

SAMA INSIDER

November 2017

**Depression does not
discriminate – even
doctors suffer from it**

**SA's first free
ADHD screening,
early-intervention
initiative launched**



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Diane de Kock
Editor: SAMA INSIDER

Focusing on mental health

This year, the month of October was recognised internationally as Mental Health Month, and served as a reminder of the many challenges facing sufferers.

According to the WHO, the most common mental disorders that have an impact on our ability to work productively are depression and anxiety. Over 300 million people suffer from depression around the world, and 260 million are living with anxiety disorders.

The South African Depression and Anxiety Group (SADAG) states that one in every six South Africans will suffer from a mental-health problem at some time in their lives. And yet only 27% of South Africans reporting severe mental illness receive treatment, which disturbingly means that three-quarters are not accessing any form of mental healthcare.

In this issue we chat to Dr Sindi van Zyl about her battle with depression. She believes that doctors and healthcare workers, in particular, often do not see the signs of depression in themselves – read her story on page 8.

At least 1 in 20 children suffer from ADHD, the most common psychiatric disorder in children, says Dr Renata Schoeman of the Goldilocks and The Bear Foundation. The foundation, launched in March this year, is the first to offer non-profit ADHD screening and early intervention in underserved communities, at schools. On page 15 and 16, read about how you can get involved by becoming more informed, offering assistance, donating or sponsoring this valuable initiative.

Dr Wim Beukes (page 19) delivered his presidential address at the SAMA Tygerberg branch on how to rediscover a passion for medicine. He addressed the many challenges facing young doctors and offered an inspirational perspective on tackling them.

Two psychiatrists, Dr Piotrowski and Dr Kirimi (page 20) discussed the Mental Health Act and substance-induced psychiatric mood disorders during a CPD meeting at the Griqualand West branch. An interactive discussion ensued on how to treat issues that arise from clinical-practice work.

The overriding message has to be that it is time to break the silence by raising awareness in the workplace of the symptoms and treatment of mental disorders, and addressing the stigma surrounding them through continuing education and communication.

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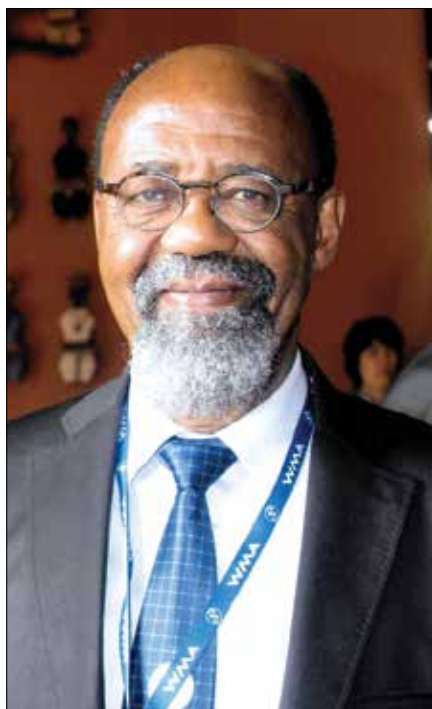
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A farewell and a tribute to SAMA

Prof. Dan Ncayiyana, SAMA president



Prof. Dan Ncayiyana, SAMA president

With my reign as president of SAMA coming to an end in November 2017, this is my last contribution to the *SAMA Insider* column "From the President's Desk". I am truly honoured to have been elected to this position a little over a year ago, and I am thankful for the opportunity the office afforded me to gain insight into the inner workings of the medical association from within. To borrow from the US vernacular, it's been a blast.

Doctors often ask: what does SAMA actually do? What is my membership worth to me? A lot, as I discovered during my tenure as president, and I will endeavour to share some of what I have learnt in this column.

SAMA head office in Pretoria is a hive of activity. I have been astonished at the level of energy and effort quietly and yet competently exerted by SAMA staff in providing the administrative wherewithal to serve the membership and promote the interests of the profession for the benefit of society at large. The real workhorses at the coalface are SAMA members who volunteer their precious time to serve in a kaleidoscope of structures, including councils, committees and various task teams dealing with practice issues and

challenges; trade-union representation for employed doctors; human rights, law and ethics; health policy; education, science and technology as it pertains to health and medical practice; junior doctors' concerns (JUDASA), and a host of other practice-related challenges.

SAMA is regularly consulted by the National Department of Health, and the association itself proactively gets involved in health and medical policy-making in order to ensure that such policies are in the best interests of the doctors and the patients they serve. The association keeps close tabs on health legislation, and is a frequent participant in parliamentary health-portfolio committee meetings, to help shape or at least influence health legislation. SAMA pursues generic grievances of the membership with the powers that be, including litigation when necessary.

SAMA maintains an influential partnership with medical associations in Africa and around the world. It is highly regarded as a member of the WMA, and is often mandated to conduct research on specific topics in order to generate working documents for the agenda of the WMA annual General Assembly. In turn, SAMA ensures that WMA decisions are disseminated here at home. For instance, SAMA is currently researching the Hippocratic Oaths at various medical schools in the country, with a view to formulating a common and more contemporary version that reflects the ethos of the well-known WMA 1947 Declaration of Geneva, as amended, to be recommended for use by all medical schools in the country. Bioethics has undergone significant evolution over the decades. For example, whereas the original Hippocratic Oath was rooted in medical paternalism, medical bioethics has evolved to place patient autonomy at the centre of the doctor-patient relationship. This and other advances need to be reflected in the modern-day oath.

SAMA also provides more tangible benefits, directly or through its subsidiaries. Its publishing arm, the Health and Medical Publishing Group (HMPG), generates a stable of publications, chief among which is the *South African Medical Journal*, but also a number of specialist journals in both print

and electronic versions, such as the *South African Journal of Bioethics and Law*. HMPG also publishes the popular *South African Medicines Formulary*.

SAMA facilitates medical-liability insurance coverage for doctors, and has served for many years as a conduit for indemnity with the Medical Protection Society. SAMA has been invited to make a submission to the commission investigating medicolegal claims of the South African Law Reform Commission.

The Foundation for Professional Development, better known as the FPD, has a long reach right across much of southern Africa. FPD is a multipronged entity, but its activities include three clusters: special projects on issues such as conferencing, gender violence and HIV; an academic cluster that includes a business school and a school of health science with over 38 000 registered students; and a technical-assistance cluster focused particularly on programmes that strengthen health systems. FPD is big on community outreach. Its HIV-testing programme has covered more than a million people, and its ART programme involves over half a million patients. FPD is also a great source of CPD points through its courses and conferences.

SAMA draws its strength and mandate from the support and loyalty of its membership, currently at 14 000 practitioners. Regrettably, there are thousands of eligible medical doctors who do not yet belong, even though they regularly (if unknowingly) benefit from SAMA advocacy and representations to government and to regulatory bodies in the public domain. Advocacy and representation has never been more critical than at the present time, when the healthcare system stands on the threshold of unprecedented disruption with the impending implementation of the National Health Insurance.

Vocations such as law, accounting and even nursing have powerful associations that enjoy the robust support and loyalty of nearly all of their respective professionals. To conclude with another US urban idiom, a profession without a strong, single and unified representative association is fated – like the runt in a litter of piglets – to end up sucking from the hind tit.

Protecting participants in health research – riding the crest or being swept under?

Prof. Ames Dhai, director, Steve Biko Centre for Bioethics

Below is an excerpt from the director of the Steve Biko Centre for Bioethics, Prof. Ames Dhai's, inaugural lecture, delivered on 6 September 2017.



I think that when we consider the evolution of protectionism in our country for the participants of health research, we can see that we have been able, in a fundamental way, to fulfil Steve's hopes and aspirations for this group of people.

In health research, protectionism is the notion that human beings should be protected from the risks, harms and wrongs that could result from their participation in studies. I do not deny that scientific progress is essential – in fact I would like to start off by emphasising the importance of and need for scientific progress, and underscore that all dilemmas in health research hinge on this one question: How do we ensure that science progresses, while at the same time fully protect our participants' rights and dignities? This quandary is further increased when we consider the goal of health research – that of improving societal wellbeing.

Today, I will describe the evolution of protectionism in health research in our country since the 1800s. I will also highlight the role that the University of the Witwatersrand (Wits) has played as a leader in this context. When considering protectionism in research in SA, three distinct historical waves emerge, which I will categorise as weak, moderate and strong. Weak can be described as "researchers relying specifically on their own moral virtues and exercising freedom of choice on participant protections" (J D Moreno). Moderate protectionism is

the emergence of guidelines and oversight by bodies like research ethics committees (RECs). Strong protectionism is the inclusion of protectionism in jurisprudence, so that safeguarding participant welfare is entrenched in the law.

