

SAMA INSIDER

NOVEMBER 2013

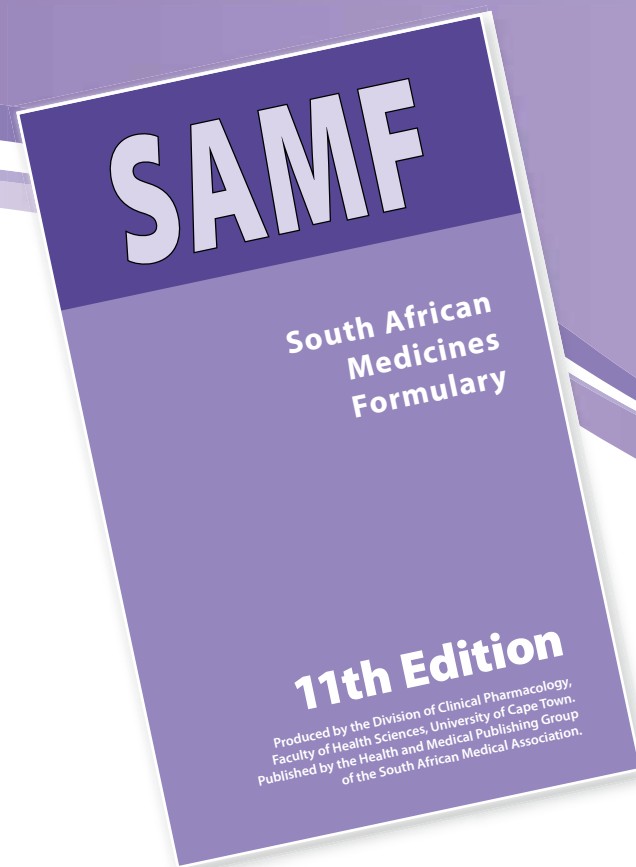


**Wits' Prof. Ames
Dhai appointed
SAMA president**



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CONTENTS

NOVEMBER 2013



The photographers name was not available at the time of going to press

- | | |
|--|--|
| <p>2 EDITOR'S NOTE
Summer of SAMA
Conrad Strydom</p> <p>4 NEW PRESIDENT WELCOMED
Meet Prof. Ames Dhai
Conrad Strydom</p> <p>6 FEATURES
Doctors spitting at their own image
Dr Mahlane Pahlane</p> <p>7 Changes to Helsinki declaration
World Medical Association</p> <p>9 Member profile
Dr Sindi van Zyl</p> <p>Benevolent Fund
SAMA</p> <p>10 PPE campaign launched
SAMA and DENOSA</p> | <p>11 Coding interpretation
Private Practice coding unit</p> <p>12 International AIDS and STIs conference
ICASA</p> <p>14 Simplifying PMDS in public service
Simon Buthelezi</p> <p>MEDICINE AND THE LAW</p> <p>16 What constitutes a benefit
Ntokozo Sibeko</p> <p>17 Risk management in medical practice and hospitals
Medical Protection Society</p> <p>19 It's all about consent
Medical Protection Society</p> <p>20 BRANCH NEWS</p> |
|--|--|

EDITOR'S NOTE NOVEMBER 2013



Conrad Strydom
Editor: SAMA INSIDER

Summer of SAMA

Change is in the air at SAMA as the association recently welcomed its new president. Prof. Ames Dhai is one of the most respected individuals in South African medicine, largely due to her work as an ethicist and educator. She is exactly what SAMA requires at the moment – a voice of moral authority, capable of reminding our members of their duty as doctors while ensuring that health industry stakeholders play by the rules. Unethical behaviour in healthcare has become a growing concern, especially among the public. Hopefully Prof. Dhai will help the association restore some of the goodwill that has been lost.

In this issue of the *SAMA Insider*, we feature an in-depth interview with the new president, as well as a call-to-arms from the recently-appointed general secretary of the SAMA Trade Union, Dr Mahlane Phalane. Dr Phalane's view on the prevailing attitude among medical doctors is both enlightening and timely, and likely to touch a few nerves in a necessary way. We also feature an update on the recently amended Declaration of Helsinki and get the lowdown on the activities of the SAMA Benevolent Fund.

The *SAMA Insider* is offered as a member service and is therefore at your disposal, so please feel free to contact me at conrads@samedical.org if you have any news or suggestions to share. Please keep us informed.

Pleasant practice until next time.

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She Ames to deliver: Meet Prof. Dhai



Incoming SAMA president Prof. Ames Dhai

The South African Medical Association (SAMA) welcomed Prof. Ames Dhai as its new president recently with a dinner at the Intercontinental OR Tambo Hotel. The position of president, which is decided annually by a national council vote, is the most senior position in the association. Prof. Ames Dhai is widely respected in medical circles for her work in the field of medical ethics and is the founder and director of the Steve Biko Centre for Bioethics at Wits, where she also teaches as a member of the health sciences faculty. *SAMA Insider* had a chance to ask Prof. Dhai about her plans for the association.

What do you see as SAMA's most important immediate goals?

I think it is very important that we build on the strengths that are already there. It is important to continue the work of people who have laid the foundation for our current struggles. No one can deny that healthcare is currently in a crisis, so the question is: how will we respond? I believe we must continue the advocacy role that we have taken up so well in the last few years. We must maintain our level of advocacy while always striving to be more effective at it.

SAMA's goal is to be an organisation that can unify South African doctors, so we must also redouble our efforts to increase our membership. We have to make it so attractive to be a SAMA member that it won't be a choice, but a necessity. The continued divisions in the medical community don't do anyone any good – we must ensure that the health profession becomes united as one body.

“I would like to see closer bonds between public and private doctors; both can learn a lot from the other, if they are willing to listen”

It is also important to keep in mind that we are part of a global community of medical practitioners. Consequently, we must think globally even when approaching localised issues. SAMA and the World Medical Association (WMA) enjoy a very cordial working relationship. We should try to expand our role in the WMA as much as possible.

How will your background as an ethicist impact your approach to the SAMA presidency?

I am very aware of the need to maintain extremely high professional standards. In medicine, the slightest mistake can have catastrophic consequences. At SAMA, we must apply the same rigour to our daily decisions, since we have the power to directly influence the way healthcare is applied in this country.

What would you most like to change about the health environment in South Africa?

Simply put, the system. An essential service such as medicine must have efficient working systems in place. But because of the terrible trio of inefficiency, mismanagement and corruption we are faced with a system that can barely support itself, let alone take care of the needs of patients. Service delivery is failing, especially in the public sector. Unfortunately, the systemic failures are so deeply entrenched that we will have to prepare ourselves for a long walk out of the current morass. SAMA must maintain its place at the forefront of this particular struggle – a position it has held for a very long time – especially now that we are beginning to see state players who are committed to change.

“The continued divisions don't do anyone any good – we must ensure that the health profession becomes united as one body”

What role should the SAMA Trade Union play in fixing the public healthcare system?

The Trade Union is one of the most exciting developments in the recent history of SAMA. It has a young, committed leadership and has managed to secure a remarkable rate of success so far. I think it is particularly important to remember that the Trade Union's gains are not only gains that impact the wellbeing of doctors; they also directly affect patients in public care.

How do you view SAMA's relationship with the Department of Health (DoH)?

The DoH is not just responsible for service delivery; they are also a policy-making body, the source of all our health legislation. SAMA must involve itself not only with the delivery of services but also with the creation of new policies. We can claim many successes in this regard so far, including our inputs in the official NHI and RWOPS policies. It is SAMA's responsibility to ensure that any policies which are enacted become effective tools to ensure justice for both patients and doctors.

Do you foresee any problems in implementing the coming NHI policy?

SAMA must lead the charge to implement the NHI or it may very well fail. It will not be an easy policy to implement, especially given the current state of public health, but in the long term it will definitely pay off. Other countries, similar to us who have implemented a form of NHI, have taken years to properly implement their policies and I think we should get ready for a long process ourselves. But we have to start

taking our preparation work much more seriously.

Finally, what can the private sector contribute to South African healthcare?

I think we are often so hung up about the state of public health that we forget just how excellent private healthcare in South Africa really is. Our private sector doctors

offer a level of care comparable to the best in the world. The private sector is a very, very important part of healthcare delivery and much of the prestige and respect afforded our profession relies on the effectiveness and innovative spirit prevalent in the sector. I would, however, like to see closer bonds between public and private doctors; both can learn a lot from the other, if they are willing to listen.

Prof. Ames Dhai

MB ChB (Natal), FCOG (SA), LLM (Natal), PGDip Int Res Ethics (UCT)

Prof. Dhai established the Steve Biko Centre for Bioethics in 2006. She is currently Director of the Centre. She is an ethicist of international standing and can be credited with entrenching bioethics as an integral aspect of health sciences in South Africa. Her expertise is in demand nationally, on the African continent and internationally. She has been directly responsible for institutionalising bioethics at the University of the Witwatersrand's Faculty of Health Sciences.

