

SAMA

INSIDER

FEBRUARY 2022

**SA has changed
tack on tackling
COVID: Why it
makes sense**

**SAMA will rise
to the challenges
of 2022**



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

**SOUTH AFRICAN
MEDICAL ASSOCIATION**



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WHAT ARE WE ABOUT

Assisting health professionals to maintain and acquire new and updated levels of knowledge, skills and ethical attitudes that will be of measurable benefit in professional practice and to enhance and promote professional integrity. The SA Medical Association is one of the institutions that have been appointed by the Medical and Dental Professions Board of the Health Professions Council of SA to review and approve CPD applications.

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Diane de Kock
Editor: *SAMA INSIDER*

A new and demanding year

February 2022, the beginning of a year that seems set to present new and continued challenges for the healthcare profession, both within SAMA and in the profession as a whole.

Prof. Risenga Chauke, SAMA President, ends his term this month: "I remain hopeful that one day, an amicable solution shall be found to truly unite doctors for the economic and general health of doctors and the nation as a whole" (page 4).

SAMA CEO Dr Nhlapho (page 6) unpacks the challenges for SAMA in 2022: "Working together with members will, I believe, continue to grow our association, and strengthen its voice on critical matters, all in the interests of serving our members better, and ensuring that their rights as medical professionals are not only protected, but promoted."

Dr Angelique Coetzee, SAMA chairperson, welcomes newly graduated doctors who will enter the public health sector as interns this year (page 8). She wishes them well and assures young doctors of SAMA's support as they enter the overstretched environment of public hospitals and their hugely taxing demands.

In December 2021, newly elected member of the SAMA board, Prof. Ames Dhali, ascended to a new role on the international stage. In the only nomination from all the represented regions, she was elected as the new chairperson of the International Bioethics Committee of UNESCO (page 5). Congratulations Prof. Dhali!

The challenges of COVID-19 promise to continue this year. SA has changed tack on tackling the pandemic. Read about why this makes sense in Prof. Madhi, Fareed Abdullah and Jonny Myers' article on page 7.

A heartwarming tribute by Heather Robertson to her father Dr Leslie Ivan Robertson (page 10) reminds us of the many challenges faced by "melanin-enriched medical students", and what it means to live a life that matters.

The *SAMA Insider* team would like to encourage readers to use this magazine as a platform for communication. We look forward to receiving articles and letters that represent the news, concerns, complaints, ideas and queries of all SAMA members.

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The battle of the economies and the impact on health



Prof. Risenga Chauke, SAMA President

An economy may simply be defined as any activity that involves production and consumption.

Within a simple unit or, for example, the ecosystem of a family, there are multiple economies at play. Scholars still debate about the number of economic systems in existence. Indeed, these economic systems are seen at play in a family unit. Regardless of whether they are traditional, command, market or mixed systems, all economies have a bearing on the health of individuals.

The economy affects health, and health affects the economy. Expanded to a grander scale than a family unit, the same factors are seen nationally and internationally – more so within the health and social sectors.

Over the years, multiple articles have been published that clearly demonstrate the correlation between the environment, social structures, the economy and health. The world today still battles to harmonise this correlation and yet public health elevated the need for stronger focus on social determinants of health.

The green economy is seen as an attempt to reduce environmental damage that will adversely affect the health of the population in the long run. The issues of climate change are becoming obvious for everybody to see today. Pollution of the environment by gases, deforestation and destruction of the ozone layer have resulted in many diseases – among others, various cancers, respiratory problems and other diseases never seen before – or have enhanced previously suppressed diseases.

It is believed that a move towards reduced carbon emissions and pollution, with enhanced energy and prevention of loss of biodiversity and ecosystems, will go a long

way towards restoring the environment and improving the health of the nation.

The recent announcement at the COP26 summit regarding assisting SA to terminate its dependence on coal to generate power and move towards clean energy power production will go a long way in contributing towards saving the environment. But this has to be managed carefully, as SA is currently hugely dependant on coal energy for power and economic, which is readily available in the country.

The pollution of our rivers and oceans adversely affects not only marine life, but the general wellbeing of the population of the Earth at large. There are very close linkages between climate change and the oceans. Melting of the ocean glaciers caused by rises in temperature has been well documented. This talks to the blue economy. With our waters being polluted, water-borne diseases are set to rise and affect the health of the population. Intentional and international collaboration on climate change mitigation is crucial. Blue economy presents opportunities of stimulating and diversifying the economy and creating new job opportunities related to sustainable fisheries, aquaculture, renewable marine energy, to name a few.

The Commonwealth states the following as “fast facts” about the blue economy:

- the worldwide ocean economy is valued at around USD1.5 trillion per year
- 80% of global trade by volume is carried by sea
- 350 million jobs worldwide are linked to fisheries
- by 2025, it is estimated that 34% of crude oil production will come from offshore fields
- aquaculture is the fastest-growing food sector, and provides about 50% of fish for human consumption.

It further states that “aquaculture has a key role to play in addressing food and nutrition security, sustainable economic development, marine resource management and health issues in Commonwealth countries”.

According to the Food and Agriculture Organization of the UN, SA aquaculture has performed below its potential, and remains a minor contribution to national fishery products and the country's GDP.

With SA's challenges of high unemployment and poverty rates, development of this culture will go a long way towards addressing these

issues. With the aquaculture sector developing, the health and wellbeing of society stands to improve.

The green and blue economies are fuelled by the digital economy, which is breaking down geographical barriers and facilitating global trade. The digital economy reflects a move from the third to the fourth industrial revolution (4IR). There is no sector where 4IR does not apply. However, this has the potential to widen the gap between the haves and the have-nots. This digital divide will have serious consequences for the health of the nation. High on the list will be mental health issues. The COVID-19 pandemic has highlighted this divide in a major way among populations, and SA has experienced the effects of this divide. This has affected pre-university students, university students and working communities.

While the digital economy can help to grow the country's economy in a substantial way, care must be taken not to leave the majority of the population behind, with resultant devastating health issues.

The digital economy has huge potential to reduce the number of jobs in companies. With a current high youth unemployment rate, in particular, and a high unemployment rate in general, the impact on health may be massive.

However, the digital economy presents opportunities for new jobs which will exclude people without certain skills. The digital economy should be grounded on inclusive economic growth. Digitisation of health also presents opportunities for increased access to care, provided that data issues are addressed.

While governments battle to improve and balance what is necessary to improve the wellbeing of their populations, it is equally important to reflect on the impact of improving economies for the sake of health.

It is important to recognise that an improvement for the better in the health of our population is of paramount importance in whatever we do as nations to address our economies.

My term as the President of SAMA has come to an end. It has been truly enriching. While I am acutely aware of the many challenges both within and outside of the organisation, I appreciate the ongoing attempts at all times to resolve them. I remain hopeful that one day, an amicable solution shall be found to truly unite doctors for the economic and general health of doctors and the nation as a whole.

Prof. Ames Dhai elected chairperson of the IBC of UNESCO

SAMA Communications Department

In early December 2021, Prof. Ames Dhai, visiting professor of bioethics and health law at the School of Clinical Medicine at the University of the Witwatersrand, ascended to a new role on the international stage. In the only nomination from all the represented regions, Prof. Dhai was elected as the new chairperson of the International Bioethics Committee (IBC) of UNESCO.

Prof. Dhai has been a member of the IBC since 2018, representing the African region as one of the committee's vice-chairpersons. Now, however, she assumes the role of chairperson, a position with a 3-year term.

"I was very pleasantly surprised when the nominations came up and every region nominated me, and I was the only nomination from all of the regions. It's a great honour, of course, but more important for me is that I represent Africa, and I can take the African footprint onto an international setting," says Prof. Dhai.

Established in 1993, the IBC is a body of 36 independent experts that follows progress in the life sciences and its applications in order to ensure respect for human dignity and freedom. The IBC provides the only global forum for reflection in bioethics.

"The IBC's core function is to try to ensure the UNESCO Declaration on Bioethics and Human Rights is implemented and 'domesticated' at member-state level. The body takes into consideration what bioethics issues are internationally, deliberates on these issues and delivers reports and statements for ethical guidance. It also networks with other international bodies to promote bioethics and human rights globally," notes Prof. Dhai.

In addition to being a visiting professor at Wits, Prof. Dhai is the specialist ethicist at the Office of the President, and CEO of the SA Medical Research Council (MRC), where she chairs the SAMRC Bioethics Advisory Panel. She established the Steve Biko Centre for Bioethics at the Wits faculty in 2007, and was director of the centre until she retired in 2019. The centre, which runs Masters and PhD programmes in bioethics and health law, has local and international recognition as a leading centre in these disciplines, and in 2013 became a World Medical Association Co-operating Centre.

"I am quite anxious because being the chair is a lot of work, and I certainly don't want to let my continent down. But I'm also excited because I think this gives me a unique opportunity to push hard the voice of justice and equity. One of the key thoughts I have is to ensure that we become the voice for vaccine equality throughout the world, and I think this role will enable that," says Prof. Dhai.

It's an issue Prof. Dhai says is critical, and that it's important that the lessons learned from COVID-19 inform preparedness for future pandemics.

"What we saw with COVID-19 was vaccine inequality. What we need to make governments around the world understand, though, is that while they protect their own citizens, there are also variants to diseases and these variants cross over porous borders. Governments can hoard their vaccines – as Canada and other high-income countries did – but if they looked at it through the lens of global equity, through the lens of harm prevention for global citizens, then we probably wouldn't be in the situation we are now. As the IBC, I see our role as one



Prof. Ames Dhai

This gives me a unique opportunity to push hard the voice of justice and equity

of ensuring we are prepared for the future but, critically, that we are prepared to share rather than hoard; it's simply something we can't allow to happen again should we have another pandemic," she notes.

