency Plan for AIDS Relief) uses the "focusing for impact" prioritisation philosophy, which currently targets 27 high-burden districts in SA.

Astonishingly, a high proportion of TB deaths are not from drug-resistant TB but from common, drug-susceptible TB. This makes a case for, inter alia, more effective education on TB. Patients need to be educated about what drug side-effects to expect, and taught that symptom improvement does not mean cure. Population-wide education is also likely to be effective in combating the high stigma associated with TB and HIV. The "90-90-90" target is a superb goal the NSP is striving towards: 90% of people living with HIV diagnosed by 2020; 90% of diagnosed people placed on antiretroviral treatment by 2020; 90% of people on treatment achieving fully suppressed viral load by 2020. To achieve the first "90", our health delivery intervention needs to move from screening to testing and immediate placing under treatment, and not only for HIV patients. This should be possible, with SA already having some of the most powerful TB diagnostic equipment in the world – the multimillion rand GenExpert – as well as an over 200-strong network of national health laboratories.

TB and its twin allies, AIDS and STIs, have intricate socioeconomic dimensions. In line with propositions by the new NSP, delegates underscored the idea that healthcare workers must understand that the biomedical model alone is not sufficient. Social and structural drivers of HIV, TB and STIs, including human rights, must be holistically addressed, as many TB (and HIV) patients have low socioeconomic status. Health workers must tackle TB comprehensively, and must take adequate patient social histories, followed by social prescribing (linking patients in primary care with a range of local, non-clinical sources of support within the community). Some delegates also argued that we are not using the municipal ward-based primary healthcare outreach teams effectively to find TB in homes.

During the audience question-and-answer session, the uncomfortable question of healthcare for immigrants came up. It is a common dilemma in SA, where foreign patients sometimes report being restricted or denied access to healthcare in state facilities. In response, Dr Yogan acknowledged that TB patients are inevitably portable across borders in a globalised environment, and because of this the Southern African Development Community (SADC) has a regional TB programme. He explained that the National Department of Health strives for a patient-centred health system, and that it was not the policy of the department or the government to deny migrants TB treatment or other care.

A radical collaborative anti-TB movement was strongly supported, and Dr Pillay's mention of an existing loose partnership between the SA National TB Association (SANTA), SA Red Cross and the National Department of Health, was encouraging. Delegates also urged the best use of the vast amounts of data at our disposal, as well as lessons that the country has learnt from the prevention of mother-to-child transmission (PMTCT) programme. For example, the dashboards used in PMTCT must be used in TB.

One panelist's question, "How can patients hold government accountable?", highlighted the role of civil society in robustly advocating for many sufferers of TB and AIDS. During his speech at the launch of the new NSP in March this year, deputy president Cyril Ramaphosa said "We know this [victory over TB and HIV] is possible because SA is blessed with an abundance of leaders in every avenue of life, in every corner of the country." What that statement does not reveal is the readiness of leadership to address the structural determinants that are sustaining TB and HIV. Addressing the underlying structural drivers of the disease will be the foremost game changer in stopping the TB epidemic from bushwhacking our citizenry.

The burden of TB – and the hope for better treatments – can be found in SA

TB Alliance

The global alliance for TB drug development, TB Alliance, is a not-for-profit organisation dedicated to the discovery and development of better, faster-acting, and affordable TB drugs that are available to those who need them.

By any measure, the people of SA are at the front lines in the global TB epidemic. An estimated 454 000 people – almost 1% of the country – become infected with TB every year. When looking at raw numbers, SA is among the world leaders in TB infections, TB/HIV co-infections, and multi-drug-resistant TB (MDR-TB) infections.

As SA's medical community knows, this is not a problem that can be tackled easily. TB is a difficult infection to cure, requiring patients to take a combination of strong antibiotics with harsh side effects for at least 6 months. If the infection is drug-resistant, treatment can last even longer – a minimum of 9 months, and up to 2 years or even longer. In fact, the treatment success rate for MDR-TB infections is about 50%, about the same as surviving an Ebola infection without any treatment.

Complicating this problem further is that most of the medicines used to treat TB were developed decades ago, and many strains of TB have become resistant to entire classes of antibiotics. Around the world, an estimated 10.4 million people contract TB every year, and 1.8 million die from the disease. New drugs are desperately needed, and new treatments need to be created to beat back this deadly plague.

TB Alliance is leading the effort to meet these needs, relying heavily on SA scientific expertise to develop new regimens that can make substantial contributions to solving the current crisis. TB Alliance is currently developing pretomanid, one of three novel TB medicines to emerge over the past few years. Another drug that was recently developed, bedaquiline, has been paired with pretomanid to provide the backbone for two drug combinations that have been studied in SA trial sites. TB Alliance is headquartered in New York City, but has an office in Pretoria as well to help facilitate this work.

The first of these regimens is BPaMZ, which combines bedaquiline and pretomanid with current antibiotics moxifloxacin and pyrazinamide. Seven of the 10 sites that used this regimen to treat patients in a recent phase-2B clinical trial were in SA.

More than three-quarters of MDR-TB patients taking BPaMZ in this trial were

Continued from page 7

clear of TB bacteria after only 2 months, a significant improvement over how these patients are currently treated. These results provide us with a great deal of hope; if BPaMZ can handle MDR-TB infections, then it can also handle drug-sensitive infections. Today's often ineffective, toxic, and expensive options for curing almost all but the most drug-resistant infections could be reduced to one simple treatment.

The second regimen to result from our SA collaborations combines bedaquiline and pretomanid with the powerful antibiotic linezolid. This regimen, BPaL, is being used to treat patients with extensively drug-resistant TB (XDR-TB), varieties of TB that can resist the effects of just about any older antibiotic.

Before TB Alliance started testing this new regimen, less than one out of every three patients who were treated with available medication survived an XDR-TB infection. XDR-TB patients were treated with the BPaL regimen in Sizwe Hospital in Johannesburg and Brooklyn Chest Hospital in Cape Town as part of an innovative study called Nix-TB. These patients, who had few other medical options, took the regimen for 6 months – as long as it takes for a drug-sensitive TB infection to be treated.

Early results indicate that this regimen is dramatically more effective than previous efforts at tackling a practically incurable infection. The ease of treatment and the shorter treatment time contribute to the regimen's effectiveness; as hard as it is to take a combination of three drugs for 6 months, it is much harder to take a larger group of drugs for 2 long years while suffering from the TB infection.

Today, drug-resistant tuberculosis accounts for more than one out of every four deaths caused by antimicrobial-resistant infections around the world. In SA, where TB is the leading cause of death, the urgent need to do better is felt just about everywhere – but the solutions that researchers are generating have the potential to turn this epidemic around. Improved treatments are an imperative, not only in terms of the financial costs and burden on the healthcare sector, but also the moral imperative to save lives. And it is all starting in SA.

SAMA update on medical cannabis for SA

SAMA Communications Department

SAMA has advised its members, and the public, that for now, cannabis remains illegal in SA for both medicinal and recreational purposes. The association made the announcement following recent developments relating to the legalisation of cannabis, which may be misinterpreted.

