HEALTH and DISEASE
DOCTORS

1975 - 1978

HANSARD 3 Q. column 239-240

21 February 1975.

93

Health and Disease
Doctors

District surgeons

26. Mr. L. F. WOOD asked the Minister of Health:

(1) Whether there is a shortage of district surgeons in the Republic; if so, what is the shortage of (a) full-time and (b) part-time district surgeons in each province;

(2) how many (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) full-time and (ii) part-time district surgeons were employed by the State and undertook their own dispensing in connection with their State services during 1974;

(3) how many patients were treated by district surgeons during 1973;

(4) how many district surgeons are in receipt of a drug allowance.

The MINISTER OF HEALTH:

(1) Yes.

(a) Natal—10.
O.F.S.—16
Cape—23.
Transvaal—36

(b) Natal—3.
O.F.S.—12.
Cape—20.
Transvaal—19

(2) (i) (a), (b), (c) and (d) Nil.

(ii) (a) 270.

(b) 2.

(c) 4

(d) 1

(3) 3 214 937.

(4) 277

HANSARD 9

Q. column 673
11 April 1975

1. 93
~~2. 320~~

Medical doctors in Langa/Nyanga/Guguletu

*11. Dr. F. VAN Z. SLABBERT asked the Minister of Bantu Administration and Development:

(a) How many medical doctors have practices in Langa, Nyanga and Guguletu, respectively, and (b) how many of the doctors practising in each township are Bantu.

†The DEPUTY MINISTER OF BANTU ADMINISTRATION AND EDUCATION:

(a) Two medical doctors have practices in Guguletu, one of whom also has consulting rooms in Langa and Nyanga.

(b) Both doctors mentioned in (a) are Bantu.

HANSARD 10 Q. Column 709-710 15/4/75

1.93

~~2. Education~~

M.B. Ch.B. degrees

219. Dr. E. L. FISHER asked the Minister of National Education:

(1) How many (a) White, (b) Chinese, (c) Indian, (d) Coloured and (e) Bantu students obtained M.B. Ch.B. degrees at the end of 1974 or early in 1975;

(2) how many in each such race group had studied at White medical schools;

(3) how many students in each such group qualified as dentists at the end of 1974 or early in 1975.

The MINISTER OF NATIONAL EDUCATION:

	(1)	(2)	(3)
(a)	580	580	75
(b)	6	6	—
(c)	50	11	6
(d)	25	17	—
(e)	16	—	—

WEDNESDAY, 16 APRIL 1975

† Indicates translated version.

For written reply:

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① 123
② 319
③ 78
④ 93 ✓

RDM 2/5/75

Urban Blacks can nov

ly BERNARDI WESSELS
Political Correspondent

LACKS will be able to wn their own homes in White South Africa on a 0-year lease basis.

This was one of the sweeping concessions announced y the Government yesterday for South Africa's urban lack millions.

Spelling out the relaxations Government policy for ty Blacks, the Minister of antu Administration and [illegible] Mr M. C. Botha also announced that:

- Blacks will be able to bequeath or sell their houses, although the site on which they are built remains municipal property.
- Traders will be allowed to deal in a wider range of commodities, establish more than one type of business, and enter into partnerships.
- Doctors and other professional people will be able to possess their own consulting rooms and offices in Black residential areas.

The new deal is a direct result of the discussions in January between the Prime Minister, the Bantu Administration Ministers, and the homeland leaders.

It is clearly aimed at removing some of the major points of resentment suffered by Blacks in urban areas and raised on their behalf at the January meeting.

Mr Botha announced the concessions at the start of the debate on his department and said the new home ownership scheme would mean a return to the position existing until 1967.

Blacks who qualified to be in urban areas would, under specified conditions, again be able to buy the right of occupation of houses on land belonging to the local authorities.

This would allow a "qualified" Black person to build his own house on an undeveloped site in a Black residential area, or aquire a house that had already been built.

He would be able to extend or alter the house, and either pay for it immediately or by payments over a long period.

He would also b[e] sell it to other "[q] persons or bequea[th] "qualified" heirs.

Asked by the [l] the Opposition, Si[r] liers Graaff, whet[her] legislation would [be] red, Mr Botha said [the] deal could be imp[lemented] with possibly a re[vision of] the relevant regul[ations].

The Minister said [pro]cedures would allo[w] licences to be [issued] annually.

Partnerships wou[ld]

Daily Disp 15/5/75

93

Call for Ciskei medical school

KING WILLIAM'S TOWN — A call for the establishment of a medical school for training doctors and post-graduate nursing staff was made by the chief whip of the ruling CNIP, Mr A. Z. Lamani in the Ciskei Legislative Assembly, here yesterday.

Mr Lamani was speaking during the committee stage on the Interior vote.

He said the medical school at Natal University and the other college at GaRankuwa were too far from the Ciskei and there was need for the training of medical staff to serve in hospitals and clinics in the Ciskei.

Mr Lamani also called for an arrangement whereby industrialists coming to the Ciskei were asked to pay reasonable wages to their black employees.

He asked the Chief Minister Mr L. L. Sebe to expedite means whereby this requst could be put to the South African Government.

He said it was a tragedy that there were only two creches in the Ciskei — at Zwelitsha and Mdantsane — and called for the provision of creches in various areas throughout the Ciskei.

The Leader of the Opposition, Chief Justice Madandla welcomed the move to have more clinics and deplored the fact that many people in rural areas had to travel long distances to receive medical attention. — DDR.

Black-White wage gap must close

Nat. Mercury 27/5/75 — Industrialist

Industrial Reporter

IT IS a matter of extreme urgency that the wage gap, between White and Black, should be closed, according to Mr. F. G. Beard, the South African industrialist.

Mr. Beard, who was speaking during a Durban seminar arranged by Professor R. Tusenius, of the Graduate School of Business at the University of Stellenbosch, said the wage gap would never be closed unless Blacks were trained to do skilled work and paid the rate for the job.

He said that the White-African wage ratio had improved since 1970 from 6,3:1 to 5:1, for those in Government employ, but in real terms there was now a gap of R329 instead of the R229 in 1970.

"The Government apparently feels that as long as African wages rise percentage - wise more than that of the Whites everything in the garden is lovely," he said.

Mr. Beard said it was unlikely that Black workers would be prepared to wait for the end of the century to get equal pay for equal work.

He said salaries for Black teachers, doctors and nurses should be made equal by 1980.

Mr. Beard said he could not agree that wage increases should come by reducing profitability.

TRAINING

"If the Black workers are properly trained to do skilled or semi - skilled work and are paid accordingly, they would certainly earn their keep — profits should soar, not decrease.

"The wage gap has to be narrowed appreciably as a matter of urgency if we and our children are to continue to live peacefully in South Africa."

Dealing with company profits, Mr. Beard said that "long - haired idealists who preach the anti-social nature of profits and who were trying to foist socialistic, or should I say Communistic, ideas on us should either be dealt with under the Suppression of Communism Act or deported to Russia."

Last year South African companies had a particularly good year. Greater volumes and more units of every kind were sold. "Small wonder that the profits soared — they would have done so had there been no inflation."

Dealing with the training of Blacks, Mr. Beard felt that the Government should carry the full cost of training. The private sector had moved slowly on in-factory training because of all the red tape involved. He suggested that an auditor's certificate could replace the costly inspections by a civil servant.

'EQUAL-PAY'

Sun Express 22/6/76

By WIM VAN WOLSEM

AN INDIAN doctor who has spoken out for equal pay for Black doctors, was sacked this week by Coronationville Hospital, Johannesburg.

Dr Abubhakar Asvat, of Vrededorp leaves his part-time job at the provincial hospital for Coloureds and Indians at the end of the month.

Dr. Asvat has been given no reason for his dismissal and is convinced it is part of an intimidation campaign "to put him in his place".

Dr Asvat said this week he received a letter from the hospital superintendent, Dr. G. Eliott, on Wednesday stating that his services as a part-time medical officer at Coronationville would not be required after the end of the month.

He went to see Dr Eliott. According to Dr Asvat, Dr Eliott told him he had written the letter "with a very heavy heart" on instructions from Dr P. C. Hauptfleisch, deputy director of Hospital Services in the Transvaal.

DR ASVAT

Dr Eliott was unable to give him any reason for his dismissal.

Dr Hauptfleisch, speaking from his home in Pretoria, said he knew nothing of Dr Asvat's case.

"I don't even know the man. Even if he stood in front of me, I would not know him."