Prof. Dhai says that after her 3-year term is over in December 2024, she'd like to have achieved much globally in terms of an ethical approach to healthcare and social determinants of health, not only in terms of issues such as informed consent, but also from a public health perspective.

"I would like us to leave with the world having a greater understanding of healthcare as a public good, and the importance of sharing public good. I also hope that policies developed by the IBC are implemented to a greater degree than they are currently," she says.



SAMA will rise to the challenges in 2022

SAMA Communications Department

2022 is going to be a busy year for SAMA, as the association continues to work hard at improving in areas identified by members as needing attention.

"Our membership survey, conducted last year, proved invaluable in giving us important data on our members' perception of the association, as well as on what they believe we need to do better. The results were encouraging, and largely point to us doing a good job on their behalf," says Dr Vusumuzi Nhlapho, SAMA CEO.

Critically, though, there is a need to focus on attracting younger members to the association, while focusing more intensely on three key areas:

- increasing the collective voice of doctors on issues that matter
- dealing with emerging and peripheral issues that affect members (such as their working environments)
- representing members more broadly in government-appointed structures.

He says that SAMA management, the board of directors and staff have taken note of these requests, and will be actively working to achieve better outcomes in these three areas. "The survey has spurred us on to do more in the months ahead."

Importantly, says Dr Nhlapho, SAMA is committed to the strategic objectives developed 2 years ago, and these remain unchanged. In his end-of-year message last year, he said, "We will continue to focus on growing membership, amplifying the SAMA brand, enhancing member value and forming key strategic partnerships. These are the pillars on which SAMA is built."

"We had to look at our structures to determine whether they are capable of ensuring that we can fulfill these objectives. After careful consideration, and with the support of our board of directors, we amended our structures to support the association. More detail on these structures, which are intended to streamline our operations and improve our efficiencies, will emerge in the coming weeks," comments Dr Nhlapho.

One change that is already visible is increased communication between the



Dr Vusumuzi Nhlapho, SAMA CEO

Member Engagement Department (MED) and the branches. Reporting lines will now move from the company secretary to the MED, and the focus of branch administrators/secretaries will be closely aligned with the activities at head office, with active participation from the branch chairpersons.

Another important task for SAMA in the months ahead is the establishment of an independent Medical and Dental Council (MDC). In the weeks ahead, a multidisciplinary workshop will be held to discuss the details.

This is an important project for SAMA in 2022 and one which will enjoy a lot of attention. The establishment of an independent MDC is critical in the near future. We believe the current framework which involves the Health Professions Council of South Africa (HPCSA) has limitations which don't serve our members' needs adequately. In the coming weeks we will reach out to members for their inputs and involvement," notes Dr Nhlapho.

"Unfortunately, we found ourselves having to actively engage with the National Department of Health on the unplaced interns and community service officers for 2022. This remains an ongoing problem for junior doctors. SAMA believes that appropriate planning from the Department of Health will go a long way in resolving this perennial problem. Engagements in this area are continuing."

As the year gets underway, Dr Nhlapho says that it's important that doctors in SA not forget that the country is still in the midst of a pandemic, and that the trajectory of the disease is still unknown.

"While the current Omicron variant seems to be presenting with relatively mild symptoms, we cannot assume that this is the end of coronavirus or COVID-19. We must remain vigilant and continue to vigorously urge for vaccinations and booster shots to be taken up. We are all still concerned that COVID-19 may take some time to completely resolve, and as we navigate the treacherous waters this disease throws our way, we must stay on high alert," he says.

Dr Nhlapho has again urged all medical professionals to encourage their family, friends, colleagues and patients to get vaccinated – and to receive booster shoots – to ensure that more South Africans are as protected as they can be against COVID-19.

2022 is going to be an important year for SAMA

"Of course, the government has relaxed restriction measures and curfews, and this may lead to more cases presenting at hospitals. Our best defence, though, is to observe and maintain the protocols that have been in place for many months now: hand sanitising, mask wearing and social distancing. It's our duty as medical professionals to spread this message along with the vaccination message," he says.

However, notwithstanding the challenges ahead, Dr Nhlapho says that 2022 is going to be an important year for SAMA, and that the association is going to do everything it can to continually add value for the benefit of its members.

"What this means is that we have to work hard and remain dedicated to SAMA, its values and its objectives. Working together with members will, I believe, continue to grow our association, and strengthen its voice on critical matters, all in the interests of serving our members better, and ensuring that their rights as medical professionals are not only protected, but promoted," he concludes.

SA has changed tack on tackling COVID: Why it makes sense

Shabir A Madhi, dean, Faculty of Health Sciences, and professor of vaccinology at the University of the Witwatersrand; and director of the SAMRC Vaccines and Infectious Diseases Analytics Research Unit, University of the Witwatersrand, **Fareed Abdullah**, director: Office of AIDS and TB Research, SAMRC, **Jonny Myers**, director: Centre for Occupational and Environmental Health, University of Cape Town

In the final days of 2021, the SA government eased its COVID regulations. On 30 December the government scrapped a curfew that had been in place since March 2020. It also initially announced an easing around quarantines and contact tracing, but subsequently reversed these plans. Nevertheless, its approach sets a new trend in how countries are choosing to manage the pandemic. Shabir Madhi and colleagues reflect on the boldness – and the risks.

What are the main elements of its new approach?

The SA government has decided to take a more pragmatic approach while keeping an eye on severe COVID and whether or not health systems are imminently under threat. This reflects acceptance that governments will increasingly be looking for ways to live with the virus, cognisant of the detrimental indirect effects that restrictions have been having on the economy, livelihoods and other aspects of society. This is particularly pertinent in resource-constrained countries such as SA.

The latest announcements mark a significant departure in terms of the way forward. They mark a pragmatic approach that balances the potential direct and indirect detrimental effects of COVID.

Our hope is that the government continues to pursue this approach, and doesn't blindly follow policies that are not feasible in the local context and ultimately yield nominal benefit.

The new, more nuanced approach is in stark contrast to reflexively imposing higher levels of restrictions as case rates increased. This suggests that the government has taken note of commentary that has provided suggestions to focus on whether the health facilities are imminently under threat, rather than simply going to higher levels of lockdown.

The main element of the new approach arises from a high level of population immunity. A sero-survey done in SA's economic hub, Gauteng, just prior to the onset of the Omicron wave indicated that 72% of people had been infected over the course of the first three waves. Sero-positivity was 79% and 93%

in COVID-19 unvaccinated and vaccinated people, respectively, older than 50 years, a group that had previously made up a high percentage of hospitalisations and deaths.

The sero-survey data show that immunity against severe COVID in the country has largely evolved through natural infection over the course of the first three waves and prior to the advent of vaccination. This has, however, come at the massive cost of 268 813 deaths based on excess mortality attributable to COVID-19.

The presence of antibody is a proxy for underlying T-cell immunity, which appears to play an important role in reducing the risk of infection progressing to severe COVID. Current evidence indicates that such T-cell immunity, which has multiple targets, and even more so when induced by natural infection, is relatively unaffected even by the multiple mutations in Omicron, and is likely to persist beyond a year. This sort of underpinning T-cell immunity that reduces the risk of severe disease should provide breathing space for at least the next 6 - 12 months, and possibly beyond that.

Although Omicron is showing heightened anti-spike protein antibody evasiveness relative to even the Beta variant, vaccine and natural infection-induced T-cell immunity has been relatively preserved.

This could explain the uncoupling of the case rate compared with the hospitalisation rate, and even more pronouncedly, with the death rate. In addition, other changing characteristics of the Omicron variant caused by the mutations appear to make it more efficient in infecting and replicating in the upper rather than the lower airway. This could also be contributing to lower likelihood of progressing from infection to severe diseases.

In the meantime, it's crucial that a number of steps are taken.

The drive to ensure higher uptake of vaccines, including booster doses for high-risk groups, needs to continue.

Also, considering that only 10% of infections are actually documented in SA because so few people are being tested, a more pragmatic approach to isolation is

warranted, mainly if people are symptomatic. This also means that quarantining will not bring about any major reduction in transmission.

There also needs to be recognition that contact tracing in the SA and other similar settings is unlikely to be of any value. This is because the average person in SA will possibly have 20 close contacts per day. And even symptomatic infected individuals are most infectious in the pre-symptomatic and early symptomatic phase.

The ineffectiveness of contact tracing and quarantine in limiting the spread of the virus in SA is corroborated by three-quarters of the population having been infected over the course of the first three waves.

In our view, there is also room for the gradual relaxing of non-pharmacological interventions. In particular, token-gesture "hand hygiene" and superficial thermal screening should be scrapped. And there is little reason not to be allowing events such as attendance to outdoor sports events.

Instead, at least for the immediate future, the government should continue focusing on interventions such as masking in poorly ventilated indoor spaces and ensuring adequate ventilation.

The issue of mandatory vaccinations is still on the radar, as it extends beyond the added risk that the unvaccinated pose to others, and the greater pressure they place on the health system when they are hospitalised for COVID.

Attention also needs to be given to how incidental COVID infections – people diagnosed with COVID when they are admitted for a non-related medical issue – are managed in hospitals. The Department of Health guidance needs to be adapted to manage these patients with the appropriate level of skill and resources for the primary reason they were admitted. And patients with severe COVID-19 disease require additional care and expertise to improve their outcomes.

Finally, an evaluation of both vaccination status and underlying immune deficiency needs to become a key element of the workup of hospitalised patients with severe COVID.

Is it clear what the goals are?

The goal has to be minimising hospitalisation and death. It is unnecessary to be stressing out the economy, other health services and livelihoods in SA. The death rate with the Omicron wave in SA is on track to be approximately one-tenth compared to the Delta wave. This means that it is possibly on a par with deaths caused by seasonal influenza pre-COVID – 10 000 to 11 000 per annum.