In November 2016, the parliamentary portfolio committee on health announced that the Department of Health would regulate access to medical cannabis for prescribed medical health conditions. We welcomed this development in a response issued to the media in December 2016.

This new legal framework was set in motion in March when the SA Medicines Control Council (MCC) published the first guidelines relating to the cultivation and production of cannabis products for medicinal purposes.

SAMA made submissions to the MCC relating to these guidelines in the interests of scientific integrity and patient safety, and to contribute to the evidence informing the principles applied.

Also in March, the Western Cape Province High Court ruled in a landmark case that laws prohibiting the cultivation and use of cannabis in the home for personal use violate the Constitution.

In the wake of these announcements, SAMA has become aware of doctors receiving advertisements for medicinal cannabis products under the misleading view that these are now legal. For this reason an update on the current legal situation pertaining to cannabis is relevant.

Despite some degrees of clinical efficacy reported internationally for health conditions, and despite the legalisation of cannabis in other countries, cannabis remains illegal in SA for both medicinal and recreational purposes. Anyone in possession of, or selling, cannabis, or cannabis derivatives, may still be charged in accordance with the Drug and Drug Trafficking Act No. 140 of 1992.

SAMA remains opposed to the legalisation of cannabis for recreational purposes in any form.

While there are clear indications of intention for the regulation of the prescribing, sale, cultivation and production of cannabis-containing products for medicinal purposes, the MCC has yet to change the necessary legislation to make medical prescribing legal, and to approve products derived from *Cannabis sativa*.

Cannabis, dronabinol, synthetic cannabinoids and tetrahydrocannabinol, and their alkyl homologues (with specific exceptions), are currently classified as a schedule 7 medication in terms of the schedules of the Medicines and Related Substances Act (MRSA) No. 101 of 1965.

This means that "No person shall … acquire, use, possess, manufacture, or supply any of the listed substances … unless he or she has been issued with a permit by the director general (of health)."

It is therefore illegal to cultivate, analyse, research, possess, use, sell or supply any of the schedule 7 classified agents without express permission, and without a permit issued by the Department of Health. Importation and exportation of such substances are also prohibited without a permit.

The ruling by the Western Cape High Court has yet to be ratified by the Constitutional Court.

Should this happen, the necessary regulatory changes will have to be effected through parliamentary processes. Until such time, individuals apprehended with cannabis and cannabis-derived products can be arrested and charged.

SAMA urges its members not to prescribe or supply cannabis and cannabis-derived products currently available on the local market, as these products have not undergone MCC processes.

Until the legalities have been fully addressed, and the necessary processes completed, to ensure prescribing of safe, good-quality commercial product for patients where clinical evidence is strong for the indication, doctors are advised to use Section 21 of the MRSA (No. 101 of 1965) to obtain the products registered by other jurisdictions.

Strategy for climate change

Dr Shailendra Sham, *SAMA environmental and climate change task team*

The SA National Adaptation Strategy for climate change has been published, and an implementation strategy is currently being developed by the SA Department of Environmental Affairs (DEA). SAMA is a stakeholder in the SA National Climate Change Committee convened by the DEA, and is represented by Bernard Mutsago and Shailendra Sham from the environmental and climate change task team of SAMA's Health Policy Committee.

A broad multipronged national response to climate change is envisaged, tailored to the local SA context and its specific socioeconomic circumstances. The climate change response will be integrated with the DEA's sustainable development policies and aligned with the Paris Agreement, which requires parties to formulate adaptation plans, implement adaptation interventions, assess climate change impact and vulnerability and build resistance.

It will focus on the three elements of goal seven of the Paris Agreement:

- enhancing adaptive capacity
- strengthening resilience
- reducing vulnerabilities.

The health sector has been identified as a key sector for intervention.

Consultations on the strategy have been conducted in all nine provinces, and issues identified include: the sustainable use of water; climate-smart agriculture; food security and hunger; the integration of ecosystem- and community-based adaptation; the development of early warning systems; and building resistance in rangeland farming.

The following objectives have been identified for strategic intervention:

- to reduce human vulnerability and build human adaptive capacity (with focus on the household level)
- to reduce economic vulnerability and build economic adaptive capacity (economy and business-wide focus)
- to ensure resilient physical capital (infrastructure focus) and resilient natural capital (natural infrastructure focus)
- to ensure institutional support for climate adaptation (enabler focus)
- to enhance public-private-civil society collaboration and stewardship (enabler focus)
- to build capacity and awareness for effective action (enabler focus)
- to enable the substantial flow of climate finance
- to improve the understanding of climate change impacts and their development implications (National Framework for Climate Services elements).

The overall aims of the response are:

- placing SA's climate change adaptation within the development context
- building a case for climate resistance
- providing strategic and policy direction
- positioning SA as a thought leader on climate resistance.

The DEA is currently collating inputs for discussion and an implementation document is expected to be finalised by mid-2017.

It is anticipated that the content and implementation of the health-related aspects of the response will be discussed and operationalised by collaboration between the DEA, the Department of Health and the medical profession, represented by SAMA's environmental and climate change task team.

Government Gazette: COID

SAMA Private Practice Department

The scale of fees for medical aid, as published by the Department of Labour in respect of the Occupational Injuries and Diseases Act No. 130 of 1993 (also known as injury on duty), was published on 7 April 2017 in the Government Gazette no. 40745. These Compensation for Occupational Injuries and Diseases (COID) fees are applicable from 1 April 2017.

Please go to our SAMA website, www.samedical.org/Private Practice/Coding/COID to download the complete Government Gazette. Please note that the amounts published in the Government Gazette are VAT exclusive.

See unit values (right) for the various groups and sections as from 1 April 2017.

Contact SAMA Coding Unit, Private Practice Department for more information: coding@samedical.org / 012 481 2073

Symbol		Description	VAT inc.	VAT excl.
1a	V	Section I: Consultative services: items 0173-0175*, 0177-0179, 0190-0193*, 0109, 0129, 0151-0153, 0130-0136, 0199	R25.65	R22.50
1b	VC	Consultation services codes 0181-0186, 0151 (COID only)	R26.13	R22.92
2	CL	Clinical procedures	R25.65	R22.50
3	A	Anaesthetics performed	R119.85	R105.13
4a	RA	Section 19: Radiology	R26.82	R23.53
5a	RO	Section 20: Radiation oncology	R28.22	R24.75
5b	ROTC	Section 20: Radiation oncology: technical component	R28.22	R24.75
6	U	Section 19.11: Ultrasound	R25.34	R22.23
7	CT	Section 19.9: Computed tomography	R25.78	R22.61
8	CP	Section 21: Clinical pathology	R26.70	R23.42
9a	AC	Section 22.1: Anatomical pathology: cytology (items 4561-4566)	R26.35	R23.11
9a	AH	Section 22.2: Anatomical pathology: histology (items 4567-4595)	R26.35	R23.11
4b	MR	Section 19.15: Magnetic resonance imaging (MRI)	R26.82	R23.53
10		5 digit radiology (SP)	R174.94	R153.46
11		5 digit radiology (GP)	R116.62	R102.30

New rehabilitation hospital for Pietermaritzburg

SAMA Communications Department

A new rehabilitation hospital, described as a one-of-a-kind facility in SA, has opened its doors in Pietermaritzburg, KwaZulu-Natal. The Royal Rehabilitation Hospital (RRH) was established to "bridge the gap" between acute, sub-acute, and home care, by five healthcare professionals in the province. The RRH officially opened in February.

