Wits’ Prof. Ames Dhai appointed SAMA president
The ESSENTIAL MEDICAL REFERENCE
for every healthcare professional!

The convenient pocket-sized design enables you to fit it comfortably into your hospital bag or coat pocket, so it can always be at hand for ready reference. South African Medicines Formulary (SAMF), produced by the Division of Clinical Pharmacology of the University of Cape Town, provides easy access to the latest, scientifically accurate information, including full drug profiles, clinical notes and special prescriber’s points. The thoroughly updated 11th edition of SAMF is your essential reference to the rational, cost-effective and safe use of medicines.
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.
She Ames to deliver: Meet Prof. Dhai

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.

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.

“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 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 NHl 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 NHl policy?

SAMA must lead the charge to implement the NHl 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 NHl, 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.

President’s dinner 2013

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 welcomed,” 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 refreshingly coursey 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.

Prof. Ames Dhai

MB ChB (Natal), FC Cog (SA), LLM (Natal), PG DIP in 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.

FROM THE PRESIDENT’S DESK

FROM THE PRESIDENT’S DESK
It is against this background of greatness, for example:

• Prof. Chris Barnard taught the world the human heart transplant.
• Dr John Snow in the mid-19th century launched the concept of hand washing to reduce the spread of cholera.

As doctors we are expected, due to the laws and ethical principles that govern our profession, to be innovative and creative.

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

• Increased protection for vulnerable groups.

It was adopted by the 18th General Assembly of the WMA in Helsinki, Finland in 1964 and has been revised six times. It is a living document and has been incorporated into several laws and regulations around the world, and has acted as an important safeguard for patients globally.
Member profile: Dr Sindi van Zyl

Johannesburg-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 insidereasked 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.

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 Abbasi, 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 1 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 member’s 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: 01193360701

Pencil 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 Manatsa. 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 South African Medical Association 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, and timely payment and support of personnel.

“This is 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

“SAMA is looking forward to making a positive difference to the working environment of our doctors and nurses,” said SAMA President Dr Janet 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.

Ralph Kirsch Golden Pen Award

Professor Mike Machaba Sathelinge, 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 given to three institutions – Groote Schuur Hospital and the University of Cape Town through the South African Medical Journal 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.

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 to the doctor’s home or rooms; ADD only to the consultation/visit items 0190-0192, items 0161-0164 or items 0131-0153, 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 added to the consultation/visit 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 0131-0153, 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, items 0173-0175, items 0161-0164, items 0166-0169 or items 0131-0153, as appropriate for an emergency visit away from the consultation/visit rooms or doctors’ homes.
- Not to be added to item 0190-0192 for consultations by doctors normally using 24-hour emergency facilities.
- Not applicable 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/anaesthetists by 10:00 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 0131-0153 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 practitioner’s normal hours.

Interpretation

- Item 0148 may only be added to the appropriate consultation/visit item (0190-0192, 0173-0175, 0161-0164) 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 bonafide 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 21:00 – 06:00 (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 applicable for 24-hour emergency facilities.
- 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: Add 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 0800 - 1700 (weekdays) and 0800 - 1200 (Saturdays), the term ‘after hours’ only applies outside of 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 consultation 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

President Zuma will deliver the opening address at the conference on 7 December. Dr Motsaoaledi 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.

Dr Mark Dybul – Executive Director, PEPFAR: 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.

Her Excellency Joyce Banda – President of the Republic of Malawi

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 at ICASA.

Mr Festus Mogae – Executive Director, UNAIDS

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 campaign calling for increased efforts to prevent the spread of HIV.

HIV 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
- Health Systems, Economics and Implementation Science

An indication of the importance attached to the conference is the fact that we received 3,441 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 at ICASA.
Simplifying Performance Management and Development Systems (PMDS) in public service

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 monitor 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 performance cycle
Performance management at the employee level is an on-going interactive process between an employee and supervisor to 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) is a document that contains all the agreed matters. It is used 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.

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What constitutes a benefit?

A brief history of the term ‘benefit’

This right is of interest not only as the direction of the source of the benefit: is it one that arises out of a contract, a statute or the direction of the source of the benefit? A brief history of the term ‘benefit’

It was held that the alleged benefit must be an unfair labour practice which is arbitrable). The intention of the LRA 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 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 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).

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. The red eye, for example, may not be recognized as the result of not asking the right questions or giving sufficient credence to the patient’s reported symptoms.

Risk management in medical practice and hospitals

Case report: The red eye: Mrs O, a 54-year-old secretary with a history of migraine, developed a severe frontal headache, 'stress' diuresis, and insidious 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 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. Mrs O made a claim naming Dr R and M, alleging a failure to suspect or diagnose acute glaucoma as the cause of her symptoms. A GP expert discussed that, of 46 cases, only 5% of patients were actually diagnosed with 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 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’s Casebook 15 (3) 2005)
Intimate examinations include examination if you and the patient are the same sex. If you are not sure whether you need a chaperone, record your decision. In a case report: The Medical Protection Society shares a case report from their case files

1. **Maintaining an open mind – being willing to revise an initial diagnosis**

This is an aspect that cannot be overstated. Medical 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 this 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.”

2. **Framing effects – different decisions made depending on how information is presented.**

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.

3. **However straightforward and routine the surgery might be, proper documentation is vital**

It was alleged by Mr K 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 the 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: errors of omission or commission.
- The case is another example of the importance of proper medical documentation.
- It also serves as an excellent reminder of the importance of keeping a clear and succinct record of all important aspects of the patient’s case.

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

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, for severe rectal pain. He was referred to Mr K’s consultant urologist, Dr S, for a vasectomy. 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.

It is all about consent
Free State hosts Positive Practice Environment (PPE) launch
Dr Dirk Hagemeister, 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 Depensation (OSD) salary translations.

At the launch attended were by DENOSA, CSUSAU 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 (PHSSB&C). 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!

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 Hindwara and Radio Al-Amar 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.”

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