

SAMA INSIDER

August 2017

Lancet national commission launched in SA

The murky business of
pharmaceutical pricing



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Diane de Kock
Editor: SAMA INSIDER

Celebrating passion and commitment

A number of young doctors in SA are dedicated, passionate and committed to striving to make things better in their fields, and receiving awards for their efforts.

In this issue, we celebrate four of these young doctors. Dr Kalli Spencer, chairperson of the SAMA Gauteng branch and JUDASA, was recently recognised as one of the Top 200 Young South Africans in the *Mail & Guardian's* annual feature in the health category (page 6).

The National Science and Technology Forum (NSTF) recently honoured two professors working in healthcare, Prof. John Ele-Ojo Ataguba and Prof. Alta Schutte, by recognising and awarding their contributions to science (page 7). Prof. Ataguba was awarded the NSTF-TW Kambule Award for an emerging researcher: postdoctoral, and Prof. Schutte the award for research and its outputs, recognising her contribution to research over the past 15 years.

Dr Anastasia Rossouw has been nominated as a finalist in this year's Businesswomen's Association of SA Regional Business Achievers award. Her passion and commitment to improving healthcare services in the Eastern Cape has made a huge impact.

SAMA's passion and commitment to HIV prevention is highlighted in the article (page 9) on the 2017 SA AIDS conference. The theme of the conference was "The long walk to prevention: Every voice counts" – "an aptly themed conference that achieved much in the deliberations and outcome ... however, the promising scientific acceleration towards a vaccine, the commitment to mounting a prevention resolution, the resolve to annihilate stigma and the use of a social-determinants-of-disease approach have provided much inspiration," write the authors Bernard Mutsago and Dr Lindi Shange.

SAMA branches showed their commitment to giving vision to the visually impaired (Lowveld); honouring members for their service to SAMA (Eastern Province); creating awareness for children with special needs, and welcoming the miracle train (Goldfields), and donating blankets to their community during one of the coldest months of the year (West Rand).

If there is anyone at your branch who you feel should be acknowledged in *SAMA Insider*, please submit your suggestion to the editor: dianed@hmpg.co.za.

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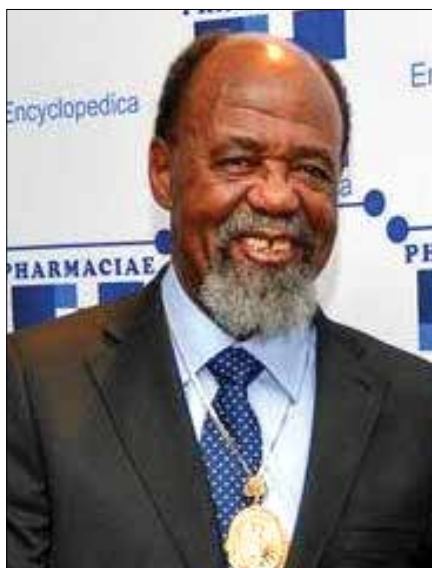
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The murky business of pharmaceutical pricing



Prof. Dan Ncayiyana, SAMA president

In 2015, a young US entrepreneur named Martin Shkreli earned himself the unenviable title of “the most hated man in America”. His company, Turing Pharmaceuticals, acquired the sole US rights to market Daraprim, the drug used to treat toxoplasmosis. He then promptly raised the price nearly 500%, from USD13.50 to USD70.50 a pill, making it virtually unaffordable for most patients – mainly HIV/AIDS sufferers – who depended on it. The story became headline news, and evoked much public anger. But according to Dr Daniel J Stone’s column in the *Los Angeles Times*, “Turing’s profiteering was merely a more extreme version of the standard industry practice ... that maximizes profit at the expense of all other values.” He goes on to charge that “the drug companies are ripping us off, pill by pill, shot by shot. Instead of working to earn reasonable returns by relieving our suffering and saving lives, they now focus on profits above all.”

But how are pharmaceutical products priced? That, in the words of Churchill’s description of Russia, is “a riddle wrapped in a mystery inside an enigma”. To be fair, pharma devotes huge sums of money to the development, production and testing of new drugs. Not infrequently, significant research resources may be devoted to a tantalising molecule that eventually proves worthless and ends up in the rubbish bin. Drugs that are potentially effective must undergo rigorous testing from animal studies to human clinical trials. The successful drug must then jump

through a series of costly regulatory hoops before it is licensed by the FDA in the US, and equivalent agencies in other countries. In recognition of these costs, manufacturers are allowed patent exclusivity for 20 years to recoup their investment before competing companies can copy the drug formula to produce and market generic equivalents at lower prices.

However, manufacturers also benefit significantly from taxpayer funding. The scientists and much of the basic science, as well as clinical trials that comprise the backbone of the production, are derived from tax-supported universities and academic research institutes. As some authors have put it, the evolution of a new drug “starts with good science and ends with good medicine”. Just how much publicly funded research contributes to pharmaceutical drug discovery in quantifiable terms is a matter of debate, but Tufts University researchers who have looked at the facts and done the sums conclude that “it is evident that the private sector [pharma industry] needs the public sector [academic research units] ‘to do good science’, while the public sector needs the private sector to transform that scientific capital into products that benefit society, and thus to do good medicine.”

However, the mechanism by which pharma determines the price of drugs remains opaque to the public and to many health economists. No wonder, then, that pharmaceutical pricing is one of the most regulated businesses in the world, though much less so in the US, where even the public health system, known as Medicare, is legally barred from negotiating favourable procurement terms with the industry. Unsurprisingly, therefore, the US has by far the highest pharmaceutical prices in the world. In Canada, ethical medicine prices have been regulated since 1987 by the Patented Medicines Prices Review Board, and as a result, drug prices are significantly lower, and Americans living along the border regularly step across to fill their prescriptions at Canadian pharmacies, where drugs are cheaper.

Originator pharmaceutical companies have a few tricks up their sleeves to retain high drug pricing long after the patents run out. One is simply to create a new company to continue to sell the same ethical drug as a generic, in new packaging. The other

is to collude with a generic manufacturer, for a substantial consideration, not to bring its product to market. The third practice is to buy the competitor, in order to keep selling the generic at a higher price. Major companies will often collude or merge with competing major manufacturers to eliminate competition. Then there are the inexplicable and often outrageous price increases that are frequently reported around the world. The University of Utah’s Erin Fox reports how their hospital budget was thrown out of equilibrium when “Valeant suddenly increased the price of isoproterenol from USD440 to USD2 700 a dose.” It is perhaps most telling that pharma spends more money on marketing than on new drug research.

Drug pricing in SA

In 2004, SA became one of the few middle-income countries to regulate pharmaceutical pricing. The government introduced the policy of a single exit price (SEP) for medicines, and put a stop to inducement discounts, additional levies on medicines and other stunts to obfuscate price gouging. The implementation of the SEP effectively meant that the private pharmaceutical sector had to adjust from a free to a regulated market, where price ceilings were set by the government at source, and the pricing process changed from opaque to transparent. Dispensers may charge an additional dispensing fee to cover their operational expenses, depending on the price of the medicine.

SEP has been quite effective in protecting the consumer from greedy drug pricing. However, SA is not immune to attempts by pharma to try to beat the system. According to recent reports, the SA Competition Board is investigating three major pharmaceutical companies for allegedly fixing the price of certain cancer treatments, including the widely used breast cancer drugs Herceptin and Herclon. Aspen has been accused of inflating cancer drugs in the UK by up to 1 000%, and has faced price-gouging legal proceedings in countries such as Italy and Spain.

“Sadly”, observed Ben Chu in the UK *Independent* on 30 August 2016, “there’s no magic policy pill that will cure pharmaceutical profiteering – only a carefully administered course of corrective treatment.”

Lancet national commission on quality launched in SA

Bernard Mutsago, SAMA health policy researcher

SAMA received an invitation, through the office of the SAMA chairperson, to attend the launch of the National Commission on High-Quality Health Systems in the Sustainable Development Era (the HQSS Commission) in SA. The launch took place on Friday 12 May 2017, at the Premier Hotel in Pretoria. Attendees on behalf of SAMA were Dr Selaelo Mametja (SAMA's acting general manager and head of the Knowledge Management and Research Department) and Mr Bernard Mutsago (SAMA health policy researcher). The other SAMA members present, Prof. Ames Dhali and Prof. Lizo Mazwai, were in attendance in their personal capacities as commissioners of this new national structure.

The rest of the delegates comprised several researchers, academics, policymakers, medical schemes, healthcare workers and other interested parties from the SA health industry, both public and private. The Deputy Minister of Health, Dr Joe Phaahla, gave the opening address. The Minister of Health, Dr Aaron Motsoaledi, and the Director General, Ms Precious Matsoso, unfortunately could not attend this event due to other commitments.

