

SAMA INSIDER

NOVEMBER 2021

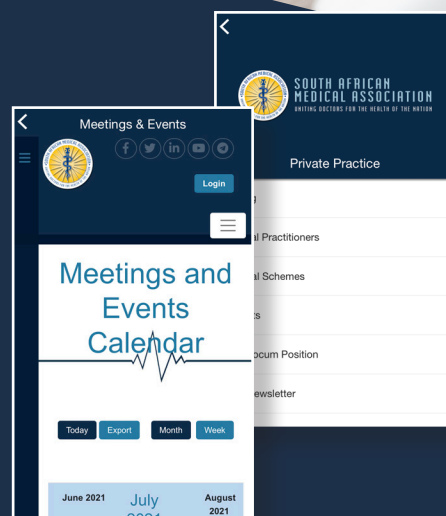
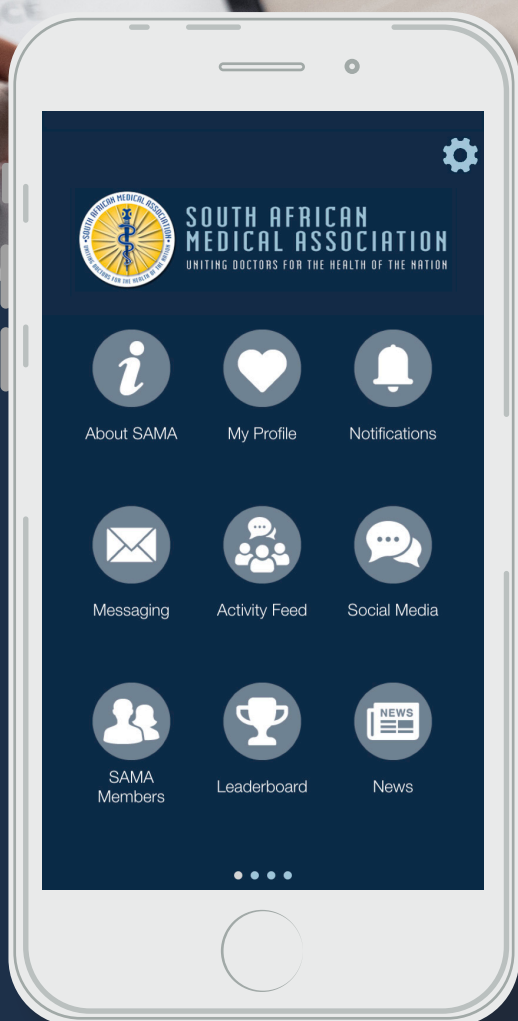
Mentorship for rural clinicians – a new vision

The safety of doctors is paramount



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Diane de Kock
Editor: *SAMA INSIDER*

A fair reflection

Wellness, mentorship, trauma, pollution, safety, personal freedom, treating mental health and ageism are all covered in this issue of *SAMA Insider*. Is this perhaps a fair reflection of some of the healthcare realities facing doctors in SA today?

SAMA President Prof. Chauke discusses internal and external wellness (page 4). "How does one maintain wellness when everything around a person, both internally and externally, is in turmoil?" Since 2019, RuDASA has made mentorship a key strategic focus, recognising that rural doctors needed high-quality and accessible mentorship, support and capacity-building (page 5). This year the Rural Africa Mentorship Program (RAMP) was born to answer the call.

Trauma is a result of dealing with grief and loss on the COVID-19 frontlines, says psychiatry professor Jackie Hoare (page 6), and in SA it is compounded by the burden of HIV and TB, a strained healthcare system and a social context of inequality and violence.

New WHO air quality guidelines detail clear evidence of the damage that air pollution inflicts on human health (page 7), while the poor state of security in the healthcare system, specifically for doctors in public institutions, is a major concern for SAMA (page 10).

Timothy Carey, in his article on "What objections to COVID-19 control measures tell us about personal freedom" (page 11), looks at the objections to the measures being taken to combat the virus, and what they mean. "We have our greatest freedom when we protect the freedom of others."

Growing evidence suggests that the psychosocial role of traditional and spiritual healers can help to relieve distress and mild symptoms of common mental disorders. This has resulted in a call for "greater collaboration between Western medical specialists and African traditional healers in providing primary healthcare for the one in three South Africans who experience common mental health disorders, of whom 75% go untreated" (page 13).

Ageism impacts health, particularly as life expectancies lengthen and the world population of people over 65 increases (page 14). "Older people can combat ageism if they are able to see negative perceptions as false, inaccurate and off-base."

All articles offer some positive advice and/or suggestions on how to deal with the challenges.

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The importance of internal and external wellness



Prof. Risenga Chauke, SAMA President

The WHO defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. In 2019, SA was one of the countries that scored the lowest in the Indigo Wellness Index, with a score of 0.28, out of 191 countries. The key 10 measures used were healthy life expectancy, blood pressure, blood glucose (diabetes risk), obesity, depression, happiness, alcohol use, tobacco use, inactivity (too little exercise) and government spending on healthcare. This begs the question: “How does one maintain wellness when everything around a person, both internally and externally, is in turmoil?”

Our world is characterised by endemic diseases and disruptive pandemics. Most of these are devastating to individuals, societies and economies. It's not surprising that 6 of the 17 Sustainable Development Goals are directly related to health matters. To date, the world is still trying to imagine life beyond COVID-19. The pandemic has also shone a spotlight on how these issues affect the rich v. the poor. Diseases such as AIDS, malaria, TB and rheumatic heart disease have also highlighted issues of health disparities resulting from systemic issues beyond one's control. How does one remain well while not being part of the solution?

How does one remain well when there is political turmoil within one's country, and beyond? War and political unrest have affected the living conditions of citizens and delivery of care, and caused economic losses. Greed is a disease threatening democracies and social justice. The days of benevolent

leadership seem to be numbered, and the days of malevolent leadership appear to be here. This benevolent v. malevolent way of doing things doesn't start at national or international political level, but begins at home and in local communities.

How does one protect wellness when there is so much carnage on our roads? Everyone driving feels that the road belongs to themselves. In SA, 26 out of 100 000 people die on the roads – far higher than the global average of 18 per 100 000. One can imagine the impact of these accidents on individuals, families and the health system. The number of motor vehicles on the roads increases every year, and public transport appears every year to be a thing of the past. There are various reasons behind these numbers, and some have to do with use of seatbelts, drinking and driving and the general attitude of road users. How does one remain well in the midst of road rage and all these challenges?

How does one become well when climate change is threatening food safety, and begets unparalleled devastation around the world? Weather patterns are no longer the same, and climate change will affect the frequency and severity of extreme weather events. Yet destruction of the environment continues unabated for the selfish reasons of those who gain from it, despite various efforts to tame it from those who want to save the world for future generations.

How does one become well when the rich are becoming richer and the poor becoming poorer? It's like living in parallel worlds. Societal values and cultures are eroded in the name of the economy. The economy surrounds people no matter what they are engaged in – whether sitting and doing nothing, or engaged in an activity. It is at play, exploiting the vulnerable, no matter what LSM level they are at. How does one remain well?

These are a few examples that rob us as individuals of our wellness. In order for an individual to be well, there must be spiritual, social, emotional and physical wellness.

The solidarity that health professionals has played and continues to play a major role in combatting illness. The current pandemic especially talks to spiritual wellness. As individuals, we continually seek meaning and a higher purpose to our existence. The sacrifices one makes for others, the nation and the world may derive from religious faith, heritage or other sources of inspiration, and

speak to spiritual wellness. Being a medical practitioner is a calling that allows us to touch lives, enriching our own spiritual lives beyond measure.

Social wellness is a function of how we connect and engage with others and our society in a meaningful way. The impact of health workers, from cleaners and laboratory technicians to the head of a clinical department, allowed us to be celebrated and referred to as “health heroes” in the community during the pandemic. We need to build on the successes gained during the pandemic to bring the profession closer to society. The question is, how do we, as health professionals, continue to affect communities beyond the pandemic in a visible way? How do we continuously increase our visibility and engagement on issues related to social determinants of health?

The issues of emotional wellness have been highlighted numerous times during this pandemic. A second question remains: how do we, as health professionals, accept and express our feelings, and walk the journey of processing our feelings? Carers need to practice self-care, and the work environment needs to assist individuals in doing so. Is counselling enough to address issues of emotion? The connection between spiritual, social and physical wellness, and emotional wellness, is clear. We are products of our thoughts, behaviours, relationships and the environment we live in. These dimensions work together, hand in glove.

Our physical bodies reflect our intrinsic wellness. The environment around us also has an impact on mental wellbeing. Physical health and green spaces are associated with mental wellbeing. Therefore, environmental cleanliness, provision of clean water and dignified sanitation and infrastructural development have a direct impact on our extrinsic physical wellness. One cannot exercise if the environment does not allow one to. Again, as health professionals, we have a duty to keep ourselves physically healthy, but also to advocate for the health of society.

Wellness is more than the state of being free from disease: it includes societal, spiritual, emotional and environmental wellness. Social determinants of health are a collective responsibility, and they cut across different sectors.

Well individuals make a well society, and a healthy society is a productive society.

Mentorship for rural clinicians – a new vision

Dr Madeleine Muller, family physician and senior lecturer, Walter Sisulu University, RuDASA executive mentoring portfolio



"See one, do one, teach one." This was the age-old phrase during my time as a medical student, and one which has accompanied me on my path as a medical doctor.

I still remember putting in my first-ever stitch (in material of any kind) to close up an episiotomy on my first day in the labour ward in my fourth year. The nurse had kindly drawn me a wonky 3D sketch outlining the basic anatomy. I somehow managed, albeit excruciatingly slowly.

This is still a daily lived experience for many young doctors as they do their first stint in A&E, or their first call in a rural district hospital as a community service officer. If you are lucky, a medical officer will show you some exotic new skill (once), and from then on you just have to "get on with it".

But fortunately, the world is changing. Not only is our understanding of the science of education and learning expanding, but so is technology. Online distance learning trainings, instructional YouTube videos, helplines, WhatsApp groups and, since COVID-19, the ever-ubiquitous Zoom meetings, have vastly expanded the ways in which we can learn, teach and mentor.

Even more importantly, the paradigm is shifting. Reminiscing on "how rough it was when I was a young doctor" no longer demands that we make our new rural colleagues suffer. Rather than a first day in a rural hospital being an initiation ritual, we are asking: how can we mentor and support these doctors? How do we improve health service delivery? How do we retain clinicians in rural healthcare? And how do we prevent burnout in our young bright-eyed graduates?

The Rural Doctors Association of South Africa (RuDASA) has always had rural support as a key part of their activities. Every Rural Health Conference includes conversations on how to better equip and support our rural colleagues.

At the Rural Health Conference in 2019, mentorship became RuDASA's key strategic focus. It was recognised that one of the biggest challenges for rural doctors were high-quality and assessable mentorship, support and capacity-building.