This death rate also needs to be considered relative to other preventable deaths. TB is an example, which is estimated to have caused 58 000 deaths in SA in 2019.

It is impossible to say what the characteristics of future variants could be over time. But the experience with the Omicron wave in SA provides some comfort that immunity against severe disease and

death will continue tracking downward, particularly if vaccine coverage can be increased to 90%, particularly in the >50-year age group. The high force of infection that has likely transpired with Omicron will also further contribute to enhancing protection against severe COVID-19 in the immediate future.

What are the risks?

The major risk is the unpredictability of new variants that evade all aspects of past infection and vaccine-induced immunity. But this is likely to be the result of the evolution of the virus rather than any changes in policy.

Another risk is failure to change the pandemic mindset, and failure to appreciate that with Omicron the epidemic phase of

COVID-19 is coming to an end. The country and all its institutions and people need to prepare to get back to a previous life – most notably the health services.

The SA government appears to have come to appreciate that past practices have had limited success in preventing infections, and fully appreciate the detrimental effects that restrictions have had on the economy and society. In addition, it has run out of road to continue with what has unfortunately not yielded much benefit. Despite all the severe lockdowns, SA still ranks high with a COVID death rate of 481 per 100 000.

Source: The Conversation, 7 January 2022. <https://theconversation.com/south-africa-has-changed-tack-on-tackling-covid-why-it-makes-sense-174243>.

SAMA welcomes 2022's new intern doctors

Dr Angelique Coetzee, SAMA Chairperson



Congratulations on coming this far; your years of study, dedication, blood, sweat and tears are finally paying off. This is an exciting new phase in your career, and the hard work you have put in will now be put to use as you continue your journey in our wonderful and rewarding profession. You have made sacrifices, and there have sometimes been difficult decisions and compromises you have had to make to get to where you are now. In the end, though, you will realise that the struggles you have endured have all been worth it; you are on your way to becoming a medical professional, someone others look up to.

We are all privileged to be part of a profession whose goals are to improve the health of our fellow human beings, and to prevent illness and death. Doctors practise medicine as members of a team, and those of us who have been in the profession for many years know that good medical care revolves around good teamwork. SAMA is part of that team, offering a united voice for healthcare professionals, and strength in numbers.

Being a doctor in SA has its own challenges, as there are not enough of us. Some of you will work long hours and experience difficult conditions as a result of SA's high burden of disease. You may face unexpected challenges, and possibly some unfairness. Please remember that SAMA is here to look after your interests – never hesitate to call and discuss your concerns. You can find your local representative in the hospital where you work, at the closest SAMA branch or in a senior colleague who is a SAMA member. More information can be found on the SAMA website: <https://www.samedical.org>.

We encourage you to take part in SAMA activities. As a recently qualified doctor, we also urge you to join the Junior Doctors Association of SA. This is a critical time in healthcare in our country, and we hope that you will be an active member of your association. You have a unique opportunity

to influence decisions and advocate for your profession, your patients and your community.

As you begin your internship I want to offer some advice: enjoy this time, and don't stop learning. Also, don't take yourself too seriously. Yes, you are tasked with an incredible responsibility, but you have trained to get here, and you have the knowledge. Consider each moment as it comes, and grow to become the best version of yourself that you can be. Also, take this time to do two important things: firstly, make new friends and learn new things. Secondly, make mistakes – you can still do this. I know it sounds silly to point this out, but no-one is perfect, and everyone makes mistakes, including doctors. The best doctors, though, are those who learn from their mistakes, so don't be afraid to learn. You will find yourself in new situations and strange circumstances, and you will be faced with tough questions and challenged with difficult decisions. That's good. The more you are pushed, the more you are challenged, the better you will become. Look around you, soak it all in, and learn, not only from senior doctors and healthcare professionals, but from your friends and from your patients. The lessons each of these people give you now will be invaluable for your medical journey.

Stay healthy, stay positive and keep going.

A new report shows worrying growth of the diabetes pandemic

Ayesha Motala, professor and head of Department of Diabetes and Endocrinology, University of KwaZulu-Natal

Diabetes is rising at an alarming rate. One in 10 adults worldwide – 537 million people – now live with the disease. This is higher than the 463 million adults who lived with the condition in 2019. It presents a significant global challenge to the health and wellbeing of individuals, families and societies. Diabetes now ranks among the top 10 causes of global mortality, responsible for an estimated 6.7 million deaths in 2021.

Africa accounts for 6% of these deaths. One in 22 (24 million) adults in Africa are living with diabetes.

The continent's highest prevalence rate (11.3%) is in SA, where one in nine adults have diabetes: 4.2 million people. Yet almost half are undiagnosed. This year, SA is predicted to register 96 000 deaths due to diabetes, and an estimated USD7.2 billion rise in diabetes-related health expenditure. This is a huge hit to the country's economy, and equates to USD1 700 per person.

These new figures are revealed in the 10th edition of the International Diabetes Federation Diabetes Atlas, which gathers information on the burden of diabetes from countries across the world. It is compiled by the federation's Atlas Committee, which I am a part of.

Sharp increase

The Atlas projects that 783 million adults will be living with diabetes by 2045. That's an estimated 46% increase, compared to expected population growth of 20% over the same period.

With such a sharp increase expected in global prevalence, it's clear that diabetes is spiralling out of control. It can no longer be ignored.

This year marks 100 years since the discovery of insulin. Insulin is a hormone that lowers the level of blood glucose. There has never been a more appropriate time to reflect on the impact of diabetes and highlight the urgent need to improve access to care for the millions affected.

The urgency is even greater because COVID-19 has placed an additional burden on people living with diabetes, making them more susceptible to the worst complications. We are yet to see the impact of lockdowns, use of masks and the potential risk of COVID-induced diabetes on population health. There is



a widely held concern that the pandemic may have caused a further rise in the prevalence of diabetes and its complications that will manifest over the coming years.

When diabetes remains undetected or is not adequately addressed, people with diabetes are at higher risk of serious and life-threatening complications, such as heart attack, stroke, kidney failure, blindness and lower-limb amputation. These complications result in a significantly reduced quality of life, and higher healthcare costs.

Access to diabetes care

Diabetes does not discriminate: it is a disease that can affect anyone, regardless of socioeconomic status or national boundaries. Globally, 88% of adults living with undiagnosed diabetes are in low- and middle-income countries. But even in high-income countries, almost a third (29%) of people with diabetes have not been diagnosed.

Low rates of clinical diagnosis are often a result of insufficient access to healthcare and lower capacity in existing health systems.

And even 100 years after the discovery of insulin, one in two people with diabetes who need insulin are unable to access or afford it. Left untreated with insulin, type 1 diabetes is fatal.

Other fundamental components of diabetes care, such as oral medicines, self-monitoring equipment and supplies, education and psychological support and access to healthy food and a place to exercise

are also unavailable to many people living with or at risk of diabetes across the world.

Action to turn the tide

Fortunately, much can be done to reduce the impact of diabetes. Evidence suggests that type 2 diabetes can often be prevented. And early diagnosis and access to appropriate care for all types of diabetes can avoid or delay complications in people living with the condition.

It is vital to secure affordable access to the fundamental components of diabetes care for all who need them, ensure prompt diagnosis and timely treatment and improve efforts to prevent type 2 diabetes.

I believe there are some rays of hope. The centenary of insulin has attracted greater attention to the diabetes cause. Earlier this year, the WHO launched the Global Diabetes Compact, and UN member states adopted a resolution that calls for urgent co-ordinated global action to tackle diabetes.

These are important steps toward addressing the continued and rapid rise of diabetes prevalence, particularly in countries that do not have a national diabetes plan or coverage for essential health services. But more action is needed. We cannot wait any longer for diabetes medicine, technologies, support and care to be made available to all that require them.

Source: The Conversation, 6 December 2021. <https://theconversation.com/a-new-report-shows-worrying-growth-of-the-diabetes-pandemic-173096>.

My dad, Dr Mac, taught me what it means to live a life that matters

Heather Robertson

Two months ago, on 25 October, my father, Dr Leslie Ivan Robertson, fondly known as Dr Mac, Doc Mac, Mac, Papa and Dad, ended his long journey on Earth. Fortified with his two Pfizer vaccines, he managed to dodge Alpha and Delta, but not his final nemesis, a stroke.

He flew away just before the highveld sun spilled its dawn palette of pink, orange and gold on an array of cumulonimbus clouds that hung over the Unitas Hospital in Centurion. In the high care ward at Unitas, where he spent the last 5 days of his life, my father was treated by nurses and doctors who would have made him proud if he was cognisant. Because they cared. And treated their patients with dignity and compassion. Just like he did his entire life as a medical practitioner.

My father lived 20 more years than the Bible's allotted three score years and ten, and reluctantly retired from his popular diabetic practice at the Netcare Parklands Hospital in Durban 4 years ago, at the age of 86. Now that the aftershock of his departure is slowly easing, I thought it fitting to reflect on his life and legacy, which, like many SA lives and legacies, do not make our headlines because they are not what we journalists deem newsworthy enough, big enough or nationally impactful enough to warrant telling in our first drafts of history.

This recollection of my father's life is not told just by me, one of the flawed first drafters of history, but in collaboration with him, through his own oral and written reflections, and other family members, colleagues and patients whose lives he affected.

Born on 20 April 1931 to Maude and William Robertson, at 40 Chatham Road, Salt River, Cape Town, Leslie Ivan Robertson was nicknamed Mac by his cousins after a character in a comic strip called Mac and Tillie the Toiler. As people often spelt his name the feminine way (Lesley), he preferred to be called Mac throughout his life.

