

SAMIA INSIDER

MAY 2016

**Acknowledging
contributions to our
nation's health**

**How many days will you be
working for the taxman
this year?**



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EDITOR'S NOTE

MAY 2016



Diane de Kock
Editor: *SAMA INSIDER*

Standing together

Some articles in this month's *SAMA Insider* reflect the strength of our members when they stand together or step forward in order to make positive changes.

The SAMA Education, Science and Technology Committee, on page 5, invite members and the public to nominate doctors and/or other individuals who they think have made significant contributions in bringing health to the nation. Twelve awards will be presented at the National SAMA Conference in October. We appeal to our readers to give these nominations some thought and to take time to fill out a form which is available on the website (www.samedical.org).

Drug abuse is a huge problem in South Africa. In the article on page 7 we emphasise how important it is for healthcare professionals to keep themselves informed about drugs, the way they work, the potential for abuse and the effects of addiction. Pulling together in order to fight this challenge is vital and for this reason we will publish an in-depth article in the next edition on Drug Wise and an interview with the Deputy Chairperson of the Central Drug Authority, David Bayever.

On page 9 Wandile Mphahlele reports on a recent SAMA victory when SAMA represented a member at the CCMA.

We hope the article by Gert Viljoen on tax will inform and assist readers in understanding relevant tax issues, how they affect you and how to take advantage of tax-free savings accounts.

Prof. Ernette du Toit is a shining example of stepping forward to fill a gap. We pay tribute to her, as she retires this year, for helping to make a bone marrow registry possible in South Africa.

Happily, page 20 is filled with branch news this month – we look forward to hearing a lot more from SAMA branches.

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Published by the Health and Medical Publishing Group (Pty) Ltd
Block F, Castle Walk Corporate Park, Nossob Street
Erasmuskloof Ext. 3, Pretoria

Email: publishing@hmpg.co.za | www.samainsider.org.za | Tel. 012 481 2069
Printed by Tandy Print (Pty) Ltd

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Mind the gap!



Prof. Denise White, SAMA President

It was with regret and sadness that we learnt in February of Prof. Janet Seggie's untimely resignation as Editor-in-Chief of the *South African Medical Journal* (SAMJ). After assuming the position in 2012, Prof. Seggie has worked tirelessly for the SAMJ and it is to her credit that the journal has flourished under her editorship. Her academic leadership and professional experience ensured a monthly issue of high quality and scholarship that highlighted the

multiple aspects of clinical and scientific research in the country. Also, for the interest of its diverse readership, the SAMJ included up-to-date commentary on contemporary medical and political issues relevant to the profession as a whole. Prof. Seggie was passionately committed to academic excellence and to the survival of the 118-year-old journal into the future.

Her decision to resign was possibly unsurprising in view of the potential challenges raised by the recent hierarchical restructuring of the Health and Medical Publishing Group (HMPG), as well as proposed substantive reforms of both the focus and format envisaged for the SAMJ. In an article in the April edition, the CEO of HMPG has outlined the new vision for the journal.

Change and reform in systems must not only be embraced but also interrogated in a democratic society. It is therefore important that the readership gives voice to its satisfaction or concerns about the proposed changes to the SAMJ.

In my opinion, a number of questions need to be raised. Importantly, has HMPG provided convincing evidence that its proposed restructuring will meet the needs of a diverse

academic and general readership? Furthermore, has the readership of the SAMJ been provided with the opportunity to comment on HMPG's vision and to make suggestions and recommendations on future content?

Although I understand that certain constituencies were consulted it appears that, in general, these questions are inconclusive.

It is important to emphasise that, in bridging the gap between old and new systems, valued aspects of the former must be safeguarded and preserved to avoid "throwing the baby out with the bath water".

It is therefore hoped, and expected, that a democratic and inclusive process of consultation with the readership will now prevail and that the resulting outcome will come to reflect the best of both worlds.

Prof. Seggie set a high standard, one that should not be disregarded or diminished. To this end SAMA and the medical profession are indebted to her for her laudable contributions not only to the SAMJ but to the entire academic enterprise in the country. We wish her success and fulfilment in all her future activities.

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Acknowledging significant contributions to the health of our nation

Dr Mergan Naidoo, *Chair: SAMA Education, Science and Technology Committee*

The Education, Science and Technology subcommittee of SAMA would like to invite members and the public to nominate doctors and/or other individuals who they think have made significant contributions in bringing health to the nation. We are looking for individuals recognised by their peers, patients and communities as those who have made a difference to science, the healthcare environment, communities and individuals. These outstanding individuals will be honoured at the National SAMA conference and merit awards ceremony that will take place from 21 to 23 October 2016 at the Sandton Convention Centre.

For nominations to be valid please complete the nomination form that is available on the website (www.samedical.org). This nomination form requires the following details to be provided:

- Motivation not exceeding 500 words supporting the reason for nomination. Submissions must be in English to avoid key elements being lost in translation. This is the most important element in determining the placement of candidates into categories.
- The motivation should entail a short, concise extract from the candidate's curriculum vitae (CV) detailing:
 - Special area of interest, research, publications, awards, community involvement
 - Other personal details, **including a photograph**, such as name in full, professional status, personal contact details and address
 - The CV may be provided as additional information but the nomination form is essential
 - The name and contact details of the person/branch submitting the nomination form.

Nominations received after the due date (31 July 2016) will NOT be considered.

The following are awards that are open for nominations under specific categories:



Human Rights and Health

Medal of Honour

This is the most prestigious SAMA award and is reserved for an individual who has displayed the very best in human effort and personal sacrifice. This may include a forfeiture of freedom and dedicating their life to the cause of humanitarian service. One would expect this individual to show an iconic international footprint. It is not uncommon to have such individuals being subjected to detention, interrogation, torture, incarceration or even being exterminated in their pursuit of their ideals.

Previous recipients of this award include Dr Fabian Ribeiro and Prof. Marian Jacobs.

Medal of Transformation, Equity and Justice

This nomination must show evidence that this individual has taken up the fight for transformation, justice and equity even in the face of personal sacrifice, material loss or threat to security. The nominee should be a campaigner for justifiable changes within the medical fraternity and his or her activities may include those that promote unity within SAMA or fights for equal opportunity across the race or class divide in academia, industry or state structures. The individual could also be someone who champions the cause for equity in the delivery of medical and healthcare services, especially to the poor, needy, indigent and disabled.

Gender Acclaim Award

This award is made to a female colleague for her outstanding contribution to a medical or non-medical field which may have helped alleviate human rights abuse. This colleague may have overcome personal difficulties such as parenting, chauvinism and other prejudice such as race, colour, creed or sexual orientation. This contribution should be widely acknowledged nationally or internationally.

Previous recipients of this award were Dr Ozma Lineo Mbombo, Dr Wilma Lotter and Prof. Ames Dhali.



Medicine Awards

Fellowship in Art and Science of Medicine

The nominee should display an iconic international footprint by obtaining international acclaim of excellence in the practice of medicine, both as an art and a science. This award is generally reserved for an exclusive group of members who have been endowed with the special privilege for moving the frontiers of medicine forward or widening the horizon in achieving a greater understanding of medicine. The nominee should embrace the philosophy and the ethical constraints of the profession as a whole. They may champion the cause of healthcare despite obstacles. This award is equal in prestige and status to the:

- Heroes in Medicine Award (CANADA)
- Member of the Institute of Medicine (USA).

Previous awardees included Prof. Machaba Michael Sathekge and Prof. Bongani Mayosi.

Extraordinary Service to Medicine Award

This individual should display an outstanding contribution to medicine in a dedicated field. The incumbent should have pursued, with a single-minded purpose, a chosen area of interest in medicine and made a substantial contribution in the research promotion and advancement of that field. The work must extend beyond the ordinary terrain of medicine into the wider community and nation. Publication of work in internationally accepted medical journals is a prerequisite.

This award was previously conferred on Prof. Jagidesa (Jack) Moodley.

We are looking for individuals recognised by their peers, patients and communities as those who have made a difference to science, the healthcare environment, communities and individuals

Lifetime Achievement Award

The nominee must have dedicated his/her life in the single-minded pursuit of medicine as a career, with distinction. This is awarded to individuals who have given a productive lifetime of distinguished service to medicine, making the profession proud. Loyalty, dedication and professional conduct are worthy of emulation.