In February of 2020 we attempted a first small-scale "Thriving in rural care" workshop for new rural clinicians in the Eastern Cape. But we were stumped by the same obstacles that had always tripped us up: the isolation and distance of rural facilities, the challenge of doctors taking time away from busy and already strained healthcare delivery and the high cost of training.

In March 2020, everything changed. Not only were we faced with a devastating new disease that urgently needed capacitation of clinicians, but traditional face-to-face trainings were no longer possible. Now, online meeting platforms such as Zoom and Teams have revolutionised the world of training and mentoring. It seemed surreal, the ease with which Eastern Cape doctors could, for example, have an evening Zoom meeting with Prof. Graeme Meintjies, updating us on successes with high-flow nasal oxygen at Groote Schuur Hospital in Cape Town. Online meeting technology had existed for years, but COVID-19 finally forced us all to engage with it. Everyone, no matter how remote and technologically challenged, could access a Zoom meeting.

In February of 2021, RuDASA, assisted by Walter Sisulu University and the Rural Health Advocacy Project, took their community service officer in-serving programme online, creating a six-week Rural Onboarding Course.

And finally, at the Rural Health Conference in September 2021, our mentorship vision could expand to include possibilities we had never previously thought achievable.

The Rural Africa Mentorship Program (RAMP) was born.

RAMP is a vision of a network of mentors across Africa, providing mentorship through a variety of platforms to clinicians working in rural or underserved areas. We already have pockets of extraordinary mentors

and amazing projects providing innovative support to young clinicians and students. But there are areas in SA and beyond that are not so lucky, and clinicians feel isolated, out of their depth and often overwhelmed. This network could include any rural healthcare clinician – doctors, rehabilitation health service providers, clinical associates, nurses, pharmacists, dentists, dieticians, etc.

RAMP has three main objectives at the moment:

- to identify and create a framework through which effective mentoring can take place. For this we need input, ideas and best practices from mentors across the country. We need your input!
- to identify a clear skill set, tools, capacities and attitudes that form part of high-quality and effective mentorship. Being a great clinician does not automatically translate to being a great teacher. What does a good mentor look like? Becoming clear on the capacities required to be a good mentor will inform training and development.
- to create, provide and make accessible high-quality training on mentorship and teaching, including the effective use of a wide range of methodologies. As part of this process, RuDASA has created a short online workshop on key tools and tips to increase capacity of mentors, both new and experienced: <https://youtube.com/playlist?list=PL93P77MhyfHujRKwEqycGD8K01A9KelnR>.

The aim is to grow this into a fully-fledged accredited training programme.

We invite anyone involved in mentoring, whether in academic institutions, large regional hospitals training interns, district hospitals, district clinical specialist teams, etc., to join RAMP to help us develop this vision. We will be creating focus groups, Google surveys and email circulars to harvest ideas and suggestions for the RAMP network. Members of our RAMP focus group are welcome to engage as much as they wish to – there are no expectations or requirements. To join is free and voluntary.

To be added to our database, please contact Dr Madeleine Muller on mentor@rudasa.org.za. Let us create a rural health network where no clinician is left behind!

Grief, loss – we are all traumatised, says psychiatrist on the COVID-19 frontlines

Biënne Huisman for *Spotlight*

In her bright white office, psychiatry professor Jackie Hoare leans against a faux fur blanket on her sofa as she reflects on grief in a time of COVID-19.

Even though we are socially distanced, our masks remain on, as Hoare is in daily contact with COVID-patients at Groote Schuur Hospital, the academic healthcare facility attached to the University of Cape Town (UCT).

At the time of the interview, SA just exited its third wave, which saw Hoare inside COVID wards for the past 3-and-a-half months.

"I'm managing the mental health of patients admitted with severe COVID pneumonia," she says. "So I work with and am part of the frontline COVID team at Groote Schuur. I'm based in the high-care nasal flow oxygen units, across three different wards with about 55 beds, and also in our ICUs, which expand as required."

Physical touch in a time of COVID

Hoare pioneered the Division of Consultation-Liaison Psychiatry at UCT's Department of Psychiatry and Mental Health in 2011. Voice low through her mask, she explains that this model brings mental healthcare directly to patients, across hospital sectors. Within the COVID pandemic, this has meant being at the bedsides of COVID patients, providing counselling, comforting and holding the hands of the very sick and dying, and at times breaking the news of a family member's passing.

"I manage distress through whichever appropriate kind of talking therapy," she says. "I tailor the talking therapy care to the patient that I have in front of me, and that could be anything from using a CBT [cognitive behavioural therapy] model to mindfulness, to problem-solving therapy. But sometimes talking therapy isn't enough, and I need to use medication to manage the distress – which is enormous."

"This is a critical condition, and people are very much aware that they're fighting for their lives. And not only that, many of them have witnessed people die in the wards around them and have witnessed people being intubated and have witnessed people being resuscitated. So it is an incredibly traumatic unit. The high care and intensive care units, in particular, are very traumatic."

In a show of compassion, Hoare decided during the first wave – against a backdrop of public fear and scientific uncertainty – to physically touch up to 50 COVID patients a day.

"It was frightening," she says. "But I made that decision. I mean, it was very hard. In a usual consultation, I have an hour with the patient to make an emotional connection. In a critical care unit, where people are exhausted, fighting for their lives and short of breath, sometimes all I have is 5 - 10 minutes to make that connection; to help somebody feel safe, to help them feel listened to, valued, and respected. I could not do that in PPE [personal protective equipment], standing a metre away. I pretty much douse myself with alcohol sanitiser while in there – because I'm touching people all the time, holding their hands. Sometimes sitting on their beds. Every single time I touch something, before touching something else, I sanitise. That's the job, that is what I need to do."

Running over capacity

According to hospital spokesperson Alaric Jacobs, Groote Schuur treated a total of 20 771 COVID patients between April 2020 and August 2021, of who 741 were admitted to ICUs.

While the end of the third wave comes as a huge relief, Hoare points out that time for respite is scarce, as psychiatric services, previously de-escalated to care for COVID patients, are resumed.

Hoare describes the mental health fallout due to COVID-19 as "massive, absolutely enormous," with Cape Town psychiatric wards running at 20 - 30% over capacity. This includes wards at Groote Schuur Hospital, and state mental health facilities Stikland and Valkenberg.

She notes a lack of research into COVID's mental health impact in SA, however, pointing to a global study published this month in the medical journal *The Lancet*, which cites a quarter increase in major depressive disorder and anxiety due to COVID. According to the study, women and children are the most affected.

The complexities of grief

Essentially, an individual's grief response is shaped by personal resilience, which can be



Professor of psychiatry Jackie Hoare manages the mental health of patients admitted with severe COVID pneumonia at Groote Schuur Hospital (photo: Biënne Huisman/Spotlight)

traced back to early childhood nurture and possible abandonment wounds or other trauma. Starting in infancy, humans form bonds to special people, animals, places and securities. When these bonds break, painful losses ensue. Grief is a normal response to loss.

While Hoare dismisses the notion of a "grief crisis" – as put forward in some more sensational media headlines – she says that within the pandemic, grief is prevalent and complex. She adds that "normal grief" can last up to 6 months, within which time it is normal for a person to struggle and to feel distressed.

"Grief is personal and it's individual, and it may be different for each person," she says. "Normal grief can be conceptualised as lasting for up to 6 months. Symptoms in this time vary, and can include even more unusual experiences, like hearing the voice of the person who passed away, or seeing the person who passed away. That is considered normal grief and is not pathological in any way. It is when symptoms extend past the 6-month period or start to include worrying things like suicidal ideation that we start thinking about it as so-called abnormal or complex, or prolonged grief. But in the vast majority of people, even those who have really intense symptoms, they're usually resolved within the first 6 months."

Hoare reiterates the complexity of grief in this time – saying that it occurs in layers.

“We are all grieving,” she says. “We’re living in a world of tension where we don’t know quite how or when we might get to the other side. And of course, the assumption of whether we’ll ever be on the other side is still up for debate. We have lost our normal way of life. People have lost their jobs. There have been financial stresses, etc. Many people have also experienced COVID or severe COVID. So then add to that the experience of losing a parent or losing a child. Or losing a brother and a sister ...”

‘The unimaginable and the unspeakable’

Also to be reckoned with is the impact of accumulated trauma on healthcare workers. Especially given the perception in the profession that vulnerability is a weakness.

In a letter to *The Lancet* published earlier this month, Hoare notes how healthcare workers in lower- and middle-income countries such as SA face additional challenges. She points out that pandemic trauma is compounded by the burden of HIV and TB, a strained healthcare system and a social context of inequality and violence.

“Initially, we had difficulty accessing the doctors working in high care and intensive care units, to provide mental health support to them,” she says. When contacted to offer support, she says the common reply from

doctors was that others need your help more, and we’re fine.

“This changed when we made the decision to work in the high care wards, experiencing the work in those units first-hand.”

Once she joined the frontline team, sharing in their trauma, frontline healthcare workers opened up more readily, says Hoare. “Our colleagues were experiencing the unimaginable and the unspeakable. The only way they could begin to speak of what they were going through was through us having had an embodied experience alongside them.”

Hoare’s “collegial-based intervention” argues for integrating mental health professionals into COVID frontline teams.

“People in the [Groote Schuur healthcare frontline] group said a number of times: ‘We can only talk here because no one can understand exactly what we’ve been through,’ or they would say, ‘You understand because you are here with us, you are one of us.’ Trauma can isolate one from those who have not been through the same experience, while at the same time binding together those who have,” she says.

Empathy first

How does she herself absorb the sadness associated with her work? Behind her mask, Hoare’s face is impassive. “It is hard,” she says. “I am, we are all traumatised.”

She declines to discuss her personal feelings further.

While gearing up for the fourth wave, Hoare hopes to encourage more people to get vaccinated. The “vast majority” of recent COVID hospital admissions were unvaccinated, she says.

Wrapping up, she draws a distinction between so-called “anti-vaxxers” and vaccine-hesitant people, highlighting the key roles of empathy and patience.

“My experience of working with vaccine-hesitant people admitted to our wards is that an open, empathic listening approach by healthcare workers helps to overcome many of their difficulties,” she says.

“You know, face-to-face, as long as you can approach them with empathy first – not evidence first – being open and patient and listening to their fears really helps. Because their fears are real for them. Their reasons for not being vaccinated are real. And you need to respect that. And if you can do that, you can help them through that ambivalence. Because that’s what I mean: vaccine-hesitant people are actually more ambivalent than absolute. If you can help them resolve that ambivalence, they will get vaccinated.”

Source: Spotlight, 13 October 2021: <https://www.spotlightnsp.co.za/2021/10/13/mental-health-grief-loss-we-are-all-traumatised-says-psychiatrist-on-the-covid-19-frontlines/>

New WHO global air quality guidelines aim to save millions of lives from air pollution

World Health Organization

New WHO global air quality guidelines (AQGs) provide clear evidence of the damage air pollution inflicts on human health, at even lower concentrations than previously understood. The guidelines recommend new air quality levels to protect the health of populations, by reducing levels of key air pollutants, some of which also contribute to climate change.