Dr Asvat said from his surgery in Soweto that he had challenged Dr Hauptfleisch in a public statement about a year ago after Dr Hauptfleish had said there was a critical shortage of doctors in the Province's Black hospitals. "I told him his administration only had to bring salaries of Black doctors up to the level of those of their White counterparts and the problem would be solved.

"My remarks were not very well received in Pretoria."

Earlier this year Dr Asvat was involved when threats were made of possible action against certain medical products because Black doctors at Coronationville claimed they were being snubbed by the White representatives of a particular pharmaceutical firm.

Dr. Asvat told me the firm in question threatened "they would go to Pretoria about him".

health services face chaos — doctor

(93)

Sunday Express 29/6/75

By BARRY STREEK

DOCTORS working in the homelands urgently need bigger financial incentives to prevent chaos in the health services in the Black areas.

These incentives will have to be given soon, says Dr G. H. Roux, of Rustenburg, writing in the "South African Medical Journal."

But while the position of doctors may be gloomy, one medical victory has been won in KwaZulu: a report published recently shows that the incidence of TB is on the decline.

Dr Roux says the position of medical men in the Transvaal homelands was a real problem.

Not only were doctors inadequately paid, but they had to work in professional and social isolation — and this isolation was made worse by the present speed restrictions.

Besides isolation, a doctor in the homelands had to work "under difficult circumstances which has hardly any parallel in White areas and in private practice."

Compared to the R3 000 to R5 000 a month which doctors formerly at mission hospitals were now earning in private practice, senior doctors could not earn more than R12 600 a year in the homelands.

DOUBLED

He suggested that the present salary structure of doctors in the homelands be doubled and that all White State workers in the homelands be given 25 per cent of their salaries tax free.

"If this matter is not quickly put right, chaos could develop in our homeland health services."

While these medical care problems have developed, the report of the South African Medical Research Council, which was released in Parliament recently, showed that the incidence of TB in KwaZulu had decreased from 4,3 per cent 17 years ago to 1,7 per cent. The risk of infection is decreasing at a rate of seven per cent a year.

A three-year study in Pretoria among people of all racial groups shows that since 1957 the risk of infection had diminished by 13 per cent among Asians and by 17 per cent among Coloureds and Africans.

The report also showed that one of the causes of liver cancer among Black people —

200 plead for sacked doctor

RDM 1/7/75

(93)

By AMEEN AKHALWAYA

NEARLY 200 nurses and other staff members at Coronationville Hospital have signed a petition calling for the reinstatement of Dr Abubaker Asvat, who was allegedly dismissed because of his opposition to racial discrimination.

A similar petition was signed by 16 doctors at the hospital last week.

Dr Asvat, a part-time senior medical officer in the hospital's casualty department, said he was given a letter two weeks ago by the superintendent, Dr G. Elliot, terminating his appointment from yesterday.

Dr Asvat claimed he was dismissed because he has continually attacked racial discrimination.

A staff member said yesterday that the petition would probably be handed to Dr Elliot today. Nurses, laboratory technicians, radiographers, cleaners and orderlies had signed it.

"We are appealing to Dr Elliot to do everything in his power to get Dr Asvat reinstated," said a nurse. "We were shocked at his dismissal. Dr Asvat's attitude towards patients, doctors, nurses and general staff was beyond reproach. We believe his loss to the hospital is irreparable."

Dr Elliot was not available for comment yesterday. The director of hospital services, Dr H. A. Grove, is overseas and no one from his department could be reached for comment.

Dr Asvat, who had been at the hospital for three years, said he would continue in private practice before deciding whether to apply again for a hospital post. "I am deeply touched by the concern shown by my colleagues at the hospital," he said.

Equal pay mooted for educationists

3/7/75

Mercury Reporter

SHOULD White teachers in South Africa take a voluntary wage freeze until their Black colleagues reached pay equality?

This is one of the controversial questions posed by the chairman at yesterday's Natal Teachers' Society symposium in Durban on The Teacher, Leader or Follower in Society.

Mr. A. Morphet, senior lecturer in English at the University of Natal, Durban, said teachers should not accept a freeze as it would do nothing to solve the inequality of the system itself.

Black pupils would still be paying for their books and it would tend to mask such inequalities which would be "welcomed" by the authorities.

Professor P. M. Smythe, Professor of Medicine, University of Natal Medical School, said there was no other question among doctors that caused more animosity and bitterness than salary discrimination.

"And yet sanctions-bound Rhodesia pays equal salaries and wealthy South Africa does not. I can't understand why there is this difficulty," he said.

"The general attitude of the African in their medical school and in Rhodesia as a whole, was infinitely better than in South Africa.

"I would support such a move. It would be a start. This is a very fundamental issue in terms of creating happy relations in South Africa."

The question which raised the issue was whether teachers should comment, in and out of the classroom, on inequalities in society.

Professor A. L. Behr, Professor of Education at the University of Durban / Westville, said people became teachers because they had certain values and if they did not make these known to their pupils, they were "talking with their tongues in their cheeks."

"I don't believe in separate universities or in the idea of separation but that does not disbar me from working in such a structure to enable people to get the full advantage of my thinking," he said.

He counselled that change of these inequalities should be brought about by lobbying the authorities and not by direct confrontation.

Worse off now

Mercury Reporter

FIFTY-EIGHT percent of teachers in South Africa are receiving less than they were before last November's salary increases because of galloping inflation.

This was revealed at the Natal Teachers' Society conference when a call for an immediate increase in salaries and a request that they be tied to an independent cost of living index was debated.

During discussion, it was pointed out that some jobs in the public sector, such as the Railways, carried higher salaries than those paid to qualified, degreed teachers.

Although headmasters had received big increases, teachers at the bottom of the scale had found that the rate of inflation was already more than their increases.

The NTS is also to ask that all temporary staff who have worked continuously and satisfactorily for the Natal Education Department for at least three years should be appointed to the permanent staff. This particularly concerns married women.

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Natal Mercury 8/7/75

Pay snub for city's Indian doctors

Municipal Reporter

DURBAN CITY COUNCIL yesterday decided—by a [illegible] 11 vote—to pay Indian doctors up to R150 a month less than their White counterparts, and to stick to a Black-White wage gap for punch card operators.

White doctors will earn R7 740 — R11 700 a year while the Indian doctor earns R6 300 — R9 900 a year.

To help the critically short - staffed City Health Department the council was asked to approve posts for five new White doctors and one Indian doctor.

When the proposal was put to council yesterday, Councillor Mrs. Sybil Hotz asked that it be referred back so that salary scales could be evened.

"I disagree entirely with any difference in earning between these men or women," Mrs. Hotz said, "they all spend the same time at medical school getting the same qualifications."

Nine councillors spoke in favour of Mrs. Hotz's reference back. Mr. Jim Higginson said Indians were obliged to go through the same training as White doctors, and often had to pay more for that training.

Former Mayor, Mr. Ron Williams, said he believed in the same rate for the job, and would support Mrs. Hotz in any professional field.

Mr. Cheek said councillors seemed afraid that parity would cause a "ripple effect" in the wage scales, but a start on rate for the job had to be made somewhere.

Both Councillor Dudley Norman and Deputy

TURN TO PAGE 2

Doctors' pay snub

Natal Mercury 8/7/75

From Page 1

Mayor Dr. George Hollis spoke in support of Mrs. Hotz, but when it came to the voting, both voted against the reference back.

Chairman of the Policy and Finance Committee, Mr. Royce Kincaid, who spoke against the reference back, told the councillors not to get "political," and asked them to be "realistic."

"We must first ask what the job is worth," he said, "when we speak of the rate for the job. Councillors always want to raise the non-White rate, never to lower the White rate," he added.

He called for job evaluation before paying rate for the job.

Councillor Mrs. Pat Geary asked the councillors to "completely ventilate" race matters at closed Policy and Finance Committee meetings, "because these things create headlines at the moment."

Councillor Rob Olufsen, who summed up the debate on behalf of the Joint Advisory Board, said the salaries were in line with State salaries, and the State was busy decreasing the wage gap.

After the reference back on doctors' salaries had been defeated, Councillor Hans Exter spoke against the Black - White wage discrimination in punch card operators' salaries.

"These people are being paid according to the number of keys they depress in an hour, so if their output is identical, surely their salaries should be the same?" he said. "The machine doesn't know the colour of the operator," he added.

The council voted for the discriminatory wages with three dissents recorded by Mrs. Hotz, Mr. Exter and Mr. Pieter Breytenbach.

Asked for the council's policy on wage discrimination, Mr. Kincaid said last night:

"There is no categorical policy on the 'Black - White wage gap' other than a more-than-willingness to advance the non-Europeans' pay as quickly as possible within the framework of the ability of the city to pay."