Like many in their neighbourhood, the family was very poor. They did not have a car or a fridge, and only had use of an outside toilet. Maude died in early 1939, when Mac was 7 years old. She had pulmonary tuberculosis, for which there was at that time



Dr Leslie Ivan Robertson with his ubiquitous camera on a Vietnam trip (photo: Robertson family collection)

no cure. After her death, he, his two brothers and father lived at first with his aunt and uncle (who eventually became white and shunned the rest of the coloured side of the family), and later with another aunt and then his granny. During the time he spent with aunt number two, another eight members of his close family also died of tuberculosis. He recalled sharing a bed with his cousin and waking up to find him dead. It was this dreaded disease that robbed him of his mother and so many other family members that made Mac solemnly promise to work for a cure when he grew up.

Mac's early education was at Wesley Practising School and then Trafalgar High School, where he had the privilege of being taught by Ben Kies, an anti-Stalinist and anti-colonialist left-wing political activist and theorist, teacher and advocate. Mac's greatest memory of Kies at Trafalgar High was an English exercise in the art of empathy that stymied his entire class. Kies told them to write three pages explaining the concept of colour to someone who was born blind.

It was not Kies, but Mac's working-class father who urged him to become a doctor. As they could not afford the fees, he had

to work all his holidays in the furniture factories where his father, a French polisher, was employed. He also served as a wine waiter at the posh New Orleans Club for many weekends, and he was paid to paint lines on the legs of young women from his neighbourhood who could not afford stockings.

Mac studied medicine at UCT, where he and the nine other "brown" students were told by the dean of medicine that if they saw a white corpse when attending a postmortem in the mortuary, they should remove themselves and stand at the back. During the first week of their third year, they were also told to sit at the back of the A5 main lecture theatre, and to leave the room if the patient wheeled in for diagnosis was white. What this meant was that UCT's racist policies led to my father and his nine fellow melanin-enriched medical students missing out on clinical medicine teaching of certain diseases.

After graduating, Mac applied to but was turned down at the only hospital in Cape Town that would accept coloured doctors, but he was accepted at McCord Zulu Hospital in Durban, where he had spent a working

holiday at the end of his fourth year of study 2 years earlier. One of Mac's most vivid memories of McCord was treating the then-leader of the ANC and Nobel Peace Prize winner Chief Albert Luthuli, for a coronary attack, a disease which at that stage had not been known to afflict black patients. Mac was summoned to assist Chief Luthuli by his daughter Hilda (Thandeka), who was a staff nurse in the adult male section. Even though he was a junior in the paediatric section, she did not trust any of the other doctors to treat her father.

It was at McCord that Mac also befriended nursing sister Amy Weaich, who he helped flee the country via Zambia after her anti-apartheid activist husband, Basil Weaich, was arrested by the Security Branch. I was an infant when this happened, and only came to know of this part of my father's life when Amy shared this story at his memorial service.

She recalled: "Many people were not aware of the support Mac gave not only to me but many others. This was very risky for him and his GP practice and his family, but he continued to support me and to help me leave the country. Once I was in Zambia I could not communicate with him anymore as the Special Branch was watching the mail of all my friends. Many of those who supported me were intimidated by the police."

After a few years of learning to be a paediatrician at McCord, Mac started a medical practice in the Durban suburb of Sydenham. Quite soon after this he was able to fulfill his promise to help save people suffering from tuberculosis when he became a part-time medical superintendent at the Friends of the Sick Association (FOSA) TB settlement. By now there were drugs (very cheap drugs) that cured just about all cases of this disease, leaving him with the sad thought that his mom and half his cousins and his wife's family would still have been alive if the drugs had been found earlier. At his practice, Mac became an expert in sexual medicine (both he and my mother Barbara would run sex counselling workshops at his surgery), and he helped improve many a patient's quality of life by prescribing that famous blue pill.

Dr Mac was a member of the SA Medical and Dental Council (SAMDC). His colleague and friend Dr Uttam Govind recalls that he, with many others such as Prof. Frances Ames, were shocked to see how the late Steve Biko was treated by several white doctors



Mac and 7-year-old Heather on a road trip (photo: Robertson family collection)



Mac and Heather on a Vietnamese cooking course (photo: Robertson family collection)

(specialists and district surgeons), who were not charged by MASA and the then SAMDC for their actions. These organisations were finally persuaded by Dr Robertson and others to discipline the so-called Biko doctors.

In 1969, Mac was asked to work in the Diabetic Unit of the Addington Hospital, and he spent the next 30 years there, eventually as the senior doctor in charge. He also participated in numerous research projects designed to help diabetic sufferers, and travelled to many parts of the world to learn more about the disease, which by the year 2025 will affect more than 3 million South Africans.

Always uncompromisingly himself, even when he came across as blunt, stubborn and rude as a curmudgeonly bull in a china shop, Mac was seen as a saviour by his many patients in Sydenham and the greater Durban area who he healed, whose babies he helped enter in this world, whose lives he saved. This story told by one of his patients, Gaynor Bowes, explains why: "I was little when Doctor Mac paid a visit to our home as my sister wasn't well. My mom complained of a headache, and he took a look at her as well. He said this doesn't look good, and a few hours later had her admitted to Wentworth Hospital. She'd had a brain haemorrhage at age 30.

"She was taken to theatre the next day. Doctor was on his way out that evening when the hospital called to say his patient (my mom) had died. He dropped everything and rushed to the hospital. My mom was lying on the gurney ready for the morgue. He removed a plug from the suture site and a drop of blood fell, so he decided to resuscitate her, much to the disbelief of the nurses as she had been dead more than 35 minutes by that time.

"His words were: 'Where there's blood there's life, and she deserves the chance to live.' Mom was resuscitated and lived till 77, all faculties intact, save for an unsteady gait at times and a slur (but still able to swear like a trooper).

"The other amazing thing that many don't know is that for years Doc treated our family free of charge, as my father left soon after and my mom was unable to work."

Stories like these shared by patients, colleagues and friends of my father after his death, make me realise what it means to live a life that matters. A life of passion and service to others, a life of love and laughter despite the innumerable hurdles and disasters that get flung in your path.

Source: Daily Maverick, 5 January 2022. <https://www.dailymaverick.co.za/article/2022-01-05-my-dad-dr-mac-taught-me-what-it-means-to-live-a-life-that-matters/>.

Gender-based violence increases mental health strain in the shadow of COVID-19

SAMA Communications Department

A “shadow pandemic” of increased violence against women and girls has followed in the footsteps of the COVID-19 pandemic, with heightened mental health impacts on victims of gender-based violence that will outlast the physical health sequelae of the pandemic.

While the economic, social and physical health impacts of COVID-19 take up the spotlight, the pandemic has also worsened SA's already high rates of mental illness and gender-based violence, says specialist psychiatrist Dr Yumna Minty of the SA Society of Psychiatrists (SASOP).

Studies have shown that women who are victims of physical or sexual violence at the hands of their intimate partners are twice as likely to experience clinical depression as women not exposed to interpersonal violence, and are at greater risk of attempting suicide, she said.

During the annual 16 Days of Activism against Gender-Based Violence campaign (25 November - 10 December), SASOP called for firmer policy interventions and improving multistakeholder collaboration between government agencies (police, justice, health, education and social development sectors), civil society and NGOs for an integrated and co-ordinated response to the problem.

“With a new variant of the coronavirus recently identified and the prospect of a fourth wave of infections and renewed restrictions on the cards, we also need to ensure that both government and civil services such as helplines, victim support centres and shelters are able to remain operational regardless of lockdown level, and can extend their capacity for online and telephonic advice and counselling.

“Given that remote working under pandemic conditions means that women may be stuck in their home environment with an abuser and be unable to leave or make a phone call to seek support, alternatives such as SMS and WhatsApp helplines have provided these women with a lifeline, and should be continued even beyond the pandemic,” Dr Minty said.

Globally, one in three women experience physical violence, mostly by an intimate

partner. UN Women reports that all types of violence against women and girls, especially domestic violence, have increased around the world since the outbreak of COVID-19.

In SA, one in five women who have ever been in a relationship have experienced physical violence at the hands of a partner, and one in 16 have experienced sexual violence by an intimate partner.

SA women are murdered at a rate that is four to five times the global average, at least half of them by their intimate partner. Women make up two-thirds of the victims of sexual offences, including rape, and SA's prevalence of rape is among the highest in the world, standing at five to six times the global average.

Similar to other countries, domestic violence reports to the police and calls to helplines increased in SA with the onset of lockdowns to curb the spread of the COVID-19 pandemic.

“It has been widely reported that more than 2 000 gender-based violence cases were reported to police in the first week of lockdown in March 2020, a 37% increase over the weekly average in 2019. An Oxfam study on the worldwide increase in gender-based violence during the pandemic states that calls to domestic violence hotlines in SA increased by 69% during the first month of lockdown.

“This is a clear indication of the scale of what President Cyril Ramaphosa has called the ‘second pandemic’ of gender-based violence in SA. Conditions such as remote working and isolation with abusers, restrictions on movement, school closures and having to adapt to remote and home schooling, financial worries due to feared or actual job losses, and generally struggling to cope with drastic life changes brought about by the pandemic have all contributed to both increased mental stress and worsening levels of domestic and interpersonal violence against women,” Dr Minty said.

She said that even before the pandemic, worries about personal safety and becoming a victim of crime affected SA women more than men.

Women in SA are more fearful of walking alone in their neighbourhoods in daylight

or at night, walking to work or shops, taking public transport and allowing their children to play freely in public open spaces or walk alone to school.

“All of these fears in turn contribute to heightened levels of stress and anxiety, which impact on women's mental health. Women live in constant fear of violence and threats to their wellbeing and that of their children – from strangers, family members and, worst of all, their intimate partners.

“Women exposed to violence and trauma are more likely to develop post-traumatic stress disorder (PTSD), depression, anxiety and substance abuse problems. They are also more likely to cope poorly with the general stresses of life, have low self-esteem and disordered eating patterns,” she said.