Since the WHO’s last 2005 global update, there has been a marked increase in evidence that shows how air pollution affects different aspects of health. For that reason, and after a systematic review of the accumulated evidence, the WHO has adjusted almost all

the AQG levels downwards, warning that exceeding the new AQG levels is associated with significant risks to health. At the same time, however, adhering to them could save millions of lives.

Every year, exposure to air pollution is estimated to cause 7 million premature deaths, and result in the loss of millions more healthy years of life. In children, this could include reduced lung growth and function, respiratory infections and aggravated asthma. In adults, ischaemic heart disease and stroke are the most common causes of premature death attributable to outdoor air pollution, and evidence is also emerging of other effects,

such as diabetes and neurodegenerative conditions. This puts the burden of disease attributable to air pollution on a par with other major global health risks such as unhealthy diet and tobacco smoking.

Air pollution is one of the biggest environmental threats to human health, alongside climate change. Improving air quality can enhance climate change mitigation efforts, while reducing emissions will in turn improve air quality. By striving to achieve these guideline levels, countries will be both protecting health and mitigating global climate change.

The WHO’s new guidelines recommend air quality levels for six pollutants, where

evidence has advanced the most on health effects from exposure. When action is taken on these so-called classical pollutants – particulate matter (PM), ozone (O₃), nitrogen dioxide (NO₂), sulfur dioxide (SO₂) and carbon monoxide (CO) – it also has an impact on other damaging pollutants.

The health risks associated with particulate matter equal to or smaller than 10 and 2.5 µm in diameter (PM₁₀ and PM_{2.5}, respectively) are of particular public health relevance. Both are capable of penetrating deep into the lungs, but PM_{2.5} can even enter the bloodstream, primarily resulting in cardiovascular and respiratory impacts, and also affecting other organs. PM is primarily generated by fuel combustion in different sectors, including transport, energy, households, industry and agriculture. In 2013, outdoor air pollution and PM were classified as carcinogenic by the WHO's International Agency for Research on Cancer.

Air pollution is one of the biggest environmental threats to human health, alongside climate change

The guidelines also highlight good practices for the management of certain types of PM (for example, black carbon/elemental carbon, ultrafine particles, particles originating from sand and dust storms) for which there is currently insufficient quantitative evidence to set AQG levels. They are applicable to both outdoor and indoor environments globally, and cover all settings.

"Air pollution is a threat to health in all countries, but it hits people in low- and middle-income countries the hardest," said WHO Director-General, Dr Tedros Adhanom Ghebreyesus. "The WHO's new air quality guidelines are an evidence-based and practical tool for improving the quality of the air on which all life depends. I urge all countries and all those fighting to protect our environment to put them to use to reduce suffering and save lives."



An unequal burden of disease

Disparities in air pollution exposure are increasing worldwide, particularly as low- and middle-income countries are experiencing growing levels of air pollution because of large-scale urbanisation and economic development that have largely relied on the burning of fossil fuels.

"Annually, the WHO estimates that millions of deaths are caused by the effects of air pollution, mainly from non-communicable diseases. Clean air should be a fundamental human right and a necessary condition for healthy and productive societies. However, despite some improvements in air quality over the past three decades, millions of people continue to die prematurely, often affecting the most vulnerable and marginalised populations," said WHO Regional Director for Europe, Dr Hans Henri P Kluge. "We know the magnitude of the problem, and we know how to solve it. These updated guidelines give policy-makers solid evidence and the necessary tool to tackle this long-term health burden."

Global assessments of ambient air pollution alone suggest hundreds of millions of healthy years of life lost, with the greatest attributable disease burden seen in low- and middle-income countries. The more exposed to air pollution people are, the greater the health impact, particularly on individuals with chronic conditions (such as asthma, chronic obstructive pulmonary disease

and heart disease), as well as older people, children and pregnant women.

In 2019, more than 90% of the global population lived in areas where concentrations exceeded the 2005 WHO air quality guideline for long term exposure to PM_{2.5}. Countries with strong policy-driven improvements in air quality have often seen marked reductions in air pollution, whereas declines over the past 30 years were less noticeable in regions with already good air quality.

The road to achieving recommended AQG levels

The goal of the guideline is for all countries to achieve recommended air quality levels. Conscious that this will be a difficult task for many countries and regions struggling with high air pollution levels, the WHO has proposed interim targets to facilitate stepwise improvement in air quality and thus gradual, but meaningful, health benefits for the population.

Almost 80% of deaths related to PM_{2.5} could be avoided in the world if the current air pollution levels were reduced to those proposed in the updated guideline, according to a rapid scenario analysis performed by the WHO. At the same time, the achievement of interim targets would result in reducing the burden of disease, the greatest benefit of which would be observed in countries with high concentrations of fine particulates (PM_{2.5}) and large populations.

Ferrari mechanic to the Springboks

SAMA Communications Department

The glitz. The glamour. The international travel and fancy hotels. Throw in touring with the Rugby World Cup champions, and it sounds like a dream job for anyone. In reality, though the pressure of always winning, and of carrying the hopes and dreams of a nation thousands of kilometres away, is a serious weight on the touring party.

"Look, it's amazing to be with the Springboks, and to be their team doctor, and there certainly are a lot of pluses to this job. But, honestly, it's also really tough work, and being away from your family for a long period is difficult," says Dr Lehlogonolo Jerome Mampane, team doctor and head of the Boks' medical team.

Jerome is speaking days after returning from a gruelling 6-week trip to Australia and New Zealand, where the Boks played in the Rugby Championship. As the team's doctor, Jerome was intimately involved in every aspect of the team's preparation as he ensured all the players were fit and ready to compete.

"When I first started with the Boks in 2016, I was honestly starstruck. There I was, standing with greats such as Bryan Habana, and I was totally in awe. I must say, that was a special feeling. Now, after being with many of the current players since their Junior Springbok days, I have more of a connection with the guys, and there is a trust relationship built over time. These things don't just happen, but I'm in a good place with them, and they rely on me to make the right decisions regarding their health on and off the field, as well as to advise them appropriately in making the right decisions. I also understand a lot of their idiosyncrasies – which every athlete has – and that helps me treat them most effectively," he says.

Jerome started off considering studying physiotherapy at the University of Cape Town, but after a call to his home by Dr Tim Noakes, he was convinced to go into medicine.

"It was kind of surreal. Here's Tim Noakes phoning my parents' home landline and having this conversation with me. He says I should consider medicine and that's exactly what I did; I'm really glad I made that decision. I also wanted to be involved in some capacity in sports, and doing this now is the fulfilment of that goal," he says.

He says he knew he wanted more than sitting in an office, seeing patients in a



consulting room or doing ward visits. Being involved in sports was his aim.

"Sports medicine was a good direction for me because I always thought athletes and rugby players honour God in a specific way in how they portray themselves in interviews, and for me rugby was a natural fit. But it's also challenging because where I am now, for instance, there's a lot of attrition among the players, and there's always a huge amount of pressure because of the consequences of injuries. But I really love it," he says.

Jerome completed his MB ChB at UCT in 2006, and his MPhil in sports and exercise medicine in 2020. He has spent most of his professional career working in sports, starting as the medical doctor at the Prime Human Performance Institute in Durban.

In 2009 he worked on the Confederations Cup as the chaperone to the doping control officer (DCO), and in 2010 as the DCO at the FIFA World Cup. During the following years his work included being the chief medical officer for Team South Africa as part of the SA Sports Confederation and Olympic Committee, and as team doctor to the Springbok Women's and Springbok Sevens teams. During this time, he also began working with the Junior Springboks.

"Now many of these players are in the senior national team and our relationships are great. I also have a good relationship with Rassie [Erasmus, director of rugby at SA Rugby Union] and Jacques [Nienaber, head coach of the Springboks]. I'm not gonna lie, working with these guys sometimes makes me feel like a Ferrari mechanic, working the best of



Dr Jerome Mampane, team doctor

the best. It brings with it a lot of pressure to get things right, partly because getting it wrong has consequences for the team and for me; the intense scrutiny isn't great but it's something you learn to manage," says Jerome.

But, he says, it does exact a toll. Married with two children, Jerome says being away for so long is challenging. He says, for instance, that his toddler son "grew quite a lot" between the time he was away and the time he returned home.

"This isn't the type of lifestyle you keep for a very long time, and I actually have a lot of admiration for those people before me, such as Dr Craig Roberts who stayed in this job for many years. I mean, I'm extremely happy with the Boks, it's one of the top sports medicine

team-related jobs in the country, and it's rewarding, but it does require a good mental attitude and a strong family bond."

While back in SA, and ahead of other planned tours of the Boks, Jerome will continue to work with the team and focus on the sports medicine practice he runs with three partners, Sports Medicine Africa (SMA).

Jerome also works with the Golden Lions Rugby Union as the match-day medical lead

for the team, as stadium doctor at Ellis Park and as the team physician for Kaizer Chiefs Football Club, both of which he was involved with before the establishment of SMA.

"Ja, I'm blessed to be where I am. Being with the Boks when they won the World Cup was wonderful, and definitely the highlight of my career. I think, personally, it was also vindication to myself and my critics that I belong here, and that I'm a good doctor," he says.

Looking ahead, Jerome says he's committed to staying with the Boks through to the next Rugby World Cup to be held in France in 2023.

"Unless something substantial happens to prevent that, that's where I will be: standing on the sidelines or assisting someone on the field, hopefully playing my role to ensure we win another World Cup in the process," he says.

The safety of doctors is paramount

SAMA Communications Department

For several years now, SAMA has highlighted the poor state of security in the healthcare system, specifically of doctors in public institutions. Protecting doctors in these institutions is of the greatest importance, but incidents of violence continue unabated.

SAMA views the lack of provision of proper safety and security for doctors – indeed, for all healthcare workers and patients – as a major stumbling block to the provision of quality healthcare to all citizens. SAMA also highlights some of the more recent incidents involving doctors since 2018.

2018:

- break-in at Temba Hospital's doctors' quarters
- doctors assaulted at Witbank Hospital
- doctor survived a gunshot at Mapulaneng Hospital.

These incidents were reported to the head of department of the Mpumalanga Department of Health. Subsequent to this, a meeting was held with the head of department in May 2018, which resulted in the employment of armed security personnel at these hospitals.

2019:

- attempted rape at Pelonomi Hospital: an intern doctor was almost raped by a patient, who was arrested. As with the incidents in 2018, SAMA met representatives from the department, which resulted in tighter security measures. SAMA also offered support to the doctor, which included making sure that counselling was provided for her by the department.

2020:

- theft of motor vehicle and general concerns about safety at the Universitas Hospital doctors' quarters in Bloemfontein
- shooting of patient at Kimberley Hospital.

2021:

- two doctors and a patient stabbed at Kimberley Hospital
- complaints of poor safety at clinics in Cape Town at Weltevreden Valley Clinic in Samora Machel, the Mzamomhle Clinic Browns Farm and the Crossroads Community Health Clinic
- recent incident at Lilian Ngoyi Healthcare Centre.