"Together we have a combined period of over 60 years in servicing the public and private health sectors, and we identified a need for a sub-acute rehabilitation unit in Pietermaritzburg. The average waiting period for a patient to obtain admission to a rehab facility was 6 weeks, and the closest facility was roughly 80 km away in Durban. This, obviously, reduced the probability of a full recovery and further motivated us to open the RRH," says Mr Nirodh Sinanin, one of the partners in the new hospital.

The RRH services five hospitals in Pietermaritzburg, namely the Midlands Medical Centre, Netcare St Anne's Hospital, Daymed Private Hospital, Life Hilton Private Hospital, and the Mediclinic Pietermaritzburg. In addition, the RRH will also accommodate patients from the new private hospital in Hilton, and the expanded Mediclinic Howick.

"With the additions, and expansions, to existing hospitals, the number of patients is increasing and the need for a rehabilitation hospital became clear. We acquired property in the Pietermaritzburg CBD, and got motivations from doctors, community leaders and patients in the area. Public transport, such as taxis, stops at the site, and it is conveniently located and central," explains Mr Sinanin.

He says that what makes the RRH unique is its approach to the holistic management of patients, and its mission to integrate them into daily living. According to him, attention to detail in every aspect of the facility is critical to its success. It includes a reading area, a sun deck, a heated hydrotherapy pool with a hoist, easy lifts in and out of bed, and group and private sessions.

"It is a rehabilitation facility that caters to the needs of patients who don't necessarily need the conventional in-patient treatment of a hospital, but a more relaxed, almost home-like setting where treatment is done with a combination of professional skills, state-of-the-art equipment, and a great deal of unconditional care and support," notes Mr Sinanin.

Inspiration for the RRH came from various international facilities, and the concept was adapted to cater for the unique blend of SA patients.

"With the RRH we have a hi-tech medical facility offering a unique healing experience while still maintaining a warm, non-clinical environment, which not only assists the patients physically but also mentally. We understand much of the healing is firstly a psychological and social battle, before the actual physical component is handled," he says.

A variety of medical services and specialities are being offered at the RRH. These include services for spinal cord injuries, brain injuries, strokes, amputations, post-meningitis treatment, orthopaedic rehabilitation, multiple sclerosis, Guillain-Barré Syndrome, general rehabilitation due to weakness or restriction of physical function following prolonged bedrest, critical care syndrome, renal failure, cancer and surgery.

The services offered are aimed at an individual patient's recovery of realistic functional ability, regardless of the severity of the initial injury. The therapies offered include physiotherapy and occupational and speech therapies, including allied healthcare of dieticians, social workers, psychologists, and rehabilitation nurses.

The hospital currently operates with 52 beds, but plans are to grow that to 102. There are roughly 100 people employed at the facility.

New i Hospital envisions better eye care

SAMA Communications Department

A new eye hospital is scheduled to open in Pietermaritzburg in October, almost 8 years after the licence for the project was first approved by the KwaZulu-Natal health department.

Founding members Dr Enslin Uys, Dr Ed Anderson and Dr Mark Harrison first applied for a license in 2007, when KwaZulu-Natal was the only province not to have a specialist eye hospital. Since then Dr Andre Burger and Dr Sanjay Lalloo have also joined as members.

"There were a lot of hurdles to overcome since then. We had to find suitable land, apply for rezoning, and work with the local heritage agency before we could proceed. Building has started on the project, and we expect the two-storey building to be completed in October this year. Our vision here is to offer top quality eye care to as many patients as possible," explained Dr Uys.

Initially, the hospital, which will be known as the PMB i Hospital, will have 10 beds and one dedicated eye theatre. In phase 2 of the project, a second eye theatre will be added along with an additional 10 beds.

"There will be a day hospital on the first floor, with the five doctors' consulting rooms on the ground floor of the 2 000 m^2 facility. We have also made provision for ample parking. Services offered will include all ophthalmic procedures and investigations, with state-of-the-art equipment," said Dr Uys.

The hospital will be located in Alan Paton Avenue (previously Durban Road), in close proximity to the Mediclinic Pietermaritzburg, Netcare St Annes Hospital, the Midlands Private Hospital, and the recently opened Royal Rehabilitation Hospital.

According to Dr Uys, the team hopes to expand eye-care services offered beyond Pietermaritzburg, and would like to include areas such as the Midlands, Estcourt, Greytown and places further north, as well as areas such as Cato Ridge and further south.

"Importantly for us, the hospital will also be involved in annual outreach programmes of the Ophthalmological Society of South Africa, helping to reduce cataract blindness, as well as monthly programmes which benefit those patients who are not on medical aids," Dr Uys concluded.

PMDS – how it affects grade progression

Keletso Makwe, *industrial relations advisor*

SAMA has received complaints/grievances from members who are due for grade progression in terms of resolution 3 of 2009. The members have reached the threshold in terms of the number of years required to progress to the next grade; however, their employers refuse to effect the progression, citing the fact that they have not been assessed and are therefore not eligible for progression.

It is both the employer's and employee's responsibility to ensure that PMDS assessments take place

Upon investigation, in the majority of the cases we established that members had not had their performance management and development systems (PMDS) assessments done, in some instances for years. It is both the employer's and employee's responsibility to ensure that PMDS assessments take place, but the employee stands to lose more, as they can be adversely affected without proof of performance. Employees mostly argue that the employer sat and did nothing about the issue, and therefore they are not to blame.

It is convenient for the employer to forget/delay the assessments, as it makes it easy for them to argue at a later stage that there is no record or proof that the employee performed as per the required standard. It can also assist the employer should they decide to discipline an employee for poor performance in the future. It would also justify or assist their failure to increase the employee's grade as required.

SAMA represented a member who had been overlooked for a grade progression as stipulated in the collective agreement (Annexure A1 PHSDSBC, Resolution 1 of 2010). The member (Dr X) had completed the required 10 years' experience as a specialist, and was due to progress to grade 3, as per the resolution. The employer argued that although he had reached the 10-year threshold, Dr X had not satisfied all the requirements, as there was no evidence that his performance as a grade 2 specialist had been average or above average.

The argument was based on the fact that there had been no performance assessment conducted while he occupied the post. His argument was that he had performed way above average and that it was a known fact. He had not been assessed for a certain period but the employer was at fault as they failed to assess him. The commissioner presiding on the matter agreed with the employer, citing Resolution 1 of 2010: in order to progress to the next grade, the employee must have his/her years' experience and average performance recorded.