Prof. Dhai's special interest is in the field of research ethics. She is proactive within both research ethics at Wits University (where she is co-chair of the Human Research Ethics Committee) and research ethics further afield, including the National Health Research Ethics Council.

President's dinner 2013



SAMA chairperson Dr Mzukisi Grootboom introduces the speakers

SAMA was proud to host its annual President's Dinner on 4 October 2013 in the Okavango Room of the Intercontinental OR Tambo Hotel.

The new president, Prof. Ames Dhai, received the president's medal from her predecessor, Prof. Zephne van der Spuy, who was on hand to welcome the incumbent. Prof. van der Spuy noted her satisfaction at handing over the reins to a woman, taking it as an indication of the changing gender norms within the medical community. “By the time I entered my third year in medical school, there were only three women in our class, and we weren't exactly welcome,” she said.

Prof. van der Spuy provided a brief overview of her year as president and described the experience as “interesting”, noting SAMA's involvement in the Cyril Karabus saga, the Declaration of Helsinki

and the World Medical Association (WMA) as personal highlights. She closed her talk by reminding those present that the overarching goal of SAMA was to unite the medical profession: “A house divided against itself cannot stand”.

Prof. Dhai took to the podium to the sound of ululation, courtesy of the SAMA Trade Union's leadership contingent. After delivering a refresher course on the history of SAMA, Prof. Dhai emphasised the fact that the association was designed to empower doctors and provide a space where medical professionals could put aside their differences and work towards a common good. Prof. Dhai noted that the association had travelled a very arduous path to get to where it is currently, and reminded those present that SAMA should seek justice not only for doctors, but for patients as well.

Doctors spitting at their own image

Dr Mahlane Pahlane, SAMA Trade Union General Secretary



- Shortage of medication and equipment has resulted in hopelessness and helplessness.
- Our working conditions have become unbearable and life threatening; murders and rapes of doctors on duty are things we have grown to witness with horror.
- We have allowed economics, politics and lawyers to dictate the course of medical management.
- Hope has given way to self-hatred. The vision we used to display has been displaced by venom against each other. Animosity has killed our unity and we fragment at the slightest provocation.
- Everyone is using doctors' skills and expertise to create wealth, but the doctors themselves remain overworked and underpaid.

The medical profession has proven that the adage 'ignorance is bliss' is a fallacy. As doctors we are expected, due to the critical nature of our work, to have a great body of knowledge not only of human physiology and anatomy but of the profession and society as a whole.

Doctors should not turn complaining about everything into a specialty; rather they should turn challenges into opportunities to be innovative and creative.

The medical profession in South Africa has been a pioneer in social development, for example:

- Dr Ignaz Semmelweis introduced the concept of hand washing to reduce the rate of infections.
- Dr John Snow in the mid-19th century introduced clean drinking water to prevent cholera.
- Prof. Chris Barnard taught the world the human heart transplant.

It is against this background of greatness, hope and strength that we have to pause and wonder what went wrong. South Africa used to be the crème de la crème of medicine. Doctors used to be in charge of their own profession. Doctors used to manage healthcare, and the system was functional. Doctors used to enjoy respect. Unfortunately all this has changed for the worse:

- Doctors and the entire profession are called 'tsotsis' by those who lead them.

All these afflictions are self-imposed. We suffer from self-hatred to the extent that we spit at our own image in the mirror. It was the visionary decision of MASA (Medical Association of South Africa) to form a trade union on 11 November 1996. Unfortunately some want to accuse the current leadership of SAMA of introducing tendencies that are foreign to the association. Trade unionism had been a principle of MASA and SAMA inherited that.

We face fundamental challenges that we will conquer only if we are united. It shouldn't matter what name we attach to our form of unity: association, social club or even union. What is of paramount importance is that the structure should put the profession first, carry itself in a dignified manner and follow the laws and ethical principles that govern our profession and country. As Nelson Mandela said: "It doesn't matter whether the cat is black or white, as long as it catches the mice".

The power dynamics of today demand that we mobilise, unite and organise ourselves to tackle the challenges we are all facing. Regulations and laws were passed that are detrimental to our core existence, and we had no mechanism to tackle them. The medical profession was hopeless and helpless when politics and economics made a mockery of HIV management in this country. Medical aid schemes are exploiting this weakness and are dealing with us however they want. They dictate which treatment we can give and

what they can or cannot pay for. This takes place while we bruise each other and form opposing splinter groups.

We have a choice: adapt or die, swim or sink. We can either build a vibrant and united organisation or break it into dysfunctional micro-particles. We should always remember that when the private sector demonises the public sector and vice versa it is the profession that becomes the ultimate loser.

Our vision and mission are very clear. We base our activities on Charles Boelen's 'Five Star Doctor':

- We strive to rejuvenate the medical profession to be the excellent care providers they used to be.
- We endeavour to capacitate doctors to be decision-makers.
- We commit to be eloquent communicators of health issues and the medical profession.
- We need to develop community leaders who live by the biopsychosocial model.
- We shall never rest until we have visionary, effective and efficient managers who will turn the healthcare system around.

It is prudent at this point to stop and ask yourself, which star doctor are you? The first step is for us to love ourselves. If we don't have love for ourselves, we can't give it to each other. And most importantly, we can't expect others to love us if we ourselves don't love each other. We can't afford to waste time and energy fighting each other while our peers elsewhere are inventing a robot that can perform prostate operations. We have to live in peace with each other to be able to deal with the real challenges facing us:

- The amorphous NHI.
- The escalating rate of litigation against doctors.
- Hostile management.
- Over-regulation.
- Adverse treatment from medical aid schemes.
- Lack of safety and security both in private and public health institutions.
- Poor conditions of service.
- SAMA, not medical aid schemes, must develop evidence based protocols.
- Revive research and innovation in the medical profession.
- Build a united, relevant, vibrant, efficient and effective medical organisation.



World Medical Association publishes revised Declaration of Helsinki

World Medical Association

Significant changes have been made to one of the world's most important international ethical documents. After a revision process lasting two years, the WMA has released an updated version the Declaration on medical research, which next year celebrates its 50th anniversary.

The World Medical Association (WMA), adopted and published at its annual General Assembly in Fortaleza, Brazil, October 16-19 the revised Declaration of Helsinki document that will determine the way medical research is carried out on human subjects across the world.

Delegates at the WMA's annual Assembly in Fortaleza, Brazil, voted overwhelmingly to support changes to the Declaration, which not only provide for increased protection for vulnerable groups involved in research, but also include a new provision for compensating people harmed as a result of participating in research. In addition there are expanded requirements for post-study arrangements to ensure that participants involved in research are informed of the results and have access to any beneficial treatments that emerge.

Representatives of the South African Medical Association (SAMA), including newly elected president Prof. Ames Dhali and vice-chairman Dr Mark Sonderup, have been part of the extensive revision process by serving on the workgroup. SAMA Chairman, Dr Mzukisi Grootboom and Prof. Dhali delivered final inputs on the Declaration at the WMA General Assembly in Fortaleza where the new document was formally approved and adopted. SAMA is proud to have contributed and participated on the world stage in a matter that has great implications for the way medical research is conducted on the African continent.

It was because of the lack of research ethics that the WMA came into being in 1947. The Second World War experienced research of the most inhumane, horrific kind. Physicians and others were involved in subjecting prisoners and patients to research that could only be described as a brutal violation of any sort of human right and dignity. In response to these atrocities, physicians from 27 nations met in 1946 to establish an organisation promoting

ethical conduct and practice. And so the WMA was born. Today it is a body representing 102 national medical associations around the world.

The WMA's primary consideration over these past 66 years has been and is the protection of the safety, dignity and rights of research subjects and this has been encapsulated in the Association's most important set of guidelines, the Declaration of Helsinki. This document, first published in 1964, lays out ethical guidelines to protect patients, by setting standards for the medical profession. It was the first significant effort of the medical community to regulate research itself, and forms the basis of most subsequent documents. It was the post World War II Nuremberg Code that formed the basis of the Declaration. Subsequently the Declaration has been incorporated into several laws and regulations around the world, and has acted as an important safeguard for patients globally. This proves that the value of the research ethics of the document remain unchanged.

Over the years, the Declaration has been revised six times. It is a living document and the WMA has taken the view that in the fast changing world of medicine the Declaration too must change. Recently, there have been some important amendments, although the core principles of the document remain unchanged.

The latest revision follows a two-year process of elaborate discussion and consultation. In 2011 the WMA set up a small workgroup to lead the process. All the WMAs 102 national medical associations were invited to suggest possible changes and outside experts attended four conferences held in different parts of the world to discuss how the Declaration might be revised.

The result is a revised document. Among the significant changes are:

- Increased protection for vulnerable groups. The Declaration recognises that some research populations are disadvantaged or vulnerable and have an increased likelihood of incurring additional and greater harm than others.
- There is more protection for participants. In addition to strengthening protection

from risks there is a new provision for compensation for subjects harmed as a result of participating in the research.