Previous awardees include Prof. Andrew Argent, Prof. Andries Stulting, Dr Joseph Teeger and Dr Helen Rees.

The Spirit of Medicine Award

This award recognises the contribution made by an individual who has:

- Provided extraordinary service to his/her community or nation extending beyond the field of medicine
- Distinguished him/herself both in the field of medicine and also in areas beyond in

creating an enabling environment and/or living habitat, or working in the wider interest of mankind

- Championed the cause of the poor, the indigent and dispossessed within a given ecosystem and/or community
- Provided selfless service to medicine which includes community health without a view to material gain or personal recognition
- Displayed through practice that medicine is a "calling" and is recognised by his/her peers as a role model.

Previous recipients of this award include Dr Geoff Govender, Dr Stephen Grobler and Prof. Robert Golelele.

Young Leader Award

This award is made to a doctor, less than 35 years of age at the time of nomination, who is making a difference to his/her community and/or healthcare environment. The following criteria apply:

- This colleague may be in a research-oriented environment and be making significant contributions. The nominee should be endorsed by an accredited research institute or university.
- This award may also be made to an individual on the recommendation of the public sector doctors representative body, or to a colleague who has shown extraordinary service to his/her community or healthcare environment.

This award was previously given to Dr Vuyane Mhlomi.

Community Service Award

This is awarded to an individual who has rendered outstanding service over a sustained period of at least 20 years. Any of the following criteria may apply:

- This nominee may have taken a leadership role in managing a specialised field of medicine in the community, e.g. caring for physically and mentally challenged patients.
- The nominee may have rendered humane, innovative care, under extremely trying conditions, be they in the face of poor or lack of facilities, or conditions calling for personal sacrifice.
- The nominee may have taken an educative and mentorship role in adding value to the health of a community, such as empowering communities to grow their own food, maintain good health, improve sanitation, etc.

Emerging Scientist Award

This award recognises outstanding research done by a registrar attached to any South

African university who publishes his/her Masters Degree in Medicine (MMed) research as partial fulfilment of his/her degree in the calendar year preceding the award ceremony and is judged by his/her peers to have performed outstanding work in the field of medicine. The requirements for this award will involve completion of the nomination form as well as providing the committee with the following.

- An electronic copy of the publication
- Evidence that the manuscript has been published in a peer-reviewed scientific journal
- A letter from the university confirming that the registrar is/was registered as an MMed candidate
- Journal standing, such as the current impact factor of the journal, may serve as supporting documentation
- Article metrics may also serve as supporting documentation.

Service Excellence in the Private Sector

This is a new award for private sector doctors who have been making a difference in their area of practice. The criteria for this award are as follows:

- The doctor must have been a practising medical doctor for at least 10 years
- Evidence of making a difference in his/her community must be submitted with the nomination
- The doctor must show compassion and empathy towards patients.



SAMA Loyalty Award

SAMA Award of the Year

This award is given to a SAMA member who has maintained distinguished service to SAMA of an extraordinary nature, as judged by his peers.

Previous recipients of this award include Dr Fazel Randera, Dr Akthar Hussain and Dr Gregory Mbambisa.

Standing together to tackle drug abuse

SAMA Communications Department

Understanding drugs: the way they work, the potential for abuse, and the effects of addiction, is important for all healthcare professionals. And, because new drugs enter the market at regular intervals, and old drugs are “enhanced” with new concoctions, it’s vital that healthcare professionals keep themselves as informed as possible.

For this reason SAMA (Gauteng North Branch), as well as the Pharmaceutical Society of South Africa (PSSA) (Pretoria Branch), recently held a Drugwise Workshop on the University of Pretoria’s Prinshof Campus.

Because new drugs enter the market at regular intervals, and old drugs are “enhanced” with new concoctions, it’s vital that healthcare professionals keep themselves as informed as possible

The day-long workshop, held on Saturday 9 April, was presented by David Bayever, a lecturer and researcher at the University of the



Dr André Marais (SAMA Gauteng North), David Bayever (Presenter), and Dr Angelique Coetzee (Chairman, SAMA North Gauteng), pose for a picture ahead of David Bayever’s presentation to 150 delegates at a drugwise workshop in Pretoria.

Witwatersrand’s Faculty of Health Sciences. Bayever is also the Deputy Chairperson of the Central Drug Authority, and a leading expert on drug abuse in SA.

“Drug abuse, and drug-related problems, is a big problem and we need to understand what we are dealing with. I am extremely glad to see all of you here, doctors and pharmacists, as we have to pull together to confront this challenge,” said Dr Angelique Coetzee, Chairman of the SAMA Gauteng North Branch to the approximately 150 attending delegates.

In his presentation, Bayever gave a detailed breakdown of the impact of drugs on society, the different drugs available, and the way in which especially illicit drugs are gaining a foothold in various communities.

“Drug use easily becomes drug abuse, and it is our ethical responsibility to understand and treat the abuse of illicit drugs. We have a duty to not only stay informed, but to also manage the unintended consequences of drug use,” Bayever said.

Speaking after the event, Morne Adamson of the PSSA said it was encouraging that so many people across the medical fraternity attended.

“It was a great event, and we are extremely happy that this important topic has received the attention of SAMA and PSSA members because they need to work together to deal with it. It is also important that this is one of the first events we have held jointly with SAMA, and we are sure it won’t be the last,” he said.

SAMA, PSSA in show of unity to address major problem

Dr Coetzee also praised the hard work behind the scenes of SAMA Gauteng North Branch member Dr André Marais in organising the event, and for bringing different healthcare professionals together for the workshop.

*An in-depth article on Drug Wise, and an interview with David Bayever, will appear in the next edition of **SAMA Insider**.*

Adult hospital Standard Treatment Guidelines and Essential Medicines List 2015

Prof. A G Parrish, Chair of the Adult Hospital Level Committee; Dr J Jugathpal, National Department of Health, Essential Drugs Programme; Ms T Leong, National Department of Health, Essential Drugs Programme

A new version of the Adult Essential Medicines List (EML) Standard Treatment Guidelines is now available. Previous versions were distributed as a paper copy handbook. The current version is already available electronically on the National Department of Health website, and an electronic app (similar to the existing TB, HIV and primary care apps for Android and iPhone) will be available soon.

The recently completed review of the Adult EML involved the perusal of over 1 175 full text articles and systematic reviews, and the production of 29 medicine reviews. In total, 40 new medicines were added and 24 were removed. Some of these changes were simple swaps, for example, erythromycin was replaced with azithromycin. New indications (396 in total) were added for existing medicines, and some indications were removed (271). The process provided some rewarding and fascinating insights into the interaction between current medical "truth" and the underlying evidence.

The process provided some rewarding and fascinating insights into the interaction between current medical "truth" and the underlying evidence

The brief of the committee was to review the previous handbook with a view to updating therapeutic advice for clinicians working in district and regional hospitals (i.e. hospital medicine excluding tertiary services). New medicines would only be added if there was sound evidence of efficacy, safety and affordability. Existing medicines would also be



The cover of the Hospital Level Adults STGs and EML, 2015

reviewed if there were new safety concerns, or new evidence cast doubt on previously accepted efficacy.

After initial review, individual revised chapters were sent, around the country, for stakeholder comment and revision. It was requested that reviewers provide supporting evidence for proposed corrections or additions. Many individuals around the country made time to contribute in detail, spotting errors, giving new insights, and providing robust and valuable critique.

Some proposed additional medicines are clearly effective. However, there was often less clarity about safety with the maturity of this evidence often lagging years behind the efficacy information. Adding such medicines with the possibility that they might have to be removed later was considered premature, but this does raise the issue of the appropriate timing of the addition of new medicines to a middle-income country formulary. If added too early, costs are high and harms incompletely defined; if too delayed, then potential benefits to patients are foregone.

Requests for inclusions of some older medicines were often very enthusiastic, but the background evidence justifying what was regarded as standard of care was occasionally disconcertingly weak. It was

recognised that further research on these agents is unlikely and formulary decisions have to be made using criteria other than hard evidence of efficacy. This raises the question of what those criteria should be, and how they should be weighted in decision-making.