The parties agreed to settle the matter on the basis that the employer would assist the employee with the outstanding PMDS and a supporting letter confirming his performance. The dispute was therefore resolved at arbitration. Dr X later reported that he did get the assistance to obtain proof that he had performed as required, and that his grade was adjusted.

It should be noted that had the matter proceeded to a full-blown arbitration, the commissioner would have ruled in favour of the employer, as he made it clear during the discussions that the employee had not met the requirements due to lack of evidence that he had been assessed.

We always advise members to insist on being assessed, as it is a requirement by policy

Some reasons provided by members for not doing PMDS assessments are:

- They are too busy with patients and do not have time to do the assessments, as they are time-consuming.
- Managers do not show interest in assessing them and make the excuse that they are busy elsewhere.
- Some managers don't seem to have full knowledge of how the PMDS assessments should be conducted.
- Their supervisors/HODs delegate the responsibility to juniors to conduct the process.
- Irreconcilable differences with their managers get in the way.
- Supervisors use the process as a punitive measure.

There have been instances where members were assessed, but did not keep copies of the document. The employer or HR department denies having a copy, or reports that they have misplaced it. This has caused major frustrations, as the employee has no evidence of having been assessed. It is therefore advisable for employees to always make copies to prevent frustration.

We always advise members to insist on being assessed, as it is a requirement by policy, and should be viewed as a tool to assist and not to punish them. Where supervisors appear to be reluctant or to delay the process, the employee should place it on record that they attempted to initiate the process but were not assisted. The matter should also be reported to the HR department and/or the CEO. If the institution fails to assist, they should contact SAMA for intervention.

Conclusion

The policy/guide is designed to help line managers and personnel practitioners to plan, develop performance contracts, monitor employee performance and conduct performance reviews and annual performance assessments. It also provides information on the easy use of the PMDS tools by managers and employees in general.

In terms of the Public Service Regulations 2001, all departments are required to develop and implement PMDSs.

In the majority of disputes referred to the bargaining council for arbitration, the employer relies on the lack of assessment records/evidence in deciding whether or not to implement resolution 1 of 2010. The bargaining council commissioners agree that although the resolution does not specify how to determine performance, the PMDS is the only recognised system to address such.

MEMBER BENEFITS

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WHO elects first African head

Diane de Kock

On 23 May, member states of the WHO elected the first-ever director-general from Africa, Dr Tedros Adhanom Ghebreyesus, former Ethiopian health minister. He was nominated by the government of Ethiopia, and will begin his 5-year term on 1 July 2017.

Dr Tedros, as he is known, beat the British candidate, Dr David Nabarro, after three tense rounds of voting. Third was Pakistan's Dr Sania Nishtar. The decision by member states was announced at the World Health Assembly in Geneva after a fraught campaign.

The campaign to lead the WHO has been long and hard fought. It began with the nominations of six candidates in September 2016. The first one to fall by the wayside in January, when the WHO's executive board selected the finalists, was the Hungarian former health minister Dr Miklós Szócska, followed by Italy's Dr Flavia Bustreo and France's Prof. Philippe Douste-Blazy.

The candidates travelled the world, seeking to win votes from member states. For the first time, they debated together on public platforms and set out their manifesto commitments in online videos.

Prior to his election, Dr Tedros served as minister of foreign affairs, Ethiopia from 2012 to 2016, and as minister of health, Ethiopia from 2005 to 2012. He has also served as chair of the board of the Global Fund to Fight AIDS, Tuberculosis and Malaria; as chair of the Roll Back Malaria (RBM) Partnership Board; and as co-chair of the board of the Partnership for Maternal, Newborn and Child Health.

As minister of health in Ethiopia, Dr Tedros led a comprehensive reform effort of the health system, including the expansion of the country's health infrastructure, creating 3 500 health centres and 16 000 health posts; expanded the health workforce by 38 000 health extension workers; and initiated financing mechanisms to expand health-insurance coverage. As minister of foreign affairs, he led the effort to negotiate the Addis Ababa Action Agenda, in which 193 countries committed to the financing necessary to achieve the Sustainable Development Goals.

As chair of the Global Fund and of RBM, Dr Tedros secured record funding for the two organisations, and created the Global Malaria Action Plan, which expanded RBM's reach beyond Africa, to Asia and Latin America. Dr Tedros will succeed Dr Margaret Chan, who has been the WHO's director general since 1 January 2007.

The first-ever director-general from Africa, Dr Tedros Adhanom Ghebreyesus

Dr Jeremy Farrar, director of the Wellcome Trust, said: "I'm pleased to extend my congratulations to Dr Tedros on his appointment to the most important job in global health. As someone who has worked tirelessly to reform health systems in Ethiopia and across Africa, he will bring great insight and the political leadership necessary to restore trust in the WHO at a critical moment in its history.

"Tedros's predecessor has done much to improve the WHO's response to epidemics in the wake of the Ebola crisis of 2014/15, but there is more to be done. Tedros has the power to herald a new era in how the world prepares for and responds to epidemics, including building partnerships, strengthening public health systems, and developing new vaccines and therapies that are available to all who need them."

Assistance needed with developing educational resources to assist colleagues

SAMA Education, Science and Technology committee

The Education, Science and Technology (EST) committee of SAMA has resolved to assist foreign-qualified doctors by partnering with the Foundation for Professional Development (FPD) to develop a bridging course that will improve the knowledge and skills of these foreign-qualified doctors, many of whom are returning South Africans. It is anticipated that the bridging course will assist both students who self-fund and those who are funded by the SA Department of Health (DoH). The additional objectives of the course are to give students exposure to the SA context, and to assist them in passing the HPCSA entrance examination. The country has an overall shortage of doctors, and it is hoped that these individuals, once registered with the HPCSA, will make a meaningful contribution to the provision of healthcare in this country.

The FPD, which has the necessary expertise in health professional education, is hoping to partner with interested individuals to develop training resources for these doctors. The standard of education needs to be set at the level of the exit examination of an SA final-year medical student. The FPD will develop the online course, and is currently negotiating with the DoH to establish short relevant clinical placements for these students.

A request is being made for colleagues with expertise in medical education to submit training material in the form of short videos or podcasts that may be used to reinforce clinical communication, examination, procedural and emergency skills. If any colleague can assist, the EST would like you to submit a brief concept note of your contribution. All contributions will be acknowledged.

Please send your concept note to:

Dr Chris Visser
Clinical Supervisor: Integrated Health Systems
Foundation for Professional Development
012 816-9000
ChrisV@foundation.co.za

Feeling trapped in SAMA?

Dr Ayodele Aina, *SEDASA National Chairperson*

SAMA was formally constituted on 21 May 1998 as a unification of a variety of doctors' groups that had represented a diversity of interests. Today, SAMA is a non-statutory professional association for public and private sector medical practitioners. SAMA functions as a non-profit company registered in terms of the Companies Act, as well as a public sector organisation registered in terms of the Labour Relations Act. SAMA, a voluntary membership association, exists to serve the best interests and needs of its members in any and all healthcare-related matters.