Doctors' pay row: new call

(93)

STAR 9/7/75

Own Correspondent

DURBAN — The equal pay for Black doctors row that flared in the Durban City Council this week took a new turn today with a call by Mr Derrick Watterson, MEC, for an urgent meeting at top level to "establish for once and all," equal salary scales in South Africa.

Mr Watterson called on the Minister of Health, Dr S W van der Merwe, to convene a meeting of the State Health Department's co-ordinating council, which fixes salary scales for doctors in the public service.

Durban city councillors responded to Dr van der Merwe's statement that the city council should not have "arbitrarily" decided it would lose its Government subsidy if it gave White and Indian doctors equal pay by calling on him to put his worls into action.

The Minister said all cases would be treated on their merits by his department.

The council, which gets a seven-eighths subsidy from the State Health Department for all doctors in its employ, decided on Monday to pay its Indian doctors up to R1 800 a year less than White doctors.

WELCOMED

The action of the city council in maintaining the pay disparity between its White and Black doctors has been strongly attacked by the United Party and Progressive Party, who at the same time welcomed the hint by the Minister of Health that attempts to close the wage gap would receive favourable State consideration.

The Progressive Party's national spokesman for health, Dr Alex Boraine, said the action of the city council was totally out of spirit with the general movement in South Africa.

Mr Lawrence Wood (UP), MP for Durban Berea and the secretary of the UP's parliamentary health committee, said: "I am very encouraged to hear the Minister imply that if the State were approached they might give favourable consideration to some form of assistance in closing the wage gap."

Unequal salaries —Council rapped

Cape Times 9/7/75

Cape Times Correspondent

DURBAN. — The Minister of Health, Dr S W van der Merwe, said last night that the Durban City Council should not have decided "arbitrarily" that it would lose its Government health subsidy if it put White and Black doctors on the same salary scales.

"Durban should not arbitrarily decide they will have to foot the extra bill without first applying for the subsidies," the Minister said, and added: "All cases like this will be treated on their merits by my department."

When told that it was being argued by certain Durban city councillors that the subsidies would be lost if the doctors were put on equal pay scales, Dr Van der Merwe replied: "But this is done in Cape Town."

On Monday the Council voted 12—11 in favour of paying Indian doctors up to R150 less than White doctors. And one of the reasons put for this was that the Council would lose its Government subsidy if equal salaries were granted.

Tvl left in the cold on equal pay moves

RDM 11/7/75

Staff Reporter

THE TRANSVAAL Provincial Administration will soon be on its own among major public authorities in refusing to equalise the pay of Black and White doctors, the United Party's spokesman on hospitals in the provincial council, Mr Dave Epstein, said yesterday.

Mr Epstein said the country's two biggest local authorities—Johannesburg and Cape Town — had abandoned pay discrimination between doctors of different race groups.

In Natal the Durban City Council was willing to abandon racially differentiated pay, but it was afraid of losing its government health subsidy if it did.

Responding to this, the Minister of Health, Dr Schalk van der Merwe, told the Durban City Council recently it should not arbitrarily decide that a subsidy would not be paid if it equalised doctors pay.

Dr Van der Merwe said the Durban council should know that the Government was moving in a "special direction" at present.

Mr Epstein said this was a clear reference to the commitment to move away from discrimination and a virtual go ahead to abandon pay differences based on race.

He said it would cost a fraction of the total Transvaal provincial hospitals' budget of R123-million a year—in fact only R77 000—to raise the pay of Black doctors working for the province to the level of White doctors.

"It's not the question of availability of funds nor the amount involved, nor is it a question of Blacks being less qualified than Whites. The continued pay discrimination can, therefore, only be sheer race discrimination," Mr Epstein said.

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Sunday Tribune 13/7/75

By DEVEN MOODLEY

MORE THAN 50 Black doctors who qualified overseas have been told to "walk the streets" while White interns are taken in at Black hospitals.

WHITES GET POSTS BUT BLACKS TOLD: COME BACK IN 1976

The doctors, who trained in Dublin and in India, came home two weeks ago to find all Black hospitals full — some with White interns. They were told to wait until next year, when they might be accepted.

Now Blacks are demanding to know why Whites are being put in Black hospitals at the expense of the few Black doctors who struggle through medical school.

Dr W. K. Botha, director of hospital services in Natal, said doctors from recognised colleges will be accepted as soon as vacancies arise, possibly next year.

The frustrated doctors have appealed to the Indian Council and other Black leaders for help.

Mr J. N. Reddy, chairman of the council, said he was disturbed that a handful of Black doctors could not get jobs in provincial hospitals.

"If they were Whites I am sure something would be done without any trouble. I don't see why these interns, who are merely clerks in the first year, can't be accepted in White hospitals until there is space in our Black hospitals."

Challenge

Whites work in Black hospitals, and he challenged the province to throw open White hospitals.

Mr Botha said he would gladly throw open the White hospitals to Black interns but all the White hospitals, even Addington, are full.

The Minister of Health, Dr S. W. van der Merwe, said he was surprised more than 50 doctors were out of work.

"Though this is a provincial matter, we could do something if we were told of the position."

He warned that preference would be given to doctors who qualified in South African universities and schools.

"After this we could see to those who come from overseas. I know there is a tremendous shortage of Black doctors but what do we do if we don't have enough doctors to train the interns?"

But I was told most Black hospitals could use more interns.

Dr Botha said he will do his best to get the doctors internships in other hospitals.

A Northern Natal doctor, Mr Abdul Omarjee, said he turned down a job in Australia to come back to South Africa. He has travelled all over the country in search of an internship.

"I was terribly upset when I was told I have to wait until next year," he said. "Now it seems I have to look to neighbouring countries to find a job."

(93)

UP men flay city council on pay issue

13/7/75

Tribune Reporter

SENATOR Eric Winchester and MPC Mike Woollam yesterday slated Durban City Council — unofficially controlled by the UP — for its "incredible" timidity in stamping out petty apartheid.

And they were joined by the Progressive Party, which accused Durban councillors of plain, old-fashioned "gutlessness."

"I find this incredible," said Senator Winchester. "Durban is lagging behind almost every major centre in the country — not only on pay, but on petty apartheid as well."

Mr Woollam said: "It's abou time Durban stopped making statements and began taking a positive lead."

Refusal

The two senior United Party men were commenting on the council's refusal this week to pay the City Health Department's Indian doctors the same as their White colleagues.

Another issue was its failure to open the reference library to all races.

Councillors who voted against a pay equalisation — the differential is about R150 a month — justified their stand by saying it would probably have deprived them of the Government subsidy for health.

But this argument disintegrated overnight when the Minister of Health, Dr S.W. van der Merwe, made it clear that Durban was way out of step.

"The Durban Council knows South Africa is moving in a specific direction at the moment," the Minister said.

"Durban should not arbitrarily decide it will have to foot the extra bill without first applying for the subsidies."

Black and White municipal doctors in at least three other major cities — Johannesburg, Cape Town and Port Elizabeth — are paid on the same scale.

"The council seems to be completely out of step with the rest of the country. For years now it has been hiding behind the Government's skirts — and now even the Government is leaving it far behind," said Senator Winchester.

"Now, as usual, they've simply been made to look stupid."

Positive

Mr Woollam said: "Durban is supposed to be a centre of opposition to the Government — yet the Nationalists seem to be moving in the right direction and Durban is lagging far behind."

Mr Harry Pitman, the Progressive Party leader in the province, said: "It's high time they showed a bit of guts and stood up for something positive."

Footnote: "The power base of the United Party, where it can practise what it preaches, is here in Natal and we are to be judged by what we have done" — Mr Radclyffe Cadman, Natal leader of the party, writing for the Sunday Tribune in March this year.

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Hopes to end bar on SA doctors

ARGUS 15/7/75

The Argus Correspondent

JOHANNESBURG—The Minister of Health, Dr S. W. van der Merwe, said last night that South Africa was hopefully anticipating the day which would end all obstruction to 'our fullest participation on the international scene.'

He was opening the jubilee congress of the South African Medical Association in Johannesburg before an audience which included many delegates and visitors from other countries.

Dr van der Merwe said South Africa wanted an end to obstruction of its international participation 'in serving the alleviation of human suffering wherever the need is greatest.'

Any situation where non-medical and non-humanitarian considerations barred South Africa from rendering genuine professional assistance beyond the country's boundaries was 'as much in conflict with our ethical commitment as if we were to withhold our services from our own fellow citizens,' he said.