While the country heads towards local government elections in November, SAMA is concerned that the security issues faced by doctors fall under the radar. It is for this reason that SAMA continues to highlight these issues, and to push both national and provincial governments to increase their levels of security at public institutions so that those trained to care for patients are able to do so knowing that their safety is protected.

SAMA recommends the following:

- appointment of trained and qualified security staff who are dressed in identifiable security uniform
- recording and documentation of persons coming in and out of each institution, including doctors who are staying in staff quarters
- installation of boom gates at parking areas
- access cards for all staff
- improvement of lighting outside parking areas

- mobile security guards 24 hours a day
- installation of burglar bars and gates at all health facilities
- provision of panic buttons at all facilities
- installation of CCTV cameras at all facilities.

SAMA's rights remain reserved on the failure by the National Department of Health to implement stricter security measures that are in any case mandatory, as provided for in the Occupational Health and Safety Act No. 85 of 1993.

MPS comment

The Medical Protection Society (MPS) joins with SAMA in condemning incidents of violence and abuse against doctors.

Commenting, Dr Graham Howarth, head of medical services – Africa for MPS said: "Sadly, these incidents accord with the experience of many doctors supported by MPS. Late last year, a MPS survey found that almost one in three (31%) healthcare professionals in SA have suffered verbal or physical abuse from patients, patients' families or members of the public.

"Violence and abuse against doctors is deplorable, and adds yet another source of anxiety for doctors at the worst possible time. Protecting doctors from violence is a vital challenge, and one that must be met by national and provincial governments, hospitals, institutions and the wider healthcare community."

What the objections to COVID-19 control measures tell us about personal freedom

Timothy A Carey, director: Institute of Global Health Equity Research, Andrew Weiss, Chair of Research in Global Health, University of Global Health Equity

As the protracted global battle with SARS-CoV-2 continues to rage, objections to the measures being taken to combat the virus are increasing. Protests have been reported in countries such as the USA, the UK, Australia, Thailand, SA, France, Italy and Greece. In some instances, the protests have become violent, resulting in injuries and arrests.

The core of the objections, whether they are about vaccinations, lockdowns, social distancing or mask-wearing, seems to concern an apparent erosion of personal liberty. Liberty, or freedom, has been fiercely pursued and protected throughout history. Some of the greatest accomplishments in social living have been realised through the introduction of policies and laws that provided freedoms to those who were previously marginalised and persecuted. Efforts to address colonialism, racism and inequity are relevant examples. To be sure, there is still a long way to go, but progress, however slow and punctuated it may be, is being made.

SARS-Cov-2's unrelenting assault on our health status and systems could be another opportunity to leap forward in our understanding of liberty and social living. Advancing the freedom of all might be accelerated if the relativity of freedom was more readily acknowledged and explicitly discussed.

Freedom, in its simplest terms, is being able to do what you want. The key to freedom, then, is about what you want, what I want and what we all want. It is about being in control. It is about pursuing the goals that are important to us. Control is concerned with agency and, unsurprisingly, both agency and freedom have been identified as important to health. Health can in fact be understood as a state of being in control.

Limiting freedom

The relativity of freedom is unavoidably inevitable. If I am paid a sufficient amount of money, I am free to save up to buy a house. Wanting to buy a house, however, necessarily impacts on my freedom to spend money on other things. If I want to pursue part-time study to get a better job, then my freedom

with regard to how I spend my leisure time is immediately curtailed.

People, then, limit their own freedom by the goals they have, but their goals can also limit other people's freedom. When slave owners had the freedom to buy and sell people as slaves, they were undoubtedly doing what they wanted, but they were also interfering monstrously and deplorably with the freedom of the people cast as slaves.

More recently, some jurisdictions have determined that people do not have the

In a cruel twist of fate that might actually reveal the secret to successful social living, we have our greatest freedom when we protect the freedom of others

freedom to intentionally transmit HIV through unprotected sex. Similarly, a person does not have the unrestrained freedom to drive a car through a busy shopping mall and annihilate the freedom of shoppers.

The daily news is replete with examples of people having their freedom removed because of the way they interfered with other people's freedom. Freedom's relativity is inherently entwined with our nature to want to be in control. Fundamentally, we are driven to control our circumstances and conditions. During our controlling, however, from time to time we will, either inadvertently or by design, thwart the controlling of others. It is easy to appreciate that the anger of the COVID-19 protesters arises from the curbing of their ability to control where they go, when they go and how they go there.

It is part of the paradox of freedom that curtailing the freedom of some can have the effect of increasing the freedom of many. The great American medical physicist William T Powers suggested that "the childhood of the human race is far from over. We have a long way to go before most people will understand that what they do for others is just as important to their wellbeing as what they do for themselves."

Joseph Stiglitz, the Nobel prize-winning economist, applies the same thinking to the inequity in wealth distribution. He points out that increasing inequity is the flipside of shrinking opportunity. Shrinking opportunity is nothing more than a constriction of the ability to control. He reminds those who are at the top 1% of the money pile that their fates are interwoven with the fates of the remaining 99%. This fact prompts him to suggest that "looking out for the other guy isn't just good for the soul – it's good for business".

Interwoven fates

In a cruel twist of fate that might actually reveal the secret to successful social living, we have our greatest freedom when we protect the freedom of others. Safeguarding our own freedom as a priority will lead to an endless round of pushback as others seek to do the same. As we increasingly promote the freedom of others, particularly the marginalised, vulnerable and oppressed, we can begin to relax a little and enjoy the more equitable, fair and socially just world we are creating.

Freedom is never absolute. Some freedoms are always enjoyed at the expense of other freedoms. We will never be free of COVID-19 until we are all free. Does that mean some other freedoms will, from time to time, be suppressed? Undoubtedly. Necessarily. And the forgoing of those freedoms helps the freedom to live in a healthy, connected and contented social environment to flourish.

Source: The Conversation, 23 September 2021: <https://theconversation.com/what-the-objections-to-covid-19-control-measures-tell-us-about-personal-freedom-168401>.

Now is the time to become a stem cell donor

SAMA Communications Department

Every year, thousands of people across the globe are diagnosed with both malignant and non-malignant disorders of the blood and immune system, as well as metabolic diseases. Many of these cases reach a stage where a stem cell transplantation is their only hope of survival. It is for this reason that DKMS has 10.7 million donors registered its stem cell registry, with 70 000 of these having gone on to donate to patients worldwide. In SA, DKMS Africa, formerly known as the Sunflower Fund, is seeking to drive awareness on how technology has made becoming a donor quick and easy, in order to grow the local registry.

Alana James, country executive director at DKMS Africa, says this is vital, as the chances of having a fully matched sibling donor are only 25% for every patient. Although patients of European ancestry are likely to increase the likelihood of finding a match on a national or international registry to upwards of 80%, this is not the case for patients of African or mixed-race ancestry. In the latter patients, donors are found in less than 20% of cases. Reasons for this discrepancy are the significant genetic diversity that exists in African populations, compounded by the lack of African and mixed-race donors on registries. People living with blood diseases in SA are thus at a distinct disadvantage. Alana adds, "As such, we need to recruit local donors so we can save more lives."

It's simple and easy, and has the potential to change the lives of patients

Thanks to medical and technological advances, James explains that donors and patients are now matched via more sophisticated typing of the human leukocyte antigen (HLA) region in the DNA. The sample for this complex testing is in the form of a simple cheek swab from both the patient and the potential donor. "This is much more complex than matching blood groups."

Following the Sunflower Fund's merger with DKMS, the organisation now has access to the DKMS Life Science Lab, which became the world's first HLA typing laboratory in 2013. "The lab utilises breakthrough next-generation sequencing technology, which has resulted in over 1 million potential stem cell donors currently typed per year," she says.

"We are now able to provide the most efficient and detailed donor selection process, ensuring that every patient in need of a transplant is able to find the most suitable donor as quickly as possible," adds James. However, she points out that the odds of being a match are about 1:100 000, which is why the organisation needs as many donors as possible.

Explaining the reasons why people may be reluctant to become a donor, James notes that "they believe that the process of harvesting stem cells directly from bone marrow is most commonly practised." Again, innovation in the medical and technological spheres has allowed this process to become streamlined and relatively pain-free. "Ninety percent of the time, stem cells are harvested from one's blood."

Outlining this process, James says that once matched, the donor will receive injections to stimulate release of their blood stem cells, which are present in the bone marrow, into the bloodstream. "For the actual donation, a needle is placed into one arm, and the donor's blood is circulated through an apheresis machine. This machine acts as a filter to remove the blood stem cells, and then the remaining blood is returned through a venous line in the other arm. "The whole process takes approximately 4 - 6 hours, and you can return to work within 1 or 2 days."

There is no cost to individuals to become donors, as DKMS Africa covers the cost of the DNA test required to register as a donor. There is also no cost to donate stem cells when you are identified as a match for a patient.

If you are aged 18 - 55 years and are in general good health, you can register as a stem cell donor. It's simple and easy, and has the potential to change the lives of patients for whom no other choice exists.



Alana James, country executive director at DKMS Africa

About DKMS

DKMS is an international non-profit organisation dedicated to the fight against blood cancer. Founded in Germany in 1991 by Dr Peter Harf, DKMS and the organisation's over 900 employees have since relentlessly pursued the aim of giving as many patients as possible a second chance at life. With over 10 million registered donors, DKMS has succeeded in doing this more than 92 000 times to date, by providing blood stem cell donations to those in need. This accomplishment has led to DKMS becoming the global leader in the facilitation of unrelated blood stem cell transplants. The organisation has offices in Germany, the USA, Poland, the UK, Chile and SA.

DKMS is also heavily involved in the fields of medicine and science, with its own research unit focused on continually improving the survival and recovery rate of patients. In its high-performance laboratory, the DKMS Life Science Lab, the organisation sets worldwide standards in the typing of potential blood stem cell donors.

Traditional and spiritual healers on the frontline of mental healthcare

SAMA Communications Department

Mental health professionals have called for greater collaboration between Western medical specialists and African traditional healers in providing primary healthcare for the one in three South Africans who experience common mental health disorders, of whom 75% go untreated.

SA has only 975 registered psychiatrists serving a population of more than 60 million. The vast majority practise in urban areas and the private sector, while more than 80% of the population are reliant on the public sector, with its limited mental healthcare services.

With World Mental Health Day on 10 October themed “Mental health in an unequal world”, the SA Society of Psychiatrists (SASOP) says that traditional and spiritual healers could play a key frontline role in improving access to treatment for common mental health conditions, including anxiety, depression and substance abuse, and overcoming the stigma often attached to these.

Dr Lerato Dikobe-Kalane, psychiatrist and member of SASOP, said underfunding and under-resourcing of public health are particularly severe in the mental healthcare arena, and the inequality of access to mental healthcare has been worsened by the disruptions of the COVID-19 pandemic, owing to restrictions on movement, as well as the public health sector having to focus its limited resources on COVID-19 cases.

“The low number of people receiving treatment for a mental health disorder is partly due to lack of resources and access, and partly due to resistance to seeking treatment because of low mental health literacy, stigma and discrimination, and perceptions that treatment is ineffective or that the problem will go away on its own.