There are people who don't like their organisation, including employees of the organisation.

Leaders of organisations and supervisors should be intentional and aggressive about creating a culture where members and staff feel valued, significant and fulfilled

Sometimes almost every day is a bad day for some people. This increases their stress and anxiety, which has a negative impact on physical, mental and emotional health. In many cases, these people bring stress and negativity into their homes, which negatively impacts their family and friends, and from their homes to the organisation, with equal negative impacts on colleagues and members. If you don't like the organisation you belong to or work for, if you're frequently experiencing bad days, if you feel trapped in the organisation, this article is meant for you.

Leaders of organisations and supervisors should be intentional and aggressive about creating a culture where members and staff feel valued, significant and fulfilled, a culture where people truly look forward to going to work and members look forward to visiting their organisation. However, I also believe that each of us must take responsibility for the outcomes in our lives.

Your life decisions have put you in your current situation. You might feel trapped, but you're not trapped.

Please be encouraged to answer the following question:

Why do I retain my membership or work at SAMA?

Here are a few common answers: It's the highest paying job I can find. Or it is a necessary step to get to my career goal. Or it is a meaningful mission. I'm really making a difference.

It doesn't matter what your answer is, but be honest with yourself, why do you stay?

- What is it costing me to remain a member or an employee of SAMA?
- What are the implications of this to my family?
- Is what I'm getting out of SAMA worth the cost?

If the answer to the last question is "No" – as either members or staff, change something external. Change some aspect of your current organisation, or start looking for another one where you'll look forward to going to work, an organisation where you have no problem saying that what you're getting out of it is worth the cost.

Changing organisations or jobs involves great risk and often great cost. You might not be ready for a life decision like this. You might decide that at this time it's best for you to stay in SAMA. That's 100% okay, but in that case I encourage you to change your thinking. *You're not trapped if you've made a conscious decision to stay in the situation.*

Embrace the situation and remind yourself that you've decided to pay this cost in order to receive the benefits and outcomes you seek. *Stress is caused by resistance to what is*. I know this isn't easy, but you can make a commitment to work on it.

Embrace the situation and remind yourself that you've decided to pay this cost in order to receive the benefits and outcomes you seek

For the record, I've experienced both situations. I used to do lots of locum work and day shifts, and run into night shifts after showering in different hospitals doctors' bathrooms. My car boot was always full of clothes to change into and I often didn't see my house for days. I made good money, apart from the frustration of tax deductions, but I wasn't fulfilled. After a long period of introspection, more than 10 years ago I decided to make a career change, which required a substantial pay cut. I got into a career I loved by strictly working 40 hours a week, and I've never had a moment's regret about that decision.

Subsequent to that, I have a job where I was suddenly challenged to work on a plot of land while employed in the clinical and programme management of HIV/AIDS/STI/TB. I hated the cold weather, but I loved what I got to do when I arrived on the plot. I had to constantly remind myself that the unpleasantness of the cold was part of the cost for me to do what I loved. I've never regretted staying in that job.

This article is based on a blog post by Larry Sternberg: https://leadershiplaboratory.wordpress.com/category/retention-2/

Knitting Tygerbears for children

Diane de Kock

For more than 30 years, branch administrator Emily Nel has been one of the friendly voices at the Western Cape branch, a lady known and loved by SAMA members making contact with the branch in Pinelands. Over the years and while visiting hospitals to canvas new members at intern orientations, Emily became aware of the need for knitted goods in local hospitals and her community.

Emily Nel with some of the bears, blankets and beanies she knits

She has been an avid knitter for years, initially making booties and hats for premature babies. Later she heard about the Saartjie Baartman Centre for Women and Children, a one-stop centre for woman and children who are survivors of abuse. "I like to do something in the background," says Emily, a sentiment that led her to start knitting teddy bears for the Tygerbear Foundation at Tygerberg Hospital. "The children undergo counselling and they receive a bear that they can call their own. It is soft so that it can be cuddled." Emily knits every evening, and it takes her two to three evenings to knit one bear, and in between she knits blankets for the aged in her community and beanies for an orphanage. "If I am able to make someone happy, then I am happy," smiles Emily.

TygerBear Foundation

The TygerBear Foundation has developed a unique model for the psychosocial treatment, training, support and prevention of trauma suffered by all members of the community, leading to the empowerment of the individual.

The Comfort Bear Project was initiated during the 1980s, and aims to give a knitted bear to each child patient of the unit, conveying a message of hope, love and caring. The comfort bear is an important tool for the social workers to help the children who are scared and lonely to feel special again.

The team soon realised that these teddy bears can reach many more children than originally anticipated. A teenager feeling depressed, a child who worked hard in therapy or had had traumatic treatment like chemotherapy, or had just had an outpatient visit on a special day – for all of them we need to say "I care about you." These hand-knitted teddy bears have become a primary tool in the therapy of our children, for not only do they carry a message of caring and love, the teddy bear has become a confidant in whom to confide secrets and seek comfort.

An extreme example was a little boy, admitted with severe burn wounds to his face, who came to choose his own teddy bear: after standing in front of the row of bears, he chose the "ugliest" one, as this was, as he said, the one who looked most like him. This teddy bear carried the child through his therapy, and on the day of his discharge, it was the sole possession with which he left the hospital.

A basic pattern is available for volunteers to adapt to make their own unique bear friends. If you are interested in being part of this special project, please contact the TygerBear Foundation on 021 931 6702.

SAMA supports efforts to reduce smoking

SAMA Communications Department

On Thursday 31 May, the world commemorated World No Tobacco Day. SAMA used this opportunity to call all South Africans to observe the day and to support worldwide initiatives to reduce smoking.

The theme for this year's World No Tobacco Day was "Tobacco – a threat to development".

Tobacco use is a leading cause of death, illness and impoverishment. According to the WHO, an estimated seven million people die from tobacco use annually, an alarming 890 000 of these deaths being non-smokers exposed to second-hand smoke.

"The world is paying a high price for the tobacco epidemic. The monetary, health and social toll of tobacco is staggering, and there is unanimity in much of the world (including SA) that far more drastic interventions are needed, despite pockets of resistance from the tobacco industry. Eighty percent of premature deaths from tobacco occur in low- or middle-income countries, which has implications for the country's achievement of development goals," noted Dr Mzukisi Grootboom, chairperson of SAMA.

He said the WHO is calling on countries to prioritise and accelerate tobacco-control efforts as part of their responses to the 2030 Agenda for Sustainable Development, including strengthening implementation of the WHO Framework Convention on Tobacco Control in all countries. SA became party to the framework in July 2005.

"South Africa's TB incidence is ranked the sixth highest globally, at over 450 000 new TB cases annually; about 90% of new and relapse TB cases are pulmonary TB, which is positively associated with smoking," Dr Grootboom said.