MEDICAL MANPOWER

South Africa was fully alive to its problems concerning the maldistribution of medical manpower. As in other countries which respected the freedom of private practice, South Africa had an over-concentration of doctors in the cities.

But, the Minister added, in spite of the attractions of private practice, 40 percent of South African doctors had been in full-time salaried posts in 1973 while many of the remaining 60 percent were in part-time salaried posts, were not practising or were at present abroad.

SALARIED POSTS

A high percentage of doctors in salaried posts dedicated their services specifically to the development of less-privileged segments of the population, Dr van der Merwe said.

The Minister warned that the medical profes-

93

Jobless Black doctors claim denied

Mercury Reporter 14/7/75

PIETERMARITZBURG — The MEC-in-charge of Hospitals, Mr. Frank Martin yesterday strongly denied a report which claimed that more than 50 Black doctors could not find jobs as interns in Natal hospitals.

The report said more than 50 Black doctors had been told to walk the streets because there was no work for them. The report also said Blacks were demanding to know why White interns were given work in Black hospitals.

"I very much doubt these doctors exist. They certainly have not applied for jobs in Natal," Mr. Martin said.

Interns due to begin at hospitals next year had already been allocated to hospitals last March.

"Housemen know that unless they apply well in advance, they will walk the streets."

He said the reported doctors who had qualified overseas were supposed to have been back in South Africa for about two weeks. Did these doctors expect the NPA to meet them at Jan Smuts and offer them jobs?

'POLITICAL'

Mr. Martin said he was tired of a certain section of the population twisting everything into a political argument.

"Who are these Blacks demanding to know why Whites are being put into Black hospitals?" he asked.

'Barefoot' doctors idea stamped on

(93)

Mercury Correspondent 17/7/75

PRETORIA — The South African Nursing Association has rejected the use of "barefoot doctors" to ease the shortage of medical services in some parts of South Africa.

The association's president, Prof. Charlotte Searle, speaking from the associations congress in Bloemfontein yesterday, said that South Africa had no need of "barefoot doctors" among millions of urban, rural and homeland Blacks.

She was commenting on a statement by the president of the Medical Association of South Africa, Dr. Jonathan Gluckman, that it ws inevitable that barefoot doctors would be used to serve large sections of the population.

He said this at his association's annual congress in Johannesburg.

Prof. Searle said the nursing profession was uncompromisingly opposed to the use of partly traned doctors' assistants when there were hundreds of Black and White nurses available.

"We will leave no stone — even political stones — unturned to block any effort made to introduce a system of barefoot doctors."

Prof. Searle said there was a large surplus of Black nurses admirably equipped to make skilled medical care available on a far wider basis.

The lack of skilled medical care in some areas had reached crisis proportions.

She pointed out that Black nurses, like White nurses, had a minimum of four years post-matric training.

"Against this background to talk of barefoot doctors in a developed country like South Africa is ridiculous. This is not China where the term originated, and where there are only very limited numbers of trained nurses."

Prof. Searle said this week, when the Chief Minister of Bophuthatswana, Chief Lukas Mangope, opened the Black nurses' congress at Welkom, he made it clear

Nurses hit out

STAR 17/7/75

(93)

BLOEMFONTEIN — Nurses yesterday objected strongly to a proposal that doctors' assistants should take over some of their work.

The proposal was made at a conference in Johannesburg on Monday by Dr Jonathan Gluckman, president of the South African Medical Association.

He said it was inevitable and urgent that use be made of partially trained people, the so-called barefoot doctors.

But yesterday in Bloemfontein 350 nurses at the annual congress of the South African Nurses Association protested sharply at the suggestion that certain basic tasks could be taken over by doctors' assistants.

The nurses said they had carried out these tasks with great success to relieve doctors, especially in the homelands where there was a staff shortage.

The association chairman, Professor Searle Charlotte, said the proposal implied that trained nurses were not skilled enough to help doctors successfully.

From the outset African nurses would be affected by the introduction of doctors' assistants, said the chairman.—Sapa.

‚KAALVOET-DOKTERS' KAN KALF UIT PUT RED

Oop Gesprek

OTTO KRAUSE gesels met DR. JONATHAN GLUCKMAN

SUID-AFRIKA se geneeskunde staan hoog aangeskrewe; tog kla ons volk steen en been dat die ou verhouding tussen dokter en pasiënt aan 't verdwyn is en dat mense al hoe onpersoonliker deur hul geneeshere behandel word.

Daar word aangevoer dat Suid-Afrika gans te min dokters het vir sy bevolking en vir die toenemende vraag na mediese dienste wat op 'n hoër lewenstandaard volg.

Derhalwe is ons land se dokters oorwerk hoewel hulle goed geld maak — en kan hulle kwalik meer daardie persoonlike diens van die gesinsgeneesheer lewer.

In sy voorsittersrede voor die Mediese Kongres in Johannesburg vandeesweek het dr. JONATHAN GLUCKMAN, voorsitter van die SA Mediese Vereniging, verwys na die krisis waarop sy beroep afstuur. Otto Krause het hom verder gaan uitvra oor die geneesheer-situasie wat soveel kommer wek.

VRAAG: Wat het met die verhouding tussen dokter en pasiënt verkeerd geloop? Hoe het dit só onpersoonlik geraak dat baie pasiënte deesdae voel hulle is maar net 'n nommer op 'n geneesheer se dagboek?

GLUCKMAN: Die rede daarvoor, dink ek, is dat ons in die stede te veel pasiënte het en nie genoeg gesinsdokters nie.

Die dokters self, veral in stedelike gebiede, staan onder geweldige druk om hul groot getalle pasiënte te behandel.

Baie dokters het die situasie probeer verbeter deur hul praktyke tot spesifike gebiede binne die stad te beperk. Maar dit gee aanleiding tot ontevredenheid onder hul oorspronklike pasiënte wat buite daardie gebied woon. Hulle wil natuurlik nog deur hul ou dokter behandel word.

Uitputtend

Wanneer hul ou dokter weier om hulle te kom besoek, skep dit onmin: en die pasiënt wat so uitgesluit word, ondervind die grootste moeilikheid om 'n nuwe dokter te vind wat hom sal aanvaar.

In 'n stad soos Johannesburg, waar ek my meeste ondervinding het, is daar baie min algemene praktisyns — of liewer gesinsdokters — wat nie 12 tot 14 uur per dag werk nie, dikwels sewe dae in die week. En dit is uitputtend.

Die gevolg is dat hulle hul besoeke probeer beperk en hulle sê aan hul pasiënte: „Kom na my spreekkamer toe," of „Bring jou siek kind na my spreekkamer." Daarvoor word hy kwalik geneem. Dink net aan die gevoelens van 'n moeder wat deur 'n dokter se telefoondame gesê word: Draai jou kind (met 'n koors van 100) toe en bring hom na die dokter!

Dit is voorbeelde van wat op 'n persoonlike vlak gebeur.

Geen aandag

As 'n mens verder kyk na die wanverhouding van geneeshere teenoor pasiëntgetalle, moet jy daarop wys dat die toename in lidmaatskap van mediese hulpskemas e.d.m., ongetwyfeld baie pasiënte wat normaalweg provinsiale hospitale bygewoon het, na private pasiënte verander het.

Dit is een van die faktore wat bygedra het tot die oorvolle praktyke van baie gesinsdokters.

Dit het beslis tot die geneesheer se finansiële voordeel gestrek, maar dit het ook die druk om hom vermeerder.

Hierdie faktore laat dikwels die gevoel by die pasiënt ontstaan dat hy nie die aandag kry wat hy behoort te kry nie; en dit is maklik om te verstaan hoe dit met 'n oorwerkte dokter gebeur.

VRAAG: Dit is dan 'n vraag- en aanbodsituasie wat verkeerd geloop het. Maar hoe is dit dat die mediese beroep nie toegesien het dat daar genoeg dokters is om met die bevolkingsaanwas tred te hou nie?

GLUCKMAN: Die mediese beroep as sodanig is nie verantwoordelik vir die opleiding van dokters nie.

Dit is essensieel die verantwoordelikheid van die staat om deur die universiteite mediese skole te verskaf — en dit is enorm duur inrigtings.

Ek meen daar was nie genoeg vooruitbeplanning daarvoor in die eerste na-oorlogse dekade nie.

Verdubbel

Blykbaar is daar ook aanvanklik gedink dat één nie-blanke mediese skool (dié in Durban) voldoende sal wees, maar hierdie opvatting is baie gou verkeerd bewys.