The commission is a country-level representation of the recently established Lancet Global HQSS Commission. The SA National HQSS Commission was approved by Minister of Health Dr Aaron Motsoaledi in April 2017, and was convened and officially launched by global HQSS Commissioner and Director General for Health, Ms Malebona Precious Matsoso, on 12 May 2017. The National Department of Health (NDoH) will be the secretariat for the national commission.

The Global HQSS Commission is an independent group of 30 academics, policymakers and health-system experts from 18 countries that was established to improve health-system quality at the global level. The Global HQSS Commission, which has four working groups and is chaired by Margaret Kruk and Muhammad Pate, has the following aims:

- to define health-system quality
- to describe quality of care and its distribution across tracer sustainable development goal (SDG) conditions

- to propose practical measures of quality
- to identify structural approaches to improve quality.

The commission began its work in January 2017 and is expected to publish its final *Lancet Global Health* by the spring of 2018. It is hosted by the Harvard School of Public Health.

The HQSS Commission is a highly welcome development in view of the worldwide mounting concern about the deteriorating quality of care and rising litigation in health systems. Health-systems quality is an underfunded and under-researched area, especially for low- and middle-income Countries (LMIC). Gratefully, the global commission includes experts and commissioners experienced in LMIC settings.

SA is one of the few countries nominated to establish national commissions to spearhead the work of measurement and improvement of health-system quality, through the support of the Global Commission. Over the next 2 years (SA's Deputy Minister of Health felt that 2 years was too long for an SA commission!), the SA commission will review current knowledge and produce new empirical work and policy recommendations on the level of quality in health systems, and how higher-quality health systems can contribute to saving lives and reaching the SDGs. National commissions will bring together diverse stakeholders to obtain a national picture of quality, and use cutting-edge frameworks and analytics to think anew about better measures of quality and opportunities to improve quality across the entire health system. Their findings will inform national efforts and the work of the global commission. Key local stakeholders will be invited, when necessary, to participate in the meetings of the national commission technically and as observers. The Commission's work in SA will include SDGs and National Health Insurance (NHI).

There are 15 national commissioners for SA's national commission, from both the public and private sectors. The two co-chairs are Prof. Olive Shisana and Prof. Lizo Mazwai. The other 13 commissioners were introduced as the following: Prof. Ames Dhali, Ms Vuyiseka Dubula, Prof. Lilian Dudley, Dr Rene English,

Prof. Gerhard Grobler, Mr Thulani Masilela, Dr Rajesh Patel, Prof. Adrian Puren, Mr Russell Rensburg, Prof. Laetitia Rispel, Ms Jacqui Stewart, Prof. Stuart Whittaker, Dr Gustaf Wolvaardt.

The National Department of Health (NDoH) will provide secretariat services for the national commission. Preparatory work of the national commission has already begun, and key meetings have been held. The national commission has adapted the existing versions of the WHO and the Institute of Medicine dimensions of quality, from STEEP (safe, timely, effective, efficient and patient-centred) to STEEEAP (safety, timely, effective, efficient, ethical, accessible and patient-centred). The work of the global and national commissions is guided by available terms of reference. For the global commission, two different terms of reference exist: one for national commissions and the other for working groups. There will be two expert working groups under the SA national commission, namely for:

- Ethics, chaired by Prof. Lizo Mazwai
- Quality improvement, chaired by Prof. Olive Shisana.

The other commissioners will be involved in both groups. It was announced that task teams will be established under each working group. The national commission will not necessarily "run" quality of care in SA; instead, the commission will merely consolidate the existing and new data on quality-related systems, and make recommendations to the state, with the Director-General of the NDoH putting the final stamp on the best quality measures proposed for the country. Whether or not the national commission will issue requests for proposals from capable service providers to undertake local studies on different quality-of-care models will be determined once the projected funding is in place.

The big questions about the project cost of the commission's work and how it will be funded were answered at the launch. The NDoH informed delegates that the national commission's work will require an estimated ZAR5.4m, of which 50% (ZAR2.7m) is already secured from the global fund. The balance is still to be sourced. During the launch, the WHO,

through its country office representative, pledged an unspecified amount of money in support. SAMA also pledged to support with technical expertise.

In the ensuing discussion during the launch, key issues relating to this commission came to the fore. First was the uncertain attitude of the private sector with regard to this initiative. Delegates expressed apprehension about the preparedness of the private health sector in SA to embrace this kind of initiative. In response, Prof. Olive Shisana acknowledged the validity of this concern and stated that indeed, private-sector individuals were already part of this national commission. Further, it was highlighted that, under the NHI, this private/public dichotomy will disappear. The deputy minister also reminded delegates that norms-and-standards regulations were being finalised, and that these should apply to both public and private sectors, and will assist the work of the Office of Health Standards and Compliance.

Secondly, the related issue of an existing wealth of data and disparate quality-of-care initiatives in the SA market, particularly in the private sector, that do not speak to each other or to the state system, surfaced. Prof. Shisana promised to invite various

quality-of-care stakeholders in SA to email or supply whatever systems and data they have to the commission via the secretariat, to contribute to building a unified quality-of-care system.

Thirdly, as the wave of health equity is gaining traction globally, including in SA, SAMA representatives asserted that the national commission should make social determinants of health and health inequality prominent considerations in their work. This proposal was accepted. The fourth issue, telemedicine, was put on the table by the commission chair (Prof. Shisana), who emphasised the need to consider its role in rural areas. She stated that the NDoH has a policy on telemedicine that was signed with regional heads of state. She also expressed support for the idea of involving health faculties in medical training arrangements, such as the use of tele-education to supervise community-service doctors.

A host of further valuable inputs and clarity-seeking questions were raised from the floor. For example, Prof. Karen Hoffman raised a question directed at the commissioners and, indirectly, at SAMA, on whether the commission's work will involve quality-of-clinical-care guidelines? Another

delegate, from Nelson Mandela Metropolitan University, also raised the point that it does not make sense for a Faculty of Medicine to exist separately from a Faculty of Health Sciences, using the example of the institution he comes from. He argued that the two faculties should be under one roof, so that the graduates are trained to work together for quality right from the beginning. Dr Rufaro Chatora of the WHO country office for SA noted the glaring omission of "injuries" in the focus areas of the national commission, and suggested their inclusion. The commission accepted the concern, acknowledging that injuries in SA are a serious yet preventable phenomenon, addressable by dealing with social determinants of health.

At the close of the launch, it was announced that a document portal and work portal will be established for the commission and stakeholders to discuss issues and share data and progress.

The commission on quality of care is a significant milestone in the history of quality healthcare in SA. A high-quality healthcare system is indispensable for the country. The launch of the global and national commissions on quality will certainly have a catalytic effect on the envisaged quality-of-care revolution.

Dr Kalli Spencer – noted young South African

SAMA Communications Department

The chairperson of the SAMA Gauteng branch, as well as the Gauteng chairperson of the Junior Doctor's Association (JUDASA), Dr Kalli Spencer, was recently honoured by being named one of the Top 200 Young South Africans in the *Mail & Guardian's* annual feature, published in June. Dr Spencer was recognised in the health category.

The editor-in-chief of the *Mail & Guardian*, Khadija Patel, noted in a foreword to the feature, "We have chosen these 200 young South Africans for their feats of brilliance as individuals, yes, but we have also chosen these wonderfully talented, resourceful, caring people because they remind us that all is not lost. They remind us that the pursuit of a better world is never in vain. Mostly, these young people remind us that we are not alone in the world. They remind us that it does take a village to raise a child, and together we raise villages. It is young people who remind us that we are, because they are."

The 32-year-old Dr Spencer works in urology at the Charlotte Maxeke Johannesburg Academic Hospital. A product of the University of the Witwatersrand, Dr Spencer trained at The Chris Hani Baragwanath and Helen Joseph Hospitals. It was during his training at these hospitals that Dr Spencer realised that there was a need to educate patients better, specifically about men's health issues.

In his interview with the *Mail & Guardian*, Dr Spencer is quoted as saying, "We need more emphasis on men's health and sexual health in SA. Prostate cancer is the number one cancer that kills men or leaves them with devastating complications. We have a large responsibility as healthcare practitioners to make a change, and I would like to be that change."

After studying, Dr Spencer became a member of JUDASA, which he says led him to become involved in community development and education initiatives. One of the

initiatives he was involved in setting up was getting doctors and nurses to visit Gauteng schools to educate learners on issues such as teen pregnancy.



Dr Kalli Spencer, one of the Top 200 Young South Africans

NSTF awards honour outstanding contributions

SAMA Communications Department

We congratulate Prof. John Ele-Ojo Ataguba and Prof. Alta Schutte, each a recent recipient of a National Science and Technology Forum (NSTF) Award, presented in partnership with South32 on 29 June 2017 in Johannesburg. These awards honour and celebrate outstanding contributions to science, engineering and technology, as well as innovation, in SA, and are the largest and most comprehensive national awards of their kind.