But, he said, SA has successfully implemented public health programmes against tobacco use. These include:

- Anti-smoking legislation banning smoking in public places
- Legislative control of advertising and marketing of tobacco products
- A National Strategic Plan 2017 - 2022 that seeks to address social factors associated

with the TB epidemic, and to use environmental interventions to control TB, which include tobacco smoke control
- Advocacy work by the National Council Against Smoking.

Besides TB, tobacco is also the leading risk factor for non-communicable diseases such as cancer, cardiovascular disease, chronic lung disease and diabetes, and is also a significant contributor to communicable diseases such as lower-respiratory infections.

In addition to other diseases, 16 different types of cancer are known to be caused by tobacco, due to tobacco's over 4 000 different chemical compounds, at least 250 of which are known to be carcinogenic or toxic.

The WHO calls on countries to include tobacco control in their national responses to the 2030 Sustainable Development Agenda. The WHO also emphasises the participation of all stakeholders, including the public, civil society, political leaders and healthcare providers, in national, regional and global efforts to develop and implement development strategies and plans and achieve goals that prioritise action on tobacco control.

"There is a long way to go to reducing tobacco use in SA, but we will continue to ardently advocate for this. Observance of World No Tobacco Day is a good reminder of the dangers of smoking, and we urge all South Africans to stand with us in support of this day," Dr Grootboom concluded.

Asset management for doctors

Anthea Gardner, *MD, Cartesian Capital*

As a busy professional who sells his or her time, it is crucial to allocate some of that time to planning your investment strategy. Warren Buffett said it most succinctly: "Never depend on a single income, make investment to create a second source."

Personal wealth creation, saving money and investing is all about understanding your personal risk. I'm not asking you whether you are a conservative or aggressive investor, I'm asking you to understand your liabilities and then match your risk-taking to these liabilities. The one liability we all have is old age and the need for income after we retire. Often in retirement planning, your biggest risk is not taking enough risk while you are working, and subsequently not generating enough of a pension fund to live comfortably after retirement. In the case of professionals who sell their services and have limited time, holidays, sick days and sleep hours are all times when we risk not earning money.

As a doctor, time is your greatest asset; the more you have of it, the more you can sell to generate revenue. However, time is also the biggest limitation to generating wealth – you can only sell as much of it as you have.

Proper investing is a long-term strategy, and the sooner you start, the better. We also recommend speaking to your financial advisor at least once a year to discuss how your financial situation, as well as the market, has changed.

A well-planned pension fund can eliminate the risk of not having enough at retirement. Disability insurance can mitigate the risk of incapacity to work. A diversified, well-thought-out investment fund can overcome not earning while spending time with the family, weekends and holidays. All are good risk mitigation strategies.

When planning your investment portfolio, consider the factors of:
- Time horizon: Your age to retirement and how much time you will allow yourself to create wealth.
- Diversification: Primarily investments across a range of assets that promise a variety of risk/return parameters that behave differently in different economic situations, but also the diversifying of your revenue streams.
- Volatility and liquidity are key features: Not all asset classes behave in the same manner. In general, investment products designed for short-term investments, such as money market funds, tend to deliver lower returns. However, we all need a portion of short-term investments, because the lower volatility generally associated with short-term investment products affords us the comfort of knowing we have cash when we need it. Products designed for longer term investments are expected to produce higher investment returns, but also come with higher volatility and sometimes lock-up periods that many investors look at as risk. The volatility risk means that there is a possibility that when you need to withdraw your money, your investment could be negative. Similarly, illiquidity is the inability to withdraw your money when you need it.

The key is in the planning. Unpredictability and subsequent volatility can cause much concern and discomfort for an investor, but they can also create opportunities for investment. SA's recent downgrades by the ratings agencies have sent the Rand tumbling, and in turn, the banking shares. With the exception of African Bank and its curatorship in August 2014, SA banks have historically been well-managed, and good investments. In the last 20 years, the FirstRand share has returned over 2 200% (dividends re-invested in the share). Since the downgrade, the share has fallen by over 15%. Understanding that the environment has fundamentally changed may mean that we have to wait a bit longer before deciding to buy FirstRand shares, but we do think this could present a buying opportunity in the future. Timing the market is not necessarily a good strategy; we like to emphasise that it's time in the market that is important, but the unpredictability of the market suggests that making investment decisions is best left to asset managers.

As doctors, you are likely to already be invested in growth assets – your home, your skill and your practice – and investing in the stock market is your first step to creating a second income stream.

Indaba tackles common medical challenges

Bokang Motlhaga, *junior marketing officer*

On 3 and 4 June 2017, SAMA held its first regional indaba at the East London International Convention Centre in the Eastern Cape. The association was reacting to a need to decentralise the annual SAMA conference and focus on medical challenges in selected regions during this year. The regional indabas serve as platforms for doctors, in a particular region, to tackle medical issues common in that region, and to enlighten each other on how to effectively resolve these issues.

In his opening address, Dr Mzukisi Grootboom, chairperson of SAMA, stated that SAMA recognises the need to expose the roots of medical challenges within each region – hence the regional indabas. He added that it is through these regional indabas and other medical conferences that SA will arrive at the key characteristics of the National Health Insurance (NHI).

Dr Grootboom opening the event

Some presentation highlights

Pap smear, HPV and colposcopy, by Dr Sibongile Mandondo (obstetrics and gynaecology specialist): Dr Mandondo's presentation summarised the benefits of immunisation as a key strategy for the prevention of human papillomavirus (HPV) infection and associated diseases. She also pursued an evaluation of the current status of the use of HPV vaccines, stating that, according to the latest statistics, cervical cancer is the second most common cancer in females, with a mortality rate of about eight cases reported daily. It is therefore imperative that cervical cancer screening guidelines are known.

Dr Sibongile Mandondo delivering her presentation

Current concepts in shock and resuscitation, by Prof. Jan Pretorius (adjunct professor in surgery and consultant clinical unit critical care): Prof. Pretorius commenced his presentation by contrasting the intensive care unit (ICU) of today to that of the 1990s, describing the ICU in the 90s as a "keep them dry – watch them die" setting. He looked at three needs which exist in the management of shock syndromes: the need to understand the functioning and role of the cardiovascular system in health and disease; the need to understand pathogenesis and pathophysiology – how diseases evolve and affect normal physiology as well as the need to recognise that electrolyte therapy can cause harm or worsen a patient's condition because of additional pathophysiological changes.

Healthcare service delivery to sex workers – ethical considerations, by Dr Madeleine Muller (HIV Clinicians Society co-ordinator): Dr Muller's presentation focused on the ethical responsibility of healthcare workers to treat patients equally and with care, regardless of the patient's socio-circumstances and/or background. She used the legal implications of refusing to treat a sex worker as an example, to justify the content of her presentation.