Ongeveer 15 jaar gelede het die behoefte aan meer mediese skole oral duidelik geword, maar daar is bevind — waarskynlik tereg — dat dit die beste maatreël is om die produksie van die bestaande skole te verdubbel.

Dit was 'n redelike stap, want mediese skole is nie eenvoudig bakstene en beton nie: jy moet hulle beman.

Die verdubbeling is grotendeels behaal, maar nogtans is die produksie nie genoeg om aan die behoeftes van 'n groeiende bevolking te voldoen nie.

En daarby het jy die natuurlike verlies aan geneeshere deur aftrede of afsterwe, wat nog vererger word, deur 'n emigrasie van jong dokters die land uit. Ek wonder hoe groot die absolute toename in doktersgetalle werklik is, wanneer 'n mens hierdie faktore in ag neem.

VRAAG: Wat is die posisie onder die nie-blankes?

GLUCKMAN: Sover ek weet, is daar 900 nie-blanke dokters — insluitende swartes, Indiërs en Kleurlinge — in ons land. Dit is maar 'n druppel aan die emmer wanneer 'n mens kom by die mediese bediening van die nie-blanke bevolking.

Publiek sal maar te bly wees

Die Regering probeer hierdie situasie regstel deur die stigting van nog 'n mediese skool, uitsluitlik vir swartes, in Natal.

Vererger

Maar dit verg minstens sewe, agt jaar voordat 'n mediese skool sy eerste geneeshere lewer. Daardie gedeeltelike oplossing is derhalwe taamlik ver in die toekoms.

Die posisie onder nie-blankes word vererger — en dit kan 'n mens ewe veel van die nie-blankes as die blankes verstaan — omdat die nie-blanke dokters grotendeels in die stedelike gebiede gekonsentreer is. Hoekom sal die smaak en begeertes van hulle as opgevoede mense anders wees as dié van hul blanke kollegas?

Net die skepping van 'n onafhanklike owerheid in die Transkei (wat reeds sy eie Departement van Gesondheid het) sal meer swart dokters miskien na hul tuisland gelok word.

En gepaard met die tekort aan swart dokters in die landelike gebiede, bestaan daar 'n geweldige behoefte aan mediese dienste oor die algemeen onder die swartmense.

Epidemie

Dr. Johan de Beer, sekretaris van Gesondheid, het nou die dag verwys na wat hy genoem het 'n epidemie van tering onder die swart bevolking die afgelope 25 jaar. Hy het aangetoon dat hierdie epidemie nou geleidelik afneem, maar dat die nuwe gevalle, om watter rede ook al, nog enorm baie is.

Hy het ook aangedui watter geweldige koste die behandeling en hospitalisasie van hierdie pasiënte vir die staat beteken. Tog sal niemand aanvoer dat dit voldoende is nie.

VRAAG: Sou u dan sê dat blanke geneeshere eenvoudig vir die voorsienbare toekoms basies ook die nie-blanke bevolking sal moet dra?

GLUCKMAN: Wat ten volle opgeleide geneeshere betref, is dit beslis die geval.

VRAAG: En met al hierdie druk op die beroep sal Jan Publiek nie veel kan uitsien na 'n verbetering in sy mediese dienste nie?

GLUCKMAN: As gevolg van die druk wat ek genoem het, kan ek nie 'n verbetering in die onmiddellike toekoms sien nie. Maar ek glo dat die situasie aansienlik verbeter kan word indien ons die beginsel wil aanvaar van minder opgeleide mense wat op die mediese terrein in spanne onder die toesig van en in kontak met 'n ten volle opgeleide dokter werk.

Apteker

Natuurlik sal dit hoofsaaklik in die landelike gebiede geld, en die persoon waaraan ek dink, sal 'n vol-opgeleide verpleegster wees — blank of swart — wat 'n verdere opleiding van 'n jaar of twee sal ondergaan om haar in staat te stel om heelwat mediese dienste te lewer.

Sy sal in staat wees om die meeste gewone siektes wat in algemene praktyk voorkom, te herken en diagnoseer — soos bv. seer kele, aansteeklike koorse, die meeste longsiektes, verskillende soorte maagkoors ens. — en sy sal hulle kan behandel.

VRAAG: Maar is dit nie presies wat die gesinsapteker tans besig is om te doen weens die ontoereikende situasie met u beroep nie?

GLUCKMAN: Ja. Maar ek is seker die apteker sal die eerste wees wat saamstem dat hy nie in diagnose opgelei is nie, hoewel sy vermoë in dié rigting groter as dié van 'n leek mag wees.

Ek glo dat die meeste verantwoordelike aptekers nie gelukkig voel om 'n diagnose of 'n behandeling oor die toonbank of oor die telefoon te doen nie.

In elk geval is hulle reg om 'n hele groot groep medisynes voor te skryf, beperk; en ons moet aanvaar dat indien dié soort deelsopgeleide mediese personeel wat ons bespreek het, toegelaat word om te dokter, hulle ook die gepaste medisyne sal kan voorskryf — sonder om uit die oog te verloor dat hulle saam met 'n ten volle opgeleide dokter sal werk.

VRAAG: Wie sal hierdie gedeeltelik opgeleide medici in diens neem — die staat of private dokters?

GLUCKMAN: Ek dink dit sal afhang van die omstandighede.

Gevaarlik

In verafgeleë plattelandse gebiede, veral in die tuislande, voorsien ek dat hulle onder distriksgeneeshere sal werk — en dié is in elk geval werknemers van die staat.

Maar in ander gebiede sien ek geen rede hoekom private praktisyns nie hierdie mense in diens kan hê nie.

Dit is net jammer dat die eerste eksperiment in dié rigting op die terrein van narkose moes wees — waar 'n stelsel van assistent-narkotiseurs onlangs goedgekeur is.

Ek dink dit is jammer omdat narkose 'n baie delikate en gevaarlike mediese terrein is.

Maar daar bestaan ongetwyfeld groot geleentheid om sulke mense in die veld van die algemene praktyk te laat werk.

VRAAG: Hoe aanvaarbaar sou dit vir die publiek wees?

GLUCKMAN: Ek glo dat die publiek dit oor die algemeen sou aanvaar. Die publiek is immers in groot getalle net té gewillig om deur aptekers behandel te word.

Maar ek meen dat die werklike teenkanting teen só 'n stelsel onvermydelik van die mediese beroep sal kom, 'n beroep wat jaloers is oor sy historiese standaarde.

VRAAG: Maar as dokters reeds erken dat hulle nie kan bybly veral t.o.v. die dokter-pasiënt-verhouding nie, behoort hulle tog sekerlik in hierdie ontwikkeling te vinde te wees . . .

GLUCKMAN: U is natuurlik korrek; dokters behoort nie daarteen gekant te wees nie.

Moderniseer

Maar ons is 'n baie tradisievaste beroep . . . oor die eeue heen.

Soos ek egter in my voorsittersrede gesê het, moet ons verander in 'n veranderende wêreld en ons denke moderniseer. Nie alleen in hierdie spesifieke konteks nie, maar ook t.o.v. die soort opleiding vir die dokters van die toekoms.

En die stelsel van deels opgeleide mense, werk tog goed in lande soos bv. Duitsland, Holland en Rusland, en sekerlik onder die groot volksmassa van China. Daar verneem ek, is daar nie minder as 500 000 van hierdie „kaalvoet-dokters" nie.

VRAAG: En as die geneeshere só daarteen gekant is, wie, dink u, sal die geveg uiteindelik wen?

GLUCKMAN: Ek hoop daar sal nie 'n geveg wees nie; ek hoop dat almal liewer vorentoe wil dink en onthou dat die essensiële deel van 'n dokter se geloofsbelydenis is om te sorg vir die siekes en behoeftiges, afgesien van alle ander oorwegings.

Of só sê ons altans met ons Hippokratiese Eed . . .

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Why those Black doctors can't get a job in Natal

Sun Trib 20/7/75

By DEVEN MOODLEY

AT LEAST 22 Indian doctors who trained overseas have been refused internship at Natal hospitals. And the true figure could be nearer 50.

This week Mr Frank Martin, Natal MEC in charge of hospitals, went on record as saying he doubted whether these doctors exist, in a statement to the Natal Mercury.

Last week the Sunday Tribune reported that about 50 newly-qualified doctors were without jobs in the country.

The Sunday Tribune has a list of 23 Irish-qualified and 10 India and Pakistan-qualified doctors in Natal who have been told to wait.

The list comes from Dr M. I. Essack, fund-raiser with Durban's Dublin Royal College of Surgeons Association. He said he was shocked to hear that Mr Martin was unaware of the position.