Period of weak protectionism

In SA, medical scientists were making discoveries and innovations as far back as the 1800s. Ova of bilharzia were discovered in the urine of a patient from Uitenhage by Dr John Harley in 1864. About 30 years later, in 1895, the cycle of nagana, a disease of cattle spread by a species of tsetse fly, was uncovered by Sir David Bruce of the British Royal Army Medical Corps in Zululand. Because of this, he was able to associate the disease with human sleeping sickness caused by a related parasite and transmitted by other tsetse flies. In 1912, the SA Institute for Medical Research (SAIMR) was established as a joint venture between the SA government and the Chamber of Mines, represented by the Witwatersrand Native Labour Association. Early medical research in SA was established to keep the mines in production, and not to protect the population of mineworkers against the high incidence of serious tropical diseases that they were succumbing to. The goal of medical research in SA at that time was based on narrow economic, rather than humanitarian, reasons.

As a result of rapid scientific and industrial development during the Second World War, research in many fields gained momentum in SA, especially at the University of Cape Town (UCT). In 1944, Dr Basil Schonland from Wits was requested by Gen. Jan Smuts, then Prime Minister and Minister of Defense of the country, to create the legislative basis for scientific research, and the Scientific Research Council Act No. 33 was promulgated in 1945. This act established the principle of overall government control of research, and led to the establishment of the Council for Scientific and Industrial Research (CSIR) soon thereafter. The CSIR controlled the practical administration of research in the country. Although the CSIR's

brief, while broad, did not include medicine, it established a coordinating committee (the Committee for Research in Medical Sciences) within the organisation to take medical research forward. It was this committee that established several research units, sponsored research programmes in medical schools and participated in collaborative research with institutes outside SA. The established and fully fledged universities at that time were UCT and Wits, and the Universities of Stellenbosch and Pretoria. During this period, despite the flurry of research activities, policies and laws governing medical research, the welfare of research participants was left to the sole discretion of the researchers – it was under the umbrella of the CSIR that the Wouter Basson type of research was done.

Period of moderate protectionism

1966 saw the emergence of moderate protectionism in SA, after the publication of *Ethics and Clinical Research* by Dr Henry Beecher, an emeritus professor of anaesthesiology from Harvard, in which he discussed 22 out of 50 published studies that were ethically questionable. It was Wits that took the lead in research-participants' protections. Peter Cleaton-Jones states in a publication that the Beecher paper was considered such a milestone in research ethics that 4 months after its publication, at the suggestion of Prof. John Hansen of the Department of Paediatrics at the then Baragwanath Hospital, which was situated in the racially demarcated township, Soweto, Wits formed the Committee for Research on Human Subjects (Medical), with the permission of the then vice-chancellor, Prof. Mac Crone, a psychologist by training. This could be described as the birth of protectionism for research participants in SA. Of note, no international document at this stage (neither the Nuremberg Code nor the Declaration of Helsinki of 1964) made independent research-committee oversight a requirement. The committee was the first REC in the country, in Africa and in the southern hemisphere, and probably one of the first

in the world. From the mid-1970s, other institutions in SA followed suit.

In December 1967, the historic first human heart transplant was performed in Cape Town, SA. Although it is unclear how much research preceded this procedure, there is no doubt that the operation was done in a research setting, and it had far-reaching impact. While most people around the world showered praise on SA, there were murmurs, although somewhat muffled, that research could have been better channeled in other directions towards the greater good for a greater number of South Africans, and that the research was only possible because of SA's oppressive apartheid policies. It must be noted that the wave of protectionism started by Wits had not as yet spread to UCT, where researchers still functioned under freedom of choice when it came to protecting their research participants. However, Barnard's heart transplant was undoubtedly a major medical achievement. It also underscored the need for order in the organisation of medical research in the country. The need for this order led to the enacting of the Medical Research Act (No. 19 of 1969), and the establishment of the SA Medical Research Council (SAMRC) in 1969. Its most important mandate was promoting the improvement of health and quality of life of the people in SA through research, development and technology transfer. The SAMRC was funded solely by an annual government grant. It was to co-ordinate medical research within the country and to determine the distribution of government funding for such research.

In 1978, almost a decade after the establishment of the SAMRC, its then-vice president, de V Lochner, following a visit to the WHO in Geneva, wrote out the first set of guidelines for participant protections in research at a national level in SA. The guidelines emphasised in the introduction that it was of paramount importance for any ethical code relating to medical research to err in the "direction of stringency rather than laxity, and no man should find himself in the position of solely being judge of his own morals in research" – on the face of it, a move away from the weak wave. The guidelines underscored the fact that safeguarding the rights and welfare of human subjects involved in activities supported by grants or contracts from the SAMRC was of paramount importance, and that the responsibility for this was to be borne by the investigator, the heads of departments and the institutions

concerned. The guidelines further stated that it was the policy of the SAMRC that no grant or contract for an activity involving human subjects would be made without prior review and approval of the application by an appropriate "institutional committee" acceptable to the SAMRC. Paradoxically, substantial emphasis was placed on the law, and it was stressed that particularly relevant to the decision of the committee were those rights of the subject that were defined by the law. The committee was advised to familiarise itself with those statutes and common-law precedents that could have a bearing on its decisions. It was further stated that: "The provision of this Code may not be construed in any manner or sense that would abrogate, supersede, or moderate more restrictive applicable law or precedential legal decisions."

Furthermore, in its Statement of Principles, it was affirmed that institutions should each adopt a statement of principles that would assist in their discharge of responsibilities for the protection of rights and welfare of subjects. It went on to state that: "This official guide of the SAMRC may be used as a guideline for such a statement, and care should be exercised to ensure that the principles outlined in the said statement do not supersede SAMRC policy or any legal rule."

It was ironic that for the safeguarding of rights and dignities of participants, such importance was placed on the law, especially as this was in the context of the apartheid era, where the majority in the country was oppressed and their rights legally trampled upon.

For example, on the issue of minors, it stated that the position was complicated where black Africans were concerned. Most women classified "Bantu" were usually in the position of minors, and fell under the guardianship of their father or head of the kraal if unmarried, and of their husband if married. The guardianship of a "Bantu" child was difficult to establish, as SA law and the state-imposed Bantu law were in conflict on that point. A customary union was not recognised as a lawful marriage according to SA law. This created uncertainty as to whose consent would have to be obtained for a child born in a customary union. It is remarkable that the SAMRC placed such importance on the laws, especially considering there were two sets. Bantu law applied to indigenous black South Africans, who clearly were not acknowledged as being on par with others in the country. They were considered a lesser

form of life, subhuman, with little or no moral status or human dignity, and hence did not qualify to benefit from the protections offered by SA law. In the revised guidelines in 1987, "Bantu" was replaced with "Black", and the situation with regard to black children born of a customary union was also clarified. According to indigenous law, consent had to be given by both the father and the head of the kraal. Where the child was illegitimate, consent had to be given by the mother and her legal guardian. The code went on to state that these stipulations were valid only where the researcher and subject were both black. Where the researcher was not black, the ordinary principles of SA law were valid, and the legal incompetence of black women according to traditional law did not apply. It is highly likely that these discriminatory distinctions between professionals created many tensions, conflicts and even confusion. It is clear that the SAMRC was selectively protective of the country's minority, and this wave of moderate protectionism did not fully extend to all enrolled in its research.

With the promise of transition from apartheid to democracy just around the corner, the early 1990s in SA witnessed a flurry of activities towards change in laws and policies to take into consideration the rights and dignity of all South Africans. In the context of research, the Medical Research Act (No. 19 of 1969) was replaced by the Medical Research Council Act (No. 58 of 1991), and the guidelines were further amended and replaced by *Guidelines on Ethics for Medical Research – Revised Edition, 1993*. Of note is that this set of guidelines made no reference to separate laws for black population groups, as had been the case in the previous guidelines. The guidelines and laws referred to in this document applied to all South Africans equally, irrespective of colour. This is probably because SA was on the brink of liberation and a democratic government.

Period of strong protectionism

With the advent of our democracy, it is without doubt that the Constitution of SA elevated protections for research participants from risks, harms and wrongs to the supreme law of the land – hence 1996 being the dawn of the period of strong protectionism in our country. A wide search internationally indicates that SA is almost the only country that includes informed consent for research in its Constitution. While the Bill of Rights,

the cornerstone of our democracy, makes specific reference to research in section 12(2), by affirming that everyone has the right to bodily and psychological integrity, including *inter alia* the right not to be subjected to medical or scientific experiments without their informed consent, several other sections confer protections in research – e.g. equality (9), human dignity (10), life (11) and privacy (14).