Communicating with patients to avoid litigation, by Ms Karen Lee (legal advisor): Litigation is every healthcare worker's conundrum, Ms Lee amplified this statement by reporting that there has been an alarming increase since 2009 in both the frequency and the monetary value of medical malpractice claims. She hammered home the necessity for every healthcare worker to be equipped with effective communication skills. She described doctor-patient communication as the only tool that can explain complicated medical procedures and treatments at a level that the patient understands, and the only persuasive technique that can reveal that the doctor is interested in the patient's well-being.

Ms Karen Lee delivering her talk to the attendees

Gala dinner

On the Saturday evening, after a day of intensive presentations and discussions, the conference attendees treated themselves to a glitz-and-glamour gala dinner. The attendees were astounded by Stan Sussman's use of his prestidigitation skills, which took everyone back to their early days.

SAMA would like to acknowledge the contribution made by the following organisations in making the East London Indaba a success: Zydus, Sanlam, Rand Mutual Assurance, Impilo, the Board of Healthcare Funders, Liberty, the Health and Medical Publishing Group and the Medical Protection Society.

Suspected epilepsy: When to warn

The Medical Protection Society shares a case report from their files

A girl of 8 years old, L, was brought by ambulance to the emergency department (ED) with a history of a seizure during a lesson in school. There was no reliable history: according to friends who had been playing with L, she had touched an electrical socket, fallen and then had a seizure lasting about 5 minutes, from which she spontaneously recovered.

Shortly after L's parents had arrived in the ED, she was seen by the on-call paediatric team. By this stage she had fully recovered, and her parents were keen to take her home. The paediatrician noted that there was no sign of any acute infectious aetiology for the fit, and no evidence of any burn injury associated with an electrical discharge.

It was unclear whether a head injury had been sustained either before or during the incident. Because of uncertainty around the aetiology, a CT brain scan was performed. This was reported as normal. L's parents were advised that further investigations would be organised by outpatient treatment, and to bring L back if any further episodes occurred. However, there was nothing in the notes to suggest the hospital intended to rule out anything serious, like epilepsy.

An EEG was arranged for 2 weeks later, and a follow-up appointment in 6 weeks in order to discuss the results of the EEG. Unfortunately, L did not attend EEG appointment. The paediatrician did not have a "Did not attend" policy in place, and so no further action was taken.

Four weeks later, L was again brought into the ED by a teacher from her school. On this occasion the history was a little vague; it seemed that L had fallen to the ground, possibly as a result of a faint. It was unclear whether she had hit her head on a desk or on the floor. When on the floor, she had been noted to have some persistent blinking and unusual side-to-side movements of the head and one hand.

When examined in the ED about 1 hour after the episode, L was alert and co-operative. Neurological examination was unremarkable. A further CT brain scan was performed, and again reported as normal. On this occasion, L's parents were advised that further investigations including an ECG and an EEG were necessary, that these would be arranged as an outpatient and that she would be seen with the results of these.

She was discharged, with the planned EEG and follow-up appointment booked for 2 weeks and 4 weeks ahead, respectively. Ten days later, L was found drowned in the bath at home. L's parents made a claim against the paediatrician treating L.

Expert evidence on behalf of the parents advised that had the parents been made aware of the possibility of epilepsy as a diagnosis, and been given appropriate advice, they would have prioritised the EEG appointment; and they would have followed standard advice given to parents of children with a diagnosis of epilepsy, i.e. to ensure that she was supervised during baths, or to take only showers. The claim was settled for a moderate sum.

Learning points

- Doctors may be faced with a dilemma when counselling parents about conditions in their child that are unconfirmed and still under investigation. There is a delicate balance to be found between causing undue anxiety if the condition is subsequently not diagnosed, and failing to provide parents with sufficient information for them to take appropriate precautions. In the case of a child who had had two episodes that are suggestive of a seizure over a short period of time, and in which investigations for epilepsy are underway, it would be prudent both to offer some precautionary advice to parents and to document the advice given.
- In the UK, The National Institute for Health and Care Excellence's clinical guideline 137, "The epilepsies: The diagnosis and management of the epilepsies in adults and children in primary and secondary care", issued in January 2012, states that:
  - All children, young people and adults with a recent-onset suspected seizure should be seen urgently (i.e. within 2 weeks) by a specialist (i.e. a paediatrician with training and expertise in epilepsy). This is to ensure precise and early diagnosis and initiation of therapy as appropriate to their needs.
  - Following a first seizure, essential information on how to recognise a seizure, first aid, and the importance of reporting further attacks should be provided to a child, young person or adult who has experienced a possible first seizure, and to their family/carer/parent as appropriate. This information should be provided while the child, young person or adult is awaiting a diagnosis, and should also be provided to their family and/or carers.
  - Children, young people and adults with epilepsy and their families and/or carers should be given information to include (where appropriate):
    - epilepsy in general
    - risk management
    - first aid, safety and injury prevention at home and at school or work.
  - The time at which this information should be given will depend on the certainty of the diagnosis, and the need for confirmatory investigations.

In this instance, the parents' failure to bring the child for the initial investigation may have been a contributory factor. Had a "Did not attend" policy been in place, there would have been an opportunity to review the records and to establish whether further efforts should have been made to ensure that the child was brought for medical assessment or treatment.

Border Coastal recognise members

The Border Coastal branch AGM took place at the East London Golf Club on Friday 12 May, and was attended by 97 people. The event was kindly sponsored by Ampath, Pathcare and the Life Healthcare group.

Guest speaker for the evening was Prof. Alfred Maroyi, who spoke about medicinal plants of the Eastern Cape to a receptive audience. Three branch members were present to receive their life-membership awards.

Dr Kevin Gernetzky, Dr Daya Appavoo and Dr Colin Lazarus received life-membership awards

Congratulations to Dr Sibongile Mandondo, an obstetrician in the Amathole District Clinical Specialist Team (DCST), where she has been working since November 2013, who received the local hero award. Her role is to work to strengthen obstetric and gynaecological health services at district and community levels, through supportive supervision and clinical governance. The motivation for the award read: "Dr Mandondo has approached her work in the DCST with a strong sense of duty and enthusiasm. She is a dedicated teacher and is committed to training all cadres of staff wherever she is working. She travels extensively throughout the Amathole district, training doctors and nurses, assisting with ward rounds in district hospitals, as well as doing clinical sessions in the East London hospital complex as a consultant. With her guidance, Amathole's cervical cancer screening coverage has improved to within the top 10 nationally, while stillbirth rates have also significantly decreased (District Health Barometer). In August 2016 she started visiting OR Tambo district, which does not have a DCST obstetrician. She works in this district for a week every month, mentoring and training doctors and nurses.

"Dr Mandondo has sound clinical knowledge, is a passionate teacher and mentor and remains calm under pressure. She is dedicated to providing integrated and equitable health services to the people of the Eastern Cape. She demonstrates strong leadership within her district and within the Eastern Cape Province. She has an infectious laugh and optimistic personality, believing that all difficulties can be overcome!"