One in three South Africans suffer from common mental disorders such as anxiety and depression in their lifetimes, with more than half the respondents in a recent study reporting higher levels of psychological distress since the outbreak of COVID-19, and many turning to drugs and alcohol to cope.

These ongoing fears and their mental health impacts have a knock-on effect in how women are able to function in society in their multiple chosen or designated roles as mothers, wives, caregivers, educators, employees, professionals or business owners.

“Women play such an integral role in both formal and informal social and economic structures – it is imperative to consider their needs and support them,” Dr Minty said.

“Prevention and change start with education and empowerment of both men and women. We need to move away from a patriarchal social structure and improve the economic status of women, along with better access to healthcare and education that empowers women rather than promoting submissiveness.

“For both women and men, we need to improve access to public mental healthcare and do better in combatting substance abuse that fuels violence,” Dr Minty said.

References available on request.

Urgent action required to address obstetric violence in SA

Embrace

During the 16 Days of Activism Against Gender-Based Violence (GBV) in December last year, Embrace convened a lekgotla with mothers and mother supporters to deliberate on urgent action needed to tackle the pandemic of obstetric violence in SA.

Obstetric violence refers to the mistreatment of birthing people by healthcare providers during pregnancy and childbirth, and is a violation of their reproductive health rights and basic human rights. It results in physical or psychological harm during pregnancy, birth and postpartum, and can lead to ongoing physical and psychological trauma for the birthing person, fetus and newborn. Embrace has led the public conversation on this much-neglected form of GBV, which is pervasive, systemic and ultimately reflects the broader societal devaluation of women and girls in SA as well as the normalisation of violence against them, particularly marginalised and low-income women and girls.

One of the outcomes of this multisectoral lekgotla was a joint statement of organisations and individuals working in maternal health and gender justice sectors.



Joint statement

Pregnant women, girls and gender non-conforming birthing people continue to experience disrespect, neglect and abuse, including physical and psychological forms of violence, from our reproductive health services. For more than two decades of our democracy, verbal and physical assaults and unnecessary medical procedures have been documented in our country's maternal health clinics, maternity obstetric units (MOUs) and hospital obstetric departments. This normalised state of violence against women and birthing people seeking healthcare has an enduring, negative impact on maternal health outcomes and early childhood development. The abusive treatment of women and girls in maternity services is a form of gender-based violence that reflects the broader societal devaluation of women and girls in SA and the normalisation of violence against them, particularly marginalised and impoverished women and girls.

Black and low-income women and birthing people are especially vulnerable to this form of gender-based violence, known as obstetric violence. Women and birthing people are targeted further by multiple and intersecting forms of discrimination based on immigration and refugee status, sexual orientation, gender identity, religion, ethnicity, age and disability.

The challenges faced by the healthcare system, including inadequate human and financial resources, equipment, medicines and other necessary support for those working in maternal care, contribute to obstetric violence, and must be transformed. Lack of resources cannot be an excuse to not provide humane quality of healthcare. Poor working environments or perceived unsafe practices by pregnant women and persons cannot justify gender-based violence.

SA's national clinical guidelines for maternity care outline and mandate humane healthcare. The signatories of this statement jointly call upon the health ombudsman, the ministers of health as well as women, youth and persons with disabilities, the heads of maternal and child health, provincial MECs and district health managers to use their authority to urgently take the following steps that will systematically intervene in the pandemic of gender-based violence, by addressing obstetric violence.

We call for:

- the recognition of every pregnant person's autonomy and right to accurate and accessible information delivered and in their language of choice so as to enable them to make decisions about their care. Furthermore, the right of every pregnant or birthing person to dignified, respectful healthcare throughout pregnancy, and for the recognition of their right to be free from violence and discrimination during childbirth.
- the Department of Health to prioritise the prevention of violence and ensuring of humane treatment of pregnant women and birthing persons in the department's implementation plan and applications for delivery of the National Strategic Plan Against Gender-Based Violence.
- the Minister of Health, and Minister of Women, Youth and Persons with Disabilities to develop and cost a measurable and time-bound plan to transform the resourcing of maternal health with the aim to prevent neglect and abuse due to understaffing and under-resourcing by December 2022. The Department of Health and the health system contribute to the empowerment of girls, women and birthing persons by strengthening comprehensive sexual and reproductive health and human rights education, and by improving existing reporting structures (e.g. the health ombudsman, professional bodies such as the SA Nursing Council and the HPCSA).
- political and administrative managers throughout the health systems to apply a zero-tolerance response to obstetric violence, including through education and ongoing training for healthcare workers on the rights-based approach to sexual and reproductive healthcare, and obstetric violence, applying binding punitive employment sanctions to perpetrators of violence, including directors and managers who fail to investigate and prevent this particular form of violence against women.

"We have been deeply affected by the ways mothers continue to struggle in systems that often render their needs invisible or inconsequential. The eradication of the violence experienced by women giving birth in our country's healthcare facilities requires an examination of all the many issues at play. Obstetric violence affects individual healthcare users and healthcare providers, but it is also structural – we need to look at how healthcare is organised, resourced and administered, how healthcare workers are trained and supported, as well as existing accountability mechanisms," says movement leader Julie Mentor.

Some of the signatories of this statement include mothers affected by obstetric

About Embrace

Embrace is a social movement that values and celebrates motherhood and mothers, and the critical role they have to play socially, economically and politically in SA. We believe that every mother and mother supporter can join us, and together, we can be inspired, mobilised and connected to effect change. Embrace is incubated by the DG Murray Trust.

violence, and individuals from the DG Murray Trust, Flourish, Treatment Action Campaign, University of the Western Cape (Department of Women's and Gender Studies), Rhodes University (Critical Studies in Sexualities and Reproduction), International Board Certified Lactation Consultants, Sexual and Reproductive Justice Coalition, Roam Parenting Guidance & Support, SA Registry of Community Midwives,

Perinatal Mental Health Project, Gestational Justice Research Hub, the Centre for Applied Legal Studies and many more.

We recognise that everyone has the right to live free from violence, and call for an end to obstetric violence in all its forms.

Please contact Nonkululeko Mbuli, communications and advocacy strategist: nonkululeko@embrace.org.za or 0793671991.

SAMA expresses concern over section 59 report

SAMA Communications Department

SAMA says it is concerned at the slow pace of delivery of the final report of the Section 59 Inquiry by the Council for Medical Schemes (CMS) into unfair racial discrimination against black doctors.

In August 2019, the CMS initiated an investigation into allegations from black medical practitioners that medical schemes used racial profiling against them when conducting audits. The inquiry into the allegations that black healthcare providers were treated unfairly by medical schemes based on race and ethnicity ran from October 2019 to January 2020.

Although the final report was scheduled for release in August 2020, an interim report was only released in January 2021, and confirmed that racial profiling existed. At this point, medical schemes were tasked with providing further information to the CMS, ahead of the final publication of the report.

"It has been almost a year since the interim report was published, but no final report has been forthcoming. Despite many queries sent to the CMS, there is also no indication of when that final report can be expected, nor has there been any feedback from them on the progress of the further submissions by the medical schemes. All of this is extremely concerning, as these issues should have been dealt with as quickly as possible," says Dr Angelique Coetzee, chairperson of SAMA.



"Silence on these matters won't make them go away"

Dr Coetzee says that SAMA views the allegations – and the subsequent findings in the interim report – as serious, and that they should have been prioritised for finalisation by the CMS. She says the findings of the report show that medical schemes have a case to answer, and that black healthcare workers have a right to know where they stand. She says that while these answers are still outstanding, black healthcare

workers are left to wonder whether the CMS is considering their concerns as seriously as it should, or if the lack of information is an attempt to "wait it out" until the problems go away.

"Silence on these matters won't make them go away, nor will it absolve those medical schemes found to be racially profiling our black colleagues. Instead, these matters, which should have been fast-tracked for finalisation, are being left to simmer, which is problematic for everyone in this sector. We need answers, and we need them sooner rather than later, as this will also show intent from the CMS to deal effectively with the problem," concludes Dr Coetzee.

We expected people with asthma to fare worse during COVID – turns out they’ve had a break

Bruce Thompson, professor and dean of the School of Health Sciences, Swinburne University of Technology

There were fears at the beginning of the COVID-19 pandemic that people with asthma would fare much worse than those without it. Intuitively, a disease that attacks the lungs should put asthma sufferers at much greater risk. But this hasn't been borne out.

Firstly, it's turned out people with asthma are at slightly lower risk of acquiring COVID, being hospitalised with it or indeed dying from it, compared to people without asthma. Though someone with asthma who is hospitalised with COVID is slightly more likely to require ICU admission.

In addition, asthma attack rates have substantially reduced in many parts of the world. What explains this?

Asthma sufferers aren't getting sicker from COVID

Asthma is an umbrella term for a range of diseases of the airways, which have similar outcomes – constriction of the airways causing difficulty breathing. In some forms of asthma the constriction is a result of inflammation, or rash, within the lung.

Many people with asthma take asthma preventers, which are a type of steroid drug we lung experts call “inhaled corticosteroids”. These drugs reduce the amount of inflammation in the lungs.

Interestingly, another steroid, dexamethasone, is being used as a treatment for COVID for this same reason.

Asthmatics might be inadvertently reducing the risk of severe COVID, if they contract it, by regularly using their preventers, because they are “pre-treated”, if you like.

Indeed, some preventers are thought to be “anti SARS-CoV-2”, that is, they have some ability to kill the virus that causes COVID.

What's more, some good evidence from Australia demonstrates that patients with asthma have decreased “ACE2 gene expression”. ACE2 is the point of entry for the SARS-CoV-2 virus to get into our cells.