Making sense of the numbers to improve healthcare

Prof. John Ele-Ojo Ataguba, an associate professor in the Health Economics Unit at the University of Cape Town (UCT) was awarded the NSTF-TW Kambule Award for an Emerging Researcher: postdoctoral in a period of up to 6 years after the award of a PhD or equivalent.

Prof. Ataguba has more than 10 years' research experience in many African countries, and he has a strong passion for developmental issues that pertain to Africa and Africans. His current research interests include poverty, inequality, equity in health and healthcare, social determinants of health and health financing.

Currently he teaches topics in health financing, microeconomics and quantitative health economics to graduate students at UCT. He received a bachelor's degree in economics (with first class honours) from

the University of Nigeria, and he also holds a Master of Public Health degree in health economics and a PhD in economics from UCT.

In its presentation to him the NSTF noted, "Prof. Ataguba is a leading public-health researcher in health inequality and health equity. He has made significant contributions to public-health economics research in SA. Internationally, he has contributed to innovative research on equitable health financing and universal health coverage. His research aims to understand the social determinants of health and the links between poverty, inequality and ill health.

"Critically, he undertook the first-ever comprehensive analyses of health inequalities and equity in health financing and service delivery in SA (including the public and private sectors). The results of these are central to health-sector reforms in the country. He has developed novel methodologies for assessing health financing systems, focusing on the poor and marginalised."

Prof. Ataguba says the award is important to him as it increases his desire to continue making significant contributions to shape the world for the better, through research.

"I see this award not just as a reward for the work that I do, or that I have done with my colleagues over the years, but to stimulate the interest of young folks to the interesting and often challenging disciplines of science, medicine, engineering and technology. Awards like this can arouse young students to fall in love with science," Prof. Ataguba says.

Apart from the NSTF-TW Kambule Award, Prof. Ataguba is the recipient of several awards for academic and research excellence. After earning his first degree, he received the prize as the best graduating social scientist at the University of Nigeria. In 2015, he received a Y1 rating from the National Research Foundation, SA. This is the highest rating for young researchers aged 41 years or younger.

Prof. Ataguba serves as advisor to international organisations including the WHO. He also advises national governments in many capacities. Most recently, he was appointed by the SA Minister of Health as a member of two work streams for the country's National Health Insurance programme.

"He undertook the first-ever comprehensive analyses of health inequalities and equity in health financing and service delivery in SA"

Prof. Ataguba is also currently a member of the board of trustees for the African Health Economics and Health Policy Association. This is the umbrella body of health economists and health policy researchers and practitioners in Africa.

Prof. Schutte gives her heart to hypertension research

Prof. Alta Schutte of the North-West University (NWU) was honoured with the prestigious NSTF-TW Kambule Award: Research and its outputs, which recognised her contribution to research over the past 15 years.

Prof. Schutte is the Unit Director: SA Medical Research Council Unit of Hypertension and Cardiovascular Disease. She holds the Department of Science and Technology – National Research Foundation SA Research Chair: Early Detection and Prevention of Cardiovascular Disease in Africa at the Faculty of Health Sciences, NWU. She is also the Professor in Physiology for the Hypertension in Africa Research Team (HART) at NWU.

In 2016 Prof. Schutte was selected by the prestigious medical journal, *The Lancet*, to form part of the Lancet Commission on Hypertension consisting of 20 authors from around the world. The report from the Commission was published in 2016, highlighting the 10 key actions to be addressed first to change the significant upward trajectory in raised blood pressure around the globe.



Prof. John Ele-Ojo Ataguba



Prof. Alta Schutte

In fact, based on a recent global analysis including over 19 million participants, it was found that some of the highest blood pressures were recorded in sub-Saharan Africa. The time couldn't be more right to focus on novel strategies to not only treat, but prevent the development of high blood pressure in Africa.

Within the Hart, which hosts the MRCs Extra Mural Unit for Hypertension and

Cardiovascular Disease, headed by Prof. Schutte, several research projects are under way with the focus to better understand hypertension development, and working towards better prevention strategies.

In its presentation to her, the NSTF noted her contributions to the prevention and treatment of hypertension in Africa.

It wrote, "This disease burden is greatest in sub-Saharan Africa, which is why Prof. Schutte's research focus is on understanding and identifying early predictors for the development of hypertension in SA. She does this by employing the latest cutting-edge research and by using precision medicine to not only understand disease development but to identify novel strategies in preventing and treating hypertension."

Prof. Schutte says the NSTF-TW Kambule Award is a wonderful acknowledgment not only of her own efforts, but also those of her whole research team, support staff, and family.

"This award spans 15 years and covers the early days of my postdoctoral years, when I got married, as well as the times I took off when having my two children, Jacques (11) and Anita (9). Without the dedication and support of my husband none of this would have been possible. I dedicate this award to him," Prof. Schutte says.

She says to her it is also important to support young scientists, including young women, wanting to continue a career in science. She has contributed to a report on Success Stories of young African scientists (by the SA Young Academy of Science), and is part of a committee on Women in Hypertension Research as part of the International Society of Hypertension, where she is vice president.

"All that counts is that my science matters, and that it contributes to less people in Africa suffering"

"Awards such as these are a wonderful recognition of work over the years, but, in the end, all that counts is that my science matters, and that it contributes to less people in Africa suffering from hypertension, resultant stroke, heart disease and kidney disease," Prof. Schutte concludes.

Corporate wellness a road to corporate success – SAMA

SAMA Communications Department

SAMA recently urged all corporates in SA to invest in corporate wellness programmes. The call came as the world observed Corporate Wellness Week from 1 - 5 July.

"An estimated 200 cardiovascular-related deaths occur daily in SA and 80% of these are attributable to lifestyle and behaviour. Businesses who want a healthy balance must invest in the health of their workers as a priority for their companies' wellbeing," noted Dr Mzukisi Grootboom, chairperson of SAMA. Workplace wellness activities fall under three categories: primary, secondary, and tertiary.

Primary corporate wellness programmes prompt employees to change their habits into healthier lifestyle behaviours. Secondary programmes target risky health

behaviours such as smoking, and involve screening for disease-related risk factors, while tertiary programmes address existing health problems, aiming to control or reduce the symptoms and progression of the conditions.

Most organisations offer programmes such as smoking cessation, weight management and behavioural or lifestyle coaching. Some companies will even provide financial incentives for employees who participate in different health and fitness programmes.

Recent years have also shown workplace wellness expand from single health-promotion interventions to creating a more overall healthy environment, such as the use of buildings and interior design to promote physical activity.

"Some recent wellness activities SAMA has implemented for employees include arranging for employees to get their flu vaccinations, arranging for blood pressure and blood sugar level testing, having regularly scheduled LIVUPP sessions which build employee morale, relieve stress and provide employees with valuable lessons, contributing to a more productive and enjoyable workspace," said Dr Grootboom.

Regardless of the work environment, corporate wellness programmes are designed to nurture wellness in employees. Some benefits of starting a corporate wellness programme include:

- Reduced healthcare costs
- Reduced absenteeism
- Reduced stress

- Increased productivity
- Improved morale
- Savings on healthcare expenses
- Healthier employees who will work more diligently, and miss fewer days of work due to illness.

Some recommendations for including wellness in your organisation are to:

- make programmes practical and accessible. Invest in programmes that foster

- sustained engagement, and be open to suggestions and feedback from employees.
- be health conscious in all business aspects. Replace vending machines with healthier options.
- be proactive. Offer biometric screening programmes, and provide your employees with the tools and information they need to make healthy lifestyle choices and changes.
- review catering menus and make recommendations for healthy options.

- promote daily physical activity, for example, by encouraging stairwell use or negotiating corporate discounts for health club memberships.
- start a smoke-free policy, and provide cessation resources.

"The benefits of a healthier workforce are clear, and investing in employee health and wellness is a smart business decision," concluded Dr Grootboom.

The 2017 SA AIDS conference: Highlights, promises and worries

Bernard Mutsago, *SAMA health policy researcher*, **Dr Lindi Shange**, *chairperson, SAMA Health Policy Committee*

The 8th SA AIDS conference took place on 13 - 15 June 2017 at the Durban International Convention Centre in KwaZulu-Natal. This biennial event came at a point when the world is experiencing political, economic and environmental turmoil, accompanied by devastating epidemic eruptions that have left many regions, communities and individuals more vulnerable than ever before. There were over 2 500 delegates, 200 speakers, 400 poster presentations and 70 exhibitors.

SAMA participated in this conference in various dimensions. The SAMA Health Policy Committee was represented by Dr Lindi Shange, the chairperson of the committee, accompanied by Mr Bernard Mutsago, the SAMA health policy researcher based in the SAMA head office.