These Constitutional promises have been realised in the National Health Act (NHA, No. 61 of 2003). For the first time in the history of SA, protections for all participants in research were made mandatory by statutory law in 2003; hence strong protectionism is mandated by legislation as well. Health research in terms of section 1 of the NHA includes: "Any research which contributes to the knowledge of –

- (a) the biological, clinical, psychological or social processes in human beings;
- (b) improved methods for the provision of health services;
- (c) human pathology;
- (d) the causes of disease;
- (e) the effects of the environment on the human body;
- (f) the development of new applications of pharmaceuticals, medicines and related substances; and
- (g) the development of new applications of health technology."

This definition is quite broad and covers a wide range of research activities, which, in terms of section 73 of the act, will need to be reviewed by health-research ethics committees, which are registered with the National Health Research Ethics Council (NHREC). Section 71 of the act affirms that written consent from a research participant is requisite prior to involvement in health research. This section also includes special safeguards for minors (anyone <18 years of age). The establishment of the NHREC is provided for in section 72 of the act. One function of the NHREC is determining guidelines for the functioning of health RECs that all RECs and researchers in our country need to abide by. Compliance of RECs is established at the time of audit, and soon to be accredited by the NHREC. Currently, there are more than 40 RECs registered with the NHREC. Wits has continued to play a leadership role at this level too. Prof. Cleaton-Jones and I were on the interim NHREC when the rules, policies and first set of guidelines were determined. I followed on with two terms as deputy chair

of the council, and currently we have two members from our faculty, Drs Norma Tsotsi and Jillian Gardner, on the NHREC.

Wits has in the meantime continued to be at the crest of the wave in taking the global lead in participant protections, and in 2013 established the Biobanks Ethics Committee to review biobank applications and to safeguard our participants against biopiracy – a step 2 years in advance of this being a requirement by the NHREC, and 3 years in advance of the mandate from the WMA in its Declaration of Taipei on human data and biobanks.

Is being on the crest of the wave under threat?

Having reached the crest of the wave towards realising Steve's more human face for our research participants, where are we now? There are legitimate concerns that research-participant protections could be under threat. Because of the pressures within universities to increase numbers of postgraduate students and amount of research output, and because of the research requirement for registration with the HPCSA as a clinical specialist, the general trend is that of increasing numbers of ethics applications being submitted to the RECs – hence an increase in the workload of Health RECs (HRECs). Unfortunately, in many institutions, there has not been a parallel increase in support for REC functioning.

Looking at some figures from Wits HREC (Medical (M)), we can see that there was a doubling of applications to the committee between 2003 and 2015. However, approvals at first evaluation almost halved. This has increased the workload on the HREC (M) and its secretariat even further.

So, how should we respond, given the current stringent financial realities of

SA universities and the limitations on the functioning of RECs?

Once again, Wits is taking the lead, as a decision has been taken to employ a full-time REC chair. This would be a first in the country. Members of RECs, including the chair, juggle their responsibilities to students, research and REC work. A fulltime chair would not be constrained by these duties, and would have enough time to guide members and researchers appropriately. However, this will not be enough. RECs and researchers will need to be creative about how best to address the situation. There may be a need to increase the number of RECs within institutions, and establish subcommittees to assist the chair with post-approval responsibilities. Researchers would need to include ethical principles in their research methodology in order to improve the quality of their applications, so that approval at first review could be increased and REC workload reduced. I am confident that the Wits Faculty of Health Sciences will remain at the crest of the wave of protectionism. However, I do have concerns that remaining on the crest of the wave of protectionism could well be threatened in our country as RECs grapple with coping, and hence strong protectionism could be reduced to just an exercise on paper.

Our country has long been criticised for having highly laudable laws, but which remain dormant on paper without being implemented. This is not the case currently when it comes to protecting research participants in health studies. I end my inaugural lecture by stating that we must continue upholding the human face of our research participants – being swept under the crest is not an alternative that we will be able to live with. Collectively, let's continue defending our Constitutional promises to our research participants.

Prof. Ames Dhai

Prof. Dhai, a member of the SAMA National Council and board of directors, is the director of the Steve Biko Centre for Bioethics at the Faculty of Health Sciences, University of the Witwatersrand. The centre, which she established in 2007, is committed to the values of justice, dignity, respect and freedom, both intellectual and academic, and runs Honours, Master's and PhD programmes in Bioethics and Health Law. Prof. Dhai serves regularly as a consultant/expert advisor for the World Health Organization (WHO), and is on the WHO's African Advisory Committee for Health Research and Development. She served on the (WMA) Working Group on Health Databases and Biobanks, where she was involved in developing international policy. Prof. Dhai is an ethicist of international standing who can be credited with entrenching bioethics as an integral aspect of health sciences in SA. She began her career as a medical doctor, specialised in obstetrics and gynaecology, and then went on to graduate with a Master's in Law and Ethics, and a PhD in Bioethics and Health Law.

Depression does not discriminate – even doctors suffer from it

SAMA Communications Department

Dr Sindisiwe van Zyl is a bubbly 41-year-old mother. A GP with a special interest in HIV treatment, this energetic doctor seems to have it all. But beneath the surface, Dr Sindi has a sad past, which she says she is slowly coming to terms with.

“Doctors and healthcare workers don’t necessarily see the signs of depression in themselves”

Four years ago, in April 2013, Dr Sindi was officially diagnosed with depression.

“I guess it was something I’d always lived with, but in that year a couple of different events culminated in me needing to be hospitalised, officially, for depression,” she says. In February that year, her boss was relieved

of her duties, and Dr Sindi was promoted to a manager’s position. In the same week she and her husband moved to a new house.

“Everything started unravelling, and it all just became too much for me to handle. Many patients with mental-health issues can trace back to a specific point where this happens. For me, these two events collided and I needed to go to hospital.”

In a recent article in *HIV Nursing Matters*, she described her condition as being in a dark and helpless place.

“I felt as if I was standing at the bottom of the ocean on a sunny day. I could see the sunlight streaming into the ocean, I knew that light and life were up there, but I had no will to kick myself off the bottom. I wanted to, but I just couldn’t do it,” she relates.

But then Dr Sindi got help. She was in therapy for 3 years, which has helped her deal more effectively with her condition. Through cognitive behavioural therapy, she’s been able to stop medication, and learnt to deal with problems through reasoning. There are still, she says, certain triggers, but she has learnt to cope with these more and more.

So, why is this important?

As a doctor, a healthcare worker, Dr Sindi says she hasn’t experienced any stigma from colleagues or peers about her condition. This, she maintains, is because she’s been brutally honest about her situation.

But, she says, other doctors and healthcare workers don’t necessarily see the signs of depression in themselves, which can have knock-on side-effects for their patients.

“A lot of doctors self-treat, which is fine for certain ailments and conditions. But, when it comes to mental-health issues, you cannot do this. It is vital to get outside help, and accept that we are sometimes also patients. We are human beings first, doctors second, and that realisation is extremely important to our own wellbeing.”

And, unfortunately, she says, many doctors are in denial about their own mental health.

“There’s this belief that doctors can’t ever get sick, or have mental illnesses. We have to move away from this because it’s a barrier that can cause damage to the doctor, and everyone he or she comes into contact with. I have crossed that barrier, but many of our colleagues have not,” she asserts.

“It is vital to get outside help, and accept that we are sometimes also patients”

For Dr Sindi van Zyl, life at the moment is good. She says she is looking after herself first, and that this makes a difference for everyone in her life. She is rebuilding relationships neglected due to her illness, especially with her friends and family. “It’s a long process, a slow process, but we are getting there. My message to other doctors and healthcare workers is simple – don’t run away from mental-health issues. Instead, if you believe there is something wrong, get help, and get better.”



Dr Sindi van Zyl

SAMA PhD scholarship supports genomic and biomarker analysis

Dr Cordelia M Kgokolo



The SAMA PhD scholarship has provided valuable financial support to the project entitled “Genomic and biomarker analysis in Xeroderma pigmentosum in South Africa”.

Xeroderma pigmentosum (XP) is a rare autosomal recessive disorder with diverse clinical manifestations, including DNA-repair defects that cause severe sensitivity to ultraviolet light, resulting in sun-induced skin and mucous-membrane cancers developing at an early age. The clinical symptoms and severity of the disease vary across the seven

XP complementation groups. These groups, XPA to XPG, are all the result of pathogenic mutations in genes in the nucleotide excision-repair pathway and an XP variant that results from a mutation in translesion synthesis, POLH.

The complementation groups, genetics and biomarkers of XP have not previously been systematically studied in SA.