If you have less ACE2, then there are fewer gateways for the virus to enter our cells, and there's less opportunity for the infection to take hold.

Why have asthma attacks declined?

There are a number of possible reasons why asthma attacks have declined. Asthma is a chronic condition that can flare up when sufferers are exposed to their “triggers”. Common ones are pollens, chemicals, dust mites, pets, mould, smoke or viruses.

Social distancing and locking down millions of people around the world has been a real-time case study in what staying at home would do to asthma rates.

Because people in lockdown go outside a lot less, this could reduce their exposure to pollen and other allergens and irritants outdoors, such as smoke, thereby reducing asthma attacks.

What's more, social distancing and lockdowns also significantly reduce the number of interactions between people, thereby reducing the spread of infectious diseases. We've been able to reduce COVID cases this way, and flu cases too.

In 2019, there were 302 084 flu cases notified to health departments in Australia. And that was with a significant proportion of the population vaccinated. In 2021, up to 7 November, there have been just 598 flu cases.

Along with this, we can presume there have been far fewer common colds and other types of infectious diseases.

Viruses can cause asthma flare-ups, which are known by lung experts as “viral exacerbation of asthma”. So fewer people with colds and the flu could also contribute to lower asthma attack rates.

There have also been reports of fewer people seeking medical care for fear of contracting COVID in healthcare settings, which may be another reason for fewer people seeking care for asthma.

What will happen to asthma post COVID?

We're used to tolerating a certain level of many infectious diseases in the community, particularly things such as common colds, strep throat, even glandular fever and the flu.

For most of us, this is no big deal, and the only effects are feeling not great for a few days or weeks of the year.

But for many others, these sorts of common infectious illnesses can be deadly. Think about someone with cystic fibrosis, which severely damages the lungs and digestive system. If they get a cold or the flu, it can seriously knock them around, or even kill them. Same with someone who takes medications to depress their immune system, for example, people with rheumatoid arthritis.

These infections result in many hospitalisations, which puts pressure on the whole hospital system.

From COVID, we know that there are simple measures we can take to substantially reduce the transmission of these seemingly “benign” diseases, including wearing masks, not going to work or socialising when you're sick, and washing/sanitising your hands regularly.

We've reached the milestone of having more than 80% of Australians over the age of 16 fully vaccinated against COVID, and international travel is resuming. Returning travellers are likely to bring with them new flu strains that we're totally unprepared for.

Usually flu vaccines for Australia are designed to tackle strains from the northern hemisphere winter, so we're prepared for when the new strain arrives in our winter.

But there has been such little flu overseas, and with the understandable focus on COVID, our vaccines for flu and other existing conditions may need to be revisited.

Not revisiting existing vaccines for flu and other previously common conditions may lead to a wave of flu and many other diseases, given we'll have limited immunity to them.

So we may soon see asthma attacks take off again, exacerbated by viruses.

Source: The Conversation, 23 November 2021. <https://theconversation.com/we-expected-people-with-asthma-to-fare-worse-during-covid-turns-out-theyve-had-a-break-165730>.

Grass-roots solutions that are making a difference in the fight against HIV/AIDS

SAMA Communications Department

The current shortage of healthcare practitioners in SA poses a substantial threat to the adequate provision and delivery of healthcare. Many in the healthcare sector believe that this shortage constitutes a national crisis.

SA's doctor-to-population ratio has declined well below the global average of 15 doctors per 10 000 people. Currently, we have 6 doctors per 10 000, and only 10 specialists per 100 000 people. It is not uncommon for doctors and nurses in the public health sector to work extended shifts, doing the work of two or three people, with understaffing resulting in patient backlogs, delays in life-saving interventions and a lack of medical support when dealing with epidemics such as HIV/AIDS and the COVID-19 pandemic.

Changing lives from the ground up

The Tshemba Foundation was created in 2017 to address some of these shortages, particularly in the hardest-hit rural areas. Tshemba is a medical volunteering programme that connects healthcare professionals from around the world with primary healthcare (PHC) clinics. Situated in Acornhoek in Mpumalanga, Tshemba places volunteers in the local district hospital, Tintswalo, as well as across the network of clinics in the broader region.

Over and above attracting volunteers, Tshemba also works to foster a more cohesive healthcare system in the district, bringing together the private and public sector for a more successful model of healthcare intervention.

"Volunteers play a critical role in rural healthcare, but ultimately it's the passion and dedication of everyone involved, and our willingness to work together, that is seeing results," says Inez Allin, PHC co-ordinator at Tshemba Foundation. "We are changing what PHC looks like in these rural areas by linking government, non-profits and medical volunteers. Together, the sum of our parts is exponentially more powerful than what we can achieve alone, and seeing the direct and immediate on-the-ground impact of these interventions is incredible. It's food for the soul."



Hlokomela's sex workers project (in collaboration with NACOSA) works in the communities in Mopani district, with a mobile clinic to improve access to healthcare for sex workers by providing health education, screening for HIV, TB and STIs, providing treatment and offering PrEP

Grass-roots solutions that make a difference

One such partnership is with Hlokomela, a non-profit organisation that has an award-winning HIV/AIDS educational and treatment programme, as well as a PHC clinic.

Situated in the Mopani District of Limpopo Province, near Tintswalo's feeder area, Hlokomela has successfully turned the tide of HIV and AIDS in the district.

SA has the largest HIV epidemic in the world, with 7.7 million people living with HIV. In 2020, nearly 4 500 South Africans were newly infected every week. One-third of these are adolescent girls and young women aged 15 - 24. These are staggering figures, by any stretch of the imagination.

Globally, a region is considered to be suffering a "hyper-endemic" HIV epidemic if more than 15% of the adult population is HIV-positive. SA far exceeds these numbers.

As yet, in the Maruleng Municipality, the prevalence of HIV/AIDS has dropped from 23.9% in 2005 to 6% today, thanks in large part to the interventions of Hlokomela.

Leading the way in the fight against HIV/AIDS

In 2005, Christine du Preez, a nursing sister



Tshemba volunteer Harriet went along with the mobile clinic to help the nurse with the treatment of challenging cases, and identified the need for training on STI treatment protocols

married to a Limpopo fruit farmer, started a one-room clinic on Richmond Farm. She immediately recognised that too many farm workers were tragically dying from unknown causes in Maruleng Municipality. Once it became clear that the cause was AIDS, Hlokomela secured the funding necessary to dispense antiretroviral treatment (ART),

and started an education and awareness programme to help the local community understand how to prevent the transmission of HIV, as well as that there are treatments available to suppress viral load. For pregnant mothers, ART significantly reduces the risk of transmitting HIV to an unborn child, for example.

Since then, Hlokomela has not only proven what is possible in the fight against HIV/AIDS in SA, but the clinic has grown to play an important role in PHC in the area, diversifying into a donor-funded PHC clinic, treating everything from the common cold to hypertension, asthma, diabetes and a range of chronic and acute illnesses. In a world where specialised healthcare can seem unattainable, Tshemba, Hlokomela and

"Tshemba's volunteer programme means that twice a week we have doctors working at the clinic"

Tintswalo Hospital are working together to ensure this isn't so.

"We receive chronic medication from the department of health, but our organisation's

salaries are funded through donors," explains Laverne Stebbing, clinic manager at Hlokomela. This is one of the reasons why Tshemba's medical volunteer programme is so important.

"Tshemba's volunteer programme means that twice a week, we have doctors working at the clinic," says Stebbing. "Our professional nurses assess patients and then, where necessary, we can book follow-on appointments with our volunteer doctors. Tshemba's volunteers range from generalists to specialists, such as gynaecologists and ophthalmologists. It's amazing that we can offer this level of care in our rural community and that we can change lives in one of SA's most rural areas."

24-hour resignations and their consequences

Ruan Vlok, employee relations advisor, SAMA employee relations department



Instances arise where an employed doctor intends to give a short notice period, for one of a number of reasons. In turn, doctors in the private sector acting as the employer may be faced with instances where their employees resign without working the prescribed notice period. In this article we will discuss the principles with regard to resignations and applicable notice periods, with reference to legislation in both the private and public sectors, and the applicable law and case law.

Legislation

Item 69 of the Public Service Regulations of 2016 states:

"1. An employee may resign from the public service, and for that purpose shall –

(a) in the case of any employee who has been employed for 1 year or more, give at least 4 weeks' notice of resignation;

(b) in the case of any employee who has been employed for more than 6 months but not more than a year, give at least 2 weeks' notice of resignation;

(c) in the case of any employee who has been employed for 6 months or less, give at least 1 week's notice.

2. Subject to section 16B(6) of the Act [Public Service Act, 1994], the executive authority and the employee may agree to a period of notice shorter or longer than the applicable period referred to in sub regulation (1)."

Resignations within the private sector are regulated by section 37 of the Basic Conditions of Employment Act No. 75 of 1997, which prescribes the same notice period requirements as the above mentioned item 69 of the Public Service Regulations.

Case law

In the case of National Entitled Workers Union v Commission for Conciliation, Mediation & Arbitration & Others (2007) 28 ILJ 1223 (LAC),

the employee resigned from employment without giving the proper notice as prescribed, whereafter the court came to the conclusion that employees are not allowed to give short notice periods. The court ruled that there was no legislation in terms of our labour laws, and the employer could issue summons against an employee, claiming damages under the common law for breach of contract.

Conclusion

Contracts of employment usually set out the applicable notice periods should employees wish to terminate their services, and as a result employees are contractually obliged to comply with these to prevent any adverse actions from the employer. Taking the above into consideration, one can conclude that employees are not allowed to give 24 hours' notice or any notice shorter than the prescribed periods. As resources, an employer will be entitled to deduct monies from any outstanding statutory monies still due to the employee, which will consist of an amount equal to the notice period not given. Employers may also issue summons against an employee for any damages suffered as a result of the short notice period. However, the onus of proof will rest on the employer to prove and quantify any alleged damages suffered as a result of the short notice period.