Dr Mark Sonderup was a speaker in one of the conference sessions. In all likelihood, SAMA members from SAMA branches were also participants, representing their branches or in their individual capacities. However, it appeared that several individuals and organisations might have been deterred from attending due to the exorbitant conference registration fees (ZAR6 050). The Foundation for Professional Development, a subsidiary of SAMA, managed and organised the conference on behalf of the company Dira Sengwe.

The conference programme was structured around five tracks, to give focus on priority issues in the AIDS discourse. The tracks were:

- Track 1: Basic and clinical sciences
- Track 2: Epidemiology, prevention and public health

- Track 3: Social, political, economic and health systems
- Track 4: Ethics, marginalisation and the protection of human rights
- Track 5: Best practices: Programmes, communications and community engagement.

This report captures many important issues identified and key points discussed within the themed tracks.

The conference chairperson, Dr Sue Goldstein, opened the conference. The theme of the conference, "The long walk to prevention: Every voice counts", aimed to draw out the voices of young people, recognising that the ways in which we engage with the youth now will influence how they, as adults, are able to uphold the rights and dignity of all. In line with this theme, the first session was a youth plenary themed "#Young People Speak", which saw nearly 10 young boys and girls, some HIV-positive, presenting moving speeches and performances to drive home messages around themes of poverty and equity; information and communication; accountability; and tribute to victims of gender-based violence, among other themes. One youth read an "open letter to HIV". The youth urged government to not just continue creating more and more new "nice-sounding" ineffective initiatives while the epidemic carries on.

Highlights

Mr Pholokgolo Ramothwala delivered the Nkosi Johnson memorial lecture. In a moving speech, he emphasised that HIV sufferers



Bernard Mutsago and Dr Lindi Shange

must no longer regard HIV-positivity as a death sentence. He pointed out the sad reality of people stopping their antiretroviral (ARV) or TB treatment due to stigma and fear. He also shared two critical opinions: firstly, that it takes HIV-positive people, and not healthcare workers such as doctors, to effectively influence others to adhere to treatment. Secondly, Mr Ramothwala stressed that HIV researchers and programmes must be human-centred and must engage communities, in order to understand the real needs of HIV sufferers.

Steve Letsike, deputy chairperson of the SA National Aids Council (SANAC), announced that SANAC had finally launched a national lesbian, gay, bisexual, trans and/or intersex (LGBTI) HIV plan the previous day. This development, the first of its kind in the world, was hailed as a promising arrow in the quiver of the battle against HIV in the high-risk LGBTI community. However, a curious feature of the presentations by Steve Letsike and the



Silent protest against SANAC

Deputy President of SA, Cyril Ramaphosa, was an indoor silent protest against SANAC. Protesters distributed flyers and held placards reading "shame on you SANAC". Five disgruntled civil society organisations, including Section 27, warned that they might withdraw from SANAC.

In a related discussion, it was noted that pre-exposure prophylaxis (PreP) has been rolled out in SA at specific sites, and the first implementation was among the LGBTI community, in April. This is a huge milestone given the significant size of the LGBTI and sex-worker communities in SA. The National Strategic Plan of SA limits PreP only to demonstration projects.

Another key theme of the conference was the emphasis on prevention. The Minister of Health, Dr Aaron Motsoaledi, among other presenters, recorded that as a nation we will not manage to treat ourselves out of the HIV epidemic: a prevention revolution is needed, as treating everyone will not eliminate new infections.

The presentations on TB outlined the TB challenges in the country and the chilling fact that SA remains high on the global list of 22 high-burden countries for TB. SA is within the BRICS bloc of countries (Brazil, Russia India, China, and SA) where 60% of all drug-resistant (M-DR TB) TB in the world is found. The TB/HIV co-infection rate in SA is high at 60 - 70%, while the treatment success rates for remain low, with M-DR TB at 55%, extreme drug-resistant (X-DR TB) 27%, and pre-X-DR TB 38%. Experts also pointed out that SA is under-reporting on TB when compared with WHO statistics, more so for M-DR TB.

Another key development was the launch of the Department of Basic Education's new policy on HIV, STIs, and TB during the conference. The comprehensive policy, which allows condom distribution to learners and makes sexual education compulsory, among other features, is aimed at equipping teachers with new ways of imparting knowledge on STIs, HIV/Aids and TB to learners. Although there was widespread discomfort on the policy during and after the conference, especially

among parents as well as religious and cultural groups, the department defended the policy, citing the high pregnancy rate among learners, and the fact that children represent 16% of all new TB cases in the country, while 25% of children with TB are HIV-positive. The department also argued that the HIV and AIDS Life Skills Educational Programme has been in existence in the country since 2000. With 58 000 teachers currently estimated to be HIV positive, the policy is also aimed at stemming the HIV/AIDS tide among teachers. The launch of this policy makes SA the first country in the world to implement an education-sector-specific policy on HIV/AIDS and TB.

Turning to the role of men in the HIV battle, the conference highlighted that, to attain the 90-90-90 target, we need to get men on board. Interventions to be targeted at men to break the high transmission include: getting more men tested and treated for HIV and TB; getting more men circumcised; and convincing men to stop gender-based violence. In his speech at the close of the conference, Dr Aaron Motsoaledi noted that men were generally unhealthier than women, have shorter life expectancy, have a greater prevalence of TB (much of which is untreated) and have lower rates of testing for HIV.

Alcohol came into sharp focus as a driver of the HIV epidemic. In one of the session presentations, a clear relationship between HIV infection and alcohol abuse was demonstrated, with calls for the integration of the alcohol policy with HIV/AIDS policy, for holistic management of these problems. In his presentation on the role of alcohol in HIV, Dr Shuper (Centre for Addiction and Mental Health, Canada) noted that alcohol doubles HIV risk, including via condom-less sex. Alcohol has a mediating effect at the levels of HIV acquisition, treatment (especially ART non-adherence) and prevention.

Another important discussion centred around the ongoing move to ensure that SA Police Services (SAPS) provide a service that is non-marginalising and non-judgemental to LGBTIs, sex workers and people who use drugs. SAPS members need to acquire relevant skills and knowledge in order to manage challenging situations that involve these vulnerable groups.

Promises and worries

The conference presentations and dialogue highlighted the potential of two of the most potent weapons at our disposal: the power of science, and the power of technological

innovation in the fight against HIV/AIDS and TB. Each successive SA AIDS conference holds promise for the announcement of a new HIV vaccine. As we come close to the discovery of the much-awaited HIV vaccine, delegates delightedly heard of two efficacy trials underway in Southern Africa, including one trial in SA.

The immense power of technology was highlighted during the conference. For example, technological-based HIV messaging and social-media programmes such as "Buddy Beat TB" and "Better Off Knowing" were applauded as holding promise for reaching out to younger generations.

As with any contentious issue such as HIV/AIDS, deliberations were not short of expressions of worry. Perhaps one of foremost concerns was the acknowledgement that the HIV-transmission dynamics are not fully understood at a national level. On the other hand, while PreP holds much promise in the high-risk LGBTI and sex worker communities, the worry about people on PreP neglecting condom use is already confirmed among young boys and girls (the "boomerang effect"). Relatedly, the youth complained that parents and health workers withhold sexuality information and services (e.g. contraceptives) from them.

The UNAIDS presenter expressed concern about the SA ARV-rollout programme, noting that for SA to put every HIV-positive patient on treatment is going to be very costly, in view of slow national growth, recession and dwindling global HIV funding.

Another concern is the mounting threat of drug resistance. Delegates noted that ARV-treatment will decrease HIV incidence, but the M-DR TB patients will remain a stable source of new infections. The battle is to close the tap of new infections. According to Dr Dvora Joseph Davey (Broadreach), it has been observed that the benefit of and treatment of ARV therapy is dependent on patients being retained in care, and followed up regularly. Early active follow-up of patients missing appointments reduces the proportion of patients classified as lost to follow up.

This was an aptly themed AIDS conference that achieved much in deliberations and outcomes. Indeed, the walk to HIV prevention has been long and painful. It is not certain how far we still have to walk; however, the promising scientific acceleration towards a vaccine, the commitment to mounting a prevention revolution, the resolve to annihilate stigma and the use of a social-determinants-of-disease approach have provided much inspiration.

Dr Anastasia Rossouw nominated for regional achiever's award

SAMA Communications Department

Dr Anastasia Rossouw, vice-chair of SAMA Border Coastal branch, has been nominated as a finalist in this year's Businesswomen's Association of SA Regional Business Achievers Award.

The Businesswomen's Association of SA is a platform which inspires and empowers women through building strategic relationships with leading experts in a particular field, through various networking opportunities. It also facilitates personal development through a mentorship programme and a bursary programme, while providing a platform for promoting one's business through various entrepreneurial workshops.

Each year the association celebrates the contribution and achievements made by women across various categories. Dr Rossouw is a finalist in the Women in Government category, celebrating the contribution she has made, and achievements she has attained, in improving healthcare services in the Eastern Cape.