“This points to a need for greater awareness of mental health, and encouragement to seek help, and we believe that traditional and spiritual healers can play a key role in early identification, referrals and sharing cultural understanding with treatment-resistant patients who could be referred to alternative treatment modes.”

She said SA’s estimated 200 000 African traditional and spiritual healers are highly influential in their communities, and are



often consulted as the first step in seeking advice or treatment, and that studies have shown that alternative practitioners could play an important role in addressing mental healthcare needs by offering culturally appropriate treatment.

“Traditional and spiritual healers have intimate knowledge of traditional medicine and cultural and spiritual practices and beliefs. They are respected in the community, and their advice is sought out and taken seriously.

“There is evidence that the psychosocial role of traditional and spiritual healers – informal counselling and support in improving family, community or work relationships – can help to relieve distress and mild symptoms of common mental disorders such as depression and anxiety. Traditional and spiritual healers can play an important role in assisting people with mental health issues at a primary healthcare level,” she said.

Greater collaboration between Western mental health practitioners and traditional or spiritual healers would help to educate traditional practitioners on common mental disorders, treatment options and the resources for referral for more specialised treatment, she said.

“Although there is little evidence that traditional and spiritual healers have an impact on treatment for severe mental illnesses

There is evidence that the psychosocial role of traditional and spiritual healers can help to relieve distress and mild symptoms of common mental disorders

such as bipolar and psychotic disorders, with appropriate education and information, they could assist in the early identification and relevant referral of patients,” Dr Dikobe-Kalane said.

She emphasised the need for mutual respect and understanding of each other’s roles and cultures, by both Western and traditional practitioners, in fostering a positive working relationship that could improve awareness of mental health disorders, reduce stigma and enable wider access to treatment.

The reality of ageism

SAMA Communications Department

As life expectancies lengthen and the world population of people aged over 65 booms, older people continue to face ageism – treated as invisible, stereotyped and discriminated against – which impacts on their health and quality of life, and ignores their social and economic contribution – and the situation has worsened throughout the COVID-19 pandemic.

On the International Day of Older Persons (1 October 2021), Dr Sihle Nhlabathi, member of the SA Society of Psychiatrists (SASOP), said that combatting ageism would result in healthier, more active ageing, and enable society to benefit from the economic participation and social value of the growing population of over-65s, expected to more than double by 2050.

Although they are often invisible in media and marketing, or portrayed as stereotypes, people over 65 already outnumber children under 5, and projections are that by 2050, there will be twice as many over-65s as children under 5, and they will also outnumber 15- to 24-year-olds (1.5 billion v. 1.3 billion).

"Life expectancy globally is currently about 73 years, and is expected to reach 77 in 2050. Half of all children born in 2020 are now predicted to live beyond 100, meaning older people will no longer be invisible nor irrelevant.

Unlike racism and sexism, ageist attitudes are still seen as socially acceptable

"While there are negative perceptions of older people as weak, incompetent and a burden on society, the evidence points to the contrary. With increased longevity, many people work, earn an income and pay tax well over the age of 65, as well as playing an important role in childcare. In the UK, for example, it has been shown that the contribution of older people through taxation, consumer spending and other economically valuable activities outweighs the public expenditure on their pensions, welfare and healthcare," Dr Nhlabathi said.



Research has shown that the situation in Japan, where more than a third of the population is over 60, is similar, with a very limited effect of an ageing population on economic growth. Although there is less evidence available from low- and middle-income countries, one example is Kenya, where the average of small-scale farmers is 60, making them critical to food security.

"Unlike racism and sexism, ageist attitudes are still seen as socially acceptable, and largely go undetected or unchallenged, but research has shown that ageism has significant impact on older people's mental and physical health, and their potential for active ageing.

"Social exclusion due to ageism is a chronic stress factor for older people, while ageism also leads to fewer social and economic opportunities for older people, who still have great value to offer in the workplace and society," she said.

Dr Nhlabathi said it was particularly concerning that ageist attitudes were prevalent among healthcare professionals, leading to discrimination and impacting on the quality of healthcare provided for older people.

"Ageism and false assumptions about older people's mental ability and physical health, such as assuming the person is hard of hearing or that depressive symptoms are 'normal at their age', can place older people at risk through less screening and preventive care, less information provided to them about

their conditions and less access to needed care and treatments – placing their health at risk," she said.

The concept of active ageing is promoted by the WHO to prolong and improve health in later life, by encouraging older people's continued participation in social, economic, cultural, spiritual and civic affairs, as well as continuing to be physically active.

"There is substantial research showing that job performance does not decrease with age, and also a rise in research that highlights benefits of ageing – older people have been shown to act more rationally in problem-solving and social conflicts, and to retain their knowledge and experience, and are generally more emotionally healthy.

"It makes sense then to promote active ageing and higher retirement ages, and to encourage employers to adapt working practices to the age of employees," Dr Nhlabathi said.

Dr Nhlabathi said that ageism in public discourse and policy decisions had come to the fore in the response to the COVID-19 pandemic, affecting older people's health, wellbeing and rights.

Initial perceptions of COVID-19 as affecting mainly older people led many to dismiss public health measures such as masks and physical distancing as irrelevant to them, in turn impacting on the risks to older people, while deaths of older people from the disease were seen as "inevitable" and of less

consequence than the deaths of younger people.

Ageism and a perception of older lives as less valuable was also seen in discussions and policies on the allocation of scarce resources such as ventilators.

A blanket view of all older people as “high risk”, and stricter restrictions imposed by governments on older people, such as visitors barred from care homes and retirement facilities, and orders for older people to self-isolate and stay home, worsened the isolation, anxiety and social disconnectedness already experienced by older people.

However, Dr Nhlabathi said greater intergenerational solidarity experienced during the pandemic – such as younger people delivering groceries and medicines

for older neighbours, tending to their gardens and making sure they could stay connected with loved ones via smartphones, video calling and technology such as Zoom – was a positive sign.

“Intergenerational solidarity provided significant support and important social connections for older people during the pandemic.

“Intergenerational contact has been shown to be beneficial to both young and older people, and although little is known about how to combat ageism, this, together with education and awareness-raising among medical professionals, employers and the public, seems to hold some hope for encouraging more positive attitudes to older people,” she said.

Dr Nhlabathi said that while ageist treatment impacts negatively on older people’s health, self-esteem and quality of life, there is also a risk to their mental health and wellbeing from internalising negative stereotypes of age and ageing.

“On the one hand, there is the risk that internalising these stereotypes and prejudices leads to the older person seeing less opportunity, and more limitation, in their life with age. But working with older people to develop more positive self-perceptions and attitudes towards their own ageing process benefits their health, functioning and longevity.

“Older people can combat ageism if they are able to see these negative perceptions as false, inaccurate and off-base,” she said.

SAMA welcomes Public Protector’s findings on public hospitals in five provinces

SAMA Communications Department

Sama says it is not surprised by the findings of Public Protector Busisiwe Mkhwebane of the poor state of provincial hospitals in five provinces. From August to October last year, Mkhwebane and deputy Public Protector Kholeka Gcaleka visited 17 public hospitals in Gauteng, KwaZulu-Natal, Limpopo, the Eastern Cape and Mpumalanga as part of their self-initiated investigation into the “the provision and administration of health services at public hospitals”.

Among the findings of the various reports into each of the visited provinces’ health services was a lack of proper provision of personal protective equipment, poor building and physical infrastructure, staff shortages, equipment and medical supply shortages, administrative shortcomings and delays in processing test results. Issues with waste management and surrounding infrastructure were also noted.

“We have, for many years, logged complaint after complaint from our members on the poor conditions in public health institutions in provinces. We therefore welcome the Public Protector’s reports, which confirm that these facilities are in dire need of sustainable interventions that

will enable them to fulfil their constitutional mandate of providing health services that are accessible to all,” says Dr Angelique Coetzee, chairperson of SAMA.

Sustainable interventions are key to providing proper health services for all South Africans

The Public Protector noted that parts of the investigation were intended to assess the impact of COVID-19 on public hospitals, and whether or not staff and patients were adequately protected. In almost all cases, the Public Protector substantiated claims that these facilities were operating suboptimally, and that they were failing in their legal obligations to meet the needs of the public.

“What is important, though, is that the Public Protector made several recommendations in each of the reports, and we applaud her and her office for indicating

what remedial steps are necessary. Our members are working at the coalface of health provision in SA, often under difficult conditions. We are grateful that this situation is now getting more attention because, ultimately, our goal is that every single person who needs healthcare has access to proper facilities that are well run and properly staffed, and have adequate medical resources,” notes Dr Coetzee.

Dr Coetzee says that SAMA takes note of the findings, and stresses that action should be taken with clear deadlines, as otherwise the exercise is meaningless.

“SAMA and its members are equally committed to working alongside provincial health authorities and hospital administrators to assist in dealing with the challenges, and fixing what needs to be fixed. As medical professionals we are dedicated to saving people and improving the lives of our patients, and we will do whatever is necessary to achieve these outcomes. We are thankful that these issues are being highlighted, and we trust that the Public Protector’s interventions will lead to wholesale improvements at public health facilities in provinces to the benefit of all South Africans,” Dr Coetzee concludes.

National Family Practitioners Congress a huge success

SA Academy of Family Physicians

The Department of Family Medicine, University of Pretoria, under the auspices of the SA Academy of Family Physicians (SAAFP), hosted a very successful virtual 23rd National Family Practitioners Congress from 13 to 14 August 2021. The focus was on the theme of primary healthcare in the era of the COVID-19 pandemic and beyond.

COVID-19 has instigated new local and global norms, forcing us to rethink how we do things. The virtual platform embraced this new reality by gathering brilliant minds and sharing information through scientific presentations, workshops, seminars and robust debates, making this a memorable experience for the over 400 delegates who attended.

Delegates who were not able to attend all the virtual sessions had the opportunity to catch up on missed presentations via the on-demand viewing facility after the congress.

An interesting programme included international faculty and globally recognised local participants who covered key cross-cutting themes, listening to healthcare professionals' experience of COVID-19 infections, maternal health and immunology around COVID-19 infection, and the latest information on COVID-19 across thematic tracks (variants, COVID-19 in children, long-term COVID-19 and prevention, diagnosis and treatment).

The highlight of the plenary sessions was a presentation by Prof. Salim Abdool Karim discussing COVID-19 in SA: the good, the bad and the complicated. The session reflected on some of the challenges, and a portion of the good, the bad and the complicated lessons learned in responding to the pandemic, and how we can draw upon these experiences to prepare for the next pandemic.