How vital is COVID-19 vaccination for your family?

Dr Daniel Kapelus, *vaccinologist and molecular biologist*

With COVID-19 vaccinations open to children aged 11 and up, it's more important than ever for reliable information to be accessible to parents hoping to make the best decision for their children. Critically, we need to remember that vaccines are safe, effective and reliable.

The COVID-19 vaccines available in SA are Pfizer-BioNTech and Johnson & Johnson (J&J) vaccines. Our first important note is that the vaccines – and this is true of all vaccines – are designed primarily to decrease the severity of disease, and not necessarily to prevent infection. Prevention of infection or the reduction in infection risk is a bonus of vaccines that are already working to protect you from severe disease. If you are vaccinated, you are still at risk of contracting COVID-19 and passing it on, but your risk of severe or long COVID-19 is significantly reduced. However, recent data shows that vaccinated individuals are five times less likely to be infected, and produce a lower viral load when infected – decreasing how infectious they are. Overall, if your family is vaccinated, you are less likely to contract and transmit the virus, although the risk is still present. Therefore, it is important to still behave responsibly when vaccinated: you must still socially distance, sanitise and wear masks. These non-medicinal measures are as important as vaccination in the fight against COVID-19.

Many people are concerned about the rapid development of the COVID-19 vaccines, but there is no need to worry. The development processes were streamlined and run efficiently to avoid delay and corner-cutting. Traditional vaccine development is linear, with each phase of the trial run consecutively and often funded independently. This generates a lot of time spent on administration rather than the science itself. In the COVID-19 vaccine trials, the phases were funded together and ran concurrently to save time, and the manufacturing was done at risk before and while regulatory approval was being obtained. Another thing to note is that these vaccines were developed in a highly pressurised environment with huge resources – both in terms of finances and personnel – as virtually the entire medical science world was involved in the development process. This is in stark contrast to traditional vaccine development, where you have a single team working on it



with limited resources and without external pressure. A similar situation was the recent Ebola outbreak of 2018, which also stimulated rapid vaccine development. The technology employed by these vaccines is novel, but mRNA vaccines were first proposed in 1990, and have been thoroughly investigated since then, and the viral vector design of the J&J vaccine has been used in licensed vaccines before, namely the 2018 Ebola vaccine.

Critically, we need to remember that vaccines are safe, effective and reliable

Vaccines aren't dissimilar to everyday food choices. The vaccines contain either entirely natural ingredients, or synthetic ingredients that are commonly used in processed food items that most people eat regularly. All the ingredients in the vaccines are ones that your body is likely to have seen before – just because something has a long chemical name doesn't mean that alarm bells should start ringing. For example, 3-methylbutanal

and 2-hydroxy-3-methylethyl butanoate are compounds found in bananas. The other components of the vaccines are buffering salts to balance the pH level and sugars to act as stabilisers, both of which are natural compounds. Following vaccination, all traces of the vaccine are eliminated from your system within 3 to 4 weeks, so nothing lingers for long.

Now that we know what goes into a vaccine, what happens to our bodies when we get one? The COVID-19 vaccines have a good and well-supported safety profile. After vaccination, you can expect to feel some mild short-term side-effects such as fever, chills, body aches, headaches, joint pains and general flu-like symptoms for 1 to 3 days post vaccination. The experience of such side-effects is no different from one's chance of developing side-effects after, for example, a normal flu vaccine, which most people routinely have every year.

Congratulations, your immune system is now kicking into overdrive. The vaccines do not contain an entire SARS-CoV-2 virus, nor the proteins or mRNA required to cause disease, so you cannot get COVID-19 from the vaccine. We can also confidently say that there are no noted long-term effects – between the people who participated in the original vaccine trials and the people vaccinated in the

While children are statistically less affected by severe COVID-19, they do contribute to the spread of the virus to more vulnerable people

first phases of the vaccine rollouts, we have a considerable number of people around the world who have been vaccinated for well over 18 months with no long-term side-effects observed. In terms of severe adverse effects (SAEs), the data show that the risk associated with SAEs, such as anaphylaxis, blood clots or heart inflammation, is minute, whereas the risk of developing these symptoms from COVID-19 infection itself is much greater. For example, roughly 8 per million doses of the J&J vaccine resulted in blood clots (0.000008%), while severe COVID-19 has a blood clot risk of roughly 20%. Heart inflammation observed in young males after the mRNA vaccines (Pfizer and Moderna) occurs at a very low rate of roughly 20 per million doses administered (0.00002%). In the Pfizer-BioNTech COVID-19 vaccine trials for children aged 11 - 17 years in the USA, there were no incidences of SAEs in a cohort of almost 5 000 children.

The presence of underlying health conditions such as autoimmune disorders, immunosuppressed or immunocompromised

states, asthma, pregnancy, heart conditions or allergies unrelated to vaccines or injectable medications are not contraindications of the COVID-19 vaccination. Times when it may be safer to avoid the vaccine include having a known allergy to a vaccine ingredient, a history of allergy to vaccines specifically or experience of an SAE after your first dose. This safety data has been continuously updated as more and more people are vaccinated. As of 17 November 2021, 3.23 billion people have been vaccinated globally. If the vaccines were dangerous and were commonly causing SAEs, we would know about it. We can confidently say that the benefits of vaccination far outweigh the risks.

Credible sources are our number one place to find vaccine information. Sources that rely heavily on anecdotal evidence rather than empirical evidence, or which misrepresent data and statistics, or use highly emotive language, should be avoided. Rather, stick to trusted institutions such as the WHO, CDC, NICD, university sites such as Oxford, Harvard, Johns Hopkins, etc. and mainstream media that cites sources like these. To give an example of how statistics can be misrepresented, let's look at the following hypothetical situation: a village of 100 people has 99 vaccinated people and one unvaccinated person. Two people get COVID-19, the unvaccinated person and one other. Some would report that "50% of COVID-19 cases occurred in the vaccinated people," but this is a misrepresentation. Rather, 100% of the unvaccinated people got COVID-19 and only 1% of the vaccinated people got COVID-19. Another red flag is stating correlations as causations. To give a silly example, we are the



only planet in our solar system that has death, and we are also the only one with birds, but birds aren't the reason people die on Earth (mostly – we won't talk about geese).

The crux of the matter is this: why do we vaccinate our families? The answer is simple: we want to protect our family members, our children and those around them. While children are statistically less affected by severe COVID-19, they do contribute to the spread of the virus to more vulnerable people, and can be susceptible to severe and/or long COVID-19. The risks of COVID-19 might not be as bad for children as they are for older family members, but they are far greater than the minimal risks of vaccination – which come with a host of benefits for your family, unlike COVID-19.

Death verification guidelines

SAMA Communications Department

Noting the absence of national guidelines for the verification of deaths, SAMA has produced a draft reference document designed to provide guidance about the conditions necessary to verify death.

Discussions and investigations with various colleagues from the University of Pretoria, National Department of Health, Critical Care Society of SA, Colleges of Medicine, the South African Law Reform Commission, Walter Sisulu

University and the University of KwaZulu-Natal into systems of death verification have led SAMA to the conclusion that there needs to be a better legislative framework as well as guidelines for the verification of deaths that occur outside of healthcare facilities in the country.

There is currently no formal framework outlining processes of death verification, and the SAMA Human Rights, Law and Ethics (HRLE)

Committee feels that additional guidance and legislation needs to be implemented.

SAMA has drafted an initial and simple guideline for death verification processes. The document can be accessed here: <https://www.samedical.org/file/1675>.

Please send any comments or input to Bernard Mutsago at the SAMA Knowledge Management and Research Department: Bernardm@samedical.org.

Failure to follow specialist advice

The Medical Protection Society shares a case report from their files

Following a hospital admission for status epilepticus, which was attributed to a previous cerebral insult, Mr G, a 35-year-old clerical officer, was started on an anticonvulsant regime of phenytoin and sodium valproate. Over the next few years, the medication was changed by the treating doctor several times in response to the patient's concerns that his epilepsy was getting worse. After a further seizure led to another hospital admission, the patient was discharged on vigabatrin on the advice of the treating neurologist, Dr W. Readmission for presumed status epilepticus a short while later led the treating doctor to conclude that there might be a functional element to the seizures. This was supported by a psychiatric evaluation. The patient was discharged to psychology follow-up, with a recommendation at the end of the discharge summary to gradually tail off and stop the vigabatrin. This advice was overlooked by Mr G's GP, Dr L, who continued to prescribe as before. The error was not picked up by either Dr L or the hospital despite multiple contacts and several hospital admissions over the next 5 years, for the first 3 years of which Mr G remained under the care of Dr W.

Subsequently, Mr G was seen by both Dr L and his optician complaining of tired, heavy eyes. No visual field check was carried out on either occasion. Nine months later, Mr G returned to see Dr L requesting a referral to Dr W as he had read a newspaper report about the visual side-effects of vigabatrin. An appointment was made with Dr W, but Mr G failed to attend on two occasions. An urgent referral was ultimately made by Mr G's optician several months later following detection of a visual field defect on a routine examination. The ophthalmic surgeon Dr D noted that Mr G had been on vigabatrin for over 11 years, during which time he had not been monitored. His visual fields were noted to be markedly constricted, which was attributed to the vigabatrin. Mr G was referred to another neurologist who recommended a change of anticonvulsant. Mr G was gradually weaned off the vigabatrin.



Learning points

- If a doctor signs a prescription, (s)he takes responsibility for it, even if it is on the advice of a specialist. Good communication between GP and specialist is vital to ensure that patients receive the appropriate treatment.
- Patients should be informed if there is a need for monitoring or regular review of long-term medications. Where two or more clinicians are involved in the care of a patient, agreement should be sought as to the most appropriate arrangements for monitoring. All advice should be clearly documented.
- When alerted to a potentially serious side-effect of medication, prompt arrangements for review should be made, with a specialist if appropriate.