- There are expanded requirements for post-study arrangements. This requires that participants be advised prior to the study that they will be informed of the results and if needed have access to treatments determined in the study to be beneficial.
- There is also a more systematic approach to the use of placebos, strengthening the explicit ethical requirements essential for placebo use particularly where a known effective treatment is available.
- There has also been some re-organisation and restructuring of the document with the aim of improving its readability, while preserving its character and length.

“The Declaration’s primary consideration has been and is the protection of the safety, dignity and rights of research subjects”

This is the seventh time the Declaration of Helsinki has been revised since its inception, with notes of clarification being added in 2002 and 2004. It is one of the most important international ethical regulations in biomedical research and is a core document of the WMA. It was adopted by the 18th General Assembly of the WMA in Helsinki, Finland in 1964 and consists of a collection of ethical principles which set out clear and easily readable guidelines for medical research involving human subjects.



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For further information please contact the SAMAREC/CPD Secretariat on 012 481 2000 or email us on samarec@samedical.org , cpd@samedical.org

Member profile: Dr Sindi van Zyl



Dr Sindi van Zyl

Joburg-based Dr Sindi van Zyl has become well-known in health circles for operating a blog (<http://qooh.me/DoctorSindi>) that dispenses free medical advice to people who suffer from HIV/AIDS. She has been featured on radio, TV and print media for her efforts to reach HIV-positive people directly via social media platforms. Currently, Dr van Zyl fields

queries from patients all over the world. *SAMA Insider* asked her about her thoroughly modern approach to healthcare.

Has social media changed the way you operate as a doctor?

Yes it has. It is a wonderful platform for sharing knowledge. The most satisfying thing that I have ever done is to reach out and help people through these platforms.

My heart is always touched when I receive emails from as far afield as Trinidad and Nigeria thanking me for my assistance. The blog really has taken on a very international character - I have helped people from Zambia, Zimbabwe, Malawi, Kenya, the UK and many other parts of the world.

What should the medical community do to improve the way it deals with HIV-positive people?

We have a responsibility to make sure that we stay up-to-date with all the latest information around HIV. Things are changing all the time and we need to stay informed, so that we can inform our patients appropriately.

What is the most satisfying part of helping an HIV/AIDS sufferer?

It is always heart warming to see someone who initially arrived at a clinic frail and emaciated return after a few weeks looking completely healthy.

This is entirely possible with the medicine and treatments that are available to us nowadays, and all doctors should be made aware of that.

Has the Department of Health's fight against HIV/AIDS been effective?

I would say so. Many people are on some form of treatment nowadays, so many lives are being saved.

We have a way to go but each new step that the Department of Health takes is making a difference.

What would you most like to change about the state of local healthcare?

Without a doubt, the attitude of healthcare workers. If each of us were to treat patients as if they were our relatives, we would see a great improvement in our levels of service.

Benevolent Fund takes care of doctors and their families

Although people spend a large part of their lives trying to gain security, tragedy has a habit of striking when we least expect it. During the 1940s the members of what was then the Medical Association of South Africa (MASA) banded together to form a fund for doctors and their families who were in dire straits financially.

In the intervening seven decades the name and nature of the organisation has changed dramatically along with the gender and racial makeup of its members. However, the commitment to helping destitute doctors remains the bedrock of the Benevolent Fund to this day.

"Currently, the fund is subsidised by levies attached to member subscriptions, although it heavily depends on donations for its survival," said Dr Rafiq Abbas, the chairperson of SAMA's finance committee, which administers the fund.

"Ensuring that our members or their families are taken care of in the event of

accident or death is part of the valuable service SAMA wishes to provide."

Thirty-one families receive support from the Benevolent Fund at present, with grant expenditures annually amounting to roughly a million rand. Applications for assistance are accepted from doctors and their families. These applications are carefully considered by the finance committee, usually in consultation with the applicant members' affiliated branch, which will by that time have interviewed the applicants and drafted a report about their situation.

"Usually the payments are in the form of a monthly supplemental payment to an applicant's income," Dr Abbas said. "We have however made cash payouts in the event of a doctor's family being unable to cover his funeral costs, for instance." Some examples of SAMA's interventions include grant payments made to an ailing member who suffered from dementia. After the members' death, the Benevolent Fund has continued to provide for the care of his mentally impaired daughter. Another member

had lost his ability to practice due to prostate cancer. SAMA paid him an allowance that enabled him to spend the last months of his life – during which he was terminally ill – at home.

The continued existence of the fund is dependent on member donations and SAMA appeals to each doctor in South Africa to contribute to this worthy cause. Account name: The South African Medical Association Benevolent Fund Bank: Standard Bank Branch: Hatfield Branch Branch code: 011545 Account number: 011933607

Persal does not allow for the collection of donations, so public sector doctors are requested to authorise the Benevolent Fund to collect donations by debit order. To institute a debit order, please contact the SAMA membership department at 012 481 2071.

Western Cape and DENOSA launch PPE campaign

SAMA, in partnership with the Democratic Nursing Organisation of South Africa (DENOSA), has officially launched its national Positive Practice Environment (PPE) Campaign. This campaign was initiated by the World Health Organization (WHO) and supported by the International Council of Nurses and the World Medical Association (WMA). The campaign is aimed at generating public awareness and political will to introduce and maintain improved working conditions and environments within health systems.

The campaign's launch in the Western Cape was addressed by the MEC of Health Theuns Botha as well as the president of DENOSA Dorothy Matabeni and the vice chairperson of SAMA Dr Mark Sonderup. The spirit of the meeting was exceptionally positive and the MEC made a commitment to support the campaign. He also called on SAMA to involve the department in the roll out of the PPE campaign.

In attendance were members of SAMA, DENOSA, the Treatment Action Campaign and other civil society representatives who have supported the initiative. General agreement

was reached to focus on three core areas of the campaign:

- Safety and security of hospitals and clinics;
- Rampant equipment and drug shortages;
- Timely payment and support of personnel.

"This is a landmark partnership between organised labour, civil society, the broader community and governemnt"

"SAMA is looking forward to making a positive difference to the working environment of our doctors and nurses," said SAMA's Dr Zameer Brey, who also attended the meeting. "This is certainly a landmark partnership between

organised labour, civil society, the broader community and government towards improving healthcare for all," said Dr Brey. He also noted that he was pleased that SAMA and DENOSA were taking such an active role in local healthcare. "We are encouraged by the willingness of the provincial DoH to engage with us in this campaign and trust that their appetite for engagement will not disappear."

The eight pillars of the PPE campaign:

- Workplace **safety** and security
- Timely **payment**
- Provision and maintenance of **equipment**
- Provision of essential medical **supplies**
- Provision of basic **resources**
- Appointment of **educated**, qualified personnel
- Lack of **support** for professional development training
- Lack of **respect** for healthcare workers

Ralph Kirsch Golden Pen Award

Professor Mike Machaba Sathekge, Head of the Department of Nuclear Medicine, University of Pretoria, and Steve Biko Academic Hospital was the inaugural recipient of the Ralph Kirsch Golden Pen Award created to recognise the most cited article* in the Google Scholar Database published in the *South African Medical Journal (SAMJ)* in 2010. This prize is associated with three institutions – Groote Schuur Hospital and the University of Cape Town through the Department of Medicine, and the South African Medical Association through the *SAMJ* – to which Ralph Kirsch dedicated his life. The article has been cited in Russian and Chinese medical journals and research aggregator sites.



* Sathekge MM, Maes A, Pottel H, Stoltz A, van de Wiele C. Dual time-point FDG PET-CT for differentiating benign from malignant solitary pulmonary nodules in a TB endemic area. *S Afr Med J* 2010;100(9):598-601.

The Ralph Kirsch Golden Pen Award was presented at a special dinner by Dr Nkosazana Dhlamini Zuma, head of the African Union and former Minister of Health, seen here with Prof. Mike Sathekge (recipient) and Prof. Janet Seggie, Editor-in-Chief of the South African Medical Journal.

Coding: an interpretation of items 0146, 0147, 0148 and 0149

Private Practice Department Coding Unit

Lately, confusion has reigned with regard to the correct use and interpretation of items 0146, 0147, 0148 and 0149. The following article will, we hope, promote a better understanding of the use of these codes.

Item 0146: Description

For an unscheduled emergency consultation/visit at the doctor's home or rooms: ADD only to the consultation/visit items 0190-0192, items 0161-0164 or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof.

Interpretation

- Only one of items 0145, 0146 or 0147 may be added to a consultation/visit item, (as appropriate) and not combinations thereof.
- To be added to items 0190-0192 (as appropriate) for emergency or unscheduled consultations in rooms.
- To be added to items 0190-0192 (as appropriate) for consultations by doctors normally using 24-hour emergency facilities.
- The patient is responsible for the payment if his/her medical scheme does not grant benefits for this service (not applicable to Compensation Fund cases).
- Rule P is only applicable to emergency travel to a place where the doctor does not normally perform voluntary services, such as hospital visits.

Unscheduled visit in the rooms

When a patient visits a doctor without an appointment and is prepared to wait until the doctor can see him/her, item 0146 may not be applied to the consultation – items 0190-0192 (as appropriate).