We hope that readers will find value in this handbook. It became clear that the format does not lend itself to providing background information on the anatomy of a decision, and it is felt that this may constrain uptake of the book, particularly when a medication choice is identified that is at variance with the reader's current practice. Being able to justify and debate such choices is an integral part of developing acceptance of the handbook, and it is hoped that electronic versions will allow expansion, not only by linking to selected references, but also to the review documents which elucidate the reasoning behind individual decisions. Such background documents could foster debate and provide a channel for submission of new evidence as well as rescrutiny of the old.

Visit: <http://www.health.gov.za/index.php/component/phocadownload/category/197> for more information.

Who is an employee? The locum doctor perspective

Wandile Mphahlele, *Legal Advisor: Industrial Relations*

This is a question that mostly gets asked when locum doctors have a dispute with their “employer”, especially when there is a dismissal. The latest trend by institutions when arriving at a Commission for Conciliation, Mediation and Arbitration (CCMA) hearing is to confidently make submissions to the Commissioner that the dismissed doctor was not an employee on the grounds that they were a locum doctor.

SAMA recently represented a member at the CCMA after referring an unfair dismissal dispute. The respondent argued that the doctor was a locum, therefore not an employee. They further defined a locum as: “a freelance practitioner and expected to be flexible, adaptable, resourceful, professional, quick to establish relationships, familiar with different systems, and able to independently manage risks”.

The victory was a milestone for SAMA as there is a growing tendency for some healthcare institutions to use this argument to get away with unfairness

After both parties made submissions, the Commissioner made a ruling in favour of the applicant (dismissed employee). The victory was a milestone for SAMA as there is a growing tendency for some healthcare institutions to use this argument to get away with unfairness. Upon arriving at the findings the Commissioner considered the following factors:

- The applicant rendered personal services to clients/patients of the employer.

- The applicant personally performed the service relating to the patients; he did not employ others to provide the service.
- The employer had the right to control the applicant in providing the services.
- The employer chose when and on what days to make use of the services of the applicant/employee.
- Remuneration and benefits were fixed payments to the applicant in providing the services.
- The place of work was at the consulting rooms of the respondent that provided to the applicant all the required “tools of the trade” to do the work and perform the services.

Below are other factors to be considered:

The provision of training

If an employer provides training to a person, in connection with the employer’s methods or systems, that is usually a strong indicator of an employment relationship. An employer will not normally provide training to an independent contractor. A self-employed person is responsible for ensuring his own training and for ensuring that he or she is competent to perform the services that he or she offers. As with all the other factors, the provision of training to a person does not necessarily exclude an independent contractor relationship. The provision of training cannot be used as a deciding factor in itself. The principle is that each case will be judged on its merits.

The place of work

This is another factor that may sometimes be taken into consideration. The fact that the person works at only one place may be an indication of an employment relationship; the fact that a person does not work only at the employer’s premises does not indicate the absence of an employment relationship. It is becoming more frequent these days, in certain industries, that employees work from home – the employer provides all the necessary computer equipment, and any other office equipment.

But the fact that the employees are working from home – and very often regulating their own working hours – does not exclude the employment relationship. Factors that would point to an employment relationship in such circumstances would be that the employee is still subject to the direction and control of the employer.

Contract terminates on death of employee

It is common knowledge that when an employee dies, the employment contract ceases to exist whereas the death of an independent contractor does not necessarily terminate the contract.

Members should report any unfair dismissals and/or labour practices they may face to SAMA without fear of being referred to as independent contractors

The ruling by a court, CCMA or Bargaining Council as to whether a person is an employee or an independent contractor is an important decision, and could have an adverse effect on the person concerned. For example, if declared an independent contractor, then the person has no protection under labour legislation.

Conclusion

Members should report any unfair dismissals and/or labour practices they may face to SAMA without fear of being referred to as independent contractors and they will receive the support and assistance they need.

Vaccinated communities are healthy communities

Rina van der Gröpp, Functional Head: Regional Disease Surveillance and Outbreak Response, City of Tshwane

African Vaccination Week (AVW) took place from 24 - 30 April 2016. The AVW is led by the World Health Organization (WHO) Regional Office for Africa and implemented by countries in the region.

This initiative provides a unique opportunity for countries and partners to strengthen national immunisation programmes through advocacy and partnerships.

The theme for 2016 is: "Close the immunisation gap: Stay polio free".

The focus is to strengthen national immunisation programmes in the African region, by means of raising awareness regarding the value and importance of immunisation.

The following important changes in the immunisation programme need to be highlighted:

- Polio: Part of the comprehensive polio endgame strategy by the Strategic Advisory Group of Experts (SAGE) is to introduce the switch from tOPV (trivalent oral polio vaccine) to bOPV (bivalent oral polio vaccine). The switch took place on 20 April 2016.
- Under this endgame plan – to achieve and sustain a polio-free world – the use of the oral polio vaccine (OPV) must eventually be stopped worldwide; starting with an OPV that contains type 2 polio virus (OPV type 2) and at least one dose of inactivated polio vaccine (IPV). This must be introduced as a risk mitigation measure.
- The tOPV to bOPV switch is necessary because no wild poliovirus type 2 had been recorded previously and the risk of paralytic polio disease due to the type 2 component of OPV now outweighs its benefits.

The theme for 2016 is: "Close the immunisation gap: Stay polio free"

Steps involved:

- By the end of 2015, one dose of IPV should have been introduced into all routine immunisation systems at least 6 months before the switch from tOPV to bOPV (bOPV containing types 1 and 3 polio virus). This was done by the introduction

EXPANDED PROGRAMME ON IMMUNISATION – EPI (SA) Revised schedule 2016

Age of the child	Vaccines needed	How and where it is given
At birth	BCG – Bacillus Calmette Guérin for TB	Intradermal right arm
	OPV – Oral Polio vaccine	Drops by mouth
6 weeks	OPV – Oral Polio vaccine	Drops by mouth
	RV – Rotavirus vaccine	Liquid by mouth
	Hexavalent: DaPT – IPV, HiB, HepB (Diphtheria, Acellular Pertussis and Tetanus, injectable polio vaccine, haemophilus influenza type B and Hepatitis B vaccine.	Intramuscular left thigh
	PCV13 – Pneumococcal Conjugate Vaccine	Intramuscular right thigh
10 weeks	Hexavalent.	Intramuscular left thigh
14 weeks	RV – Rotavirus vaccine	Liquid by mouth
	Hexavalent	Intramuscular left thigh
	PCV13 – Pneumococcal Conjugate Vaccine	Intramuscular right thigh
6 months	Measles	Subcutaneous left thigh
9 months	PCV13 – Pneumococcal Conjugate Vaccine	Intramuscular right thigh
12 months	Measles	Subcutaneous right arm
18 months	Hexavalent	Intramuscular left arm
6 years	Td – Tetanus and reduced strength of diphtheria vaccine	Intramuscular left arm
12 years	Td – Tetanus and reduced strength of diphtheria vaccine	Intramuscular left arm

Other supplements given together with immunisations

Vitamin A from 6 months up to 5 years (every 6 months)
Deworming from 12 months up to 5 years (every 6 months)



www.tshwane.gov.za



of Hexaxim (consisting of diphtheria, tetanus, acellular pertussis, injectable polio vaccine, *Haemophilus Influenzae* type b and hepatitis B)

- From 20 April 2016, the switch will be made from tOPV to bOPV, which does not contain the type 2 virus, in routine immunisation and polio campaigns.
- Plan for the eventual withdrawal of all OPV.

Measles changes

The current supplier of the measles vaccine (Rouvax), Sanofi Pasteur, has ceased production of their measles vaccine. The

Biovac Institute has registered a new measles vaccine (Measbio) with the Medicines Control Council (MCC) in South Africa, which was distributed to healthcare facilities from January 2016. This newly registered measles vaccine can only be administered subcutaneously and cannot be co-administered with other childhood vaccines. The schedule for the administering of the measles vaccine also changed from 9 months and 18 months, to 6 months and 12 months.

The over-arching slogan of the African Vaccination Week is: "Vaccinated communities are healthy communities".