"I myself have the names of 23 doctors qualified in Dublin and there are many more who have qualified in Pakistan and India.

"I have 10 names of doctors from India, though there are many more."

Unaware

Mr A. G. Khan, a former member of the South African Indian Council, says he has the names of 16 doctors, most of them from India and Pakistan, who have been unable to arrange internships.

His list was not accessible this week so he was unable to say whether it duplicated Dr Essack's.

If there is no duplication, the total would be 49.

Mr Martin told the Sunday ribune that when he made his eariler statement to the Natal Mercury he was genuinely unaware of the extent of the problem but had since ordered senior officials to investigate.

"But I think most of the problem is that these chaps don't apply to become interns until far too late," he said.

"Our first responsibility is to students who qualify at the Natal Medical School. Then come other South African universities, then students from overseas.

"We get given a fixed allocation of the number of interns we can accept every year. Sometimes we manage to plead for a few more, but only a few."

He resented the implication that Natal was giving preference to White interns at Black hospitals, while Blacks were forced to "walk the streets."

"I can think of only one White intern at a Black hospital. This does not include Northdale, in Pietermaritzburg, because for administrative purposes this is part of Greys Hospital, and that is White."

Placed

Dr D. L. Rankin, deputy director of Hospital Services in Natal, confirmed that of the 33 internship applications made to King Edward VII Hospital, by overseas graduates, 11 had been placed, mostly from Dublin.

"The remainder we are trying to get internships at hospitals outside Natal."

Equal pay decision

Cape Times Correspondent 22/7/75

DURBAN. — Black and White municipal doctors will be paid equal salaries, the Durban City Council unanimously decided yesterday, without even debating the question in open council.

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STAR 22/7/75

African, Coloured and Asian doctors working for the Johannesburg City Council are paid the same rate as their White colleagues, but many are working for the Transvaal Provincial Administration at discriminatory salaries.

Johannesburg employs 25 White, two Coloured, one Indian and five African medical officers. It also employs one senior African and one senior Indian medical officer.

Its capacity for employing doctors was reduced in April last year when 24 medical posts in the city council were abolished after the province took over its curative medical services.

The council now operates only preventative medical services.

In November 1972 the council took what was then a revolutionary step by paying all doctors equal salaries.

AGREED

Since then Cape Town has followed suit and yesterday the Durban City Council also agreed to pay its doctors equal rates.

Mr David Epstein, MPC the United Party's medical spokesman in the Transvaal said that according to official figures the Transvaal Provincial Administration employed 67 Indian, 14 African, 11 Chinese and eight Coloured doctors.

He said an official reply he been given in the Privincial Council revealed it would cost the province only R79 000 a year to pay equal salaries.

All city council medical officers are paid between R7 740 and R11 700 a year — which is also the State and Provincial Administration scale for White doctors — a city council spokesman said.

(See Page 7).

Minister suggests probe of medical profession

ARGUS 4/8/75

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The Argus Correspondent

PRETORIA. — The Minister of Health, Dr S. W. van der Merwe, has suggested that the South African Medical and Dental Council conducts an inquiry into professional malpractices.

Addressing the first meeting of the council in its newly constituted form, the Minister warned that:

- The medical profession was becoming increasingly materialistic.
- The number of cases of malpractice was rising out of proportion to the numerical increase in doctors.
- Relations between doctors and pharmacists needed urgent attention.

Dr van der Merwe said the composition of the council had been changed to meet changing demands, but the council itself had been evenly divided on whether it should be increased or reduced in size.

GOING WRONG

A problem of primary concern was the image of the profession. The traditional doctor-patient relationship w[illegible] in the pro[illegible] of serious erosion and [illegible] the eyes of the public the profession was becoming more and more materialistic.

The Minister said the increasing number of disciplinary investigations was becoming a source of concern. It appeared that the number of cases of malpractice was rising disproportionately and that somewhere something is going wrong.

I am forced to ask myself whether the time has not come for the council to undertake an inquiry to determine the causes of this phenomenon, he said.

COSTS

Dealing with difficulties between doctors and pharmacists, Dr van der Merwe said pharmacists were dissatisfied because doctors competed with them in prescribing and marketing, while doctors were dissatisfied with counter-prescrib-

SUNDAY TRIBUNE, AUGUST 17, 1975

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ALL-NIGHT STINTS TO HELP SICK BLACKS

Tribune Reporter

THE Deputy Secretary for Health, Dr James Gilliland, doesn't believe a desk-bound doctor should hang up his stethoscope— or his scalpel.

That's the reason for his disappearance most Tuesday nights.

After a day at the office he drives 60 kilometres to the Ga-Rankuwa hospital in Bophuthatswana, slips into a surgical gown and

Dr Gilliland

does an all-night stint in the operating theatre or casualty wards.

He often drives straight back to his office after an operation to begin another day at his desk in the Department of Health offices in Pretoria.

"I like to keep in touch with my profession, and what's more, I enjoy doing it," he said.

Dr Gilliland and about six other Department of Health officials help out at the 2 000-bed hospital because of a severe shortage of trained personnel.

Dr Gilliland believes the service will help forge closer links with the homeland.

Black doctors need facilities

Cape Times 22/8/75

PROFESSOR I W F Spencer, Professor of Comprehensive and Community Medicine at the University of Cape Town, said last night that there was a need to train African doctors and assistants.

Delivering his inaugural lecture in the Beattie Theatre at UCT, Professor Spencer said: "There is a need for post-graduate facilities so that African doctors could practise in every sphere of society, including the rural areas."

There was great urgency in the homelands for the extension of mission hospitals into a comprehensive community health service.

Professor Spencer said that a patient could not be treated in isolation from his family, work or community situation or from "the cultural, social and economic levels of existence".

● Professor Spencer said the pill had changed social mores and added to promiscuity, extra-marital infidelity and venereal disease. "It has not done much to drop the world reproduction rates, as it does not adequately reach those people of the world who need it most."

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Nurses should 'bridge gap'

Mercury Reporter 23/8/75

NURSES should be trained to diagnose and treat minor ailments to bridge the gap until more Black doctors qualified, a graduation ceremony at King Edward VIII Hospital in Durban was told yesterday.

Prof. C. L. S. Nyembezi, an editor of Zulu schoolbooks, was addressing a ceremony at which 109 midwives, 14 general nurses and 43 enrolled nurses graduated.

He said: "We are looking forward to the day when Black matrons will be in full charge of Black hospitals. Black nurses should be given the experience to enable them to take over the most senior posts."

Of the shortage of Black doctors, he said the "dice had been loaded for years" against them. For years they had been unable to receive medical training in South Africa.

When the Witwatersrand University opened its doors to Black students they had acquitted themselves well. Now that Blacks could only receive medical training in Durban not enough Africans were being admitted.

"Wits is quite willing to reopen to Black students and it should be allowed to do so," said Prof. Nyembezi.

Patients at Baragwanath Hospital were used to train other racial groups but Africans were not allowed to do their training there.

"But, to help ease the shortage I suggest a special category of nurse who can diagnose and treat simple conditions. For rural clinics this should be a male nurse because most people prefer to consult a man," he said.

Special awards and prizes were given to the hospital's top 12 nurses.

They were:

Natal Provincial Administration gold medal, Miss N. V. Mcanyana; Durban City Council gold watch for most outstanding nurse, Miss E. Sivuku; runner-up, Miss V. Feketshane and most outstanding student-enrolled nurse Miss D. Simelane.

Joint Medical Staff Committee prizes: Miss D. J. Sibiya, Miss P J. Bakane, Miss R. Machaea.

King Edward VIII Hospital Prize, Miss E. Kobeli.

Chief Matron's Prize, Mrs. E. T. Khumalo; Theatre Matron's Prize, Miss H. N. Somdizela; The Good Conduct Cup, Miss E. T. Sivuku; Midwifery Tutor's Prize, Miss G. W. Zungu.

The nursing staff presented Miss V. L. Borgen, the deputy chief nursing officer, NPA, and former chief matron of the hospital with a long service medal.

No doctor in the house

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MERCURY 1/9/75

Political Reporter

A CALL for the Government to embark on a 15-year programme to wipe out the critical shortage of both Black and White doctors has been made by the United Party's MPC for Durban Central, Mr. Cliff Matthee.

Addressing a report-back meeting in his constituency Mr. Matthee said the Government should compile and make public a blueprint of the medical facilities South Africa would need in future.

For 20 years the Natal Provincial Administration had urged the establishment of a medical school for Whites in Natal but all their pleas had "fallen on deaf ears."