Emergency in the rooms

When a patient visits the doctor's office without an appointment and insists to see the doctor immediately (taking preference over booked patients), the patient considers their condition as an emergency and it is the doctor's ethical duty to deal with it as such. In this case, item 0146 may be added to item 0190-0192 (as appropriate).

Item 0147: Description

For an emergency consultation/visit away from the doctor's home or rooms, all hours: ADD only to the consultation/visit items 0190-0192,

items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153, as appropriate. Note: Only one of items 0145, 0146 or 0147 may be charged and not combinations thereof.

Interpretation

- Only one of items 0145, 0146 or 0147 may be added to a consultation/visit item, as appropriate, and not combinations thereof.
- To be added to items 0190-0192, 0173-0175, 0161-0164, 0166-0169 or 0151-0153 (as appropriate) for an emergency visit away from the consulting rooms or doctor's home.
- Not to be added to items 0190-0192 for consultations by doctors normally using 24-hour emergency facilities.
- Not appropriate to add to items in the case of confinements in after-hour periods, where a global obstetric fee is charged.
- The patient is responsible for the payment if his/her medical scheme does not grant benefits for this service.
- Item 0147 may be added to items 0151-0153 (as appropriate) when an elective work list was not submitted to the anaesthesiologist/ anaesthetist by 16h00 on the day prior to the procedure(s).
- Rule P is only applicable to emergency travel to a place where the doctor does not normally perform voluntary services, such as hospital visits.

Item 0148: Description

For elective after-hours services on request of the patient or family (non emergency): ADD 50% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169 or items 0151-0153) and reflect this as a separate item 0148. Usage: This item is used when, for example, a patient or the family request the doctor for a non-emergency consultation/visit outside of the practitioners' normal hours.

Interpretation

- Item 0148 may only be added to the appropriate consultation/visit (item 0190-0192, 0173-0175, 0161-0169) when a non-emergency consultation/visit is made at request of the patient or the patient's family (not applicable to medical schemes' benefits and Compensation Fund cases).

- The value of this item is 50% of the appropriate consultation/visit item.
- The patient is responsible for the payment if his/her medical scheme do not grant benefits for this service.

The account will be coded as follows: Appropriate consultation code + Item 0148. Item 0146 may not be added.

Item 0149: Description

After-hours bona fide emergency consultation/visit (21:00-06:00 daily): ADD 25% of the fee for the appropriate consultation/visit item (only to be used with items 0190-0192, items 0173-0175, items 0161-0164, items 0166-0169, items 0151-0153 or item 0113) and reflect this as a separate item 0149.

Interpretation

- Appropriate for emergency consultations/visits between 21h00 - 06h00 (not applicable to Compensation Fund cases).
- Item 0149 is calculated using the appropriate consultation code plus either of items 0146 or item 0147 (as appropriate).
- Not appropriate for 24-hour emergency facilities.
- The value of this item is 25% of the appropriate consultation/visit item.
- The patient is responsible for the payment if his/her medical scheme do not grant benefits for this service.

The account will be coded as follows: Appropriate consultation code + item 0146 + item 0148.

Normal and after hours

Due to the fact that medical practice has changed over the years and doctors elect to open their offices at times other than between 08h00 - 17h00 (weekdays) and 08h00 - 12h00 (Saturdays), the term 'after hours' only applies outside the times of the doctor's normal practice hours. When the doctor advertises that he/she provide services on a Sunday, the advertised hours are considered as 'normal hours'.

Any patient seen outside the doctor's office consulting hours, is seen as an unscheduled/ emergency visit. Therefore, it is correct to use the appropriate consultation code in conjunction with item 0146.



ICASA conference to highlight progress in dealing with HIV, AIDS and STIs

Healthcare professionals, especially those dealing with HIV and AIDS, tuberculosis and sexually transmitted infections (STIs), need constantly to be at the forefront of new developments and approaches.

One of the most effective ways of learning about developments is at conferences specially focussing on these diseases. The 17th International Conference on AIDS and STIs in Africa (ICASA) is taking place in Cape Town from 7 - 11 December 2013.

"This regional gathering will explore progress in the science relating to TB, HIV and AIDS. During this conference high quality science around these issues will be presented and the outcomes of the presentations will enhance patient care whilst also informing the strategic decisions required to continue to secure health financing to meet the millennium development goals," says Prof. Ian Sanne, CEO and director of Right to Care and co-chair of ICASA.

The conference has three main categories: a scientific programme, a leadership programme and a community programme. The scientific programme has five tracks. These are:

- Basic Science;
- Clinical Science, Treatment and Care;
- Epidemiology and Prevention Science;
- Social Science, Human Rights and Political Science; and
- Health Systems, Economics and Implementation Science.

"An indication of the importance attached to the conference is the fact that we received 3 341 abstract submissions. Of these we accepted 1 312, which is significant. There will be three days of presentations with plenary speakers covering the key areas of HIV prevention and treatment and research at ICASA making it the premier HIV and AIDS conference on the continent and certainly a conference not to be missed by any healthcare professional," says Prof. Sanne.

His Excellency Mr Jacob Zuma, President of the Republic of South Africa, Her Excellency Dr Joyce Banda, President of the Republic of Malawi and the Honourable Dr Aaron Motsoaledi, Minister of Health of the Republic of South Africa, are among the high-level speakers who have confirmed their attendance to ICASA.

President Zuma will deliver the opening address at the conference on 7 December. Dr Motsoaledi, will speak on the leadership needed in the fight against HIV and AIDS on the continent and at the conference's closing ceremony. President Banda will address the conference on 'HIV and Women: From double to zero' while Mr Festus Mogae, the former President of Botswana will speak on 'Shared responsibility and global solidarity'. In addition, Dr Christine M Kaseba-Sata, the first lady of the Republic of Zambia, will deliver a keynote address at the opening.

The presence of current and former African heads of state and ministers is an indication of the importance African governments have attached to the conference. It comes at a time when these governments are increasingly under pressure to deliver meaningful results in the fight against STIs, TB, HIV and AIDS in their countries.

7 - 11 December 2013 in Cape Town
Registration closes 22 November 2013
<http://www.icasa2013southafrica.org>

ICASA conference speakers



His Excellency Mr Jacob Zuma – President of the Republic of South Africa
Topic: Opening address
 Jacob Zuma was elected president of South Africa in 2009. President Zuma's government has actively driven the expansion of HIV testing and AIDS services in South Africa.



Mr Festus Mogae
Topic: Shared responsibility and global solidarity
 Mr Mogae's presidency saw the implementation of the PMTCT programmes as well as the first national AIDS treatment programme in Africa in 2000. He, along with other African leaders, began the Champions for an HIV-Free Generation group calling for increased efforts to prevent the spread of HIV.



Her Excellency Dr Joyce Banda – President of the Republic of Malawi
Topic: HIV and Women: From 'double to zero burden'
 Sworn in as the first female president of the Republic of Malawi on April 7, 2012, President Joyce Banda is an advocate for women, children, and the underprivileged, and was hailed as one of Africa's most powerful women by *Forbes* magazine.



Her Excellency Dr Christine M Kaseba-Sata – First Lady of Zambia
Topic: Keynote address
 Before Dr Kaseba-Sata became first lady of Zambia, she was the head of obstetrics and gynaecology at the University Teaching Hospital in Lusaka. Dr Kaseba-Sata gained international recognition as a leader in the fight against cervical and breast cancer in Africa.



The Honourable Dr Aaron Motsoaledi – Minister of Health of the Republic of South Africa
Topic: Leadership
 Dr Aaron Motsoaledi is an enthusiastic champion for AIDS treatment and testing and his policies have made available free ARV's in all PHC clinics, greatly expanding access to treatment and care.



Judge Edwin Cameron – Constitutional Court Judge (South Africa)
Topic: HIV in Africa: A human rights-based healthcare response. Edwin Cameron is an internationally acknowledged AIDS activist who was the first senior SA official to state publicly he was living with AIDS. His famous opening plenary speech at the 2000 International AIDS conference in Durban highlighting the high cost of ARVs is credited with starting an international campaign to reduce the cost of ARVs.



Mr Michel Sidibé – Executive Director UNAIDS
 Mr Michel Sidibé's vision is zero new HIV infections, zero discrimination and zero AIDS-related deaths which he has made the end goal of UNAIDS. An outspoken advocate with a people-centred approach, he has called for the elimination of new HIV infections among children by 2015.



Dr Mark Dybul – Executive Director: The Global Fund to fight AIDS, Tuberculosis and Malaria
 A passionate advocate of global health, Dr Dybul became a founding architect and driving force in the formation of PEPFAR as Head of PEPFAR (2006-2009). He led efforts to expand PEPFAR's reach and helped dramatically to increase accessibility and lower the costs of treatment and prevention of HIV and AIDS.



Prof. Robin Wood – Director of Desmond Tutu HIV Centre – SA
Topic: Novel Approach to the Epidemiology of TB Transmission
 Prof. Wood is a renowned South African physician-scientist who has been on the front lines of HIV/AIDS research, treatment and prevention for nearly two decades.