"I am extremely honoured to be among the several women nominated for this award. It's a great achievement to be named as a finalist, and I am certainly very proud that the work we are doing is being recognised in this way," says Dr Rossouw.

Currently Dr Rossouw is a specialist neurologist at Frere Hospital in the Eastern Cape. She says the investment in the establishment of neurological services at the hospital over the past 3 years has yielded the desired results.

"We have achieved, among other things, improved patient outcomes and greater responsiveness to burden of disease with a 20% reduction in stroke death rates among an average of 1 350 strokes seen annually. This is also in line with the hospital's strategic focus to deliver patient-centred care to our patients," Dr Rossouw says.

Upon completion of her undergraduate degree at Stellenbosch University in 2004,

Dr Rossouw continued her internship at Addington Hospital in KwaZulu-Natal.

"It is here that my love and passion for the field of neurology was ignited. In 2007, I was accepted into the registrar training programme at Tygerberg Hospital, and here I further developed my interests into stroke medicine," she explains.

In January 2014, Dr Rossouw was appointed as the only specialist neurologist at a tertiary-level care facility in East London, becoming the first neurologist at the institution in more than 30 years. Here she provides neurological services to the central and eastern parts of the province. "The first order of business was to establish a Neurology Department at both Frere and Cecelia Makiwane Hospitals focusing on the common neurological disorders that contributed to the highest burden of disease, namely stroke, epilepsy and complications associated with HIV infection," she says.

Dr Rossouw is married with three children.

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AMCSA medicine congress a huge success

Dr Jacobus van Niekerk, AAMSSA president

This year saw another very successful Aesthetic Medicine Congress of SA (AMCSA) event at the Council for Scientific and Industrial Research (CSIR) in Pretoria, from 4 - 6 May 2017. This was the 11th AMCSA in a row.

The field of aesthetic medicine is a growing one, with new doctors joining the congress every year.

On 4 May, 30 new and/or interested doctors attended an introductory course, while an advanced course ran concurrently.

This year's congress was labelled the "most practical congress", deploying experts and key opinion leaders from SA, and a few from abroad. It has been internationally agreed on several platforms that SA injectors do not have to stand back for international ones, and that was our thinking in deploying more South Africans, rather than inviting expensive speakers from overseas.

The feedback from the trade was remarkably positive, and we are seeing new and exciting progress in the field of aesthetic medicine, whether from new registrations for companies gaining aesthetic use or new lights, lasers and devices.

We live in the age of an ageing population, but also one that is more tech savvy, even well into retirement. People see celebrities such as actors and politicians who only seem

to improve with age. People are now better informed than they were just a few years ago, and the evidence-based medicine coming forward in aesthetic and anti-ageing medicine is simply astounding.

We advocate that doctors remain practising evidence-based medicine within their scope of practice. More and more training opportunities are becoming available.

The Aesthetic and Anti-Ageing Medicine Society of SA (AAMSSA) is a SAMA-affiliated organisation that works very closely with the Foundation for Professional Development, who endorse the two-year Advanced Diploma of Aesthetic Medicine (ADAM), and we trust that the HPCSA will soon recognise this training.

AAMSSA also endorses AMCSA on a yearly basis, and sees it as the society's representative congress.

Aesthetic medicine remains a draw for doctors in this field to remain loyal and stay to practise in SA, rather than emigrate to greener pastures. We believe that it can be used to incentivise doctors to remain, but need the HPCSA to recognise our training.

For those who would like to join our society, our website address is www.aestheticdoctors.co.za. We only promote qualified doctors who belong to our society – those with a sound knowledge of aesthetic medicine are



full members, and newly joined doctors are full members, and newly joined doctors are associate members until such time as they have sufficient knowledge and experience to become full members. We also self-regulate in the industry by taking to task rogue traders, injectors and even the odd practitioner not qualified as a doctor, to prevent the delivery of services that may negatively impact the public.

Next year the congress will again be hosted at the CSIR from 10 - 12 May 2018. We invite all doctors who have an interest in aesthetic medicine to mark it on their calendars and to join us next year for this exciting event.

If interested, please follow us on www.aesthmed.co.za, www.aestheticdoctors.co.za and www.foundation.co.za.

Medical Doctors' Coding Manual – workshops

SAMA Private Practice Department

SAMA has identified the need for procedural coding training in the private sector and medical scheme industry. The Medical Doctors' Coding Manual (MDCM) training workshops will be held at the indicated venues below.

It is vital to understand coding when rendering accounts to third-party payers, as well as during the assessment of claims, as incorrect coding has great financial impact on doctors in the private sector.

The workshops will start off with "Coding 101", which provides basic training in the use and interpretation of the rules and modifiers applicable to the coding structure. Time will

also be allocated to informal discussions of general problems experienced by coders.

Training will take place over 2 days at the indicated venue. Requests for training in other centres will be considered (if we get a request for other places, there must be a minimum of 15 attendees). Included in the registration fee of ZAR2 999 per person (including VAT) is the 2016 MDCM book, training manual, attendance certificate and a light lunch (please indicate dietary requirements).

The target audiences for these workshops are:

- Doctors' staff
- Practice managers

- Bureaus
- Medical schemes.

The following dates are available for people who wish to attend (subject to change):

2 - 3 August 2017 – SAMA head office, Pretoria
6 - 7 September 2017 – SAMA head office, Pretoria.

Payment to be confirmed a week prior the workshop to secure your booking. For an invoice, please email us the company details, including the VAT number. Should you have any queries, please contact the SAMA Coding Unit on coding@samedical.org, or 012 481 2073.



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Time since death for general practitioners

Dr Ryan Blumenthal

GPs may be summoned to a scene of death and be required to determine "time since death" for medico-legal purposes. This article is intended to make the GP more comfortable in these scenarios. Diagnosing how long someone has been dead may have far-reaching medico-legal consequences.

In 1834, the first working vapor-compression refrigeration system was built. The first commercial ice-making machine was invented in 1854. In 1913, refrigerators for home use were invented. This theoretically means that a body may be refrigerated and dumped at a later date. The advent of refrigeration, therefore, theoretically nullifies the entire field of "time since death". However, notwithstanding refrigeration, a good theoretical approach to "time since death" is advised. A brief overview will be given.

This is the domain of the forensic specialist, and there is extensive literature on this subject. However, it still remains difficult!

Indications of death

This article does not look at the diagnosis of death *per se*, as this is a topic in and of itself. The indications of death are, however, the following:

- Unconsciousness and loss of all reflexes occurs, and there is no reaction to painful stimuli. Muscular flaccidity occurs immediately upon failure of cerebral and cerebellar function. All muscle tone is lost, though muscles are physically capable of contraction for many hours after death.
- If cold water is squirted into the ears (oculocaloric testing), there are no signs of nystagmus. Make sure that there is no wax in the ears!

In addition, the following effects may be seen:

Eye signs: These include loss of corneal and light reflexes, leading to insensitive corneas and fixed, unreactive pupils. Though the iris responds to chemical stimulation for hours after somatic death, the light reflex is lost as soon as brainstem nuclei suffer ischaemic failure. The pupils usually assume a mid-dilated position, which is the relaxed neutral position of the pupillary muscle, though they may later alter, as a result of rigor mortis. There may be a marked difference in the degree of dilation of each pupil, but this has no significance as a diagnostic sign either of a brain lesion or of drug intoxication. In conditions

such as morphine poisoning, where the pupils may be contracted during life, death may allow this to persist, or the pupils may dilate to the "cadaveric position".

In addition to irregular size, the pupils may lose their circular shape after death as a result of uneven relaxation. The eye-globe tension decreases rapidly, as it depends on arterial pressure for its maintenance. The eyeball feels progressively softer within minutes, and the cornea soon loses its glistening reflectivity because of laxity and failure of lachrymal moistening. The eyelids usually close, but this is commonly incomplete, the flaccid muscles failing to produce the full occlusion that occurs in voluntary closure. Where the sclerae remain exposed, two yellow horizontal strips of desiccated discoloration appear on each side of the cornea within a few hours, becoming brown and then sometimes black, giving rise to the name "*tache noire*".

When viewed with an ophthalmoscope, the retina provides the earliest positive signs of death. This is the well-known "trucking" of blood in the retinal vessels, when loss of blood pressure allows the blood to break up into segments, similar to trucks in a railway train. This phenomenon happens all over the body, but only in the retina is it accessible to direct viewing.

Heartbeat and breathing: Cessation of the heartbeat and respiratory movements were the primary markers of death before the advent of mechanical cardiorespiratory support. Determination of cardiac arrest may be made by prolonged auscultation of the chest to exclude heart sounds though, as in life, a feeble heartbeat may be muffled by a thick chest wall or chronic obstructive airway disease. *The electrocardiograph still remains unchallenged in confirming cardiac arrest.*

Respiration is more difficult to confirm, especially in deep coma, such as in barbiturate poisoning, and prolonged listening with a stethoscope over the trachea or lung fields is necessary. All archaic procedures, such as saucers of water on the chest, feathers before the nostrils and tourniquets around the fingers are only of historical interest!