Dreams of being a doctor

Mahlane Phalane, *writing in his personal capacity*

The medical profession still remains a dream to pursue for thousands of young people the world over. Applications to study medicine flood medical schools every year. Parents and aspirant students would move mountains to get acceptance, once accepted medical students spend sleepless nights chasing a dream to become a good doctor. I had a dream to become a doctor at a very young age; the reasons were not always clear, but resolute. I still have a dream of being a good, caring, competent, innovative and economically successful doctor. Today I have only achieved one part of my dream by successfully completing my medical degree, the real work remains – to achieve professional and economic liberation.

I have a dream of working in a healthcare system that gives a peasant the same treatment and prognosis as it affords a sitting state president. I will forever strive for a healthcare system that prioritises people and not profit at all costs. Together, with those who share my dream, we will build a healthcare system that does not provide health services while killing a doctor physically, professionally, socially, emotionally and of course financially. It has gone beyond a dream, mission or vision into a life-long devotion to seek solutions to our healthcare system. We need a good healthcare system to build a thriving economy, the inverse is also true, and we need a thriving economy to build an effective and efficient healthcare system. There is a mutually beneficial relationship between health and wealth; the two go together.

There are things in life that we know that we know, there are things we know that we do not know, and there are things that we do not know that we do not know. I am as sure as the sun rises from the east that medical doctors in South Africa have mastered the art and science of medicine. We are among the best in the world; we taught the world how to transplant a human heart. We perform complicated operations every day; we are constantly in pursuit of clinical excellence. We are hardworking, resilient, innovative and selfless. We save lives while putting our own lives in danger.

We are aware that there are things we know that we do not know. We do not know how to unite ourselves towards a common course or goal. We do not know how to lead ourselves, we do not know how to follow and support our leaders, because we all want to be leaders. We do not know health economics and financial

management. We lose the little money we make, after so much hard work. We do not know how to save and invest as individuals, or as a collective or how to take care of ourselves physically, socially, emotionally and financially. We do not know the concept of ownership and control. We do not know how to produce a single antibiotic, we do not own a single factory, we do not own a single medical aid scheme, we do not know how to plan and save for retirement. We do not know that our degrees and private practices cannot be bequeathed to our children. We do not know that “a good (wo)man leaves an inheritance for his(her) children, and children’s children”. We do not know that the time for solo practices is dying a painful death. We do not know that we cannot make wealth out of our labour, but we can only make a living from our labour. We do not know that ours is about busyness and not business. We do not know how to start and run businesses. We do not know that management and leadership do not depend only on age, qualification and experience, but also take innovation, bravery, ability to rally others around the same goal, pleasant personality, and clarity of vision, selflessness, integrity, honesty and hard work. We appoint and elect leaders and managers purely based on some unclear hierarchy, to the detriment of the profession. We do not know that a divided and directionless medical profession leads to poor doctors, a broken healthcare system and a sick workforce leading to poor economic activities.

At times our arrogance and education mislead us into believing that we know everything. We do not know that we do not know health economics and the health value chain. We do not know that we do not know our power; we are eagles that behave like chickens. We run away from problems in health like chickens, instead of confronting them and soaring above them like eagles. We do not know that it is our responsibility and ability to shape health policy. We should be leading the processes toward the National Health Insurance (NHI), we should be dictating to medical aid schemes how they ought to be supporting us and patients to deliver the best healthcare according to the best available medical evidence. We do not know that no public or private healthcare can survive without us, that no medical aid scheme can flourish without our services, that

pharmaceutical companies are making billions because of us, that everyone uses us as tools to make money but demonises us from making a decent living.

I still have a dream, to practise medicine to the best of my ability and knowledge. I have a dream that doctors will understand the influence and impact of health politics and health economics. Be that as it may, I know that there are a few doctors out there who share my dream, vision, passion, mission and obligation to liberate doctors professionally, financially, socially and physically. I know what Franz Fanon meant when he said that “the key is not to know the world but to change it”. I know that the current status quo in health must change. I also know that I may not know how to change it, but that it can only be changed by united, active, committed, brave and visionary doctors.

I also know that patients can no longer tolerate the inhumane treatment they get from our strained healthcare system: long waiting periods, equipment failure, shortage of staff, management disasters, and poor health outcomes, a strained health workforce and indifferent leadership. I also know that our overreliance on stretching our bodies too far in order to make a living, drowning ourselves in debt to stay in decent homes, take our kids to good schools and to drive safe cars will not be sustainable in the near future.

Attempts by government to review commuted overtime is a warning shot, the Competition Commission Market Inquiry into Private Healthcare Costs is a worrying sign, NHI will change our earning potential and ability, and medical schemes are finding ways to reject or reduce our claims. As Steve Biko once warned, we borrow from him and sound the warning bell to doctors and say “doctor, you are on your own”. The time to theorise and criticise is over; we either adapt or die. It does not matter who, where or how we are going to pursue and absolutely achieve our professional autonomy, economic liberation, social wellbeing, excellent working conditions and an effective and efficient healthcare system. I am dead sure that I and the few who share my dream and passion will not be at the same place or situation next year. The noble medical profession is bigger than individuals and their organisations. I believe Nelson Mandela left us an instruction: “It is in your hands”.



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Provide email and internet services to members. Through this agreement, SAMA members may enjoy use of the samedical.co.za email domain, which is reserved exclusively for doctors.

MEMBER BENEFITS

Save the date: SAMA Conference 2016

SAMA Communications Department

The 2016 SAMA Conference will be held at the Sandton Convention Centre from 21 to 23 October and will focus on the following themes:

- Integrated private care: A means of providing healthcare access
- Quadruple burden of disease: A threat to university health alliance (UHA)
- National Health Insurance (NHI): Moving from policy to practice
- Using technology to bring health to the nation.

A call for papers

All medical students, medical practitioners and members of SAMA are invited to submit abstracts of their scientific research to be considered for a poster/oral presentation at the 2016 National SAMA Conference.

Abstracts submitted will be reviewed by the Educational, Science and Technology (EST) sub-committee of SAMA for selection to present a poster or do an oral presentation at the conference. In addition, the best poster and the best oral presentation will be awarded a prize.

Abstracts of no more than 250 words should be submitted in line with the themes and sub-themes identified, and should be structured as follows:

- **Background:** Indicate the purpose and objective of the research, the hypothesis that was tested, or a description of the problem being analysed or evaluated.
- **Methods:** Describe the study period/setting/location, study design, study population, data collection and methods of analysis used.

• **Results:** Present as clearly, and in as much detail as possible, the findings/outcome of the study. Please summarise any specific results.

• **Conclusions:** Explain the significance of your findings/outcomes of the study for prevention, treatment, care and/or support, and future implications of the results.

The following review criteria will be used:

- Is there a clear background and justified objective?
- Is the methodology/study design appropriate for the objectives?
- Are the results important and clearly presented?
- Are the conclusions supported by the results?
- Is the study original, and does it contribute to the overall theme?

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A message to fellow healthcare professionals

Dr Tebogo Sadiki, JUDASA

Comrades, compatriots and followers of Hippocrates, the great Egyptian gods and goddesses of medicine will not forgive us for what is about to prevail in the healthcare sector, particularly the public healthcare sector in South Africa.

While our politicians seem preoccupied with their own lifestyles, the majority of our people are struggling to access even the most basic of services such as shelter, food, security, education and healthcare – this while many politicians can afford private healthcare services.

This problem is most evident in the procurement of consumables at our healthcare institutions. Patients are treated using the cheapest, and not necessarily the best, consumables. Our countrymen and women are treated when the consumables or instruments are available (purchased only after weeks of going through the three quotations system), not when it is ideal to treat their medical emergencies.

Thousands of our brothers and sisters are left waiting for surgery as if it's normal for a young patient to sit on a hospital bed for months while his family struggle to find the money for food and other basics.

When politicians are sick, they simply walk into the adequately staffed and well-equipped military hospitals, or private institutions, for immediate and accurate treatment, not the compromised treatment we see in our public hospitals.

We perpetually defend and uphold this abnormal state by reaffirming our undivided support at the polls with each election.

The time has come for health professionals to uphold the principles enshrined in the Hippocratic Oath, the Declaration of Helsinki, and the Geneva Declaration, just to mention a few.

Health professionals, in particular doctors, must rise and defend the rights of their patients. It is not ethical or morally correct for a physician to give sub-optimal care to a patient for any reason. I therefore urge physicians to refrain from these acts by rejecting the current operational status in public hospitals.