Congratulations to the research presentation prize winners at the national congress:

- Dr Leigh Wagner, a family physician at Khayelitsha Community Health Centre, received the award for best student poster. As a registrar, she explored factors influencing resilience among family physicians in Cape Town.
- Prof. Hanneke Brits, from the University of the Free State, who chairs the SAAFP national education and training committee,



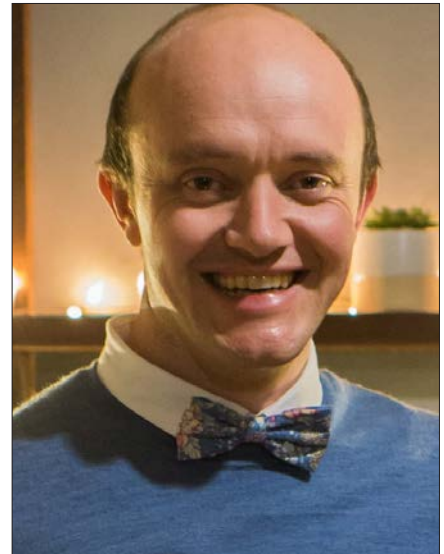
Prof. Hanneke Brits



Dr Leigh Wagner



Prof. Bob Mash



Dr John Lotz

received the award for best researcher poster. She looked at improving the reliability of clinical assessment.

- Dr John Lotz, from Madwaleni Hospital in the Eastern Cape and Walter Sisulu University, received the award for best oral research presentation as a student. He looked at the treatment of drug-resistant TB.
- Prof. Bob Mash, from Stellenbosch University and the president of SAAFP, received the award for best oral research

presentation, with his results of a scoping review on community-orientated primary care in Africa.

Our sincere gratitude is extended to the following sponsors for their support: Eli Lilly; Servier; Novo Nordisk; MSD; Equity Pharmaceuticals; Lancet Laboratories; Stellenbosch University Hybrid Learning; and Van Schaik.

We hope to see you all at next year's congress: 19 - 20 August 2022.

Employers owe employees a duty of care to ensure safety and health

Sultana Hartzenburg, *SAMA Employee Relations Department*



Labour law is there to assist you if you feel unsafe at work. Concern for health and safety is legitimate in every context of human enterprise. People can be seen as one of the most important assets in an organisation.

All employers have a duty to provide a healthy and safe working environment, and the primary piece of legislation that regulates and provides for an employer's duty of care in respect of its employees is the Occupational Health and Safety Act No. 85 of 1993 (OHSA). The OHSA is a proactive attempt by government to provide and maintain a safe and healthy working environment for all. Preventing unnecessary injury, illness and loss makes good management sense.

The OHSA places an obligation on employers to identify and reduce risks to health and safety in the workplace, and provides for the regulation and monitoring of workplaces in order to protect the health and safety of employees and other persons.

Stress and violence are increasingly noted in health sector workplaces. Doctors, nurses and social workers are all high on the list of occupations that cause 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.

In 2000, the International Labour Office, the International Council of Nurses, the WHO and Public Services International launched a joint programme to develop sound policies and practical approaches for the prevention and elimination of violence in the health sector.

The employer has a duty to provide and maintain a working environment that is safe

and without risk to the health of employees. This general duty includes the duty of an employer to inform employees of hazards to health and safety associated with any work performed, and to inform employees of the necessary precautions that must be taken to mitigate against these identified risks. Once hazards have been identified, the employer has a duty to provide and maintain safe systems of work, and to take steps and make arrangements to eliminate or mitigate hazards and ensure the safety of employees.

In terms of the OHSA, the chief executive officer of every employer is liable for contraventions of the OHSA. As such, any contravention of the OHSA can result in criminal conviction and/or up to 1 year's imprisonment of the CEO of the employer, and/or fines imposed on the employer of up to ZAR50 000, or ZAR100 000 or 2 years' imprisonment if the injury caused to the employee or any other person in the workplace would result in the employer being found guilty of culpable homicide.

The Employment Equity Act No. 55 of 1998 provides for liability of an employer in the specific circumstances where an employer fails to provide a workplace that is free of discrimination or harassment. The damages that an employer may be ordered to pay if it fails to discharge this duty are unlimited. An employer's common law duty of care may become relevant in such an enquiry to determine whether the employer took reasonable measures to prevent harm to the employee by these prohibited forms of conduct.

In addition to the legislation referred to above, the SA common law position is that an employer owes its employees a duty of care to ensure their safety and health in the workplace. If an employee is not able to frame a claim against an employer in terms of legislation above, (s)he would still be entitled to frame the claim in terms of this common law duty.

Under the common law, employers are obliged to provide their employees with safe and healthy working conditions. The scope of this duty extends to, without limitation, providing proper machinery and equipment, properly trained and competent supervisory staff and safe systems of working. If the employer fails to comply with this obligation

or meet the necessary standards of safety, any affected employees are not in breach of their contracts of employment if they refuse to work until the dangerous situation is corrected.

An employer will breach its duty of care in respect of its employees if the employer's conduct causes harm to an employee in circumstances in which a reasonable person would foresee the likelihood of injury and take steps to guard against it. Therefore, in terms of common law, in order to discharge its duty of care in respect of its employees, the employer must assess the reasonable likelihood of its employees being exposed to danger or hazards, and assess the potential for an employee to be injured or harmed, as well as the nature of the injury likely to be suffered. If the employer assesses that any such danger or injury is likely, it must take adequate steps to prevent such danger or injury to its employees. A failure to do so will result in the employer having failed to discharge its duty of care, thereby exposing it to liability.

It is critical that the employers should note that the Constitution of the Republic of SA also gives effect to the Constitutional right of SA citizens, as employees, to health and safety in the workplace. The right of employees to health and safety, and the concomitant duty of care imposed on employers to ensure health and safety, is provided for in by section 23(1) of the Constitution, in terms of which everyone has the right to fair labour practices. Fair labour practices include the right of employees to working environments that are safe and free from dangers to health or the likelihood of injury. Case law confirms that the right to fair labour practices is wide enough to include an employer's duty of care and duty to provide a safe working environment to its employees. If an employer is found to be in breach of its duty of care as imposed in terms of the Constitution, employees may be entitled to Constitutional damages.

In the case of *Piliso v Old Mutual Life Assurance Co (SA) Ltd & Others* [2007] JOL 18897 (LC), the Labour Court held that the employer had violated the employee's right to fair labour practices in terms of section 23 of the Constitution. The employer was ordered to pay the employee an amount of ZAR45 000 as Constitutional damages.

WHO recommends groundbreaking malaria vaccine for children at risk

World Health Organization

The WHO is recommending widespread use of the RTS, S/AS01 (RTS,S) malaria vaccine among children in sub-Saharan Africa and in other regions with moderate to high *Plasmodium falciparum* malaria transmission. The recommendation is based on results from an ongoing pilot programme in Ghana, Kenya and Malawi that has reached more than 800 000 children since 2019.

"This is a historic moment. The long-awaited malaria vaccine for children is a breakthrough for science, child health and malaria control," said WHO director-general Dr Tedros Adhanom Ghebreyesus. "Using this vaccine on top of existing tools to prevent malaria could save tens of thousands of young lives each year."

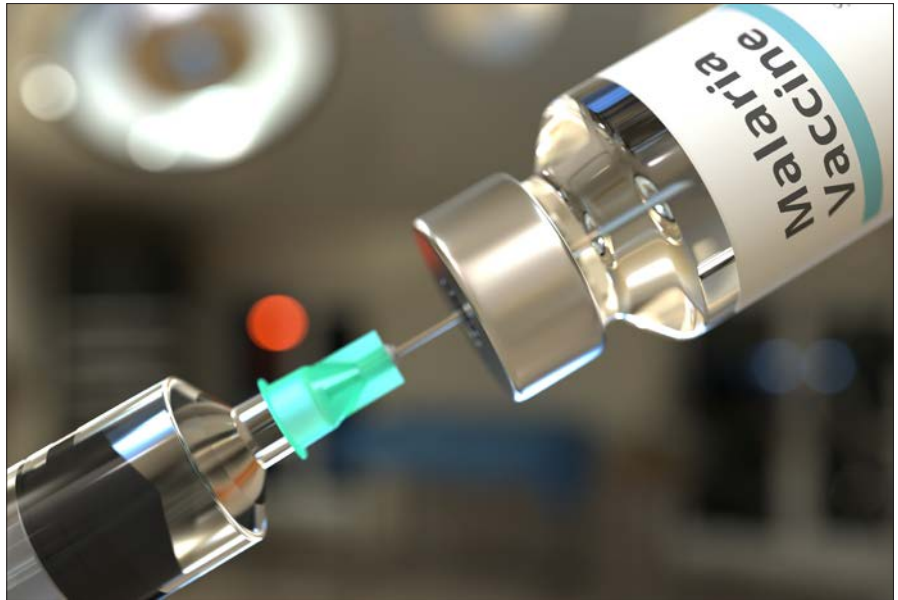
Malaria remains a primary cause of childhood illness and death in sub-Saharan Africa. More than 260 000 African children under the age of five die from malaria annually. In recent years, the WHO and its partners have been reporting a stagnation in progress against the deadly disease.

"For centuries, malaria has stalked sub-Saharan Africa, causing immense personal suffering," said Dr Matshidiso Moeti, WHO regional director for Africa. "We have long hoped for an effective malaria vaccine, and now, for the first time ever, we have such a vaccine recommended for widespread use. Today's recommendation offers a glimmer of hope for the continent, which shoulders the heaviest burden of the disease, and we expect many more African children to be protected from malaria and grow into healthy adults."

WHO recommendation for the RTS,S malaria vaccine

Based on the advice of two WHO global advisory bodies, one for immunisation and the other for malaria, the organisation recommends that:

"in the context of comprehensive malaria control, the RTS, S/AS01 malaria vaccine be used for the prevention of *P. falciparum* malaria in children living in regions with moderate to high transmission as defined by [the] WHO. [The] RTS, S/AS01 malaria vaccine should be provided in a schedule of 4 doses in children from 5 months of age for the reduction of malaria disease and burden."



Summary of key findings of the malaria vaccine pilots

Key findings of the pilots informed the recommendation based on data and insights generated from 2 years of vaccination in child health clinics in the three pilot countries, implemented under the leadership of the ministries of health of Ghana, Kenya and Malawi. Findings include:

- Feasible delivery: vaccine introduction is feasible, improves health and saves lives, with good and equitable coverage of RTS,S seen through routine immunisation systems. This has occurred even in the context of the COVID-19 pandemic.
- Reaching the unreached: RTS,S increases equity in access to malaria prevention.
- Data from the pilot programme showed that more than two-thirds of children in the three countries who do not sleep under a bed-net benefit from the RTS,S vaccine.
- Layering the tools results in over 90% of children benefiting from at least one preventive intervention (insecticide-treated bed-nets or the malaria vaccine).
- Strong safety profile: to date, more than 2.3 million doses of the vaccine have been administered in three African countries – the vaccine has a favourable safety profile.

- No negative impact on uptake of bed-nets, other childhood vaccinations or health-seeking behaviour for febrile illness: in areas where the vaccine has been introduced, there has been no decrease in the use of insecticide-treated nets, uptake of other childhood vaccinations or health-seeking behaviour for febrile illness.
- High impact in real-life childhood vaccination settings: significant reduction (30%) in deadly severe malaria, even when introduced in areas where insecticide-treated nets are widely used and there is good access to diagnosis and treatment.
- Highly cost-effective: modelling estimates that the vaccine is cost-effective in areas of moderate to high malaria transmission.