The aims of the project are to:

- Identify molecular genetic mutations in the total cohort, and in families of the SA XP population. The genetic and clinical investigations entail the assembling and phenotyping of all SA patients with XP.
- Analyse the biomarkers for oxidative DNA damage and cancer risk in the SA XP population. The evaluation of oxidative DNA adduct (8-hydroxy-2 deoxyguanosine (8-OHdG)) is important for a better understanding of the pathogenesis of disease processes. Apart from genetic configuration, environmental and lifestyle factors and poor oral hygiene provide a free-radical-generating environment, which may contribute to the development of cancer through DNA damage. Elevated

C-reactive protein (CRP) could also play a causal role in the pathogenesis of cancer. The levels of CRP will be measured and analysed in XP patients.

- Compare the clinical features and gene relatedness between two SA population groups (black and white). The results of this study will be valuable in addressing the identification of the novel mutations and complementation groups of the SA XP patients, which will lead to better diagnosis and management of the disease, and informed genetic counselling of affected patients. The significance of the biomarkers in XP could be demonstrated, with 8-OHdG reflecting the level of DNA oxidative damage, and the role of high-sensitivity CRP as a marker of cancer risk in XP patients could also be explored.

The research aspect of the project has been completed, with the publications and thesis writing outstanding.

References are available from the author on request.

The world is running out of antibiotics

World Health Organization

A report by the WHO, *Antibacterial agents in clinical development – an analysis of the antibacterial clinical development pipeline, including tuberculosis*, shows a serious lack of new antibiotics under development to combat the growing threat of antimicrobial resistance.

Most of the drugs currently in the clinical pipeline are modifications of existing classes of antibiotics, and are only short-term solutions. The report found very few potential treatment options for those antibiotic-resistant infections identified by the WHO as posing the greatest threat to health, including drug-resistant TB, which kills around 250 000 people each year.

“Antimicrobial resistance is a global health emergency that will seriously jeopardise

progress in modern medicine,” says Dr Tedros Adhanom Ghebreyesus, director general of the WHO. “There is an urgent need for more investment in research and development for antibiotic-resistant infections, including TB, otherwise we will be forced back to a time when people feared common infections and risked their lives from minor surgery.”

In addition to multidrug-resistant TB, the WHO has identified 12 classes of priority pathogens – some of them causing common infections such as pneumonia or urinary tract infections – that are increasingly resistant to existing antibiotics, and urgently in need of new treatments.

The report identifies 51 new antibiotics and biologicals in clinical development to treat priority antibiotic-resistant pathogens,

as well as TB and the sometimes deadly diarrhoeal infection *Clostridium difficile*.

Among all these candidate medicines, however, only eight are classed by the WHO as innovative treatments that will add value to the current antibiotic treatment arsenal.

There is a serious lack of treatment options for multidrug- and extensively drug-resistant *M. tuberculosis* and Gram-negative pathogens, including *Acinetobacter* and *Enterobacteriaceae* (such as *Klebsiella* and *E. coli*), which can cause severe and often deadly infections that pose a particular threat in hospitals and nursing homes.

There are also very few oral antibiotics in the pipeline, yet these are essential formulations for treating infections outside hospitals or in resource-limited settings.



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"Pharmaceutical companies and researchers must urgently focus on new antibiotics against certain types of extremely serious infections that can kill patients in a matter of days because we have no line of defence," says Dr Suzanne Hill, director of the Department of Essential Medicines at the WHO.

To counter this threat, the WHO and the Drugs for Neglected Diseases *initiative* (DNDi) set up the Global Antibiotic Research and Development Partnership (known as GARDP).

On 4 September 2017, Germany, Luxembourg, the Netherlands, SA, Switzerland and the UK and the Wellcome Trust pledged more than EUR56 million for this work.

"Research for TB is seriously underfunded, with only two new antibiotics for the treatment of drug-resistant TB having reached the market in over 70 years," says Dr Mario Raviglione, director of the WHO Global TB Programme. "If we are to end TB, more than USD800 million per year is urgently

needed to fund research for new anti-TB medicines."

New treatments alone, however, will not be sufficient to combat the threat of antimicrobial resistance. The WHO works with countries and partners to improve infection prevention and control and to foster appropriate use of existing and future antibiotics. The WHO is also developing guidance for the responsible use of antibiotics in the human, animal and agricultural sectors.

A just health system: Our common vision

Dr Gwen Ramokgopa, MEC for Health, Gauteng Provincial Government

This year the MEC for Health, Gauteng Provincial Government, Dr Gwen Ramokgopa, delivered the annual Steve Biko bioethics seminar lecture at the Steve Biko Centre for Bioethics, on the 40th anniversary of Steve Biko's death.



I am humbled to have been asked to deliver this lecture in honour of this ordinary young man who extraordinarily made a profound impact on society as an activist, an intellectual and a freedom fighter, and a martyr for justice.

As preparations to mark the 70th anniversary of the Universal Declaration of Human Rights for all peoples of the world unfold, it will also be time to reflect on how far we have gone in building on the foundation of the Millennium Development Goals and the implementation of the Sustainable Development Goals (SDGs), in particular Goal 3, which binds us to "ensure healthy lives and promote well-being for all, at all ages".

We must never forget that it would be a substantive recognition of their contributions if we together make advances, succeed and attain excellence in progress towards the ideals for justice held by those like Biko, who sacrificed all they were.

We must together commit to translating the occasional analysis paralysis into positive actions, and the proclaimed rights to into everyday reality.

Our common vision must spur us to work together as government and society, holding one another accountable towards arriving at the progressively realised justice in health.

Bantu Stephen Biko represents a generation of youth that uncompromisingly and resolutely advocated for a society that guarantees peace and democracy within the paradigm of a human-rights culture, and equality of all. This is a generation whose liberated minds refused to be imprisoned by even one of the most sophisticated architectures of modern-day slavery, the apartheid system, which was enforced by unbelievable brutality. These young people envisioned a future of freedom and a shared prosperity for all.

As you may know, Steve Biko could not complete his medical studies due to his involvement in the struggle for liberation. That this Bioethics Institute at Wits University and the academic hospital associated with the University of Pretoria are named after him, should be viewed as a recognition of both his unfulfilled dream of being a doctor himself on one hand, and on the other, a recognition that even the doctors who were duly registered medical professionals conspired with the apartheid regime and failed him.

Fellow South Africans, I have been requested to focus my lecture on "A Just Health System – Our Common Vision". I suspect the expectation is that of giving an assurance

that we are on track to ensure that we attain the ideal of a health system that represents the best of humanity, human solidarity and equity, especially after the LE [Life Esidimeni] mental-health tragedy and in the wake of the reported high costs of medical litigation.

There is now sufficient evidence that all the other SDGs have a direct and indirect impact on the health status of individuals and nations. This is not by any accident of history, but through concerted efforts of activism, scholarship and advocacy. Human civilisation has come a long way in acknowledging and institutionalising two critical aspects of justice and health.

Firstly, that health is essential for socio-economic development, as much as development is for health. Unfortunately, "Health in All Policies" has not adequately taken root in most financial and economic sectors, thus health expenditure not being sufficiently appreciated as an investment, and not an expense. Together there is a need for greater advocacy as part of the implementation of the NHI [National Health Insurance] provision on a health-promotion council in SA.

Secondly, that health is a fundamental human right, and that the goal of achieving the highest attainable standards of health is subject to progressive realisation – an ongoing commitment depending on available resources. The NHI policy, as a vehicle towards universal health coverage in SA, must be owned by the people and endeavours must be made to utilise every available resource earmarked for health in a responsible manner. Whether in the public or

the private sector, funds for health must be available whenever health is needed.

Being a global citizen, we must be proud that SA has a rich history of struggle and advocacy for equality, equity and justice in health, from the African's Claims, the Freedom Charter, the ANC Health Plan, the SA Constitution and, recently, the NDP [National Development Plan] 2030.

Through the perspective of health in all policies, and recently the multisectoral approach to fighting the HIV and AIDS epidemic, child and maternal mortalities are on the decline, death rates are decreasing and in what the UNAIDS [United Nations Programme on HIV/AIDS] referred to as an epidemiological miracle, life expectancy at birth has increased for both males and females. We are on track towards achieving the goal of life expectancy of 70 years by 2030.

With this progress made and within the global context of consensus and common vision, why then should we be concerned?

The world's development and evolution is not linear, as there is constant influence by contending forces with unequal access to scarce resources. Without being alarmist, there is a real risk of both the public and private health systems in our country not being able to meet the health needs of the population if we do not remain vigilant, as indicated by the following:

- the decline in medical-aid cover, due largely to economic hardships and market failure, poor management of the economy, poor leadership and uncontrolled commercialism of health as a public good
- the high levels of medical litigations affecting both sectors
- the decline in the budgets of public-health goods and services budgets in real terms, resulting in high accruals
- stubbornly high quadruple burden of disease in communicable, lifestyle, maternal and child [diseases], as well as trauma
- increasing levels of poverty, unemployment and inequality.