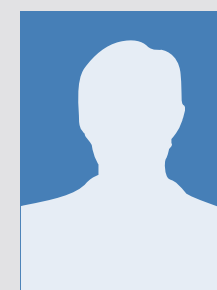
Ms Bidia Deperthes – Senior HIV Advisor with Comprehensive Condom Programming Division, United Nations Population Fund
Topic: Prevention including treatment in Africa
 Ms Deperthes is a public health expert in the HIV prevention field. She was the coordinator of the United Nations Inter Agency Task Team which focused on topics including condom QA and control, resource mobilisation and global advocacy.



Prof. Ashraf Coovadia – Founding Director at ESRU
Topic: Paediatric HIV in Africa
 One of SA's best-known HIV paediatricians, Prof. Coovadia has been an advocate for increased PMTCT services. He has played a large role in advising on government policy. Prof. Coovadia is also adjunct professor of paediatrics at University of the Witwatersrand and Paediatric consultant at Rahima Moosa Mother and Child Hospital.



Dr Chewe Luo – Senior Advisor on HIV and AIDS, United Nations Children's Fund
Topic: Elimination of MTCT by 2015 and beyond
 Dr Luo, a paediatrician and public health specialist from Zambia, has extensive experience in both HIV research and programming. She is a senior programme adviser and technical team leader for country programme HIV scale up with UNICEF headquarters in New York.



Dr Nicolas Meda
Topic: Epidemiology of HIV and STIs in Africa
 A gynaecologist and epidemiologist, Dr Meda is a site private investigator for the HPV in HARP academic consortium which is focusing on evaluating and understanding the impact of screening and treatment approaches for the prevention of cervical neoplasia in HIV- positive women in Burkina Faso and South Africa.



Dr Luis Gomes Sambo – WHO Regional Director for Africa
 Dr Sambo joined WHO in 1989 as Chief of the Inter-Country Strategic Support Team in Harare, Zimbabwe, and has been Regional Director for seven years. While at the Regional Office in Brazzaville in 1994 he was in charge of coordinating the implementation of the Health-For-All Strategy in Africa.



Dr Christine Katlama – Head of the AIDS Clinical Research Unit at the Pitié-Salpêtrière Hospital in Paris
Topic: HIV and ART a sustained response: Where are we now and where do we need to be – progress and feasibility.
 Dr Katlama's main topics of interest are clinical anti-retroviral drugs and vaccine therapy.



Dr Laurien Nyabienda – Executive Director African Council of AIDS Service Organisations (Africaso)
Topic: Targeting Zero: Role of Community
 Dr Nyabienda has been a leader in AIDS and Maternal Health research and actively promotes the role of civil society organisations in the fight against AIDS.

Simplifying Performance Management and Development Systems (PMDS) in public service



Simon Buthelezi, Industrial Relations Advisor, SAMA Public Sector Department

The Performance Management and Development Systems (PMDS) are meant to assist with performance management on all salary levels except for senior management levels in Public Service. It aims to plan, manage and improve employee performance by optimising an employee's output with regard to quality and quantity, thereby improving the department's overall performance and service delivery.

Objectives and principles of performance management

Objectives

The objectives are to:

- Establish a performance and learning culture in the Public Service;
- Ensure that all employees know and understand what is expected of them;
- Promote interaction on performance between employees and their supervisors to identify, manage and promote employee training needs;
- Evaluate performance fairly and objectively;
- Recognise categories of performance that are fully effective and better.

Principles

The key principles are outlined below:

- Performance management is done in a consultative, supportive and non-discriminatory manner to enhance efficiency, effectiveness and accountability when using resources and achieving results.
- The processes should link to broad and consistent staff development plans and align with the department's strategic goals.

- The processes are developmental, and recognise fully effective performance, and as well as performance that is consistently not fully effective and lower.

The performance cycle

Performance management at the employee level is an on-going interactive process between an employee and supervisor. Face to-face on-going communication is required throughout the cycle. The cycle begins 1 April each year and ends 31 March the following year.

Performance planning and agreement

The performance agreement (PA)

All employees must enter into and sign performance agreements at the beginning of each performance cycle. The criteria consist of Key Performance Areas (KPA's) and the Generic Assessment Factors (GAFs) and each employee must be assessed against both areas. KPA's covering the main areas of work account for 80% of the final assessment, while the GAFs make up the other 20% of the assessment score. Newly appointed employees shall complete their performance agreement within the first three months of appointment.

Personal Development Plan (PDP)

The purpose of the plan is to identify any performance output shortfall in the work of the employee, to relate this to a supporting GAFs shortfall and then to plan and implement a specific set of actions to reduce the gap. The competence gap may relate to any of the GAFs included in the PMDS or any other area of the employee's knowledge, skill and attribute requirement. The PDP should include interventions relating to appropriate skills of the job e.g. appropriate training interventions, on-the-job training, expanded job exposure, and job rotation.

Prolonged absence and staff movement

Absence during the cycle

Normal periods of leave, for example vacation leave and/or short periods of sick leave, do not usually interfere unduly with the employee's performance management cycle. In the case of other forms of absence for a continuous prolonged period of time, supervisors and

employees should have a discussion to reach mutual agreement on the ability to execute a meaningful rating for that period or for an annual assessment. If it is not possible to make a meaningful review or annual rating, this must be indicated in writing. New work plans may also need to be developed on return from a prolonged absence.

Acting in higher positions

When an employee is appointed to act in a higher position for shorter than six weeks, the workplan should be based on the post that the employee is permanently appointed to. Depending on the employee's performance during this period, recognition of performance of the duties in the higher position should be given during the performance assessment, on the workplan of the permanent post. When acting in a higher position for longer than six weeks, where an acting allowance is being paid, a workplan must be compiled for the higher position that the employee is expected to perform against.

Staff movement

When employees are transferred at the same level, it is their responsibility to provide their most recent performance assessment to the new department. Where staff members change jobs within the department during the PMDS cycle, performance reviews related to the employee vacating the post have to be completed prior to moving to the new position. If the employee changing jobs is a supervisor or manager, performance reviews for each employee under her or his control should be completed prior to her or his movement. When an employee is transferred to another department, a progress review discussion will be conducted for the current PMDS cycle prior to the employee leaving the department.

Misconduct and suspension

Decisions pertaining to performance rating should be based on an employee's actual performance. In the event of alleged misconduct, some questions need to be asked:

- What was the nature of the misconduct (e.g. financial, management)?
- Was the person found guilty or not?
- If found guilty, what was the nature of the sanction (e.g. discharge, suspension)?

- Did the misconduct and/or the sanction impact on performance?
- Was the employee suspended for a prolonged period?

NB: each case must be judged on its own merit. If a misconduct charge, and/or the hearing, and/or any sanctions have a serious negative impact on an employee's performance, it would be difficult to motivate for awarding a 3-rating or higher score and therefore for the granting of a performance bonus.

Performance monitoring review and assessment

Performance mid-term progress review

Performance review meetings are an integral part of the monitoring process. These reviews must take place as often as is practical and/or required by circumstances. The reviews are necessary to motivate and to reveal to the employee areas that need improvement and if required, to modify the PA. The supervisor should use all opportunities to discuss the employee's performance, including component meetings, report backs and informal discussions. In terms of PSR 1/VIII B.4(b) an employee's supervisor shall monitor the employee's performance on a continuous basis and give him/her feedback on his/her performance. A minimum of two formal reports are required for a performance cycle, in the middle of the cycle (September) and at the end of the cycle (March).

Annual Performance Assessment (APA)

Employees are only assessed based on the fact that they have entered and signed performance agreements for the given year. The assessment instrument is provided by HRD in each institution.

Performance moderation

Normal distribution curve of performance categories

Performance that is fully effective (average, satisfactory) is generally rewarded by means of a notch progression and a thirteenth cheque. Only performance that is significantly above expectations and outstanding should qualify for a performance award. This guideline may be taken into account when identifying trends and making recommendations for bonuses within the 1.5% of the remuneration budget.

The intermediate review moderating committee

Each department should put in place a moderating committee to ensure that

performance assessments are done in a realistic, consistent and fair manner. The committee monitors the performance management process by obtaining an overall sense of whether norms and standards are being applied consistently and realistically to employees on the same level. Refer any deviations identified from performance results or performance ratings to the supervisor and employee.

Disagreements over rating and assessment

Any disagreements between an employee and supervisor pertaining to the assessment must be resolved by the parties concerned. If not resolved the employee must submit a written complaint within ten days to the assessment appeal committee. The appeal committee will review a disagreement between an employee's confirmed assessment ratings and make a recommendation to the moderating committee. The panel consists of experts from line function, performance management, legal affairs and labour relations.

Outcomes of performance assessment

Budget for incentives

The department may not exceed 1.5% of its remuneration budget for performance bonuses and 2% of the wage bill for pay progression. Should this amount prove to be insufficient to award the maximum percentage cash bonuses, the moderating committee may scale down the percentages to ensure the Department stays within the 1.5% limit.