In the last two financial years we learned about the birth of a system in healthcare called "frozen posts" – a system conceived by politicians in an attempt to curb over-

expenditure. It is unfortunate that this baby only recognises her cousins, not her parents in the execution of her intended duties.

The administrative posts which are often occupied by politicians remain unaffected. Instead, administrative posts are created.

It is hypocritical when one visits provincial Departments of Health (DoH) and is greeted at reception by a person who is classified as a senior manager or deputy director.

While our politicians seem preoccupied with their own lifestyles, the majority of our people are struggling to access even the most basic of services

This happens while patients wait for hours at service points to get the attention of the attending doctor. The queues in our institutions of health remain unbearable. Doctors are expected to work abnormal hours to treat the majority of our people, which is mainly owing to staff shortages.

The issue of human error as a result of fatigue is then interpreted as laziness, a bad attitude, irresponsibility, or negligence. These are the harsh judgemental sentiments raised by politicians.

As the doctors are stretched to their limit, patients suffer, and, inevitably, mistakes are made. It is no wonder that we have a massive increase in litigation against the DoH.

The public healthcare sector has demonstrated over the years its inability to recruit and/or retain specialist doctors, especially in the rural provinces; this is further exacerbated by the limited numbers of specialist doctors in our country to begin with.

Despite these facts, the DoH and higher education institutions fail to appreciate the need to speedily increase the training opportunities for specialist doctors. Instead the opportunities have decreased. Our lack of progression is because of a lack of funds. Could our country be so poor that we cannot employ more doctors? Can we really afford to spend millions on developing doctors yet fail to employ them or allow them to progress and specialise?

We should, however, not only focus on the negatives; we should acknowledge the move by the ruling party in advancing the plans of the national development revolution. Ironically, while the lack of posts and registrars are completely contradictory to the sentiments expressed in National Development Plan (NDP), there have been other advances.

One of the critical developments of the NDP includes a proper implementation of the universal health coverage policy, the National Health Insurance (NHI). We therefore call for the Ministry of Health to speed up its implementation process. We urge the Minister, and the National Treasury, to urgently address the issues relating to medical officer and registrar posts, to ensure a more prosperous public healthcare service.

We must remain impartial in advocating for the rights of our patients. No one should tell us how to manage disease conditions, as we have the intellectual capability to comprehend and appreciate the significance of effective, not cheap, medical care. Let us stand together to fight for the desperately needed services and the opportunity to educate ourselves and others, so that we can all progress as one. SAMA must refrain from discussing anything else but the advancement and delivery of quality healthcare services to our fellow citizens. The leadership must occupy itself with ways to improve the conditions of health services delivered in the public sector.

We also call on members in private practice, especially the specialists, to donate their time in treating patients in public facilities. History will judge us for generations to come. Let us be the game changers. Refuse to be counted among the observers, and proudly take our right position in the development of a quality public healthcare system. *Aluta*

Unpacking autism

Dr Angelique Coetzee

Autism spectrum disorder (ASD) is a general term used to describe a group of complex development brain disorders characterised by a wide range of cognitive and behavioural abnormalities. There is compelling research evidence that a large number of genes, and environmental influences, contribute to ASD phenotypes. Gene expression is altered by both genetic mutations and epigenetic influences in different cell types of the brain.

It is known that toxic exposure during pregnancy, and complications associated with birth, can disrupt brain processes. Gene mutation associated with autism can affect brain development and functioning even before birth. Environmental factors impact the expression of sets of genes by altering methylation/hydroxymethylation patterns, local histone modification patterns and chromatin remodelling.

Symptoms of autism may not be apparent immediately after birth, but underlying brain differences accumulate. The brain can compensate for this process but if the disruption was severe, compensatory processes are no longer sufficient and symptoms emerge.

Given the complexity of the brain, this might explain why a child's development seems normal, only to regress into autism. It might be that the initial brain development disruption kept on worsening, or that the compensatory mechanisms failed.

At the International Meeting for Autism Research (IMFAR) 2014, studies were presented on how epigenetic signatures may provide indirect biomarkers of exposure that can affect the risk of autism. The researchers exposed mice to different chemicals and then looked at their offspring several generations later. The "great grandchildren" of the exposed mice showed behavioural changes although they had never been exposed to the chemicals used in the trials. This ripple effect is called germline exposure.

The DSM-5 Diagnostic Criteria for ASD, and related diagnosis of social communication disorder (SCD), should be used when screening for development disorders. Of importance is that Asperger syndrome, and pervasive developmental disorders – not otherwise specified, are no longer present in the DSM.

A clear understanding of the difference between both conditions is needed, which can prove to be difficult at clinical level.

Social (pragmatic) communication disorder

Briefly this is divided into four diagnostic criteria areas. A summary of the criteria shows persistent difficulties in the social use of verbal and non-verbal communication for social purposes, and impairment of ability to change communication to match context or the needs of the listener. These include difficulties following rules of conversation and storytelling, and no understanding of what is not explicitly stated, or the ambiguous meanings of language.

The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement or occupational performance. The onset of symptoms is in the early developmental period but deficits may only fully manifest when social communication demands exceed limited capacity. All the above symptoms are not attributed to another medical or neurological condition or to low abilities in the domains of word structure and grammar, and are not better explained by ASD, intellectual disability, global development delay or another mental disorder.

Autism spectrum disorder

A summary of diagnostic criteria as per DSM-5 classification:

- Persistent deficits in social communication and social interaction across multiple contexts, currently or by history. This manifests through social-emotional reciprocity deficits, for example failure of normal back and forth conversation and reduced sharing of interests, emotions or affect.
- Non-verbal communication behaviour deficits used for social interaction, e.g. abnormal eye contact and body language and lack of facial expressions
- Deficits in developing, maintaining and understanding relationships, e.g. difficulty in making friends. Severity is based on social communication impairments and restrictive repetitive patterns of behaviour.
- Restricted, repetitive patterns of behaviour, interests or activities, as manifested by at least two of the following, currently or by history:
 - Stereotyped or repetitive motor movements, use of objects or speech
 - Insistence on sameness, inflexible adherence to routines, or ritualised patterns of verbal or non-verbal behaviour
 - Highly restricted, fixated interests that are abnormal in intensity or focus

- Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects).
- Symptoms must be present in the early development period (may manifest fully when social demands exceed limited capacities, or may be masked by learned strategies later in life).
- Symptoms cause clinically significant impairment in social, occupational or other important areas of current functioning.
- These disturbances are not better explained by intellectual disability or global development delay. Intellectual disability and ASD frequently co-occur; to make comorbid diagnoses of ASD and intellectual disability social communication should be below that expected for general developmental level. There are currently no reliable prevalence studies in South Africa (SA) on autism and related disorders.

According to an article published by the Right to Education Project, the Department of Basic Education in SA estimated that at least 489 036 children with disabilities and of a school-going age are not attending school at all.

The 2013 General Household Survey indicated that 67% of children with disabilities not attending school were severely disabled, and would therefore need placement in special schools. In March 2016 The Centers for Disease Control and Prevention (CDC) in America released their latest report, which showed that 43% of children identified with autism only received comprehensive development evaluations by the age of 3, despite the fact that 87% had development concerns noted in their medical or educational records before then. Autism can be reliably diagnosed around the age of 2 years. Early intervention treatment services can greatly improve a child's development by learning important skills between birth and 36 months, such as speech therapy and occupational therapy.

Applied behaviour analysis and communication approaches can play a significant role. There is no cure for ASD, and diets and medical treatments seem to be controversial.

SA needs to develop advanced training programmes for universal screening of children under the age of 3 at primary level for identifying development brain disorders.

How many days will you be working for the taxman this year?

Gert Viljoen, *VPROF*

A local thinktank measures the amount of time it takes for taxpayers to pay their income taxes. In 2016, it will take until 25 May ("Tax Freedom Day") before taxpayers can earn for themselves – in other words from 1 January to 25 May (146 days) you effectively pay your taxes and from 26 May to 31 December your earnings are your own.

This is 5 days longer than in 2015 and 43 days more than in 1994! Currently for every R2.54 we earn R1 is paid in taxes. In 1994, of every R3.62 we earned, R1 went to the fiscus.

We desperately need economic growth but this is being undermined as taxpayers are one of the key pillars to stimulate growth.