I would like to argue that while the private health sector and civil-society organisations that provide health services do this on a complementary and voluntary basis, the state is obligated to ensure that it works with society in general in ensuring that the common vision of a just health system and equity in health is not lost.

I further would like to argue that the public health system in SA, which caters for 84% of the population, remains one of the

most important assets of our democracy as citizens.

Many of us still do not understand how it was possible that the LE tragedy could happen in this day and era after so much has been achieved.

For our common vision of a just health system to remain on course:

- Enabling and responsive institutional mechanisms that empower citizens to claim their right to health must be strengthened.
- Stakeholder involvement and participation must be institutionalised – including community-based organisations, activists, scholars, youth and other sectors.
- Multisectoral approaches to tackle socioeconomic determinants have to be strengthened.
- Continuous sharpening of "human consciousness" to care, to act and to empathise without fear or favour, including the principle of zero harm [that] must characterise the healthcare system.
- Scorning of poor management, reckless use of resources and ensuring consequence management for mediocrity, ineptitude and corrupt tendencies.
- Investing in a culture of innovation and excellence, including in the use of smart technologies, data analytics, research and celebration of excellence.
- Mobilisation of society to dialogue, and tackle risk factors as we together co-design the universal health coverage (NHI) most appropriate to close the disparities of ZAR1 200 per population *vis à vis* ZAR12 000 between public and private sectors [that] cannot be sustained.

I have no doubt that all of us gathered here today embrace the global consensus of health being a fundamental human right, and universal health coverage as a translation of human solidarity for quality healthcare for all when needed, and thus for effecting this right.

I have no doubt that all of us gathered here today share the need to understand and advocate for what it takes to make real that which is a common vision towards a sustained just health system.

I have no doubt, too, that we all deeply share the need to promote scholarship, dialogue and social action, as a quest to fill the gaps between identity, agency, citizenship and social change in general, including in health.

Unlike Biko's suited oppressors, we should not allow ourselves to be left cold by the deaths of LE mental-health patients, nor the

daily plights of patients who are subjected to long waiting times in the public sector, or even those facing catastrophic health expenditures in the private sector.

Let me end by saying that the Department of Health in Gauteng belongs to the people of Gauteng. We have begun a process of strengthening the voices of staff, communities and other stakeholders as partners.

Already we have adopted recommendations of the provincial health forum that the voices of families be heard in cases of involuntary and assisted patients through a family committee. We have established an interim patient-safety and medical-litigation advisory panel to send a message of zero tolerance to medical negligence.

We have established a high-level health committee to leverage optimally technology and other modernised interventions for efficiency and improved patient experience of services, including the reduction of waiting times. Consultation with the private sector in this regard has begun, as we endeavour to establish a province-wide health-information management system.

Thomas R Oliver, editor of the *Guide to U.S. Health and Health Care Policy*, states that the startling progress in life expectancy and infant mortality for the country as a whole was offset by equally startling disparities in those same health outcomes across socioeconomic groups and geographic areas. He further quotes from Donald Scohn, a philosopher and systems analyst, in his book *Beyond the Stable State*:

- The loss of a stable state means that our society and all its institutions are in continuous processes of transformation. We cannot expect new stable states that will endure even for our lifetime.
- We must learn to understand, guide, influence and manage these transformations. We must make the capacity for understanding them integral to ourselves and to our institutions.
- We must, in other words, become adept at learning. We must become able to transform our institutions in response to changing institutions which are "learning systems", that is to say, systems capable of bringing about their own continuing transformation.

Let's together take lessons from the journey travelled so far, and root our vision towards justice in health among the people. This will bring health rights closer more quickly and in a sustained manner. The people are their own liberators; we are just at their service.

SA Drug Policy Week tackles effective drug policy

Dr Lindi Shange, SAMA Health Policy Committee



The recent SA Drug Policy Week held in Cape Town from 1 - 4 August 2017 came at the right time, as SA is struggling to manage the scourge of substance use. In this second follow-up article, I wish to continue to elaborate on the discussions that took place at this conference.

The City of Tshwane and the University of Pretoria (UP) are working together on a project called COSUP (Community-Orientated Substance-Use Project). The project was started in response to the scale and growth of substance-use disorder in Tshwane. The project is funded by the City of Tshwane and led in research and training by the Department of Family Medicine, UP. It is being implemented in collaboration with the Gauteng Department of Health, Tshwane District, and the Gauteng Department of Social Development, as well as various NGOs and UP departments where operational service delivery is already in place.

COSUP sent several delegates to participate in this conference, and many lessons were learnt with a view to implementation. COSUP, making use of a multidisciplinary team, helps people, families and communities to understand and manage substance use and its related risks.

Dr Johnny Strijdom from the Department of Social Affairs, African Union Commission, presented the common African position from the United Nations General Assembly Special Session (UNGASS) in 2016, and the probable political declaration and plan of action on the world drug problem, 2019, and the following key commitments were agreed on:

- To undertake policy and legal reforms to focus on a balanced and co-ordinated, holistic and multisectoral approach to drug control, and to adequately address drug use and drug trafficking in all its forms, including reducing the harms associated with drug use, such as increased vulnerability to HIV, and expanding health and social services for those with problematic use and their families.
- To treat drug use and drug dependence as a public-health issue, with socioeconomic causes and consequences. People who use drugs must be offered support, treatment and protection, rather than be faced with punishment and a criminal record. This includes the provision of alternatives to arrest, sentencing and incarceration.
- To offer greater support for drug-use prevention, evidence-based treatment, care and harm reduction.
- To strengthen the role of civil society in health, harm reduction and development issues.

We need a rational, scientific, sensitive, empathetic and compassionate multidisciplinary approach

The opioid-substitution therapy (OST) advocacy session reviewed existing OST programmes, and found that they were inadequate or non-existent. This session encouraged participants to advocate for increased access to OST, and for a reduction in its cost. High on the agenda was also the

need for availability of OST clinics/service sites, along with training and developing of networks of healthcare professionals to run them.

David Bayever, chairperson of the Central Drug Authority, mentioned that such a conference should help delegates to recognise the need for a dramatic shift in policy, based on the human rights of substance users, and the impact that policy can have on their ability to be reintegrated into and to become meaningful members of society.

A call was also made to apply a rational evidence-based approach to compare the harms of different drugs (including alcohol and cigarettes), and then to decide on the most appropriate and rational policy outcomes.

Following the ideas of Ethan Nadelmann, founder and former director of the Drug Policy Alliance, USA, I suggest that SAMA should try to:

- seek the opportunity to lead – are there opportunities in this country, in this region, to do productive, health-science based, human-rights driven interventions that inform policies on drugs?
- understand the potential to provide leadership, by allowing us as the membership on the ground to challenge ourselves on our own prejudices, and to understand the values of the broader communities of which we are part
- look for unique local solutions that make sense to our communities and the people we serve
- help to develop more scientific research, to guide members as to how to provide evidence-based treatments
- play a drug-policy advocacy role to make sure that these policies do not impact negatively on the people who use substances, but respect their human rights.

We need a rational, scientific, sensitive, empathetic and compassionate multidisciplinary approach. There is no one silver bullet to address all the issues. This is a complex issue that needs an integrated approach, including consulting the community of substance users – as they say, "Nothing for us, without us."

Free resources for SA doctors

SAMA Communications Department

Today we are all constantly attached to our mobile phones and computers, and depend on them to provide us with digital aids of every description. There are many apps, databases, programs, toll-free hotlines and online courses (complete with CPD accreditation) available to medical practitioners, a lot of them for free. This is the second in a series of articles on these free resources.

Medicines Information Centre hotline

The Medicines Information Centre at the University of Cape Town, in collaboration with FDP and USAID/PEPFAR, offers doctors, nurses and pharmacists the free service of a toll-free national HIV and TB healthcare-worker hotline. The service offers free clinical assistance with the treatment of HIV and TB patients. Contact 0800 212 506 or 021 406 6782, or alternatively send an SMS or "please call me" to 071 840 1572, or visit www.hivhotline.uct.ac.za. The service is available from Mondays to Fridays from 08h30 to 16h30, and is staffed by specially trained drug-information pharmacists who share

50 years of drug information experience between them.

Statin intolerance

Patients sometimes consult their doctor or clinic wondering whether their statin is the reason they have been a bit forgetful, were diagnosed with diabetes, or have had leg pain. The **American College of Cardiology's Statin Intolerance App** was released to help walk you through that clinic visit systematically. It includes the questions you should ask, and then provides an interpretation of the likelihood of actual statin intolerance, as well as making follow-up suggestions. It is available from iTunes.