Next steps for the WHO-recommended malaria vaccine will include funding decisions from the global health community for broader rollout, and country decision-making on whether to adopt the vaccine as part of national malaria control strategies.

Financial support

Financing for the pilot programme has been mobilised through an unprecedented collaboration among three key global health funding bodies: Gavi, the Vaccine Alliance; the Global Fund to Fight AIDS, Tuberculosis and Malaria; and Unitaid.

Groote Schuur, first African public hospital to perform robotic surgery

SAMA Communications Department

In a historic event for the Western Cape, Groote Schuur Hospital this week announced that it would be the first public sector hospital in Africa to perform robotic surgery.

The da Vinci Xi fourth-generation robot, which will be used in theatres at the hospital, was launched on Wednesday 13 October 2021.

The da Vinci Xi system enhances surgical performance by creating a natural extension of the surgeon's eyes and hands. It can be used across a wide spectrum of minimally invasive surgical procedures, and has been optimised for complex, multi-quadrant surgeries.

Robotic surgery has many benefits for patients:

- The patients have a shorter hospital stay and recovery time.
- Patients have less pain and scarring.
- The risk of infection and blood loss is reduced.
- It provides improved visualisation due to magnified 3D imaging and the ability to change colour visualisation to better identify structures, which leads to more precise surgery and improved clinical and functional outcomes.

The CEO of Groote Schuur Hospital, Dr Bhavna Patel, said, "We at Groote Schuur Hospital are proud to continue innovating with this cutting-edge technology. The da Vinci Xi is the first of its kind being used in Africa, and we are the first public sector hospital to start robotic surgery in SA. We are proud to be able to offer our patients the benefits of these new techniques that lessen operating time, complications and hospital stay, with a quicker recovery time."

Congratulating the hospital, Western Cape Provincial Minister of Health, Noma French Mbombo, said: "Once again, the Groote Schuur Hospital has come up with groundbreaking technology, where they will perform robotic surgeries ... the timing is perfect, because after this surgery, patients have a shorter hospital stay and recovery time, which allows them to get home quicker to be with their families and to return to work. For us, this means we will have space to accommodate more people."



"The focus has been on COVID-19, but now we are in the process of phasing in non-COVID illnesses. We are facing an insurmountable backlog, but with this innovation, we have hope of catching up. I applaud the team of the hospital."

"Robotic-assisted surgery has become the new standard of care as an option for minimal invasive surgical intervention. This new technology allows surgeons to perform many types of complex procedures with more precision, flexibility and control than is possible with conventional techniques. It was initially pioneered with urological surgery, but now it has been extended to and not limited to colorectal, general, cardiothoracic surgery and urogynaecology,"

added an excited Dr Samkele Salukazana, robotic surgery co-ordinator at Groote Schuur Hospital.

"We are most excited to be the first state unit to acquire the state-of-the-art fourth-generation da Vinci robot. Acquiring a robot in our institution will improve our multidisciplinary approach to complex surgery, training and, of most importance, functional and clinical outcomes to our patients. It is also exciting that we will match the standards and access to the latest technology to our state patients, as robotic surgery has been in the private sector for more than 8 years in SA. We are looking forward to making the Groote Schuur Hospital/UCT Robotic Programme a success."

Pulled in all directions

The Medical Protection Society share a case report from their files

Mrs J was a 32-year-old female patient with a long history of neck pain following a road traffic accident. The pain was localised to the left side of the neck and left shoulder, with only very occasional paraesthesia in her left hand. Despite regular analgesics and exercises, the pain was still troublesome, and she was keen for a specialist opinion. Mrs J was referred to Dr M, a pain consultant.

Dr M noted slight restriction in neck movement on the affected side, and elicited tenderness over the left C5/6 and C6/7 facet joints. Imaging revealed fusion of the C3 and C4 vertebrae, and some loss of normal cervical spine curvature, but the vertebral bodies and spaces remained otherwise well-preserved.

Dr M recommended C5/6 and C6/7 facet joint treatment, and told Mrs J that there was a 50% chance of getting long-term pain relief. He suggested two diagnostic injections with local anaesthetic followed by radiofrequency lesioning if benefit was felt. Dr M went through the risks of the procedure with Mrs J, including lack of benefit, relapse of pain, infection and damage to nerves. Mrs J returned for the first of the two diagnostic blocks. The block was performed in the lateral position, and Dr M injected a mixture of 0.5% levobupivacaine and triamcinolone. The block provided good pain relief, and Mrs J felt it was easier to move her neck.

Mrs J later returned for the second diagnostic injection. She was placed in the prone position and local anaesthetic infiltrated into the skin. Using biplanar fluoroscopy, 22G spinal needles were inserted toward the C5/6 and C6/7 facet joints. Dr M then attempted to inject a mixture of lignocaine and triamcinolone at the lower level.

Unfortunately, as soon as Dr M started the injection, the patient jumped with pain, and her left arm twitched. The procedure was abandoned.

Despite a normal neurological examination immediately after the procedure, the patient later the same day developed numbness in her left arm and right leg. She also complained of headache when sitting up, as well as pain in her left neck and shoulder. As she felt dizzy on standing, Dr M decided to admit Mrs J for overnight monitoring and analgesia.

The next morning, Mrs J was no better. She felt unsteady on her feet and complained of



Learning points

- Although it is commonplace for a doctor to assume multiple roles, this case highlights the risks during an individual procedure. Dr M was acting as an anaesthetist providing sedation, analgesia and reassurance, while at the same time carrying out the facet joint injections.
- Although Dr M warned the claimant about the possibility of nerve damage, this does not mean that a defence can necessarily be made. Both the expert pain consultant and radiologist concluded that neither needle was positioned as intended prior to the injection, and that the lower needle tip was clearly within the spinal canal and thus potentially within the substance of the cord.
- The experts were of the opinion that a pain medicine consultant should be confident in interpretation of live radiological imaging, including needle trajectory, and accurately determine needle trajectory and position prior to performing the procedure. It is important to allow the necessary time regardless of other pressures, and to follow guidelines published by professional societies or bodies, e.g. the International Spinal Injection Society. There is a body of opinion that advises against the use of particulate steroid injections in the cervical area.
- When an elective procedure or service has been offered to a patient, the practitioner may feel an obligation to fulfil this, even when they may not be entirely confident about doing so. Where there is any doubt or concern, it is far better to abandon the procedure or seek a second opinion, particularly where a mistake may lead to a serious complication.

a burning sensation in her right leg, as well as weakness and shooting pains in her left arm. Dr M decided that a second opinion was required, and referred Mrs J to a neurosurgical colleague. An MRI was arranged, which unfortunately demonstrated signal change in the cord at a level consistent with the intended facet joint injection.

Over time, the MRI changes improved, but Mrs J continued to suffer from terrible neuropathic pain. It affected many aspects of her daily life, and she found it difficult to return to work as she was not able to sit for any length of time. A spinal cord stimulator was inserted by another pain specialist to try and help with the pain, but this was largely

unsuccessful and was later removed. Mrs J subsequently lost her job and, following that, decided to bring a claim against Dr M.

Expert opinion

The case was reviewed for MPS by Dr F, a specialist in pain management. Dr F was of the opinion that the initial assessment and management plan were entirely appropriate. She was somewhat critical of the approach used by Dr M for the diagnostic injection, as it was not consistent with the planned approach for the radiofrequency lesioning and, in her opinion, more likely to be associated with the possibility of damage to the spinal cord. She also felt that the use of triamcinolone in the

diagnostic injections could be criticised, as injection of particulate matter into the spinal cord is known to be associated with a higher risk of cord damage.

Dr W, an expert neuroradiologist, was concerned about the images he reviewed from the second diagnostic injection. He concluded that neither needle was within the respective facet joint, and that the lower needle tip was within the spinal canal at the level of C5, less than 1 cm from the midline. Dr W also confirmed that the MRI abnormality corresponded with the position of the lower needle tip.

Dr F concluded that insufficient images were taken to satisfactorily position the needles. She also noted that only 40 seconds

had passed between the images taken for the first and second needle insertions, inferring that the procedure had been carried out with some haste.

MPS then instructed a causation expert to comment on Mrs J's progression of symptoms. Prof. I concluded that the development of neuropathic pain in the right limb was understandable, although the disabling effects were more than he would have expected. While the patient did have a history of neck pain, her symptoms were consistent with a lesion affecting the spinothalamic tract on the contralateral side of the cervical spinal cord. The case was considered indefensible, and was settled for a high sum.

Closure of a private medical practice

Thato Molefe, candidate attorney under supervision of director Nicola Caine, MacRobert Attorneys

This article summarises the steps relating to the procedural and ethical requirements for the closure of a medical practice. The following guidelines, although not authoritative, provide sound ethical and procedural guidance for closing a practice.

Informing patients of closure of practice

In terms of section 10.5 of the HPCSA's "Guidelines on the keeping of patient records", whenever a medical practitioner in private practice wants to close his/her practice, (s)he shall inform his/her patients at least 3 months before the closure that:

- the practice is being closed as from a specific date
- requests may be made that records be transferred to other health practitioners of their choice
- from the date of closure, the records will be kept in safekeeping for a period of at least 12 months by an identified healthcare practitioner or health institution with full authority to deal with the files as he or she may deem appropriate, provided the provisions of the rules on professional confidentiality are observed.

When a request is made by the patient for the transfer of records to another health practitioner of the patient's choice, the

medical practitioner must obtain a consent form from the patient to transfer copies of the patient's medical records to the patient's new service providers, and place a dated copy of the consent form in the patient's medical record.

Confidentiality and patients' records

Compliance with section 10.5 does not mean that once the 12 months has lapsed, the original patient records should be destroyed. Section 9 of the HPCSA's guidelines states that once 12 months have lapsed:

- health records should be stored for a period of not less than 6 years as from the date they became dormant
- for mentally incompetent patients, health records should be kept for the duration of the patient's lifetime.

Section 9 of the HPCSA's guidelines also states that "for minors under the age of 18 years, health records should be kept until the minor's 21st birthday, because legally minors have up to 3 years after they reach the age of 18 years to bring a claim". To be on the safe side, this should be followed by practitioners (although it is pointed out that in terms of the Prescription Act No. 68 of 1969, claims by minor patients may prescribe, meaning that a claim can no longer be instituted, prior to the period mentioned in the guidelines,

depending on the particular circumstances of each case).

Section 9 of the HPCSA's guidelines provides that health records should be stored in a safe place and, if they are in electronic format, safeguarded by effective passwords.

In the event that the closure of the medical practice pertains to a psychiatric one, and given the sensitivity of psychiatric records, these should only be released to either another psychiatrist whom the patient will now be consulting, or alternatively, the patient's GP.

By the same token, and in accordance with section 3.12 of the guidelines in psychology, it is necessary to continue to treat as confidential information regarding a patient after the professional relationship has ceased, and to plan in advance for the protection and safekeeping of the patient's records. Although this is a guideline specifically for psychologists, all medical practitioners would be well advised to take cognisance of it.