This was perhaps the prime reason for the existing shortage of White doctors. Such a school was essential. Whether it was situated in Durban or Pietermaritzburg was "immaterial," Mr. Matthee said.

Referring to the "hopelessly inadequate" supply of Black doctors to staff hospitals and clinics Mr. Matthee said he believed the chief reasons were the existence of job reservation and differential pay based on colour.

Many Black doctors went overseas to further their studies and did not return.

'LET FOREIGN DOCTORS WORK HERE' PLEA TO GOVT

By DEVEN MOODLEY

Sun Trib. 28/9/75 (93)

SOUTH AFRICAN Indians gave R100 000 this week to the Royal College of Surgeons in Dublin.

And early next year a record 31 Black medical graduates from Dublin will arrive in South Africa to intern at provincial hospitals.

There will also be a record number from India and Pakistan later this year — for after 1978 the Medical Council will not recognise India and Pakistan-trained doctors.

The Indian Council has asked the Government to intervene and allow Blacks to be trained in these countries because of the problems faced by Indians in being admitted to the medical school in Durban.

And this week Mr Frank Martin, MEC in charge of Natal hospitals, warned that unless the overseas-trained doctors make arragements they will have no jobs when they arrive.

Mr Martin disclosed that nearly all the 50 doctors who had to "walk the streets" this year because Natal hospitals were full have now been given jobs.

Many of them went to Transvaal and Cape hospitals.

"With so many doctors arriving from overseas and with the limited quota — 11 — we have from the Medical Council, there are bound to be problems. These doctors must apply in advance."

Meanwhile 11 Cairo trained doctors are without jobs because of the Medical Council's decision to stop recognising them. The Minister of Health, Dr Schalk van der Merwe, has been asked to lift the ban on the Cairo doctors.

A further 185 South Africans are due to qualify at Cairo University in the next four years. All will face the same fate unless the Medical Council reverses its decision.

Dr M. I. Essack, fund raiser with Durban's Dublin Royal College of Surgeons Association, said the R100 000 collected from Indians would go to the new wing of the Dublin college, to be opened next year.

"South Africa is lucky to be allowed so many students. There are 149 there."

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SA needs more doctors

UCT News Oct. 1975

Professor Jannie Louw, head of the division of Surgery, expressed alarm at the urban concentration of doctors in South Africa, the scarcity of non-white graduates and the constant brain drain when he addressed the UCT Medical History Club at the Medical School Library on Monday, October 14.

He spoke on the history of medicine in South Africa over the past 50 years, an address he delivered at the Golden Jubilee Conference of the South African Medical Association in July.

South Africa was now in a position to train about 800 medical graduates a year, but this number still fell far short of growing demands, he said.

'On the other side of the coin, however, is the upsurge of general practice and the supplementary health professions,' Professor Louw said.

The ratio of doctors to population in South Africa was one to 1 900. This was still far from the ideal of one to 800 in Western countries, but better than anything elsewhere in Africa where the rate could sometimes be one in 72 000, as in Ethiopia.

'There have been tremendous advances in medicine throughout the world, and it is gratifying to record that South Africa has not lagged behind, and in certain fields has been in the vanguard,' Professor Louw said.

Discussing the establishment of medical faculties, Professor Louw said the University of Cape Town, which has the country's oldest faculty, had trained 4 718 M.B. Ch.B. graduates by the end of 1974, since the first two doctors were capped in 1922.

In the same period UCT had awarded postgraduate medical degrees to 392 doctors.

He paid tribute to the administrations of the four provinces for the establishment of teaching hospitals, and especially to the Day Hospitals System created in Cape Town by Dr L.A.P.A. Munnik.

The Medical History Club has monthly meetings during the academic year and all interested are welcome. Details of programmes are available from the Librarian, Medical School.

The last lecture this year will be on Monday, November 10 at 8.15, Doctor's Room, Medical School Library, when Professor J.F. Brock will talk on 'Food or Heart Transplant.'

(1) 262 Natal

(2) 93

Health pay competitive says Ash

Mercury 5/11/75

Mercury Reporter

MR. RODNEY Ash, the chairman of Durban's Municipal Service Commission, which appoints staff to the critically-short Department of Health, said yesterday that he was not aware that Durban's salaries were uncompetitive.

In an interview with the Mercury, Mr. Ash said he was under the impression that Durban's salaries were "reasonably competitive."

Last week the City Medical Officer of Health, Dr. Colin MacKenzie, told the City Council that his department was critically short of medical manpower which could cripple the city during an epidemic.

Dr. MacKenzie was directed to inform the Municipal Service Commission of the understaffing crisis.

Mr. Ash said other municipalities were equally short of medical personnel.

Asked why Durban was losing health inspectors to smaller municipalities like New Germany, Pinetown and Richard's Bay, Mr. Ash said different circumstances prevailed in the smaller places where the inspector often had senior status.

Mr. Ash said Durban paid more than the State Health Department laid down for the grade and said that out of Durban, Johannesburg, Pretoria and Cape Town, Durban was better than two, but worse than one.

In Durban inspectors' salaries ranged from R5 007 to R7 806 a year whereas Johannesburg ranged from R5 112 to R7 980.

Mr. Ash said it was difficult to lure people away from their jobs, especially from the Reef where housing was provided or subsidised. The commission had already recommended that Durban look into the possibility of providing staff housing.

"We have improved holiday bonus recommended a gratuity on retirement and recommended that in some cases leave can be converted into cash. There is also medical aid, a pension and generous leave conditions," he said.

Black medical group to offer bursaries

D.D. 18/11/75

1. ~~Educ~~ University
2. 9.3

KING WILLIAM'S TOWN — Because of a concern for the education of the black child, the Eastern Cape Black Medical Study Group has undertaken to offer bursaries to any matric student who intends doing medicine.

This is the first time doctors in the Eastern Cape have undertaken to offer opportunities to students to further their studies.

This was revealed by the secretary of the group, Dr Mamphela Rampele, in a statement inviting students about to do or already doing matric with intentions to do medicine or any para-medical course, to apply.

The group, Dr Rampele said would also make loans to medical students at university who are in financial difficulties. In such cases, she said, the loan would be payable according to certain stiuplated terms by the group. — DDR.

W/E ARGUS 29/11/75
(1)93

FOR UWC

Political Reporter

THE Minister of Health, Dr S. W. van der Merwe, said today he expected there would be close co-operation by established White universities in the training of Coloured doctors at the new medical faculty to be established at the University of the Western Cape.

In an interview in Cape Town, he said he hoped and accepted that both the University of Stellenbosch and the University of Cape Town would want to help, especially in post-graduate training.

There would be scope for such co-operation in both the academic and clinical fields.

Dr van der Merwe was elaborating on his announcement at Worcester last night that the Cabinet had decided to go ahead with the plan to establish a medical faculty and training hospital for the University of the Western Cape.

He said land adjoining the University of the Western Cape had been set aside for the project.

Asked about the estimated cost of the project, the Minister said it was not possible to give a figure at present. The figure of R65-million mentioned previously in news reports was 'not unrealistic when one thinks of the escalation of costs.'

The new medical faculty could take up to 10 years to establish, judging from previous experience.

STAGES

It would be established in stages, starting with basic science buildings, some of which were already in existence at the UWC, and then buildings needed for second- and third-year studies.

It could be expected that the training hospital would be completed before the full medical faculty came into operation.

The Minister said it was important that attention be given from the start to the question of establishing para-medical services.

A committee would now start with the actual planning of the project.

CRITICISM

Meanwhile, the decision to establish the faculty of medicine has been criticised by a Coloured politician and a Coloured doctor.

'The evil of it is that it will be a faculty to train Coloured doctors to treat Coloured people who have Coloured diseases,' Mr A. 'Lofty' Adams, Labour Party CRC member for Kasselsvlei, said.

It would be far better for the Government to extend the medical faculties at the universities of Cape Town and Stellenbosch, he said.

This was also the opinion of a Cape Town Coloured doctor who said he was 'not satisfied' with the plan to establish the faculty at UWC.

'The standard at this university will not be as high as other universities. Students would not get the best training.'

However, the decision to establish the medical faculty at UWC was supported by the national leader of the Federal Party, Mr W. J. Bergins.

'There is a great shortage of Coloured doctors and the establishment of this faculty might be a solution to this problem,' he said.

Overtime pay for doctors

Argus 21/11/75

A NEW allowance scheme for the extra hours doctors work at hospital has come into effect throughout South Africa.

Under the new scheme doctors who work more than 16 hours extra a week will be paid a fixed amount which will be added to their monthly salaries.