CASP

There are a lot of great apps out there to help you keep up with medical literature. But even more important than just knowing the latest papers is being able to critically appraise them. The **Critical Appraisal Skills Programme (CASP)**, developed at Oxford in the 1990s, gives clinicians a systematic approach to developing that skill. While there are other apps that do this for us, such as **Journal Club**, **CASP** makes us

do the work but gives us the necessary expert tools in an easy-to-use format. It's a free tool to help hone your evidence-based medicine skills. It is available from iTunes.

Discovery Health – intern SafeTrip

The Discovery Health Vitality intern SafeTrip initiative gives young doctors a free ride – junior doctors frequently complete protracted shifts that leave them punch-drunk with fatigue in preparation for the drive home. "Late-night driving and driving when tired are related to higher rates of accidents," explains Dr Goodman, chief medical officer of Discovery Health. "Launched in March 2017, Discovery intern SafeTrip gives intern doctors the option to take a free Uber cab ride home following a long shift. "While our state healthcare sector works to implement broader solutions to challenges interns face, Discovery intern SafeTrip has provided immediate support to young doctors. Our investment in their safety ensures that the future complement of this country's healthcare professionals remains secure," he adds.

For more information, visit www.discovery.co.za.

WMA partnership provides medical education online

World Medical Association

The WMA is helping to accelerate physicians' learning, to improve healthcare standards worldwide, through its strategic partnership with the World Continuing Education Alliance (WCEA).

The WCEA is a leading global provider of specialist continuing-education platforms, which also works in partnership with the International Council of Nurses and other world associations in different sectors. This partnership will see the rollout of a system that will improve the dissemination of education to physicians worldwide through a truly global continuing-education network – the first of its kind.

"With an umbrella membership of over 10 million physicians, the WMA seeks to influence medical ethics, human rights

and equal access to medical education around the world," said Dr Otmar Kloiber, the WMA's secretary general. "Online education provides a unique opportunity to connect the top educators with physicians, improving knowledge and healthcare regardless of geographical location."

Medical professionals will benefit from being able to access increasing volumes of high-quality courses from a single online platform. This will allow them to expand their skill sets and knowledge, to continually improve patient care. In many cases these courses also count towards the legislated learning requirements imposed on professionals in order to renew their licences to practise.

As WCEA founder, Graham Hellier MBE, explains, "Educators want to educate, they

do not want to have to deal with software platforms, global licence compliance, marketing their courses and making sales-tax payments in each country where their education is sold. The WMA service makes it extremely easy for educators to take their content to the far corners of the globe, giving their knowledge and expertise a reach that was previously unattainable."

Another exciting aspect of the project, and an important consideration for the WMA when they entered into the partnership, is in providing physicians in developing nations with access to world-class education. Educators who charge for their courses are requested to allow them to be distributed to physicians in developing nations for free. The WMA initiative will therefore help to bridge the gap between high- and low-resource countries.

SA's first free ADHD screening and early-intervention initiative launched

Dr Renata Schoeman, *The Goldilocks and The Bear Foundation*

Do you remember the story of Goldilocks and the three bears from your childhood? Have you ever considered why Goldilocks got herself in such a lot of (potential) trouble? Perhaps she struggled with inattentiveness, absentmindedly wandered off into the woods, and then impulsively entered a strange house, and in her usual hyperactive way started climbing on furniture. She was lucky, but thousands of other kids aren't ...

At least one in 20 children in SA suffers from attention-deficit/hyperactivity disorder (ADHD) – the most common psychiatric disorder in children – marked by symptoms of inattentiveness, hyperactivity and impulsivity. Unfortunately, many children suffering from ADHD remain undiagnosed, or if diagnosed, do not receive optimal treatment. Access to healthcare is not a given for many South Africans. Research has indicated poor identification and treatment of common mental disorders at primary healthcare level, and limited access to specialist resources, with a service delivery and treatment gap of up to 75%. Although mental-health clinics exist in the public sector, children with ADHD often never reach this point of diagnosis and treatment due to a lack of awareness and knowledge in their communities. They are never screened for ADHD, and may be

labelled as naughty, or “stupid”, or just silently fall out of the educational system and only come to our attention when absorbed into the criminal justice system.

What is ADHD?

Since the first descriptions of ADHD, more than 10 000 clinical and scientific publications have been published on the disorder.

ADHD is best understood as a biopsychosocial condition: it is medical in origin, but is affected and influenced by the environment, and social and emotional aspects of the person and situation. However, research shows that genetic (hereditary) and neurological (such as pregnancy and birth complications, brain damage, toxins and infections) factors are the main causes of ADHD, rather than social factors (such as poor parenting and diet). ADHD is one of the most strongly genetic conditions – it runs in families, with a heritability chance of almost 60% for a child if a parent has ADHD, and a 70 - 80% chance for a twin if the other twin has ADHD. Research has demonstrated imbalances of chemical messengers (neurotransmitters such as dopamine and noradrenalin) within the brain, as well as differences in the development of self-management systems in the brains of individuals with ADHD (e.g. changes in areas of the brain responsible

for concentration, regulation, organisation, planning, time-management, decision-making, etc.).

Inattention manifests behaviourally in ADHD as difficulty in sustaining focus, wandering off from tasks, lacking persistence, paralysing procrastination, poor time management, inefficiency and being disorganised. Hyperactivity refers to excessive motor activity when it is not appropriate, or excessive fidgeting, tapping or talkativeness. Impulsivity refers to hasty actions that occur in the moment without forethought and that have high potential for harm to the individual. This may reflect reward dependence and a need for immediate gratification. Impulsive behaviours may manifest as social intrusiveness, a low frustration tolerance, mood lability and losing one's temper, making important decisions without consideration of long-term consequences, and addictive behaviours.

ADHD, if not treated, can cause significant personal, interpersonal and social burdens, impacting negatively on overall quality of life. A child with ADHD is six times more likely to have another psychiatric disorder (such as depression, anxiety, substance-abuse disorder, conduct disorder or oppositional defiant disorder) or learning disorders and self-esteem problems. Research has also



Renata (Goldilocks) and Nic (The Bear) at the Cell C AfricanX Trailrun

shown that those diagnosed with ADHD complete on average 2 years fewer of formal schooling, and attain a lesser employment status, than those without.

Can ADHD be treated?

The first evidence for the effectiveness of stimulants in the treatment of ADHD dates back to 1937, when Bradley conducted a trial with Benzedrine in children with ADHD. Since then, many studies have been conducted and established the efficacy of both stimulant and non-stimulant medications in the treatment of ADHD in children and adolescents, and more recently also in adults. Pharmacotherapy plays a primary role in the treatment of ADHD, but psychosocial interventions (psycho-education, cognitive-behavioural therapy, parental guidance, supportive coaching or assistance with daily activities) are an integral part of management.

Although some hype around the “addictiveness” of ADHD medication was created, it is fact the opposite: treating children with ADHD protects them against becoming addicts! In a 10-year follow up study of a sample of 140 boys originally aged between 6 and 17 years, 73% had received some level of treated with stimulants at some stage during childhood (some also continued this into adulthood). The researchers found no association between treatment with ADHD medication and alcohol, drug or nicotine-use disorders in later life. Other studies also clearly showed that untreated ADHD increased the risk of developing substance-abuse problems during teenage years or later life.

The Goldilocks and The Bear Foundation

The Goldilocks and The Bear Foundation (#gb4adhd) was launched in March 2017 by Cape Town-based psychiatrist, Dr Renata Schoeman, and



Goldilocks and The Bear with the ECNA crew at The Valley school

businessman and top SA athlete, Nic de Beer. The foundation (#2017/112190/08, #191-227NPO) is the first to offer non-profit ADHD screening and early intervention in underserved communities at schools. This will ensure early referral, diagnosis and treatment, and improve the quality of life of these children. The initiative aims to initially screen 500 children per month (of the estimated 200 000 in the Western Cape who currently have no access to such services), and to broaden the reach nationally. However, the Goldilocks and The Bear Foundation is not only about ADHD. “We aim to provide access to mental-health services for all children who currently do not have access to care – whether it is due to lack of awareness and knowledge, or due to services being absent in their respective areas. We therefore go to underprivileged school, create awareness about mental health and learning difficulties, train teachers and guide parents, and screen children for the presence of any issue that may impede their educational attainment and functioning. We then refer the children for the necessary services – whether it is optometrists, audiologists, educational psychologists, or to the public psychiatric services for the initiation of treatment.”