The new branch council members for 2017 - 2020 are:

Dr Kim Harper - Immediate past chairperson/ treasurer
Dr Mzulungile Nodikida - Chairperson
Dr Stacey Rossouw - Vice-chairperson / assistant clinical secretary
Dr Luvuyo Bayeni - National councillor
Dr Madeleine Muller - RUDASA rep.
Dr Richard Makomba - Private practice specialist rep./signatory
Dr Simon Comley - Clinical secretary / JUDASA rep.
Dr Sinazo Shinta - National councillor / EST national rep.
Dr Xhaka Shasha - Branch councillor

The AGM was followed by a delicious three-course dinner and dancing. Left-over food was collected and delivered it to The Manor senior citizens' home. "Many thanks for providing a scrumptious meal to about 20 residents … SA society is inclined to forget older people, especially those who have very little," said Bronwyn Lenton, manager of The Manor.

Dr Kim Harper with the recipient of the local hero award, Dr Sibongile Mandondo

Griqualand West, MPS host CPD meeting

The Griqualand West branch and the Medical Protection Society (MPS) hosted a CPD meeting on Monday, 22 May 2017 at the Protea Hotel, The Big Hole in Kimberley. The topic discussed at the meeting, which was presented by Dr Volker Hitzeroth, was: "MPS medicolegal: A practical approach to a request for your clinical information – pause, peruse, protect and don't panic."

Dr Volker Hitzeroth qualified as a doctor at the University of Pretoria in SA, and went on to qualify as a specialist psychiatrist at the University of Stellenbosch. Among other postgraduate qualifications, he completed a master's degree in medical law and ethics. He currently works as a medicolegal adviser for MPS in the UK. He was also in full-time private practice in SA, and previously had experience within the public health sector. His clinical interests include addiction, medical law and medical ethics. Alongside a number of colleagues, he founded the SA Addiction Medicine Society.

In his presentation, he used a case study to lead an interactive discussion on how to deal with difficult issues that arise from clinical practice, including regulatory matters, claims for clinical negligence and complaints, with special attention to patient medical records and practitioners' notes.

Dr V Hitzeroth with Dr MJ Ngundu, chairperson of Griqualand West branch

Financial day for students

The Tygerberg-Boland branch sponsored lunch for 230 final-year medical students at their annual financial day in Tygerberg on 6 May 2017.

The branch uses this event to build positive relationships with Stellenbosch University and the medical school, as well as recruiting final-year medical students as SAMA members.

Sandra Ferrone (second from left), branch secretary of Tygerberg-Boland branch, with students completing the student membership forms

Goldfields branch council

Congratulations to the following council members for Goldfields branch 2017 - 2020: Front: Riekie Hoffman (administrative service provider). Back, from left to right: Dr David Botes (treasurer), Dr Flip Nieuwoudt (chairperson and co-ordinator of CPD events), Dr Paris Daniel (representative for GPs), Dr Tjaart Taute (secretary), Dr Piet Janse van Rensburg (employed doctors' representative), Dr Johan Spangenberg (representative for specialists)

KZN Midlands CPD meeting

A very successful MPS roadshow CPD meeting was held on 24 May 2017 in Pietermaritzburg. Dr Hitzeroth was the guest speaker.

MPS speaker Dr Volker Hitzeroth on the right, with SAMA KZN Midlands chairperson Dr G T T Buthelezi

Gauteng North hand-over dinner

On 7 June 2017, the outgoing branch council members met with the new council, at Tuscan BBQ, to hand over the baton. Prof. Risenga Chauke, outgoing vice-chairperson, spoke about the challenges facing SAMA and the branch, sharing branch successes over the past years. He emphasised the continued commitment of former branch council members towards the goals and ambitions of the branch and SAMA holistically, declaring that former branch council members were willing to assist the new council.

The SAMA Gauteng North 2017 - 2020 branch council members are: Dr Tshilidzi Sadiki (chairperson), Dr Lindi Shange (vice-chairperson), Dr Julius Kunzmann (honorary secretary), Dr Chandré Balie (treasurer), Dr Mmameriana Boshomane (marketing and event co-ordinator), Dr André Marais (CPD co-ordinator), Dr Angelique Coetzee (GP representative), Dr Mandilakhe Msingapantsi, Dr Mphele Malaudzi (employed doctors' representative), Dr Pam Mathabule (specialist representative), Dr Steve Selepe, Dr Tsametse Mohlamonyane. The branch is supported by Ms Judy Mills, branch administrator.

Dr Tshilidzi Sadiki, the new chairperson, thanked the outgoing branch members and their families for their hard work and support. Dr Sadiki emphasised that the new branch council will build on a solid foundation, and that he was thankful for continuity, as some members of the previous branch council were serving on the current council. He mentioned the trials that lay ahead for the branch.

Dr Sadiki presented service certificates and appreciation gifts to the outgoing branch council members.

Prof. Chauke receiving a gift from Dr Sadiki

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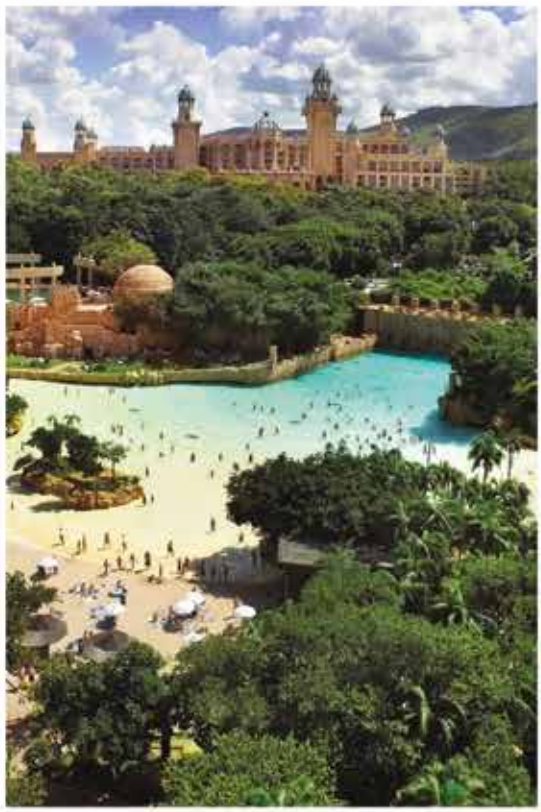

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Pre-Congress Workshops & Meeting

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Urogynaecology Workshop
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Infertility Workshop
Contraception Workshop

South African Society of Gynaecologic Oncology Meeting

FRIDAY 8 SEPTEMBER 2017

Session 1: Obstetrics
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Session 3: Medicolegal and Ethics
Session 4: Gynaecologic Oncology
Session 5: Reproductive Medicine

SATURDAY 9 SEPTEMBER 2017

Session 6: Urogynecology
Session 7: Maternal Medicine
Session 8: Fetal Medicine
Session 9: Endoscopy
Session 10: A Look into the Future

Invited International Faculty

Prof Phillip Bennett | United Kingdom
Dr Mark Slack | United Kingdom
Prof Frederic Amant | Belgium

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