Pay progression

Employees on OSD are eligible for pay progression to the maximum notch of the salary level attached to their posts. Progression to the next higher notch within the employee's salary is based on a period of continuous service and performance, and is not automatic. An employee must complete a continuous period of at least 12 months on her or his notch (1 April to 31 March) and must be performing at least at the level of fully effective (satisfactory), as assessed in terms of the PMDS. Only valid notches on the salary level must be used in the process of progression.

Performance bonus

A performance bonus is a financial award granted to an employee in recognition of sustained performance that is significantly above expectations and is rated as such in

terms of the rating scale. In order to qualify for the granting of a bonus, an employee must complete a continuous period of at least twelve months on her or his salary level on 31 March of a year.

Managing performance not fully effective

Supervisors are required to first identify the course of the poor performance and then deal with unacceptable performance of employees under their supervision. The supervisor must comply with the procedural requirements of PSCBC Resolution 10 of 1999 and Resolution 1 of 2003.

Important role players in the application of the PMDS

The supervisors

A PA should be jointly developed with each employee. Supervisors must ensure that:

- Employees understand the functions and the importance of performing their own tasks.
- Quarterly meetings are held for evaluation purposes.
- Feedback is provided to all employees.
- Employees are given assistance to improve poor performance.

The employee

Employees are responsible for developing their draft performance agreements on the required objectives, KRAs and GAFs and other aspects of their job that have been previously clarified by the supervisor.

The head: human resources development

Human resources development ensures that:

- The system is made available and that relevant role-players are trained.
- Dates for submissions are set.
- The moderating committee is appropriately constituted and organised labour is consulted.

Moderating committee

This committee monitors the performance and management process by ensuring that norms and standards are adhered to and applied consistently and realistically.

Assessment Appeal Panel (AAP)

This appeal panel is established by the executive authority to manage disagreements over ratings that may arise during the assessment process. It is critically important that this panel is constituted in line with the guidelines in the PMDS policy.

What constitutes a benefit?

Ntokozo Sibeko, Legal Advisor, SAMA Industrial Relations



ns 186(2)(a) of the Labour Relations Act (LRA) 'the provision of benefits to an employee' falls under the definition of an unfair labour practice. There has probably been more litigation over the meaning of the word 'benefit' than any other term in the LRA. If something is found not to be a benefit, the CCMA may not have jurisdiction to deal with it as an alleged unfair labour practice. The intention of the LRA appears to have been to distinguish between disputes about wages (an interest dispute that is not arbitrable) and disputes about benefits (a rights dispute which is arbitrable).

A brief history of the term 'benefit'

This rights/interest distinction takes one in the direction of the source of the benefit: is it one that arises out of a contract, a statute or a collective agreement? In the leading case of *HOSPERSA and another v Northern Cape Provincial Administration (2000) 21 ILJ 1066 (LAC)* it was held that the alleged benefit must be an existing entitlement in a contract, collective agreement or statute. But then, in a minority judgment of *Goldstein AJA in Department of Justice v Commission for Conciliation, Mediation & Arbitration and others (2004) 25 ILJ 248 (LAC)* it was suggested that it would be meaningless if unfair labour practice claims were confined only to claims to pre-existing rights originating ex contractu or ex lege. Then came the judgment in *Protekon (Pty) Ltd v CCMA and others (2005) 26 ILJ 1105 (LC)* in which Todd AJ reached a similar conclusion, holding that an employee may have recourse to the CCMA's unfair labour practice jurisdiction not only in circumstances in which s/he has a cause of action in contract law. Then in *Imatu and another v Umhlathuze Municipality*

and others (LC case no D 644/09, date of judgment: 06 May 2011) (also referred to as *IMATU obo Verster v Umhlathuze Municipality (2011) 32 ILJ 2144 (LC)*) Lagrange J defined 'benefit' to be advantages conferred on employees which did not originate from contractual or statutory entitlements, but which have been granted at the employer's discretion.

The Apollo decision

This takes us to the recent decision of the Labour Appeal Court in *Apollo Tyres South Africa (Pty) Limited v CCMA and Others (DA1/11) [2013] ZALAC (21 February 2013)*. In this case the employer, needing to cut staffing levels, initiated an early retirement scheme for some of its employees. The CEO addressed various groups of employees and informed them about the early retirement scheme that the employer intended to initiate.

Subsequent to these meetings, a notice relating to the scheme was placed on the notice board at the employer's premises. The notice stated that the early retirement scheme applied to monthly paid staff between the ages of 46 and 59. It also stipulated that a successful applicant would receive two months additional pay and an ex-gratia payment computed on a sliding scale depending on the applicants age.

An employee, Hoosen, applied but was refused entry into the scheme. She was not told that, despite the notice, an applicant had to be between 55 and 59 to qualify. She resigned and while serving notice she referred an unfair labour practice dispute to the CCMA. The commissioner ruled in her favour. A preliminary point raised at the CCMA was that the early retirement package was not a benefit the CCMA has jurisdiction and in any event it was unfair not to grant Hoosen the early retirement package. The CCMA ruled it had jurisdiction to arbitrate the dispute and found that it was unfair to deny Hoosen entry into the scheme. The commissioner also ordered the appellant to pay Hoosen R123 637.22 which represents what she would have received had she been granted the benefit.

The employer unsuccessfully took that decision on review to the Labour Court and subsequently appealed to the LAC. In the appeal, the employer did not seek to challenge in any material respect the factual findings of the CCMA but disputed whether the early retirement scheme for which Hoosen applied and was refused entry, constituted a benefit as contemplated in Section 186 (2) of the LRA. The LAC found in favour of the employee that the

retirement scheme was a benefit and so within the ambit of s 186(2) of the LRA. The LAC found that the term 'benefit' must be interpreted to include a right or entitlement to which the employee is entitled, as well as an advantage or privilege offered or granted to an employee.

The implications of the decision

Aadil Patel (Director and National Practice Head, Employment, Cliffe Dekker Hofmeyr) discusses this judgment in an online article *'The benefits saga: Is it finally resolved?'*

He submits that a bargaining council or the CCMA must, when determining whether to exercise jurisdiction or whether to exercise the power to adjudicate a dispute regarding benefits, first determine whether the claim is one where the employee is attempting to assert an entitlement to new benefits, to new forms of remuneration or to new policies not previously provided for by the employer.

If the employee's claim is so based, the CCMA and/or bargaining council do not have the power to determine that dispute and the employee must embark on industrial action.

However, the CCMA or bargaining council may adjudicate a benefits dispute in light of the Apollo decision in two instances:

- Where the employer fails to comply with an obligation that it has towards an employee;
- Where the employer has provided the employee with an advantage or privilege that has been offered or granted to an employee in terms of a policy or practice subject to the employer's discretion.

Some examples of disputes that may now be adjudicated by the CCMA are:

- A bonus scheme where the employer retains the discretion to grant a bonus or not.
- A car allowance scheme where the employer has the discretion whether to grant a car allowance or not.

Simply put, the CCMA or bargaining council may now have the power to scrutinise a discretion that the employer has under a policy, contract, practice or collective agreement.

This judgment is a call for employer consistency, transparency and fairness in the way benefits are administered. It should also alert us to the fact that the rights/interest distinction is now more blurred.

This article is published courtesy of WorkLaw.

Risk management in medical practice and hospitals

Medical Protection Society

A misdiagnosis is not necessarily negligent if the diagnosis seems reasonable, but doctors are expected to put themselves in a position to make a reasoned deduction to explain a patient's signs and symptoms. It is not always the rare-but serious conditions that escape clinicians' diagnostic skills (although these probably account for a disproportionate number of claims); common conditions such as myocardial infarction can also be missed.

The overwhelming majority of clinical negligence claims in general practice arise from a failure to arrive at the correct diagnosis in a timely manner. There are many reasons for this. Sometimes the presentation is atypical or a disease is masked by another condition. Sometimes the patient is uncooperative or fails to turn up for appointments. Or the patient may have a rare disease whose symptoms mimic a common and less serious condition. All of the above are understandable reasons for failing to reach a diagnosis, so a diagnostic failure in these circumstances can often be defended as long as the doctor applied reasoning based on the information available to him and made comprehensive notes.

There are other reasons for failure to diagnose, however, that are less easily defensible, and that is usually because the doctor failed to gather the right information on which to base the diagnosis. The essential requirements for making a reasoned diagnosis are:

- Reviewing the most recent entries in the patient's records.
- Taking a relevant history.
- Carrying out an appropriate physical examination when necessary.
- Arranging appropriate investigations or a referral when necessary.
- Making adequate follow-up arrangements.
- Being willing to revise your (or a colleague's) initial diagnosis if the clinical picture changes or the patient does not respond to treatment.

Reviewing the most recent entries in the patient's records

It is good practice to review the last few entries in a patient's records just before a consultation. Sometimes there may be outstanding issues that should be followed up, but there will also be cases where you are seeing the patient for an ongoing problem that is not responding

to treatment. As signs and symptoms may evolve between consultations, being able to compare earlier presentations with the current one can provide invaluable clues to a diagnosis.