During the past 4 months, the #gb4adhd team has visited 13 schools, completed screening at 11 (providing access to services to more than 6 500 children!). It has referred more than 50 children for the treatment of ADHD, 15 for the treatment of anxiety and depression, and more than 120 for auditory

and visual support, occupational therapy, educational psychologists, and social workers. They have received very positive feedback from communities and schools, and also received widespread media coverage.

Goldilocks and The Bear need you!

Although we offer our time *pro bono*, and some kind professionals also offer services *pro bono*, we do have expenses – i.e. rent, the salaries of the nurses, travel expenses (to be able to see the children at the schools), telephone expenses (to arrange the appointments, etc.) and all the copies of the screening documents and information pamphlets. We also need to “buy in” some services (e.g. of psychologists). Most of our fundraising to date is via the running events we do, such as the 91 km Cell C AfricanX Trailrun, where we have managed to secure a podium position (and were chosen as the best-dressed team), the Paarl Rock 8-hour challenge, the Comrades and the OUTsurance/KFM Gun Run, and donations via a crowdfunding page (BackaBuddy). However, we are in need of more sustainable contributions from corporates and individuals – either in the form of sponsorships, corporate social investment (CSI) initiatives, or monthly contributions.

Please visit our website at www.gb4adhd.co.za and Facebook page, <https://www.facebook.com/gb4adhd/>. For more information, contact us at info@gb4adhd.co.za.

References are available on request.



Modern physicians' pledge approved by WMA

SAMA Communications Department

On 15 October SAMA joined thousands of physicians around the world in welcoming a modern successor to the Hippocratic Oath.

Physician leaders, meeting at the WMA's annual General Assembly in Chicago on 14 October 2017 approved revisions to the Declaration of Geneva, which was adopted by the Association in 1948.

The revised Declaration, to be called a pledge, refocuses the text to reflect changes over the decades in the relationship between physicians and their patients and between physicians themselves. As a result, the new pledge makes specific reference for the first time to respecting the autonomy of the patient, which is not included in the current text. It also includes a new obligation for respect between teachers, colleagues and students. The present Declaration says students must respect their teachers, but there is no reciprocity.

There is a new obligation on physicians to share medical knowledge for the benefit of their patients and the advancement of

healthcare. Also added is a requirement for physicians to attend to their own health, wellbeing and abilities in order to provide care of the highest standard.

The current Declaration of Geneva is used across the world by physicians. In many countries it is actually part of the medical professional code and in some it is legally binding. However, in other countries it is either not used at all or is adapted in some way.

The WMA is now expecting that the revised pledge, agreed following a two-year revision process, including a period for public consultation, will become a global ethical code for all physicians. WMA President Dr Yoshitake Yokokura said: "The new wording respects the unique character and significance of this Declaration, but focuses more on important ethical principles not in the current version and not expressed explicitly.

"The life of physicians today is completely different to what it was in 1948 when the original Declaration of Geneva was adopted. Since then, the Declaration has become a core document of medical ethics and a modern

version of the 2 500-year old Hippocratic Oath. We hope that the Declaration approved today will be used by all physicians around the world to strengthen the profession's determination to maintain the highest standard of healthcare for patients."

These changes bring the ethical issues faced by modern day physicians into focus

Dr Mzukisi Grootboom, chairperson of SAMA, says the new pledge is an important development: "These changes bring the ethical issues faced by modern day physicians more sharply into focus, and provide a solid base to deal with them more effectively. As guiding principles for our profession we welcome them, and believe they will leave a meaningful ethical impact on all of us now and in the future."

SAMA hosts CPD at Odi Community Hospital

Sarah Molefe, junior marketing officer



Dr A Ramokoka (emergency care doctor at Odi Community Hospital) and Bernard Mutsago (SAMA health policy researcher)

SAMA conducted a CPD session at Odi Community Hospital in Mabopane, Gauteng on Friday 22 September 2017. The topic for the session was "Climate Change and Health".

SAMA has noted a need to hold more CPD sessions and ensure that doctors are enlightened about matters of interest in their work environments.

The presenter on the topic, Bernard Mutsago of the SAMA Knowledge Management and Research Department, highlighted the fact that the health sector and the medical profession can no longer afford to ignore the impacts of climate change on human health, given the costly negative externalities of climate change.

Delegates gained knowledge about the various possible links between climate change and the burden of disease in SA, such as the expanding malaria zones, more diarrhoeal

diseases, increased hunger and malnutrition, and increased diseases and injury from heat waves and other natural disasters, among others.

Delegates also engaged with the content of the WMA's Declaration on Health and Climate Change. SAMA is a member of the WMA which is globally spearheading climate-responsive action by medical doctors, such as building resilient health systems and encouraging ecofriendliness in medical practice and doctors' daily lives.



Health professionals attending the CPD meeting

Problematic anaesthetic

The Medical Protection Society shares a case report from their files

Mrs B was a 57-year-old woman with a past history of breast cancer that had been treated with a mastectomy and adjuvant therapy. She re-presented to her specialist surgeon, Dr F, 3 years after the original surgery with a worrying 2 cm lump in the vicinity of her mastectomy scar. Dr F recommended an urgent excision biopsy of the lump under general anaesthetic.

On the day of surgery, Mrs B was reviewed by consultant anaesthetist Dr S. She told Dr S that she had been fine with her previous anaesthetic and that she had no new health problems. Dr S reassured Mrs B that it would be a routine procedure and that he anticipated no problems. He warned her about the possibility of dental damage and a sore throat, and promised that he would not use her left arm for IV access or blood-pressure readings, because of the previous lymph-node dissection on that side.

In the anaesthetic room, Dr S reviewed the anaesthetic chart for Mrs B's mastectomy procedure. He saw that Mrs B had received a general anaesthetic along with a paravertebral block for postoperative analgesia, and that this technique appeared to have worked well. He did not, however, discuss this with Mrs B.

Dr S inserted a cannula in Mrs B's right arm and induced anaesthesia with fentanyl and propofol. He inserted a laryngeal-mask airway, and anaesthesia was maintained with sevoflurane in an air/oxygen mixture. Mrs B was then turned on to her side and Dr S proceeded to insert left-sided paravertebral blocks at C7 and T6. Although Dr S used a stimulating needle and a current of 3 mA, he had difficulty eliciting a motor response at either level. At T6, Dr S finally saw intercostal-muscle twitching after a number of needle passes. Twitches were still just visible when the current was reduced to 0.5 mA, and Dr S therefore slowly injected 10 mL of bupivacaine 0.375% with clonidine. At the upper level, Dr S could not elicit a motor response despite several needle passes. He eventually decided to use a landmark technique and injected the same volume of local anaesthetic mixture at approximately 1 cm below the transverse process.

Dr S then administered atracurium 30 mg, and Mrs B was ventilated for the duration of the operation. The operation was largely

uneventful apart from modest hypotension, which Dr S treated with boluses of ephedrine and metaraminol.

At the end of surgery, Dr S reversed the neuromuscular blockade and attempted to wake Mrs B. However, Mrs B's respiratory effort was poor and she was not able to move her limbs. Dr S diagnosed an epidural block caused by spread of the local anaesthetic. He reassured Mrs B and then resedated her for approximately 40 minutes. Following that, she was woken again and her airway was removed. Weakness of all four limbs was still noted.

Over the next 5 hours Mrs B regained normal sensation and power in her lower limbs and left arm. However, her right arm remained weak, with an absence of voluntary hand movements. She also had gait ataxia on attempting to mobilise. An MRI was performed the following day that demonstrated signal change and subdural haemorrhage in the spinal cord at a level consistent with her persistent symptoms.

Mrs B remained in hospital for physiotherapy and rehabilitation. Her walking and right hand function gradually improved, and she was discharged 3 weeks after her operation. Six months later, Dr S received an attorney's letter stating that Mrs B was still having problems with her hand and was seeking compensation.

Expert opinion

The Medical Protection Society (MPS) instructed Dr M, a specialist anaesthetist, to comment on the standard of care. Dr M was critical of Dr S for four major reasons: Dr S had failed to inform Mrs B that he intended to perform a paravertebral block, and failed to discuss the risks and benefits of such a technique. He was somewhat critical of the decision to perform the block with Mrs B anaesthetised. He opined that had Mrs B been conscious or lightly sedated, she would have alerted Dr S when the needle was in proximity to nerve tissue. However, Dr M did concede that there was a body of responsible anaesthetists who would support the notion of performing a paravertebral block with the patient anaesthetised.

He was critical of Dr S's decision to persist with the block when he was struggling to

locate the correct needle position. He felt that Dr S should have abandoned the block or called for help. He also concluded that the technique used by Dr S was very poor, given the complications that followed.