More concerning is that 1.1 million people (3.7% of the population) pay more than 70% of the income tax bill.

While these are alarming statistics, how do South African (SA) taxpayers stack up globally?

Global trends – are we taxed too heavily?

Governments are tightening up on taxpayer deductions as pressure to pay country debt increases. In 2015, world personal taxes rose by 0.41%. Social security taxes rose by 0.66%. VAT has spread around the globe and 160 nations have implemented a VAT system.

What is of interest is that the global consensus for the optimal rate for VAT is seen at between 15 and 20%. This means there is scope to increase SA's VAT rate to at least 15%. That would bring in R20 billion in increased government revenue. There have been hints from the Treasury that a VAT increase is being seriously considered for the 2017/18 tax year.

The other important factor is that SA has minimal social security taxes, which includes the UIF at 2% of earnings and the Compensation for Occupational Injuries and Diseases Act which starts at 0.11% of staff earnings. In other developing countries, such as Russia they are over 30%.

Local corporate rates also stack up favourably globally. In fact we have the sixth lowest tax rate in Africa.

Our top marginal tax rate of 41% puts us at number 31 in the world.

So all in all tax rates charged in SA stack up reasonably well versus those in other nations.

The major concern is the narrowness of our personal income tax base, with just under 4% of the population paying over 70% of income tax. It should also be noted that most of the tax increases in the last few budgets have targeted this group. Clearly this is not sustainable and it puts at risk the increased collections that SARS have been showing these past years.

Catch 22 and the tax base

It also highlights the catch 22 situation we are now in. The government has to increase tax to reduce the budget deficit, but as it does this so it puts pressure on the 4% who pay most of the taxes. The solution to this is to increase economic growth, which will widen the tax base. But one of the main engines for economic growth is the 4% who will have little incentive to ignite economic growth as they focus on paying higher taxes.

Taxpayer beware: SARS can now unilaterally extend "Prescription of Assessment" periods

Until the recent change in our tax laws, prescription of assessments (the expiry date when SARS could still reassess a return submitted) in practically all cases took effect:

- After SARS issued an assessment – 3 years after the date of assessment
- After the taxpayer issued a self-assessment (such as VAT or your PAYE submissions) – 5 years after the date of the self-assessment
- If the taxpayer did not complete a self-assessment, 5 years after SARS issued an assessment
- In cases where no self-assessment was required, 5 years after the payment was due.

Having the certainty of fixed prescription periods is an important part of balancing honest taxpayer's rights with the Commissioner's right to collect taxes that are due.

Why has SARS changed this?

SARS argues that:

- An inordinate amount of time is often spent clarifying whether or not SARS is entitled to information that it requests
- There are cases where the taxpayer is slow in providing requested information, knowing that prescription will soon come into effect
- Finally, many of the cases are extremely complex and cannot be resolved before prescription takes effect.

What are the new prescription periods and how do they affect you?

To provide at least some balance for taxpayers' rights, the new right to extend differentiates between less complex but obstructive cases and complex matters. In principle the former seeks merely to extend the period to match that for which the taxpayer has obstructed SARS, whereas the latter provides a stated maximum period to continue to audit and investigate complex matters irrespective of taxpayer assistance.

The two changes are reflected as follows:

- Obstructive matters: If a taxpayer fails to provide SARS with "relevant material" within the time frame specified, then prescription may be extended by a period approximate to the delay in submitting the information. Similarly, SARS may extend prescription by the time taken to resolve whether or not SARS was entitled to the information requested. When SARS decides to extend prescription, the taxpayer is to be given a notice period of 30 days. This notice period is to be within the prescription timeframes i.e. 3 years or 5 years from date of assessment. As SARS determines what is relevant material and approximate, this gives SARS wide latitude in watering down prescription and also no maximum period is prescribed.
- Complex matters: Prescription may be similarly extended where a tax audit or investigation relates to:
 - The application of the doctrine of substance over form
 - Anti-avoidance provisions

- The taxation of hybrid entities or hybrid instruments
- Transfer pricing provisions.

In this case a notice period of 60 days is required.

If you are about to face a tax audit or investigation in these areas (note that it is SARS who decides if they are applicable), it will be important you provide information to SARS as timeously as possible. You will no longer have prescription time on your side.

If a taxpayer wants to contest these provisions, the tax law provides no objection or dispute process. You can only invoke the Public Access to Justice Act (PAJA) or a high court review of the decision, which means going to court – a costly exercise.

The powers given to SARS are widespread – it is important to seek expert advice if you face an extension of prescription for assessments.

Relief in sight for workers losing their jobs

The parliamentary Portfolio Committee on Labour has recommended amendments to the Unemployment Insurance Act. As these have received support from all parties, it is almost certain to be promulgated into law in the next few months.

In view of the difficult economic conditions and high unemployment in SA, this is welcome news.

The major amendment is that unemployment benefits will be extended to 12 months from the current 8 months.

Other improved benefits include:

- Increased maternity benefits
- Benefits to learners and civil servants in learnership programmes
- UIF benefits for people on short time.

This is sound legislation as the UIF is considerably over-funded, which also means there is little likelihood of UIF contributions going up any time soon.

Prepare now for leasing changes that will impact your business

If your accountant uses International Financial Reporting Standards in compiling your financial statements, and if you lease assets, then changes are coming that you need to start preparing for. The International

Accounting Standards Board has mandated new accounting treatment from 1 January 2019.

Many businesses have cash flow issues, and as leasing conserves cash, they are users of leasing services. For these businesses, it is worth getting to grips with these new rules.

The good news is there is plenty of time to prepare for the change but the changes will be complex and could have an effect on your ability to get loan finance.

How does it affect me?

With a few exceptions (see below), operating leases will fall away. Instead of writing off lease payments to the income statement, you will be required to bring the value of the leased asset onto your balance sheet and provide for the lease repayments as a liability. Depending on the number of leases you have, this could materially affect your balance sheet.

The income statement will also reflect changes. Operating lease costs will now be shown as interest expense and depreciation.

The major changes

The major changes will be:

- All leases will need to be reviewed and, unless they fall within the limited exemption rules, will need to be capitalised.
- Exemptions include leases of 12 months or less for minor items (see example below).
- Leases for intellectual property, licensing agreements, leases for nongenerative resources (oil, minerals), service agreements and leases for biological assets are also exempt.
- You will be required to identify and strip out non-lease components, e.g. a photocopier lease contains a service agreement of, say, R150 per month. This R150 per month will be shown separately in the income statement. All contracts are to be scrutinised to see if they contain a "right of use". If they do, they will probably fall into the new rules.
- Your asset base increases as the value of the lease is shown as an asset on your balance sheet.
- You show more debt on your balance sheet as the liability for the lease will be included in the balance sheet.
- Overall the changes net out over time

but generally expenses will increase in the first few years and then decline in future years.

- Operating profit increases but depreciation and interest expense rise.
- Your cash flows are unchanged.
- Key business ratios change such as earnings per share, return on equity and the gearing of the business (debt to equity ratio). This could affect how banks view the strength of your balance sheet.
- It can also have internal implications, e.g. if staff bonuses are calculated using say, return of earnings, their bonuses will alter.

Start planning now

Depending on the number of leases and contracts you have, this could be a time-consuming and complex process – especially as you will have to set up new systems, accounting policies and methods of valuing leases. Also you need time to assess the effect this could have on your ability to borrow funds.

Speak to your accountant who can guide you through this process.

Tax-free savings accounts are working: Are you taking advantage of them?

In the 2015 Budget, Finance Minister Nene introduced a tax-free savings incentive. It allowed R30 000 per person per annum to be invested in a variety of funds including unit trusts, exchange tracker funds (ETFs), savings accounts and insurance products. Tax-free savings accounts (TFSAs) are capped at R500 000 contribution per individual.

Within four months of the launch of TFSAs more than R280 million had been invested by more than 46 000 investors. Research has shown that TFSAs will outperform other traditional investments as there is no tax payable.

If you haven't yet invested in TFSAs speak to your accountant or broker.

Your tax deadlines

Only the normal run-of-the-mill tax deadlines apply in April 2016, but the annual employer PAYE reconciliation (EMP501) is due on 31 May 2016. As this can take some time to do, the earlier you begin this process, the more time you leave yourself to iron out errors. Remember there are penalties for late submissions.