As a result of the damage to his eyesight, Mr G brought a claim against Dr W for negligent prescription of vigabatrin and failure to warn him of the side-effects. Mr G also brought a claim against Dr L for continuing to prescribe vigabatrin against the advice of the neurologist, failing to review the medication at regular intervals and failing to refer to an ophthalmologist.

Expert opinion

The Medical Protection Society's GP expert was critical of Dr L's failure to act on the

neurologist's advice to tail off the vigabatrin, and for the absence of any record that Dr L monitored the patient or reviewed his medication. Dr L's decision to refer Mr G to an epilepsy specialist once he was alerted to the potential side-effects was appropriate, and Dr L could not be held accountable for Mr G's failure to attend a number of appointments, which may have contributed to the delay in diagnosing the visual field defect. The claim was settled on behalf of Dr L and Dr W for a reduced but still substantial sum.

Branch councillors meet and share

The Free State branch (FSB) held their year-end dinner function at Avanti restaurant, Woodlands Hills, in Bloemfontein on 15 November 2021.

The branch expressed their appreciation to their councillors for all the time they spend attending meetings, and all the work done by this group of dedicated SAMA members, and acknowledged the supporting role played by their spouses.

Prof. Hagemester, chairperson of the branch, presented the opening and welcome speech, and Dr van der Bijl made a toast to SAMA.

The dinner was an opportunity for branch councillors to meet and share memories.



Dr Chantelle van der Bijl (SAMA FSB honorary secretary) toasts SAMA

KZN Midlands join fun run/walk

The Cancer Association of SA invited the KZN Midlands branch to be part of the CANSA 5 km Fun Run/Walk held on 20 November 2021 at Voortrekker High School.

Doctors were invited to bring a friend to join the run and to visit the SAMA stand, which was enjoyed by all. The event promoted both breast and prostate cancer awareness, and the importance of early detection.



Best dressed winners of the day



Dr C N Gama



Dr H Ramnarain and Dr S Foolchand

Letters to the Editor

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

Please note that letters:

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

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



GWB donate metal detectors to NC DoH

SAMA Griqualand West Branch (GWB) recently donated two hand-held metal detectors to Robert Mangaliso Sobukwe Hospital (RMSH), Northern Cape Department of Health (NC DoH), to ensure proper screening of all and to promote safety for medical staff.

The hand-held metal detectors were presented to the NC DoH head of department, Mr R Strydom, and CEO of RMSH, Dr K A Kantani, by the branch administrator of SAMA GWB, Sultana Hartzenberg, at the emergency unit at RMSH.

The concern for health and safety is legitimate in every context of human enterprise, as people are one of the most important assets in an organisation.

Stress and violence are increasingly noted in health sector workplaces. Doctors, nurses and social workers are all high on the list of occupations with serious stress levels, while violence in the health sector constitutes almost a quarter of all violence at work. Employers and workers are equally interested in the prevention of violence and severe stress at the workplace.



Mr Riaan Strydom (HOD, NC DoH), Sultana Hartzenberg (administrator, Griqualand West branch) and Dr Alastair Kantani (CEO of RMSH)



Mr Alfred Kolobe (RMSH head of security), Sultana Hartzenberg (administrator, Griqualand West branch) and Christine Lamprecht (director: security management, NC DoH)

Griqualand West thank councillors

The Griqualand West branch recently expressed their appreciation to their councillors for the time they spend attending meetings, and all the work done by this group of dedicated SAMA members.

The branch also said a big thank you to their spouses, as it is a sacrifice that affects the whole family. A social event was held on 9 December 2021 at the Hussar Grill restaurant in Kimberley.

Dr Lesego Diphatse presented the opening and welcome speech, and Dr Mbesi Joseph Ngundu, chairperson of the branch, made a toast to SAMA.

The dinner was a good social encounter for branch councillors to meet and indulge in sharing memories.



Back row: Jean de Villiers, Dr Mbesi Joseph Ngundu, Dr Lesego Diphatse and Nigel Hartzenberg; front row: Dr Ilse Blanchè, Lutendo Diphatse and Sultana Hartzenberg

KZN Midlands membership drive

On 24 and 25 November 2021, the KZN Midlands branch joined the Mediclinic team on a membership drive in Kokstad.

SAMA and non-SAMA members were visited and welcomed with open arms. Information was exchanged by handing out a branch information pack and SAMA items to each doctor as a token of appreciation.

Mandy Hattingh (KZN Midlands branch secretary) met up with Nongcobo Faku (Transkei branch secretary) in Mthatha during the visit. Building relationships is key, and part of growth.



Ms Nongcobo Faku (Transkei branch secretary) and Mandy Hattingh (KZN Midlands branch secretary) in Mthatha



Charl Rautenbach (ER 24 Pietermaritzburg), Mandy Hattingh, Jason Paydanna (ER 24 Pietermaritzburg)

Donating to the Angels' Care Centre

At the end of last year, the KZN Midlands branch reached out to the Angels' Care Centre as part of the branch Corporate Social Investment (CSI) project for 2021.

The Angels' Care Centre was established by concerned residents in the Umgeni area in order to address the needs of desperately poor children from the local informal settlements. The organisation focuses on assisting 400 children through the provision of preschool education, aftercare facilities, a feeding scheme and healthcare programmes, which include a crisis centre to assist victims of gender-based violence.

During December 2021, the Angels' Care Team handed out Christmas presents, which included colouring books, crayons and soft toys donated by the branch.

Georgina Purdon from Angels' Care said: "We can't thank everyone who was involved enough. What a special way to end a very difficult year. I am still smiling from ear to ear knowing that these children felt so loved and cared for."



Children receiving gifts



SAMA welcomes the following new members who joined our association in December.

Cape Western branch

Michael Robert Cooke
Jacques Henning de Vos
Andrea Robyn Williams

Gauteng branch

Jessica Irvine
Makhosazane Radebe



How to kick-start your career in 2022

The idea of practising as a medical Locum is often a topic that scares people into accepting that a full-time position is their only option, when flexibility is what they really want.

But looking for a full-time position in an established medical practice can take time, and a qualified medical professional shouldn't need to look hard to find a stable career in the medical industry, and this is also why Locuming should feel appealing and accessible to you.

Qualified and looking to gain experience?

Consider a season of Locum work as a way to kick-start your career before diving into full-time practice work, or in the interim stage while looking for a full-time position in an established medical practice.

If you have qualified in your medical field and registered with your professional body, you have the opportunity to Locum. A Locum is a medical practitioner who has full certification and qualification in their field and is temporarily covering an important medical position. For example, should a practice reach capacity and need to lighten the workload on permanent staff, a Locum will step in to ensure that the increased capacity need is met.

Practising as a medical Locum, in whichever field of study you have qualified in, is a good way to get broad experience. You have the flexibility of working in multiple different practices building experience and your patient list as well as gaining an understanding of procedures, operating systems and styles of management. It is wise to approach your career with an open mind while allowing yourself to be exposed to many diverse working environments to build up an arsenal of knowledge before opening your own practice. Regardless of what your end goal is, a broad understanding will benefit you as a working professional in the long run.

Allow yourself the flexibility

On coming out of an academic environment, it is good to allow your career to work for you as a professional at times. After working hard over a number of years to achieve your qualification as a medical practitioner, easing into full-time work could benefit you in your longevity as a passionate medical professional, as most graduates begin work on the brink of burnout. Locum work is a great way to achieve an "easing in" phase and assist with paying off any student debt while building your career.

Taking charge of your skilled hours by utilising our LocumBase platform, you have the power to set which days you would like to work and which days are blocked off from your calendar. As a Locum on our platform, you also have the opportunity to decide how much you'd really like to earn for those days you work in relation to your experience, and you can find some rate guidelines here.

Working as a Locum during the COVID-19 pandemic

This has been a challenge for Locums, as the constant change of work environments can increase the chances of contracting the virus. However, doctors who have opened their doors are ensuring that their practices are completely disinfected and everything is kept in a sanitised condition.

Locum work is a good way to ease into the direction you'd like to take, and if you find a routine that works for you, you have the opportunity to be your own boss while practising as a Locum. With the opportunity to decide when and how you work, you have the opportunity to continue along the Locum career path. Locum work can be a successful career choice in the medical industry, and with free tools such as LocumBase.

Sign up today to kick-start your Locum career here.

Contact us at hello@locumbase.com for any questions you may have, or drop us a WhatsApp on 0790133962.

**KICK-START
YOUR CAREER IN**

2022



As a recent **Medical Graduate, consider a season of **Locum** work as a way to kick-start your career before diving into full-time practice work or in the interim stage while looking for a full-time position in an established Medical Practice.**

SIGN UP HERE TO KICKSTART YOUR LOCUM CAREER TODAY!



LocumBase.com



Contact us via **WhatsApp** for Business on **079 013 3962** or email one of our client success advisors at **hello@locumbase.com**

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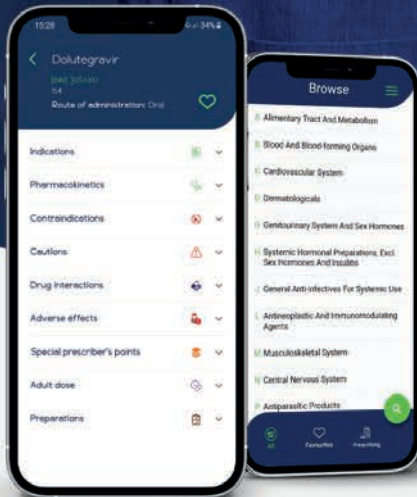
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