Dr M was critical of the levels chosen by Dr S to perform the block. He felt that C7 was too high, given that the dermatomal level of the surgery was approximately T4. He also felt that the surgery was very minor and did not warrant the paravertebral block. Dr M was of the opinion that infiltration of local anaesthetic by the surgeon, combined with simple analgesics, would have sufficed.

On the basis of the expert evidence, MPS concluded that there was no reasonable prospect of defending the claim. The case was eventually settled for a substantial sum.



Learning points

- A local anaesthetic block should only be performed when there is a clear indication.
- The risks and benefits of the block should be discussed with the patient and clearly documented. The process of consent for any operation should be a detailed conversation between clinician and patient, with documented evidence. The incidence and potential impact of any common and potentially serious complications should always be discussed, and the discussion documented.
- Local anaesthetic blocks should only be performed by practitioners with appropriate training and expertise.
- If difficulties are encountered, either the procedure should be abandoned or assistance summoned.

Tygerberg past president inspires young doctors

Tygerberg branch recently held their annual social function at the Nitida wine estate, a small family-owned estate in the Durbanville area.

At the function, the outgoing president, Dr Wim Beukes, delivered his presidential address on how to rediscover a passion for medicine. "I want to inspire those of us who have been drawn down, burned out and have lost some sense of purpose in our daily struggles as doctors. This is a worldwide phenomenon," said Dr Beukes. "I read an article on the internet the other day with the heading *How Being a Doctor Became the Most Miserable Profession*. In this article, Daniella Blake mentions that 300 doctors worldwide are expected to commit suicide this year, while nine out of ten doctors discouraged others from joining the profession. Not surprisingly, many doctors want out. Peter Jordan, Fedhealth Medical Aid's principal officer, echoed the same sentiments in an article on *Times Live* in 2014, stating that 'South Africans used to want to study medicine, but the profession is viewed negatively now. It is easier to become an actuary.' He also said that the poor treatment of doctors during community service encouraged them to seek work overseas. 'The average age of a specialist is 55; I fear in general private practice it might be worse. We don't find career medical officers in our primary healthcare facilities any more.'

"How do I inspire a young generation or challenge those of us who have become lethargic in our efforts to be the best we can be? I want to inspire all of you tonight to rediscover your joy and the passion for medicine; to expect miracles every day and find happiness in fulfilling your purpose and so become a master of your profession.

"We are amidst a storm, threatening the very meaning of what we stand for and the important work we do. Tonight I want to give you a little bit of perspective. I want to shine light on this storm. I want to change your perspective on the storm we as medical professionals are facing.

"What happens if light hits the rain in the storm at a certain angle?

"We become aware of an amazing natural phenomenon – a rainbow.

"To be able to see this beautiful wonder of nature we have to step back, maybe look around, but it is actually always there, just depending on your perspective. This is



Outgoing branch president Dr Wim Beukes (centre) and branch administrative secretary Sandra Ferrone with some of the medical students who attended the function

also true for our profession. Young doctors, when the storm is at its worst remember the rainbow is in there, you just have to change your perspective. The rainbow implies completeness with its perfect number of seven colours. Our aim as doctors should be to always strive for completeness, perfection, to become the master of our profession."

Dr Beukes went on to describe how to change that perspective by realising that the colours all infuse the beauty within that rainbow. He used colour psychology to emphasise what the colours stand for and define our vision and purpose for medicine as profession.

"Red – rediscover your passion and love for what you do. **Orange** – be sure to communicate well and keep a sense of creativity in how you practise medicine. **Yellow** – have an attitude of life-giving energy and hope, whether a baby is born or a loved one lost. **Green** – nature and its biology is at the core of what we practise and, remember, unpredictable. We sometimes do not understand it and controlling it – impossible. **Blue** – balance and growth. Remember to balance your work, family, faith and self and to grow in all aspects of this. It needs us to sometimes change our priorities – you will be a better doctor. Blue also signifies trust, compassion and patience – all part of our ethical code professionally. **Indigo** – is all about heavenly grace, reflection, wisdom and integrity. These attributes will help you get you through disappointments and failures – we are not perfect. The last colour, **violet**, relates to our spirituality – medicine in my opinion

is not a job, it is a belief system. Remember what you do is bigger than yourself in a system where illness is the norm. If this is your purpose, rest assured your rainbow will always shine bright."

He ended: "In summary, is my profession miserable? I think we are sometimes the source of our own misery. If we expect the industry, our coworkers, our executive bosses, the government, or possibly our patients, to provide us with a sense of value, we are begging to be miserable.

"I admit that I have not mastered it all, but let the rainbow and its colours be a reminder of where our value lies, and that being a doctor is not just another job.

"Let us change our perspective on our obstacles, see the colours of the rainbow and remember that they all are necessary to provide the beauty and awe a rainbow inspires. Be passionate and love what you do.

"Be creative and learn how to be the best communicator, give your patient life by providing hope. Remember to balance what you do with how you feel and be patient with your patients. When we do find ourselves at the end of life, be it our own or beside our patients, let us reflect, learn, grow and acquire wisdom. Strive to be a master of your profession, and above all, don't forget the miracles and the grace by which we do this calling, fulfilling our purpose as instruments in God's hands."

The full presidential address is available from Sandra Ferrone at Tygerberg Boland branch.



Dr I N Blanche (middle), vice chairperson of the Griqualand West branch, with Dr Z Piotrowski (left) and Dr N K Kirimi (right)

Mental health discussed at CPD meeting

The Griqualand West branch hosted a CPD meeting on Thursday, 28 September 2017, at 13 Bishop Avenue, Kimberley. The topics discussed at the meeting, which were presented by Dr Z Piotrowski and Dr N K Kirimi, were the Mental Health Care Act No. 17 of 2002, and substance-induced psychotic mood disorders.

Dr Z Piotrowski completed his MB ChB and MMed Psychiatry degrees at the Medical University, Warsaw, Poland. He worked in the public health sector in Kimberley and has recently retired after 28 years. Now a consultant psychiatrist at the West End

Hospital Department of Psychiatry, his interests include general psychiatry.

Dr N K Kirimi qualified as a doctor at the Medical University of Southern Africa (Medunsa) in SA, and went on to qualify as a specialist psychiatrist. His clinical interests include child and adolescent psychiatry and he is currently working full time in the public health sector in Kimberley as head of the West End Hospital Department of Psychiatry.

In Dr N K Kirimi's presentation, he used case studies to lead an interactive discussion with the group on how to deal with and treat issues that arise from clinical practice work.

Dangerous malaria outbreak strikes Lowveld

A woman who recently visited the Lowveld area is in a coma and fighting for her life after she and her husband contracted malaria last month. This has fuelled fears that parts of the Lowveld not previously classified as transmission areas may now pose a danger.

In previous years, most malaria cases occurred in the Ehlanzeni area, a malaria-endemic district. Chris Nobela, of the Mpumalanga Department of Health, confirmed that 552 malaria cases were reported in primary-healthcare facilities in the province in September, whereas only

132 cases were reported during the same period in 2016. Nobela said some of these cases had been reported in Mbombela, White River and other traditional low-risk areas.

The woman was initially treated at the Nelspruit Mediclinic, but was transferred to Rob Ferreira Hospital, where she is undergoing haemodialysis. A tracheotomy was performed to ease her breathing.

Robin Baard, the patient-experience manager at the Mediclinic, confirmed that they had admitted 37 confirmed malaria patients in September, mainly from the Lowveld area.

Dr Ben Prinsloo, a pathologist from Lancet Laboratories in Pretoria, quoted the National Institute for Communicable Diseases (NICD), indicating that milder winter conditions in the region were favourable to ongoing mosquito breeding. The institute advises healthcare workers to be more alert for malaria in any person living in, or recently returning from, a malaria area and who presents with flu-like symptoms.

"We have intensified activities to make communities understand malaria, and health facilities are on high alert for suspected cases," Nobela said. "More malaria drugs and test kits have been procured, and vector surveillance is used to check what type of mosquitoes we will deal with."

Source: Mariana Balt, Lowvelder, 6 October 2017



Tracey Gurnell (West Rand branch) and Shelley Warner (Gauteng branch) hosting the SAMA table at this year's Netcare Symposium

West Rand hold successful CPD symposium

Hundreds of doctors attended the annual CPD symposium hosted by Netcare West Rand hospitals and the SAMA West Rand branch at Misty Hills in September.

The symposium, which took place over 2 days, gave doctors the opportunity to share new and interesting information and findings with each other, and network in a beautiful setting. Medical topics as well as ethical issues were discussed, and each doctor was presented with a certificate recognising their participation in the weekend symposium.



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