2016 MDCM training workshops

SAMA Private Practice Department

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

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

The workshops will start off with Coding 101, which provides basic training in the use and interpretations of the rules and modifiers applicable to the coding structure. Time will also be allocated to informal discussions of general problems experienced by coders.

Training will take place over 2 days at the indicated venue. Requests for training in other centres will be considered (there needs to be a minimum of 15 attendees). Included in the registration fee of R2 999 per person (including VAT) is the 2016 MDCM Book, training manual, attendance certificate and a light lunch (please indicate dietary requirements).

The target audience for these workshops are:

- Doctors' staff
- Practice managers
- Bureaus
- Medical schemes.

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

Dates	Venue
11 - 12 May 2016	SAMA Head Office – Pretoria
25 - 26 May 2016	SAMA Head Office – Pretoria
8 - 9 June 2016	SAMA Head Office – Pretoria
22 - 23 June 2016	SAMA Head Office – Pretoria
6 - 7 July 2016	SAMA Head Office – Pretoria
20 - 21 July 2016	SAMA Head Office – Pretoria

Payment to be confirmed a week prior to the workshop to secure your booking.

For an invoice, please email us the company details including the VAT number. Should you have any queries please contact the SAMA Coding Unit on coding@samedical.org or 012 481 2073.

SA's bone marrow registry pioneer retiring

It's perhaps hard to imagine, but 25 years ago there was no bone marrow registry in South Africa (SA). Today, it's still a costly and difficult procedure for those with leukaemia or other serious blood diseases to get life-saving treatment. Most often it's a "military operation", says the doctor who helped make it all possible, Prof. Ernette du Toit. Marelise van der Merwe writes in a *Daily Maverick* report that just shy of her 80th birthday, Du Toit is on the verge of retirement. She co-founded the South African Bone Marrow Registry (SABMR) in 1991, after working in the area of transplants for some time. Van der Merwe quotes her as saying: "I was in the right place at the right time. I was working in the tissue typing lab for organ transplant, as a young doctor. The first heart transplant took place in 1967 – we did the matching and I was the second in command – and that gave me fantastic opportunities."

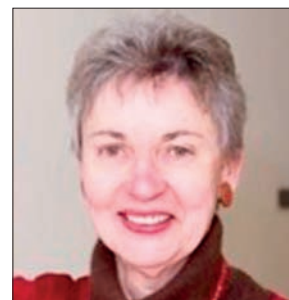
"That was a turning point in my life. I was sent all over the world. I learnt about transplants – heart transplants in particular – as a result of that involvement."

One of her colleagues in Holland suggested that she study further, and she achieved her post-doctorate. Eventually Du Toit took over the running of the tissue typing laboratory, matching the tissues of all individuals who had

transplants from those not related to them, and by 1991 she was approached by Prof. Peter Jacobs (Haematology), who told her he wanted to do some experimental work, including a bone marrow/stem cell transplant. With the assistance of some of the laboratory staff, they began transplanting stem cells in rabbits, and the work expanded to humans, transplanting cells within families, because that was the easiest way to obtain a match. By 1991, the foundations had been laid to start transplants between unrelated people.

"That was a big challenge," says Du Toit. Even within families, only 25 - 30% of patients find matching donors. The remaining 70-odd% must search for an unrelated donor. Finding a match, whether among family or strangers, is up to chance. "It's the luck of the draw," Du Toit explains. "Every individual has about a 1 in 100 000 chance of finding a match in the general population. But some people never find a match and others find many."

At the beginning, the SABMR had only a handful of employees, and the organisation was told to "join the club" – form a relationship with the World Marrow Association, in order to get donors from elsewhere in the world, which remains an essential part of the service. According to the SABMR's data,



Prof. Du Toit

approximately 24 million donors are registered worldwide today in over 50 countries and over 70 separate registries. SA alone has about 74 000 donors – a comparatively small pool. "You can imagine how difficult it is to find donors from such a small pool," says Du Toit. "It can only serve around 25% of our needs."

Now, after decades of saving lives, Du Toit is ready to pass the baton. "I've got a wonderful feeling it will be quite nice to do nothing," she says. "My husband and I would like to travel some more, maybe look after my grandchildren. Life will be more family centred. We will go to concerts, read, walk." She pauses. "But I will probably keep in touch with the laboratory."

Source: Marelise van der Merwe, *Daily Maverick*

A rash oversight

Medical Protection Society

Mrs B was a housewife with a 4-year-old son. She had been trying to have a second child for some time and eventually conceived. She rang Dr L, senior partner at her general practice, to inform him of her positive pregnancy test.

Her son developed chickenpox and seemed under the weather so Mrs B phoned her surgery to make an appointment with his general practitioner (GP). While she was talking to the receptionist she asked if she was at any risk from chickenpox since she was 8 weeks pregnant. The receptionist tried to be reassuring and told Mrs B that there was no risk from chickenpox and that only German measles or rubella would cause concern.

Mrs B's husband took their son to the appointment with GP Dr Y the next day. Dr Y confirmed the diagnosis of chickenpox by inspecting his widespread vesicles. He had noted that examination of his ears, nose and throat had been acceptable and that his chest was fine. His management notes were very minimal and just stated "advice given".

On a separate occasion, Mrs B visited Dr Y to arrange antenatal care. She did not mention her son's chickenpox because she had felt reassured by the advice he had given her husband when he had attended with their son. Dr Y made no notes of this consultation although he arranged a dating ultrasound scan and an appointment at the antenatal clinic.

Mrs B developed the same spots as her son and immediately panicked about her pregnancy. She became anxious that the baby could be harmed so rang her surgery to make an appointment with her GP. The receptionist informed her that only emergency appointments were available so she could not get an appointment that day. She also told



Mrs B that "nothing could really be done for chickenpox". Mrs B was still anxious so the receptionist agreed to put her through to the practice nurse. The nurse also tried to reassure her and reiterated the receptionist's advice.

Mrs B, who had had two miscarriages in the past, still felt very anxious about her pregnancy. She felt upset and rang her husband at work. He rang the surgery and demanded that his wife should have an appointment with a GP that day. An appointment was eventually made with Dr L, who made no notes of the consultation. Mrs B stated that Dr L said there was "no need to worry about any risks to her pregnancy with respect to her chickenpox".

Mrs B went on to have a normal dating and 20-week scan. Her chickenpox was never discussed in her antenatal appointments. She had a normal delivery at term. Her baby, CB, was 4.54 kg and breastfed well.

When CB was 3 months old, the health visitor, noticed a squint and a referral was made to a paediatrician. At 5 months old it became evident that CB had an abnormal posture. Mrs B's chickenpox at 8 weeks gestation was noted by the paediatricians, and congenital varicella syndrome (CVS) was diagnosed. CB had severe visual impairment, seizures, scoliosis and learning difficulties.

Mrs B was completely devastated that her chickenpox had not been managed while she was pregnant and she made a claim against her GP, Dr L.

The opinion of a GP expert was sought. He thought the standard of care was indefensible because the receptionists had provided clinical advice without discussing it with a doctor first. He felt that Mrs B should have been able to speak to a doctor. Had a doctor seen Mrs B when she had the chickenpox contact, he stated that varicella antibody testing would have been arranged.

If varicella IgG had been negative, then Mrs B should have been offered varicella zoster immune globulin (VZIG). It was his opinion that a "reasonable GP" would have concluded that there was no benefit in giving VZIG when Mrs B was seen with the rash. The claim was settled for a high amount. Dr L was criticised in his capacity as senior partner in the practice for allowing administrative and nursing staff to provide negligent medical advice.

It was also agreed that he had personally provided negligent advice to Mrs B concerning the risks to her and her unborn baby resulting from exposure to the varicella virus. He had also failed to test Mrs B for immunity to the varicella virus and administer VZIG once the results were known.

Learning points

- Clear and accurate note-keeping is an important aspect of providing good clinical care. It is also vital when trying to defend a case. Dr Y's records were very minimal and some consultation notes were completely missing. The case was consequently impossible to defend.
- Reception staff should not provide medical advice. It could be easy for them to act outside their competence so clear roles and responsibilities should be set.
- If a pregnant woman consults you worried about a chickenpox contact:
 - Define "contact". Significant contact usually means face-to-face contact in the same room for 15 minutes or more.
 - Ask the woman if she has had chickenpox. If she has a negative history or is unsure, test for varicella zoster IgG urgently.
 - Consider her susceptible if IgG is not detected.
 - Post-exposure prophylaxis with VZIG can be given if susceptible within 10 days of the exposure and may attenuate the disease in pregnant women.
 - If the woman is antibody negative with significant contact or if she has the vesicular rash, then expert advice should be sought.