Eliciting a relevant history

This may include past medical history and family history as well as the history of the patient's presenting condition. The great majority of medical diagnoses, up to 90% in the case of chest pain, for example, are made on the basis of the history alone. By the same token, many diagnoses are missed simply because the doctor concerned did not elicit a full history, thus missing crucial clues to the correct diagnosis (see the case report, *The red eye* below for an example of the consequences of not asking the right questions or giving sufficient credence to the patient's reported symptoms).



Case report: The red eye: Mrs O, a 54-year-old secretary with a history of migraine, developed a severe frontal headache, noticing flashing lights and cloudiness in her field of vision. These symptoms came on over about 24 hours. She consulted Dr R, who noted the symptoms of headache, 'misty' vision and red eye and diagnosed conjunctivitis, prescribing fusidic acid ointment. By the next day Mrs O was much worse; she had an excruciating headache, photophobia and vomiting. Her vision was worsening and she requested a home visit. Dr M attended and noted that there

was inflammation of the right conjunctiva. Both corneas appeared normal and the pupils were equally reactive. She diagnosed migraine and gave Mrs O an intramuscular injection of diclofenac. Dr M advised Mrs O to attend the emergency department of her local hospital if things did not settle within 48 hours. Mrs O went to hospital two days later where acute angle-closure glaucoma was diagnosed. After pharmaceutical treatment she underwent a right-sided trabeculectomy a few days later. Mrs O's vision was seriously and permanently impaired in both eyes. She was registered partially sighted and her ophthalmologist anticipated that she would be registered blind within five years. The 48-hour delay in Mrs O's ophthalmological assessment had led to severe and irreversible damage to both eyes with no prospect of recovery. Mrs O made a claim naming Drs R and M, alleging a failure to suspect or diagnose acute glaucoma as the cause of her symptoms. A GP expert discussed the case with Dr M, who reported that Mrs O had not mentioned any problems with her vision; this, combined with the absence of corneal or pupillary signs, had led her to reject a diagnosis of acute glaucoma. Despite this, the expert felt that Dr M's actions would be difficult to defend; even if this symptom was not volunteered, it should have formed part of Dr M's routine assessment, been directly asked about and documented in the notes. Mrs O had given a clear history of visual cloudiness to Dr R on the preceding day. The expert felt that the combination of severe pain, visual impairment and red eye should have prompted Dr R to seek an emergency ophthalmological opinion after Mrs O's first presentation. An ophthalmology expert concluded that the 48-hour delay in Mrs O's ophthalmological assessment had led to severe and irreversible damage to both eyes with no prospect of recovery. The claim was settled out-of-court, and liability shared equally between the two GPs. (Based on *The Red Eye MPS Casebook* 13(4) 2005.)

Carrying out a physical examination

This is usually a crucial component in formulating a reasoned diagnosis. It may seem that the patient has told you all you need to know in order to make a diagnosis, but a physical examination may provide you with more information, or at least confirm

your initial impressions from listening to the history. The cases seen at MPS where a failure to examine has proved crucial are usually where the practitioner has avoided a rectal or genital examination (as in the case reported below), but there are also plenty of cases where the doctor failed to examine a patient's throat or the fundus of the eyes, or to palpate an abdomen or listen to chest sounds, and therefore missed important clues.

Case report: Lax examination: Mr B, a 46-year-old taxi driver, consulted his GP, Dr K, about pain in the rectum and constipation. He mentioned that he had had infected piles before, for which he'd been prescribed antibiotics. Dr K was satisfied by the explanation of symptoms and wrote a prescription for laxatives and antibiotics. She did not examine the patient. Three days later Mr B visited Dr K again, complaining of worsening pain and feeling unwell. He reported profuse sweating and rigours. He said he had passed a small amount of motion, but was still experiencing rectal pain. Dr K checked his temperature and examined his abdomen, chest and ENT, which were all unremarkable. She diagnosed resolving constipation and coincidental viral infection and advised Mr B to continue the antibiotics. She thought that the sweating might be a side effect of the Prozac Mr B was also taking and changed his prescription. The following evening, Mr B's wife drove him to the emergency department as he was experiencing intense pain in his rectum. The cause was quickly diagnosed as a rectal abscess. Admission to hospital was organised and aggressive surgical treatment was required. Mr B subsequently sued Dr K. A GP expert was critical of Dr K for her failure to carry out a rectal examination, which delayed the discovery of the abscess. The claim was settled for a substantial sum because Mr B would have required less radical surgery if he had been referred earlier.

Chaperones

While their role is ostensibly to reassure patients, chaperones also protect doctors from false allegations of sexual abuse. You should, therefore, out of respect for the patient and for your own protection, always offer a chaperone when you intend to carry out an intimate physical examination, even if you and the patient are the same sex. Intimate examinations include examination

of the breasts as well as the genitalia and rectum. The issue of chaperonage is not always straightforward. For example, many patients reject the offer of a chaperone because they find it embarrassing to have another person present during an intimate examination. In most cases this is not a problem – just record in the patient's notes that a chaperone was offered and the patient declined the offer. Sometimes, though, you may feel that it is personally risky for you to proceed without a chaperone present. Although this is a difficult situation to deal with (to insist on a chaperone implies that you distrust the patient), you should trust your instincts and simply tell the patient that, because of the nature of the examination, you would prefer a chaperone to be present. If the patient still refuses, then you must decide whether to proceed without a chaperone or to suggest that the patient see another doctor. Such decisions are not an easy judgment call, but you should be particularly wary of carrying out an unchaperoned intimate examination if the patient has any of the following problems: A history of sexual abuse, apparent difficulty in recognising professional boundaries, mental impairment or mental instability. If you do decide to go ahead, be scrupulous in your documentation, in all cases, you should explain carefully to the patient what the examination entails and why it is necessary. You should also take care to preserve the patient's dignity and privacy by the use of gowns, drapes and screens.

If a chaperone is present during an examination, record their identity and status in the patient's notes. If you offer a chaperone, and the patient declines, you should record this fact too. Ideally, the chaperone should be someone with clinical training, such as a nurse. If no clinically trained assistant is available, it may be necessary to use a member of the patient's family as a chaperone, but this is far from ideal. If a suitable chaperone is not available, you will have to make a judgment as to whether the examination can be postponed until appropriate arrangements can be made.

In an emergency you may have to proceed without a chaperone. If so, record your decision and the reason for it in the patient's notes. You may sometimes find yourself

seeing patients when no-one else is present on the premises at all. Although this is a less than ideal situation that you should avoid if at all possible, you should place your patients' needs first.

Maintaining an open mind – being willing to revise an initial diagnosis

This is an aspect that cannot be overstated. MPS case files stand testimony to the many instances in which a patient's failure to respond to treatment is plainly indicating that it is time to review the diagnosis, yet the patient's doctors blindly persist with it. This is a cognitive weakness that all clinicians should be aware of and guard against. Experts in human factors call the phenomenon 'diagnostic fixation', and have described it in the following terms: "When examined in retrospect, the factors that led to a missed or significantly delayed medical diagnosis often seem starkly conspicuous: (1) a quick, confident diagnosis was made and/or (2) contrary evidence that kept presenting was ignored."

The 'quick, confident diagnosis' is usually made by employing heuristics (in other words, a 'rule of thumb'). Heuristics, while useful, may easily lead one astray because they depend on a range of cognitive biases, a few of which are described below. So, if you diagnose using heuristics (which almost all doctors do), it is imperative that you do not fixate on your initial diagnosis and remain open to new information that may contradict it.

Heuristics-based diagnosis: Shortcuts in reasoning occur on a subconscious level, employing a variety of heuristics. Some of those commonly used in diagnosis are:

- Availability heuristic – likelihood is judged by how easily examples spring to mind.
- Anchoring heuristic – the tendency to stick with initial impressions.
- Premature closure – failure to pursue several alternatives.
- Framing effects – different decisions made depending on how information is presented.

Redelmeier D, the Cognitive Psychology of Missed Diagnosis, Annals of Internal Medicine (2005).

Acknowledgement: The above article is taken from a series of risk management booklets issued by the Medical Protection Society (MPS) and is published with their consent.

It is all about consent

The Medical Protection Society shares a case report from their case files

Mr K, a 37-year-old self-employed businessman, consulted his general practitioner, Dr P, requesting sterilisation. Mr K stated that although he had two children, aged 17 and 9, he wished to undergo a vasectomy. Dr P explained to Mr K that the procedure was irreversible, and Mr K stated he still wished to go ahead and intended to use his private insurance. Hence, Dr P referred Mr K to a consultant urologist, Dr S.

The patient saw the urologist and was subsequently listed for a vasectomy. Dr S then carried out the procedure under local anaesthesia, with no immediate complications. A few days following the procedure, Mr K noticed some weeping from one of the wound sites, and attended Dr P, who prescribed a course of antibiotics.

By the end of the seven-day course, the situation had worsened with increased weeping at the wound site as well as pain both at the wound site and in the testis and groin on that side. Mr K attended the Emergency Department (ED).