Determining time since death

Having confirmed death, the techniques used to determine "time since death" include

the examination of supravital reactions, body temperature, rigidity, lividity, potassium concentrations in vitreous, putrefaction and entomology.

Supravital reactions: Immediately after death, there exist certain supravital reactions. The intermediate period after death is the supravital period. External stimuli to the corpse may be "life-mimicking" for up to 12 - 15 hours! This is because death is a process and different cells take different times to die. Supravital reactions include:

- Tendon reaction (Zsako's phenomenon): Striking the lower third of the thigh above the patella causes upward movement of patella for 2 - 3 hours post mortem.
- Idi muscular contraction: A localised muscular contraction (bulge) occurs at the point of stimulation, such as when striking the biceps muscle with a reflex hammer. This may be observed several hours after Zsako's phenomenon. This phenomenon is worth investigating and documenting.
- Electrical excitability of skeletal muscle.
- Pharmacological excitability of the iris muscle.

Casper's rule: Johan Ludwig Casper (1796 - 1864) was a German medical examiner. This rule determines the speed ratio of decomposition of the human body in air, in water and underground (approximately 8:2:1). It is based on the dissimilar amount of oxygen in the air, water and underground.

Body temperature: This is also referred to as *algor mortis*. After death, the body cools until it reaches the temperature of its surroundings, which happens within 8 - 12 hours at the skin surface. The core of the body takes three times longer to cool. This process is affected by conduction, radiation, convection and evaporation.

This is the best estimator of time since death during the first 24 hours. It is accurate during the intermediate, pseudolinear phase of the sigmoid cooling curve. All measurements assume the body died at normal body temperature (37 °C +/- 0.4 °C)

Cooling equations also assume that the environmental temperature remained constant over the post-mortem interval. Other factors that may influence your result are body mass, movement of air, humidity,

clothing and immersion in water. Beware of hypothermia as a death mimic!

A good rule of thumb is that a temperature loss of 1°C per hour occurs during the first 24 hours. However, this is not a perfectly linear function. As mentioned, the cooling curve graph is almost sigmoid-shaped. There is an initial phase with a lag period of approximately 0.5 - 3 hours. In the intermediate phase, temperature drops linearly. In the terminal phase, this drop slows, as the core temperature approaches that of the environment.

The key to determining body temperature is to measure the "central temperature" of the body. Rectum, tympanic, endo-buccal, axilla, groin or liver temperatures may all be considered as central temperature measurements. Long rigid probes of at least 10 cm are typically used for liver and rectal temperatures. For GP purposes, there is little need to incise a wound in the region of the liver of the deceased to insert a thermometer, or to insert a 10 cm rigid thermometer probe up the rectum of the deceased either. Such invasive scientific techniques may offend the bereaved. A normal electronic tympanic thermometer in the ear should suffice!

Once you have recorded the central temperature, you should record the surrounding environmental (air) temperature. There are nomograms available that, together with the weight of the deceased, will give you a relatively accurate *time since death*. One such nomogram is Henssge's nomogram.

The Henssge nomogram is the most elaborate and easy-to-use system developed to establish time of death from body cooling, taking into account the main influencing factors (body temperature, ambient temperature and body mass). Henssge's nomogram is probably the best way to go! Henssge's nomograms may be downloaded online at http://www.rechtsmedizin.uni-bonn.de/dienstleistungen/for_Med/todeszeit.

Friedlander, a US pathologist of Kansas City University of Medicine and Biosciences, with an interest in pathology education and forensic pathology, has designed and published a time-of-death applet, which may also be accessed at his website at <http://www.pathguy.com/TimeDead.htm>. The applet is based primarily on the formulas developed by Henssge, and takes many parameters into account.

Rigidity: Rigor mortis occurs due to complex physicochemical changes in muscle proteins after death, including the conversion of muscle glycogen to lactic acid. The muscle typically contracts when the myosin shifts, but the lack of adenosine triphosphate prevents it from

detaching, and the muscle therefore remains contracted.

Rigor mortis typically begins 3 - 4 hours after death, and it is fully established within 8 - 12 hours. It then remains unchanged for 36 hours, and typically disappears within 2 - 3 days.

Nysten's law: Pierre Hubert Nysten (1771 - 1818) was a French physician and physiologist who wrote *Recherches de Physiologie et de Chimie Pathologique* (Paris, 1811). Post-mortem muscle stiffness proceeds from the head downwards (in a craniocaudal direction). Rigor mortis was first described in the literature in 1811, under what is now known as *Nysten's law*: The order in which rigor mortis occurs is face, neck, trunk, upper limbs and finally the lower limbs.

Numerous factors affect rigor mortis, such as the temperature, violent exercise prior to death, muscular development and cause of death. The concept of "cadaveric spasm" is now suspected to be a myth!

Lividity: Other terms for lividity are hypostasis, livor mortis, or plurifocal staining of the skin. Lividity is due to the gravitational settling of blood, and depends upon the posture of the corpse. It does not appear on areas exposed to pressure. It also does not appear on those who died from major bleeding.

Lividity is usually perceptible within 3 - 4 hours after death. Lividity is at its maximum at about 8 - 12 hours after death. During this period it is still "mobile". After about 12 - 15 hours it becomes "fixed". There is a lot of subjectivity involved in the determination of lividity. As a quantitative measure, it remains somewhat imprecise.

Potassium concentration in the eye: The vitreous humour undergoes relatively predictable post-mortem biochemical changes. What is more, the eye is relatively resistant to bacterial contamination after death. During life, the potassium concentration is low in the vitreous humour. After death, there is post-mortem cessation of the "pumps" in the eye, which leads to the reversal of the potassium gradient. This potassium concentration in the eye after death therefore follows a relatively predictable linear relationship.

The physician draws vitreous humour from the lateral aspect of the deceased's eye. Inject this into a clotting tube and request potassium levels from the local laboratory. Insert the potassium value into either of these two formulae, where TSD = time since death and (K) = potassium concentration in mmol/L:

- Sturner's formula: $TSD = 7.14 (K) - 39.1$
- Madeas's formula: $TSD = 5.26 (K) - 30.9$

This may be carried out up to 5 - 7 days after death.

Assuming that there are no ante-mortem electrolyte perturbations, this method is an excellent way to determine time since death. Please remember to re-inflate the eye with water after removing the vitreous humour, as a flaccid, sunken eye will cause alarm should someone view the corpse afterwards.

Signs of putrefaction: Initial decay (36 - 72 hours) = autolysis; early putrefaction/*green putrefaction* (up to 1 week post mortem); *black putrefaction* (up to 1 month post mortem); butyric fermentation (up to 2 months post mortem); dry decay then skeletonisation; mummification (typically occurs in hot, dry environments); adipocere formation (typically occurs in warm, damp environments).

Entomology: This is the domain of the experienced, full-time specialist in forensic entomology. There is faunal succession after death. Eggs, larvae and puparia are important to consider. It is a very complicated field with multiple insect species typically involved.

There may be: necrophagous species, which are invertebrates that feed on the corpse itself; predators and parasites of the necrophagous species, which do not feed directly on the corpse; omnivorous species that feed on everything; adventive or opportunistic species, which are insects that use the corpse simply as a shelter or as a nest.

All aforementioned methods are relatively inaccurate, and there is huge inter-individual variability. A lot of subjectivity is involved in these methods. Henssge's nomogram is probably the best way to go and remains the most scientific method currently in use. Vitreous potassium is also an excellent method that provides very good scientific results.

The field of thanatology (i.e. the scientific study of death and the practices associated with it) remains difficult even for the most experienced of forensic pathologists.

In practice, a combination of methods should probably be used, namely, external examination and examination of lividity, rigidity, electrical excitability of facial muscles and chemical excitability of the iris.

So, in conclusion, when you hear one of your colleagues say "Your Honour, death occurred yesterday at 5.47 pm," know that such a statement is probably unrealistic!

A list of references is available on request from the author.

2018 CCSA is now available

SAMA Medical Coding Unit, Private Practice Department

The CCSA (Complete CPT for SA) consists of the American Medical Association's *Physicians' Current Procedural Terminology* (CPT), which is a systematic listing and coding of procedures and services performed by medical practitioners. Linked to these procedures and services is the Medicare *Resource-based Relative Value Scale*, which consists of relative value units for facilities and non-facilities, as appropriate.

The 2018 eCCSA (electronic CCSA) and the CCSA books are now available for order. Please note that the implementation date for the 2018 products is 1 January 2018. The 2018 eCCSA MS Excel version is only available after signing a contract with SAMA and accepting the conditions on which it is made available.