PE Branch's Labour Relations for Dummies Workshop

Dr James Burger

In the aftermath of the recent outcry from health practitioners and SAMA representatives regarding the proposed changes to the national overtime policy, the SAMA PE Branch realised how underprepared doctors are in labour relations disputes with employers. At our first meeting of the year, we decided that it was imperative that we help our members to be better equipped in this area to aid in our plight towards a fair and healthy working environment.

As a matter of urgency, a CPD-accredited workshop entitled "Labour Law for Dummies" was organised for 10 March 2016, drawing on the experience of the SAMA legal team. The workshop was held at the Beach Hotel in PE, which made a lovely setting for an informative and productive evening. A

capacity attendance clearly demonstrated the need for information regarding labour law and interest in discussing these topics, compounded by the allure of the delicious snacks and highly sought after CPD points.

Mr Wandile Mphahlele, SAMA Legal Advisor, flew down to the friendly city for the occasion and gave a very thorough and informative talk, before the discussion was opened up to the floor for real-life situations and issues. A variety of opinions and stories were heard, reflecting the diverse backgrounds of those in attendance.

Feedback on the workshop conveyed the value of information imparted, which managed to clarify pertinent current issues. The discussions generated afterwards were found to be particularly beneficial, especially armed with

the newly imparted information. There was also a request for ongoing regular communication regarding labour law information and related current issues in SAMA bulletins, which will hopefully go a long way to educate doctors regarding their rights in the workplace.

While we cannot allow ourselves to be bullied by our employers, we need to be properly informed so that we can positively engage with them, be it on a personal level with one's senior, or on an organisational level regarding national policy.

We all need to strive to be informed, and SAMA is striving to be the facilitator of this information and fight the necessary battles to ensure our rights are protected. We look forward to at least annual workshops of this nature.

Eastern Highveld hold successful CPD meeting

Alex Graham

On 16 March 2016, the SAMA Eastern Highveld Branch hosted an ethics lecture at the Holiday Inn Johannesburg Airport Conference Centre. Despite its confusing name, the hotel complex is situated just off the N12 highway in Boksburg, giving easy access from any direction for members in our area. Our branch offers these CPD lectures as a service to our members, with no levy charged.

The chairman, Dr Jess Bouwer, thanked members who attended; however, it was disappointing that we fell just short of our target of 50 delegates, despite several sms notifications

and notices in the SAMA weekly newsletter. This event gave those delegates who were present six ethics points, as all our speakers presented excellent ethics talks.

Our speakers were Dr Pheello Lethola from the South African National Blood Services who spoke on "Ethics in blood transfusion", followed by Ms Ulundi Bhertel who spoke on "HPCSA, NHI and the CC – the good the bad and the ugly of the healthcare sector". As social media is so much a part of our daily lives, Marli Smit (SAMA Legal Advisor) spoke on "Healthcare professionals and social media". This was a very informative talk and although it was aimed at doctors, the content

could be applied to everyone. The watch word is CAUTION with social media.

To conclude the lectures Dr Bouwer introduced Ms Jeanette Hunter, Deputy Director from the Minister of Health's office on the topic of "Primary healthcare and the role of the GP in the NHI system".

There was a lively debate after the Deputy Director's talk and many points were raised, which were carefully noted by Ms Hunter, for feedback to the Minister of Health.

The Chairman thanked all our speakers and invited everyone to join us for a finger supper.

News from Goldfields branch

Congratulations to Dr E Swart, a general practitioner in Bothaville, who received his Goldfields Branch Life Membership Certificate at a recent celebration.

The branch received an invitation from the Head of Health Free State Province, Dr D Motau, to all public health doctors, private practising doctors and members of the Allied

Health workers in Lejweleputswa District, for consultation and roll-out of the White Paper on the NHI. The meeting took place on 23 March at the Boitumelo Regional Hospital in Kroonstad.

Free State wine and dine

The Free State Branch held a very successful and enjoyable annual dinner dance on 2 April, which was attended by more than 60 members. The branch would like to thank sponsors FNB and MPS for their contribution.

During the occasion Dr F Bester was nominated and elected as the new president for the branch council for the year.



Branch Council. Back: Dr H van Schalkwyk; Dr D Menge; Dr P Menge. Front: Dr E Wolmarans; Dr F Bester. Dr N Mofolo; June du Toit (Secretary)



Students drinking a toast to SAMA



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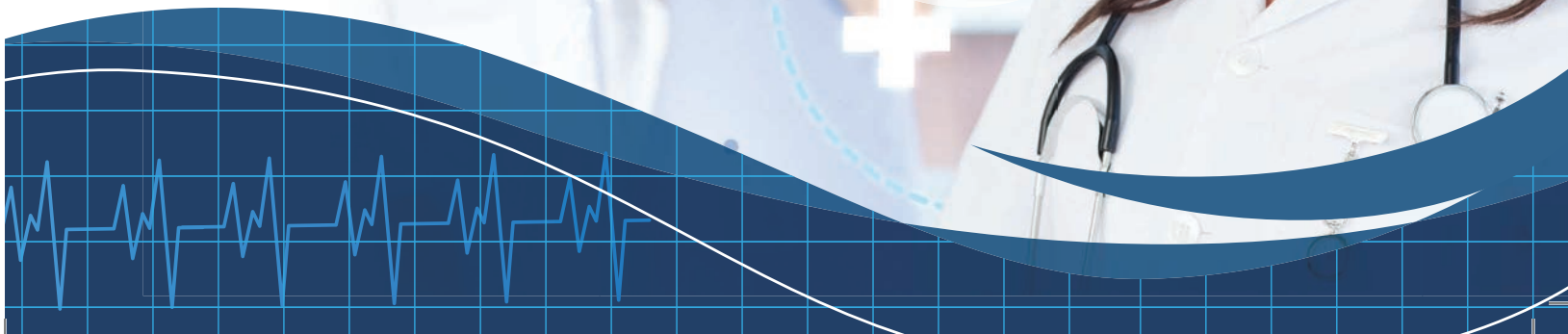
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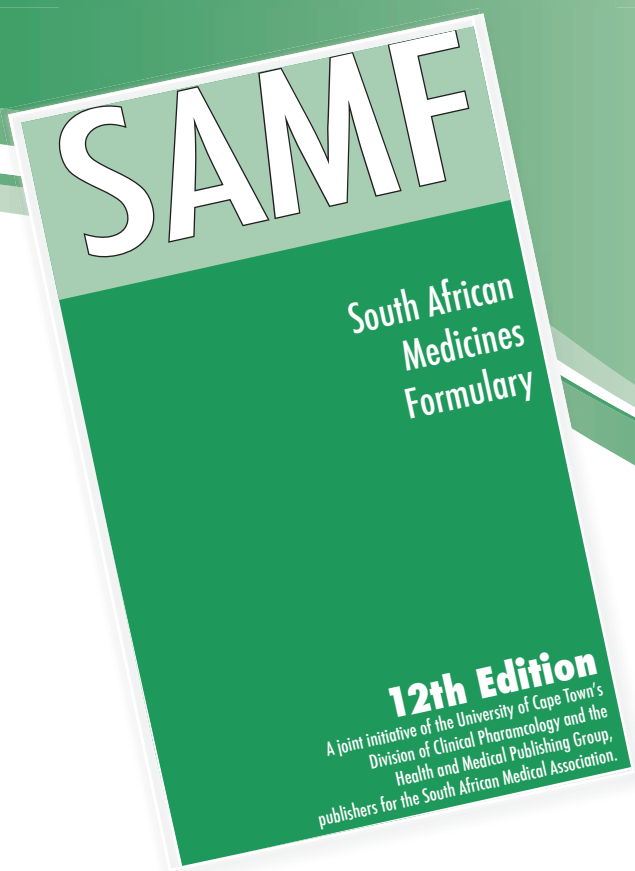
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