On assessment there his pain was reported as 10/10 and constant, thus not allowing him to sleep, despite oral paracetamol. He was discharged with co-codamol. Four days later Mr K attended a different ED and a diagnosis of post-vasectomy haematoma was made. Mr K was again discharged with yet stronger analgesics.

The following day the patient saw Dr P again and was advised to take a week off work. Things did not improve and the patient called Dr P the following day to see him at home, and was then subsequently admitted to hospital with a diagnosis of infected hydrocoele/haematoma.

After hospital admission, the wound burst and the patient was taken to the operating theatre where the infected haematoma was drained. Two days later the patient was discharged home, and subsequently reviewed four weeks later by Dr W, consultant urologist, who discharged him from further follow-up. Mr K alleged breach of duty due to lack of informed consent on the part of Dr S.

As the complication was handled appropriately and is a recognised complication of

vasectomy, no issue of technical incompetence by Dr S was alleged. The claim thus solely related to a lack of informed consent; specifically, Mr K alleged that Dr S did not warn him before he consented about the possible complication he subsequently suffered. Mr K stated that he was uncertain about whether to go ahead with the vasectomy and if he had known about the potential complications, he would not have undergone the surgery.

The signed consent form was the key piece of evidence in this case. Mr K signed a standard consent form, but one in which all complications were not printed. Therefore Dr S hand wrote the complications of pain, bleeding, bruising, haematoma and infection at the bottom of the form.

“However straightforward and routine the surgery might be, proper documentation is vital”

It was alleged by Mr K that Dr S did this after the claim was filed, and thus that Dr S doctored the consent form days after the procedure. This was proven to be untrue as a copy of the consent form was sent to Dr P with a letter stating these complications had been explained, on the same day as the initial consultation.

Dr P confirmed that Dr S did not have access to Mr K's files after the procedure and thus could not have amended the consent form at a later date as alleged. Also, Dr S had a nurse sitting in during the consent procedure and she reiterated the complications to Mr K after the initial consultation.

This practice nurse confirmed that the consent procedure by Dr S was thorough and complete. The claim was therefore

discontinued and costs were recovered from the claimant.

Learning points

- This case illustrates one of the most common reasons for litigation against doctors, and especially surgeons; that of issues of consent before a procedure. It is not uncommon for a patient to feel happy to proceed with a surgical procedure at the time of the procedure, but then to feel unhappy with that decision to proceed when he suffers a well-accepted complication.
- Vasectomy is one of the most litigious procedures for urologists, although it is one of the simplest operations within that specialty. The procedure is typically a day case and performed under local anaesthesia, taking an average of 20 minutes. However, the pre-procedure consent process and consultation typically lasts longer than this. Having copies sent to the patient's practitioner and having a nurse present during the consultation further safeguards against litigation.
- When surgeons operate on patients in the private sector and their complications are then managed by different doctors in the public sector, patients can often feel aggrieved at the operating surgeon who is now 'nowhere to be seen'. Good communication between all doctors involved in such situations can facilitate the optimal management of the patient, and thus lessen the risk of future litigation. This case provides a valuable lesson: however straightforward and routine the surgery might be, proper documentation is vital.
- There were two missed opportunities to intervene here. The patient was left unhappy and aggrieved.
- The surgeons should have given their contact details and been responsible for the follow-up arrangements.

The original case report can be found in MPS's *Casebook* Vol. 21 no. 3 (September 2013): <http://www.medicalprotection.org/southafrica/case-reports-september-2013/it-is-all-about-consent>

Free State hosts Positive Practice Environment (PPE) launch

Dr Dirk Hagemester, SEDASA Free State provincial coordinator

In line with the national cooperation between SAMA and DENOSA to improve the working conditions of health professionals in public sector facilities, the Free State branch joined forces with DENOSA in the province and had an official launch of the PPE initiative on 29 August 2013 in Bloemfontein.

This event had been preceded by a meeting between the provincial leadership of DENOSA and the SAMA Trade Union with the recently appointed Head of Department in the provincial Department of Health, Dr David Motau. During the meeting, both unions expressed their commitment to cooperation with the DoH, but outlined the burning issues from the point of view of health professionals, particularly the often insufficient staffing situation and the as yet unresolved matters around Occupation Specific Dispensation (OSD) salary translations.

At the launch attendees were addressed by DENOSA, COSATU and SAMA representatives.

Inspired by the proactive and collaborative spirit on display, the SAMA Trade Union established an on-going representation in the provincial chamber of the Public Health and Social Development Sectoral Bargaining

Council (PHSDSBC). We are admittedly still learning about the dynamics in the labour relations environment from our fellow trade unions. However, we have managed to elevate the lack of essential equipment and medical consumables in many of the provinces public health facilities to a discussion with the executive management of the provincial Department of Health. Next, we plan to address the matter of inappropriate salary translations under the OSD

and the inconsistent implementation of annual pay progressions in the province.

Even though we enjoy the benefits of an increasingly functional trade union structure, including this year's adoption of a trade union constitution and the recent First National Elective Congress, the functionality and success of our endeavours will largely depend on the active participation of our members – help us to help you!



SEDASA's Free State coordinator Dr Dirk Hagemester (centre) with DENOSA second deputy president Thandeka Msibi (left) and DENOSA provincial secretary Veronica Fransman-Hendricks at the PPE launch

KZN Coastal's Dr Nirvedha Singh receives award in India

KZN Coastal branch's very own Dr Nirvedha Singh was recently awarded the title of Ambassador of World Peace from India on 7 September 2013. Dr Singh, a public health specialist, received the title in Pilani, a small town in the Shekhawati region of Rajasthan. She was there as an attendee at the International World Peace Conference, which was attended by many world leaders from political, health and religious organisations.

Dr Singh was awarded the title for raising the profile of peace education in health care and community activities in India. She has been involved in many campaigns including raising awareness about drug abuse, HIV/AIDS, TB, teen pregnancy, woman and child abuse and cancer. She is a columnist for the newspaper *Satyagraha* (published by the Gandhi Development Trust), where she writes on world health issues.

Dr Singh has also undertaken healthcare talk shows on radio stations namely *Radio Hindvani* and *Radio Al-Ansaar* to raise awareness about health and peace issues in communities across South Africa. As Public Health Advisor to the

Department of Health she was involved in the Strategic and Operational Planning of the healthcare system in preparedness for the 2010 FIFA World Cup Soccer in Durban, South Africa

The following is an extract from a presentation Dr Singh made at the recent International World Peace Conference:

"Inner peace is important to a holistic functioning individual as it allows one to think

positively to focus clearer on the internal self and external environment. Health must be perceived as not only a state of complete physical, mental and social well-being but also a state of spiritual well-being. The body is congruent with the mind and cannot be dissociated if peace is to be attained. Peace is strength and must be nurtured for inner peace and a positive environment to flourish."



Dr Nirvedha Singh (second right) after being named a Peace ambassador in Rajasthan, India



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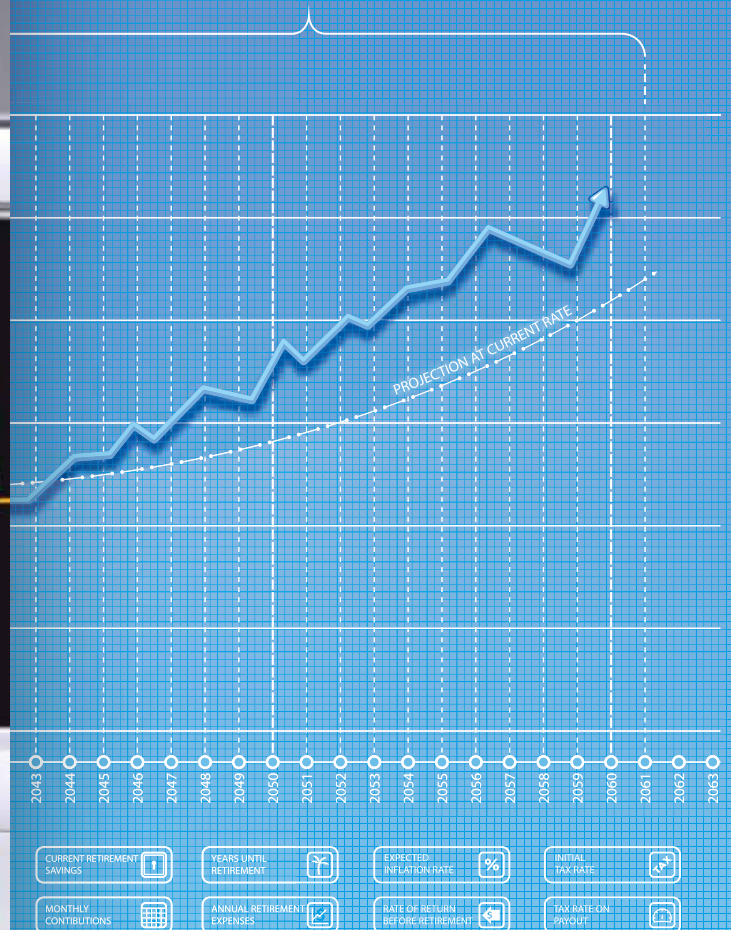


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