The order forms for the 2018 CCSA products are available on the SAMA website (www.samedical.org) – click on SAMA products. All orders are placed via the website, where payments can also be made. To qualify for SAMA-member reduced pricing, please log on to the SAMA website before you place your order.

The following are the prices for the 2018 CCSA products (prices include VAT and delivery). Please note that the delivery cost

is not deducted when you collect the books personally at our offices:

2018 CCSA flat file

There are two types of contracts, namely, the multi-user and the value-added reseller (VAR) agreements. In order to obtain the CCSA flat file in Excel format, you will need to sign one of these agreements and make payment, before the file can be released. Please note that the information is only available in Excel format.

Two types of licences are available:

- Multi-user agreement – intended for internal use only, such as medical schemes
- VAR agreement – intended for entities

wishing to integrate the eCCSA into their own software product, and then sell that integrated product to their customers

Questions to answer when licences are requested:

- Which licence would you like to purchase?
- How many users will have access to the CCSA information?

Pricing depends on the number of users and also on the type of licence required.

SAMA members please direct any coding queries to our coding department on 012 481 2073, and non-SAMA members please email coding@samedical.org, and we will gladly assist you.

2016 electronic CCSA (eCCSA)	
Number of licences	Price per unit
1st licence for SAMA members	ZAR300.00
1st licence for non-SAMA members	ZAR600.00
2nd – unlimited licences	ZAR450.00
2018 CCSA book sets (volumes 1 and 2)	
Number of copies	Price per unit
1st book set for SAMA members	ZAR750.00
1st book set for non-SAMA members	ZAR1 500.00
2nd – unlimited book sets	ZAR1 500.00

UFS host emergency-care refresher course

Sarah Molefe, junior marketing officer

The University of the Free State (UFS) Department of Family Medicine, in collaboration with SAMA, the Vascular Society of Southern Africa (VASSA) and Sanlam, hosted an emergency-care refresher course at the UFS on 26 and 27 May 2017.

Prof. Nathaniel Mofolo, head of department: Family Medicine at UFS, and a member of the Senior Employed Doctors Committee, stated that it is imperative that continuing professional development courses pertaining to emergency care are held regularly. It is one of the sectors in medicine which involves highly complicated medical procedures that need to be well

comprehended and followed by emergency-care practitioners.

Some of the topics discussed were:

- Management of multiple-trauma patients
- When to stop resuscitation
- Respiratory emergencies
- Pneumonia in intubated patients
- Cardiac emergencies
- Neurological emergencies.

The course was well attended by an enthusiastic audience. Throughout the presentations there was much commentary made with regard to the latest developments within the emergency-care sector, which has led to more effective service delivery in the sector.



June du Toit (SAMA Free State branch secretary) and Prof. Nathaniel Mofolo (head of department: Family Medicine, and SEDASA member)

Incompatibility and the rationale for dismissal?

Phumzile Gwala, *industrial relations advisor*

Incompatibility comes into play when an employee is unable to work in harmony with his/her colleagues, or is unable to adapt to the "corporate culture" of the organisation. As a result of this, productivity can be affected (in a healthcare set up, incompatibility between the nursing staff and a doctor can lead to compromised patient-care management). In any workplace, the employer has a right to expect employees to adapt to the employer's norms and standards, and to conduct themselves in a manner acceptable to other employees. Incompatibility, therefore, reflects a breakdown in interpersonal relationships, which may arise from an isolated incident, unless the employee's conduct on that one occasion was totally unacceptable such that it damages the working relationship. With that in mind, one must also point out that dismissal for incompatibility is an act of last resort, and it cannot be acceptable as justified if the employee has not been counselled.

In the recent past, the courts have confirmed other grounds for dismissal in SA law, and adherence to the correct procedure may result in a fair dismissal. Section 185 of the Labour Relations Act, 66 of 1985 states that "every employee has the right not to be unfairly dismissed." For a dismissal to be fair, the employer is required to follow a fair procedure, and the dismissal must be for a fair reason (what is referred to as substantive fairness). In other words, there must exist a valid situation of incompatibility for the employer to have a reason for dismissal based on incompatibility.

Fairness of a dismissal

In terms of the law, the employer has a duty to take necessary steps to establish whether such a situation exists. For that to be achieved, the employer must:

- investigate the circumstances giving rise to the incompatibility
- advise the employee of what conduct causes the disharmony
- clarify who has been upset by his/her conduct
- give the employee a proper opportunity to put his/her version forward
- where it has been ascertained that he/she was responsible for the disharmony, suggest remedial action to remove the incompatibility
- allow the employee an opportunity to

consider the allegations and improve the situation

- warn the employee that unless the situation improves, he/she may be dismissed if the incompatibility has caused irremediable breakdown, even though dismissal of this nature should be an act of last resort.

In closing, one would like to appeal to members to guard against being incompatible. In instances where there is a clash of personalities, it is advisable that parties should arrange a meeting to iron out issues, with the intention of mending interpersonal relationships before they get out of hand.

Case law

In *Wright v St Mary's Hospital* 1992 the employee was dismissed for incompatibility after undermining authority, incitement and losing his/her temper. The court held that dismissal for incompatibility would only be fair if the employee's conduct resulted in an irretrievable breakdown in relationships. The employer is required to seek ways of reversing the incompatibility. If the employee is believed to be the cause of the problem, he/she has the right to be given a chance to resolve it. As the court was not satisfied that these principles had

been met, it ordered the employer to reinstate the employee.

In *Jabari v Telkom SA (Pty) Ltd* 2006, the employee was dismissed on the basis that his "attitude, behaviour and general personality" were incompatible with the employer's corporate culture. The court held that the onus was on the employer to prove not only that incompatibility exists, but also that the employee is substantially responsible for the disharmony. Further to that, the employer must prove that they followed the correct procedure set out above, with regard to counselling the employee and affording him/her the chance to put his/her side of the story to the employer, and to correct the disharmony, with the intention of restoring an amicable relationship. In this case, the court held that Telkom failed to discharge the onus proving the correct procedure was followed.

In the case of *Lebowa Platinum Mines Ltd v Hill* 1998, co-workers demanded the dismissal of an employee who had insulted one of his subordinates. The employees' trade union threatened the employer with industrial action if it did not dismiss the employee. Lebowa dismissed the employee on the basis of incompatibility. The Labour Appeal Court found the dismissal to be fair in the circumstances.

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 300 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 tenth of the month in order to be published in the next issue of *SAMA Insider*.

Please email contributions to:
Diane de Kock, dianed@hmpg.co.za



Who's to blame?

The Medical Protection Society shares a case report from their files

Mrs B, 40 years old, was referred by her optician to see an ophthalmologist, Dr F, because of concerns about possible raised intraocular pressure and right-sided amblyopia. Dr F confirmed the diagnosis of right-sided amblyopia, found her to have normal intraocular pressure and documented some visual field loss in both eyes, which he considered was performance-related. He advised reassessment in 6 months, but the patient did not attend for follow-up. Dr F attempted to conduct further follow-up consultations on a number of occasions, but Mrs B failed to attend.

Ten years later, Mrs B was admitted to hospital with smoke inhalation after an accidental house fire. Her only significant past medical history was a hysterectomy for menstrual disturbance some years previously. The medical consultant on call was an endocrinologist, Dr Y, and she was discharged after 2 days under his care.

A year later she was seen by consultant gastroenterologist, Dr Z, with hepatomegaly due to alcoholic hepatitis. Soon after, Mrs B was admitted under Dr Z's care after taking an overdose of chlordiazepoxide. A junior doctor commented in the notes that she had "noticed a change in her appearance" that was "interesting, but not classically like acromegaly", and recommended further investigation. Dr Z had no recollection of hearing such comments and no further investigations were carried out.

The physical changes of acromegaly are slow to develop, and the diagnosis is notoriously difficult to make

Over 3 years later, a brain MRI scan was carried out to investigate mild neurological symptoms and memory impairment following a fall. The MRI scan showed an



abnormality in the pituitary gland, and a subsequent pituitary MRI scan showed a pituitary macroadenoma measuring 1.5 cm. Mrs B was found to have a hoarse voice caused by oedematous vocal cords, and a large tongue, nose and hands. Her prolactin level was elevated and a diagnosis of acromegaly was made. Mrs B underwent uncomplicated transphenoidal surgery to remove the pituitary tumour.

Following surgery, Mrs B had numerous medical problems caused by late-stage acromegaly and other problems related to the hormonal disturbances brought on by removal of the pituitary gland. An MRI scan the following year showed no signs of tumour recurrence.

Mrs B brought a claim against Dr F, Dr Y and Dr Z, alleging that on three occasions opportunities to diagnose her pituitary tumour were missed.