Continuity of care

There is nothing barring a medical practitioner from providing a patient with a copy of his or her last script in order for the patient's treatment to continue in circumstances where the practice has just closed. However, a patient or someone authorised in writing to do so by the patient should be the one to collect the copy of the last script.

Griqualand West branch supports vaccination

The Griqualand West branch has started a COVID-19 vaccination programme in support of the government's campaign to reach every citizen. The branch is sponsoring the programme to demonstrate their support of the COVID-19 vaccine.

The vaccination programme launched on 23 September 2021 at the Valspan Clinic, Jan Kempdorp Community Health Centre, and on 29 September 2021 at West End Hospital in Kimberley.

SAMA wholly supports the vaccination process as a safe and effective strategy in curbing the spread of COVID-19 and bringing an end to the pandemic through herd immunity. Those who do not vaccinate are creating an environment for COVID-19 to mutate into dangerous variants.

The association rejects misinformation about vaccines and COVID-19. Patients rely on informed medical experts to make decisions regarding their health. While SAMA respects every patient's right to refuse vaccination, it urges patients to make informed decisions and to speak to doctors who will present all the pros and cons based on scientifically formulated data.

The Griqualand West branch expressed its gratitude to all the healthcare workers at the vaccination sites who are playing their role in vaccinating as many people as possible.



At the West End Hospital, left to right: Nicky Hess (auxiliary nurse), Priscilla Selebogo (administrator), Gloria Mojamongwe (matron sister), Vonani Chauke (auxiliary nurse) and Dr Mbese Ngundu (SAMA Griqualand West branch chairman)

Eastern Free State branch rejects COVID-19 misinformation

On 22 September 2021, at the Dihlabeng Hospital in Bethlehem, the Free State branch extended their sponsorship of a COVID-19 vaccination programme in support of the government's campaign to reach every citizen.

SAMA rejects misinformation about vaccines and COVID-19. Patients rely on informed medical experts to make decisions regarding their health. Unfortunately, there are a few GPs in Bloemfontein who falsely represent themselves as experts in the field of transmittable diseases and vaccines, and who are also spreading false information on their social media. SAMA strongly distances itself from these physicians.

Doctors who spread false information about COVID-19 vaccines discourage patients from getting vaccinated, which can lead to preventable loss of life. SAMA believes that personal views and opinions must not interfere with science-based research, and reminds doctors that it is an ethical violation to purposefully spread false information about COVID-19 vaccines, as this can lead to many preventable deaths.



At Dihlabeng Hospital in Bethlehem, left to right: Sr Ntebaleng Magau, Mr Tsietsi Makume, Matron Dimakatso Masheane and Ms Sibongile Mpanza



Welcome to SAMA

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

Cape Western branch

Abdullah Assim
Nikita Mischka Jacobs
Andrew Chiften Mathole

Eastern Highveld branch

Retshepile Mashapa
Andile Molo
Lindokuhle Anton Nkutha
Kamuanya Bibiche Lema
Wabazele Mqali

Free State branch

Pieter Badenhorst
Nelisiwe Phelokazi Rethabile Lehasa
Madeleine Meintjies

Gauteng branch

Mohammed Cajee
Musa Omotosho Eleburuike
Michael Kanangila Ilunga
Hulisani Mathivha
Motheo Ngoanankgudi Mmotong
Tshegofaatso Motaung
Ntswaki Nonhlanhla Ngcobo
Eunice Niyobuntu
Danilo Perrone

Gauteng North branch

Nicole Shima Kamuzinzi
Tshepang Melvin Masemola
Tolarence Pogiso Matsane
Asemahle Mngcwengi
Mamello Innocent Molepo
Simon Sebego Phetoane
Nonhlanhla Catherine Sishaba
Christiaan Johannes van Wijk
Tronel Visser
Bhamjee Yanseen

Griqualand West branch

Fortune Mpuseng Ranaana

KZN Coastal branch

Selona Hariparsad
Pranav Hiralal
Talent Mthethwa
Alli Sameera

KZN Midlands branch

Everhardus Johannes Jansen van Rensburg

Limpopo branch

Karabo Raesetje Bambo
Khuliso Basetsana Mafumo

Ompha Makhera
Funzani Mauna
Vukosi Marcia Rikhotso
Shiluvana Success
Rendani Tshakata
Nicole van der Merwe

Lowveld branch

Elke Leistner
Jana Rust

Transkei branch

Martias Nselelo Mbanjwa
Sisipho Mcetywa
Luzuko Nomvungu

Tygerberg Boland branch

Emma Scriba

Vaal River branch

Katleho Maduna

West Rand branch

Thato Omphile Kwadi
Thato Moshomo

ZAR4.2m research grant for the fight against blood cancer

SAMA Communications Department

The DKMS Foundation for Giving Life (*Stiftung Leben Spenden*) invites young scientists worldwide to apply for the John Hansen Research Grant. The application deadline is 3 December 2021. The research grant is endowed with over ZAR4.2 million per successful applicant, paid over a period of 3 years. With this sum, the foundation annually supports up to four international young scientists with promising research projects in the field of blood stem cell transplantation and cell therapy.

Requirements for participation include a doctorate or comparable qualification dating back no more than 8 years.

All information on the application modalities as well as further details on the John Hansen Research Grant are available on the DKMS Professionals' Platform – professional.dkms.org/research-grant. If you have any questions, you are also welcome to contact DKMS by email: grant@dkms.org.

DKMS is known as an international non-profit organisation in the fight against blood cancer. Over 11 million potential blood stem cell donors are registered with it. In its 30-year history, DKMS has already given more than 95 000 blood cancer patients a second chance at life. In addition, the world's leading blood stem cell donor centre is also working intensively in the medical and scientific field to further improve the survival and healing chances of blood cancer patients.

Festive season is Locum season

There are not many days until Christmas, and with vaccinations available to almost all age groups, there is finally a light at the end of this tunnel.

Due to the heavy patient loads that you as a practice owner have endured, it's time to take your break. We are heading towards the festive season, and @LocumBase is ready and excited to help you with all your Locum needs!

We understand that November to January is the busiest time of the year, but also perfect for you to take the much-deserved leave you've been dreaming about all year. It is also a wonderful opportunity for Locums to make supplemental income, grow and share their experiences during this busy time and be of service to your valuable patients.

By taking that break, you are gifting yourself time to recuperate and return refreshed

By taking that break, you are gifting yourself time to recuperate and return refreshed. The danger of not taking time off for yourself could result in burnout and avoidable mistakes. Chances are that these toils may be costing you more than productivity. Keeping up the grind may be economically fruitful, but it can negatively impact your long-term performance and mental and physical health.

If you are experiencing brain fog, or feeling irritable or absent-minded, you are likely to be physically and mentally exhausted. Taking quality time to recharge alone gives you time to reflect on yourself and understand why you are feeling the way you are. It also allows time to come up with other ideas or solutions for what you may be struggling with.

Booking a Locum to come in and take your place will alleviate some of the reasons you have for not using your vacation time.

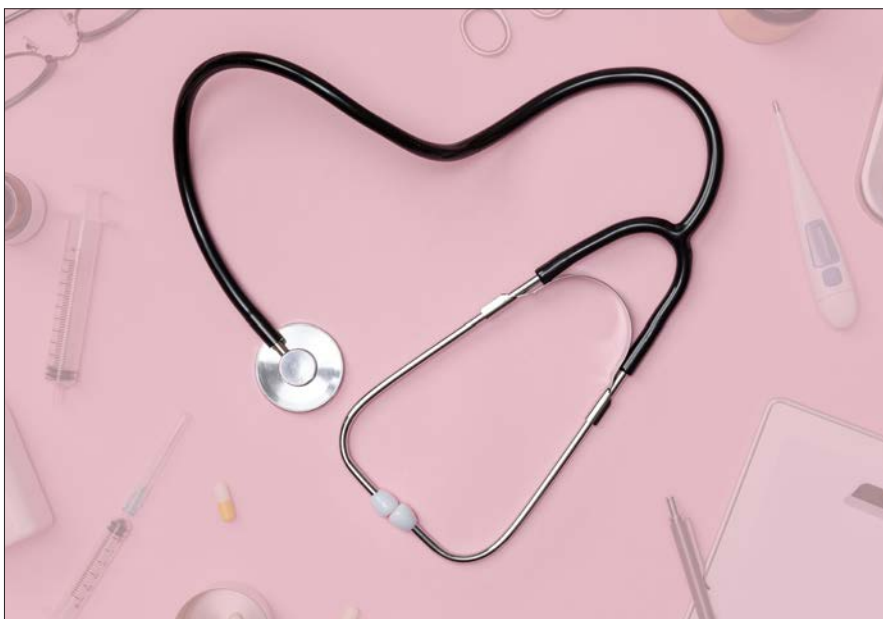
Here are a few things to consider when planning your festive break:

- A Locum allows your practice to keep up with current and excess patient loads while keeping your quality care standards intact.
- Your office will continue billing, because patients are being cared for and treated. This means there is no "real" loss of cash flow to your practice.
- Patients will appreciate not having to wait 2 or 3 weeks for an appointment, and this may increase trust in your practice and service offering.
- Give some thought to how much time you feel is necessary to on-board the Locum, and use this time to test whether they are the right fit for you and your patients. LocumBase provides the highest quality of verified Locums nationwide.
- You can keep a Locum on for a few days to make sure you do not feel overwhelmed upon your return. This transition period is crucial to keeping your energy levels stable.

Join the Locum revolution and take control of your practice growth, today.

Sign up at <https://auth.locumbase.com/signup> or contact us via email at hello@locumbase.com or WhatsApp on 079 013 3962 for more info.

You can learn more about LocumBase by visiting us on LinkedIn, Facebook, Instagram or Twitter.



FESTIVE SEASON **IS LOCUM SEASON!**

Whether you're a Practice Owner looking to take a break this festive season or a Locum looking to make supplementary income, LocumBase is here to assist you with all your needs.

Take advantage of your SAMA member benefits, click [here](#) to view them.

STEPS TO SIGN UP

1

Create your profile and encourage your favourite Locums to sign up.

2

Set an offer on your Practice Dashboard and check your profile regularly for applications to your offers.

3

Accept and manage bookings from verified Locums in one place.



LocumBase

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SAMAREC

The South African Medical Association Research Ethics Committee (SAMAREC) has been a well-established Research Ethics Committee (REC) in South Africa for the past 27 years.

As a registered REC with the National Health Research Ethics Council (NHREC), the Council reviews biomedical research proposals for research to be done in the private sector.

Ethics review is done on any type of biomedical research, including full-scale clinical trials, observational studies, device studies, surveys and registers.

If you are planning to publish your study or ensure that you comply with good clinical practice – SAMAREC is the way to go.

We offer a completely paperless system, and guarantee a quick turnaround time.

SAMAREC has a designated officer to keep you up to date with the progress of your application.

For more information, please contact the SAMAREC Officer

012 481 2046 or samarec@samedical.org