Expert opinion

Most of Mrs B's medical problems were the direct effect of undiagnosed acromegaly. The acromegaly could also have contributed

to depression, consequent alcoholism and memory loss. The menstrual disturbance may have been due to the hyperprolactinaemia. Early diagnosis and treatment would have given Mrs B a substantially better quality of life.

The claimant's expert considered that Dr F, Dr Y and Dr Z had "missed opportunities" for making the diagnosis. Significantly, a consultant endocrinologist had examined Mrs B when she was admitted with smoke inhalation. The expert commented that it is not unreasonable to expect an endocrinologist to detect the clinical signs of acromegaly during a routine clinical examination.

However, experts instructed by MPS were supportive of the care provided by the doctors. The physical changes of acromegaly are slow to develop, and the diagnosis is notoriously difficult to make in the early stages. Mrs B's alcoholism could also have contributed to the changes in her facial appearance, making the acromegalic features more difficult to pick up.

MPS issued a robust defence to the allegations. Eventually, Mrs B discontinued her claim.

Lowveld CSI project: Giving vision to the visually impaired

Bokang Motlhaga, junior marketing officer

SAMA Lowveld branch, in collaboration with the SA National Council for the Blind and the Nelspruit Lions, hosted a corporate social investment project at Matsulu community hall on 10 June 2017. The branch donated 194 pairs of spectacles, and the Nelspruit Lions club donated 100 white canes to those in need. The event was attended by elderly citizens from the Matsulu community and learners from the Lowveld High School.

The proceedings included various eye tests, handing out the correct spectacles and training those who were given the white canes on how to use them effectively.

Doctors from the Lowveld came forth to assist with the eye tests and other proceedings.

In her synopsis of what SAMA is to the attendees, Dr Bongzi Baloi, SAMA Lowveld branch council member, explained SAMA as a consolidation of SA doctors who aim to deliver beyond-expectations healthcare to all South Africans.

Various speakers of the day expressed their gratitude for the co-operation and collaboration from the organisations which came on board to make the event a success. The response from the Matsulu community was very positive, and the mission for the event, "to give vision to the needy", was accomplished.



An attendee receiving a pair of spectacles from Dr Baloi (right)



Lowveld High School learners and some of the project organisers

EP branch honours members

SAMA Eastern Province branch invited current and past branch councillors to a farewell breakfast get-together to honour Dr Ron Benson and Dr Ivan Berkowitz on 13 May 2017. The breakfast was held at a recently opened game lodge called Intle (Xhosa word for "wonderful") in the Loerie area, a 40-minute drive from Port Elizabeth. Mountain ranges, wild animals, wind farms, Jeffreys Bay and the sea provided a perfect backdrop.

The morning was sunny and the company most congenial, sharing memories of the past and enjoying a wonderful breakfast. What memories, and a thank you to Dr Ron Benson for his 46 years' service to the branch as president, chairman, honorary secretary and honorary treasurer at various times.

Dr Ivan Berkowitz could not attend the breakfast, but was thanked for 18 years' service to the branch as chairman and honorary secretary. Dr Benson was presented with a gift

and Dr Berkowitz was presented with his gift at the AGM. Present were: Dr KPTabata, Dr F Khan,

Dr Olubiyi, Prof. L Pepeta and his wife Yvonne, Dr Johan Snyman and his wife Mariana.



From left to right: Dr Johan Snyman, Dr Olusola Olubiyi, Dr Ron Benson, Dr Farhaad Khan, Dr Pumela Tabata

Goldfields creates awareness

Goldfields branch recently sponsored a community-outreach awareness campaign for children with special needs, which was published in the *EntooZ* issue of April 2017.

The first article detailed the challenges faced by parents of young adults with special needs, and the urgent need for more institutions where these adults can be housed and cared for while their parents try to earn sufficient money to ensure that their future is safe and secure.

A second article provided some background to Asperger's syndrome, listing celebrities such as Robin Williams, Susan Boyle and Bill Gates who have been diagnosed with the syndrome, and suggesting books and movies to read and watch.

A heart-warming donation

The West Rand Branch of SAMA donated a large number of blankets to the Lions Club of Krugersdorp during June, one of the coldest months of the year.

The Lions Club serves various non-profit organisations that are in dire need of food, clothing and blankets. The donation was met with deep gratitude and will go a long way in assisting those in need.

Lions Clubs International is the world's largest service club organisation. Lions are selfless people from different walks of life working together to uplift the community – ordinary people doing extraordinary things.

Lions change lives by:

- Giving sight: Operation Brightsight, eye clinics, Recycle for Sight projects and guide dog sponsorships
- Assisting communities: emergency aid during disasters like the recent tornado
- Feeding the hungry: food parcels, clothing and blankets



Tracey Gurnell (West Rand Branch) handing over blankets to Sue Wernberg from Lions Krugersdorp

- Keeping the homeless warm: making and delivering Lions Snugglers to homeless people and street children
- Educating: running education and literacy projects
- Serving: mentally and physically disabled
- Promoting environmental issues: raising awareness for endangered species.

Goldfields welcomes miracle train



On 2 June, Goldfields branch welcomed the Transnet Phelophepa Health Care Train at Welkom railway station, where it assisted patients. The train brings health and hope to thousands of rural South Africans in need of access to healthcare facilities.

Known as the "miracle train", it carries professional medical staff and modern medical equipment on board to assist these communities. While the train is in the area, residents can be screened for illnesses and educated about proper healthcare. The train enables approximately 360 000 patients to receive healthcare they would not have had access to before.

SPECIAL EDUCATIONAL NEEDS AWARENESS

TWIN BOYS

ONE AUTISTIC AND ONE NOT

by Pat Kikha | Photography Supplied

In April 1997 Agnes Mtebele and her husband were blessed with twin boys, Mawongesizwe and Ngubezizwe and they completed the family. It was only after they reached two years old that Agnes who is a teacher, realised that Mawongesizwe was not achieving the verbal milestones that his twin was reaching. Agnes consulted a doctor who referred her to an Educational Psychologist, who ran various assessment tests and discovered that Mawongesizwe could not follow instructions, had no eye contact and struggled to be fed as a baby.

Before the twins were 5 years old their father had died and Agnes was left to fend for herself and her children.

Agnes took Mawongesizwe to Bloemfontein to various doctors and received the news that he was severely non-verbal autistic and would never be able to attend mainstream schools and would socialise with difficulty. Agnes was now in a quandary, although she belonged to GEMS Medical Aid, they would not cover Mawongesizwe's medication for hyper-activity, Respiratory, and this had to come out of her own pocket.

As a single mother this was extremely difficult for her. Agnes was able to enrol Mawongesizwe at Amari School in Welkom, where he achieved at his own pace for many years.

However, now Mawongesizwe is 19 years old, too old to stay in school and there is no facility in the Free State where young adults like this can perhaps enter sheltered employment or even have a boarding facility where they can live.

Always Unique Totally Interesting Sometimes Mysterious

We really need the FS government to look into building some institution where young adults with special needs can be housed and cared for while their parents try to earn sufficient money to ensure that their future is safe and secure.

Agnes is very frustrated, as she has a job which she has to keep in order to afford to keep Mawongesizwe at home in a controlled environment. His twin, Ngubezizwe, is studying Mechanical Engineering at TOSA College in Welkom, and cannot look after him during the day. Agnes is working and at the moment his older sister, Nomagwene is playing contester until she is able to get a job. She has an Honours degree in Journalism from UFS, but has been unable to find employment since she qualified.

This is the reality of having a child with special needs, especially as they reach young adulthood and maturity!

SOUTH AFRICAN MEDICAL ASSOCIATION - OFS GOLDFIELDS BRANCH

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ETHICS FOR ALL 2017

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 **JOHANNESBURG**

 **DURBAN**

 **CAPE TOWN**

Join renowned speakers from around the world as we take an in-depth look at the risks facing doctors today.

Ethics for All gives you the insight and expertise to navigate ethical dilemmas with confidence.

This year's events will examine a range of themes including breaking bad news to patients, behavioural ethics in healthcare, and the rising cost of indemnity.

THURSDAY
12
OCTOBER
PORT ELIZABETH
Thursday 12 October 2017
17.30 – 21.30 Boardwalk Hotel

SATURDAY
14
OCTOBER
JOHANNESBURG
Saturday 14 October 2017
08.30 – 13.00 The Wanderers

SUNDAY
15
OCTOBER
DURBAN
Sunday 15 October 2017
08.30 – 13.00 Southern Sun
Elangeni & Maharani Hotel

WEDNESDAY
18
OCTOBER
CAPE TOWN
Wednesday 18 October 2017
17.30 – 21.30 Cape Town
International Convention Centre

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12th BIENNIAL



Update

2017

7 – 9 September 2017

CSIR Convention Centre, Pretoria

www.ogupdate2017.co.za

For more information please contact Sonja du Plessis or Kea Poulton
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