In the past doctors were paid on a four-hour basis. This time-sheet method of payment offended many of them who felt it did not take into consideration that doctors were on standby 24 hours a day.

FROM NOVEMBER 1

The new payment scheme was introduced in all four provinces on November 1. Doctors who work more than 16 hours a month will still receive the same amount.

The Director of Hospital Services, Dr R. L. M. Kotze, in welcoming the new system, said: It does away with most of the shortcomings of the old system. Too much emphasis was laid on the number of hours a doctor worked.

"We would like to think that all doctors are on call 24 hours a day. This has been taken into account when devising the new method of remuneration."

RDM 19/12/75 (13) (93) (2) Education - University

Overflow seen at new Black medical school

By PATRICK LAURENCE

THE new medical school planned for Africans at Ga Rankuwa, near Pretoria, would reach saturation point by 1980, Professor J. V. O. Reid, of the University of Natal Medical School, said yesterday.

Scheduled to take in its first African students in 1978, the new R30-million school will take over the training of African doctors from Natal University Medical School.

The first step in phasing out Africans from the Natal medical school begins next year with the decision to bar it from registering African first year students.

First-year students will be trained at the three African universities while the new school is being built.

Professor Reid spoke yesterday of a "screaming increase" in both the number of African matriculants eligible to apply to medical schools and the number actually applying.

The number of eligible African matriculants had risen fourfold to about 990 in the past five years and the number of actual applications threefold to about 210. Professor Reid said.

"To the best of my knowledge, the new medical school will have facilities to train about 160 first-year students," he added.

Prof Reid said: "Experience has shown that only about half the qualified applicants are eventually enrolled. For one reason or another, the other half are not acceptable."

From that, it followed that when the new medical school received 320 applications, it would be at or near its saturation intake of 160 students.

Judging from the growth of qualified applicants over the past five years, the new medical school would receive about 320 applications by 1980, Prof Reid said.

Given the shortage of African doctors, all available facilities for the training of African medical students should be used, including:

- The planned new medical school at Ga Rankuwa.
- The existing medical school at Natal University.
- All White universities prepared to accept Africans.

Prof Reid said the ratio of African doctors to the African population was about 1:40 000 — against a comparable ratio for Whites of 1:400.

Of the University of the Witwatersrand Medical School, Professor P. V. Tobias has quoted different figures to underline the same point: the number of African doctors who graduated in 1972 was less than one to 1-million Africans — against more than 110 White medical graduates per 1-million Whites.

Bantu Education Secretary, Mr G. J. Rousseau said yesterday the decision to establish the new Africans-only medical school was taken as a result of recommendations by a commission of Inquiry into the training of doctors.

The Natal University Medical School trains Asian, Coloured and African doctors (216 African doctors graduated between 1957 and 1974).

Mr Rousseau said the decision to end first-year registrations at the Natal school was taken because it was already having to cope with hostel accommodation problems.

Registration of first-year medical students at existing African universities would ease the accommodation crisis and pave the way for the switch to Ga Rankuwa.

Blunder on Black medics

The Durban Medical School should be expanded, not closed to Africans as the Government is currently doing. PROFESSOR PHILLIP V TOBIAS, Head of the Department of Anatomy at the University of the Witwatersrand writes on South Africa's desperate need for Black doctors.

It is tragic that the medical education of Africans is to be phased out of the Durban Medical School.

That school in its 24 years of existence has given the country no fewer than 216 African doctors. It has a strong desire to expand its facilities and take in even greater numbers.

We at Wits can only join our voices to the plea of the Durban Medical School and of the University of Natal to allow the School to continue admitting Africans.

The very idea of a separate medical university for Africans has no valid place in a South Africa of this day and age.

Just when somewhat freer contact between men of different races is beginning to enter the picture in South Africa, at that very moment a multi-million rand institution is to be established for medical, dental and veterinary education on a compulsorily segregated basis.

There are those who will say, "It is government policy for higher education to be segregated". But it is precisely that policy that is indefensible in today's world.

Of course, the country does need new medical schools. South Africa has only one medical school to every 4,3 million people, a mediocre showing compared with the average of one school to every two million or less in developed countries.

This would be pretty serious even if all six schools in the country were open to all parts of our 25-million population.

The fact that five of the six schools are not allowed to open their doors to Africans (except by individual permission of the responsible Minister) makes the position far graver — especially when we recall that Africans comprise over 70 percent of the total population.

On the world optimum for developed countries, South Africa should have 13 medical schools instead of its present six. So any new medical school must be welcomed. But when it is racially restrictive — and when the corollary of its establishment is that Durban Medical School has to stop taking in African students — one is forced to decry the new development.

The number of African matriculants has risen so steeply in recent years, and the shortage of African doctors is so great, that there would be enough suitably qualified applicants to fill the Garankuwa School, to continue supplying African medical students to the Durban Medical School — and, I may add, to the Witwatersrand University Medical School.

South Africa today is graduating each year, some 110 White doctors per million Whites, about 70 Asian doctors per million Asians, about nine Coloured doctors per million Coloured people — and *just under one African doctor per million Africans.*

The discrepancy will become greater when, in a year or two, the Bloemfontein Medical School graduates its first class of all-White doctors.

The proposal that there be a single African "medical university" to serve the country's entire African population (while African students are phased out of the Durban Medical School) overlooks the terrible inconvenience of African students having to come from all over the country to get their medical education at Garankuwa.

White students are able to go to medical school generally in their own province and commonly close to their large population centres. Whites can have their choice of applying to five medical schools (Cape Town, Stellenbosch, Bloemfontein, Witwatersrand and Pretoria). Blacks have no choice in the matter at all.

This is a form of discrimination against our would-be African students that can never be offset by the trappings of one fine institution near Pretoria.

It cannot any longer be seriously believed that universities and medical schools in this country will go on indefinitely being racially segregated institutions.

Even those universities that formerly did not wish — of their own accord — to admit Black students, have now expressed their willingness to take in some Black students at the postgraduate level — and in a few instances have indeed done so.

This trend, I predict, will be widespread before the end of the 'seventies and within a decade, it is foreseeable (on an optimistic view) that every higher educational institution in this country will have been moved by the tide of affairs and the changing climate of opinion to open its doors to suitably qualified students of all races.

In the light of this, it seems sadly shortsighted to decree that all African medical students must in the future receive their education at one centre.

The ceiling set for that new school at Garankuwa Hospital has been given by the authorities as 160: it has been estimated by Professor J V O Reid, the Dean of the Durban Medical School, that saturation point will be reached in 1980.

Mr G J Rousseau, Secretary of the Bantu Education Department, has been quoted as saying that it would not be reached before 1983.

Either way, the new school is nowhere sufficient to meet the need for doctors of the large and ever-growing African population.

What are needed as urgent developments are the expansion of the Durban Medical School with provision for an increased intake of African medical students, the re-opening of Wits and Cape Town universities and any others that want free admission of students of all races, and the building of another medical school, which should be open from the beginning to all suitably-qualified comers.

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Hansard 2 2nd Feb 1976 col 38

State/provincial hospitals: Sarlary scales

17. Mr. L. F. WOOD asked the Minister of the Interior:

What are the salary scales laid down for (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) doctors, (ii) dentists and (iii) pharmacists in State and provincial hospital services.

The MINISTER OF THE INTERIOR:

(a) to (d)

(i) Rank

Rank	Salary scale (R per annum) White	Coloured/Indian	Bantu
Specialists			
Professor/Chief Specialist	15 600 (fixed)	13 200 (fixed)	11 250 (fixed)
Principal Specialist	14 400 (fixed)	12 150 (fixed)	10 350 (fixed)
Senior Specialist	13 200 (fixed)	11 250 (fixed)	9 540 (fixed)
Specialist	12 600 (fixed)	10 800 (fixed)	9 180 (fixed)
Government Medical Officers			
Chief Government Medical Officer	13 200 (fixed)	11 250 (fixed)	9 540 (fixed)
Principal Government Medical Officer	12 600 (fixed)	10 800 (fixed)	9 180 (fixed)
Government Medical Officer	7 740 × 360–9 900 × 450–11 700	6 300 × 360–9 900	5 340 × 240-6 300 × 360–8 460
Intern	5 100 (fixed)	4 050 (fixed)	3 300 (fixed)

(ii) Dentists: As in respect of Government and Medical Officers.

(iii) Pharmacists: Rank and salary scale (R per annum).

White	Coloured/Indian	Bantu
Chief Pharmacist 9 900 × 450-11 700	8 100 × 360-9 540	Principal Pharmacist 6 060 × 240-6 300 × 360-7 380
Principal Pharmacist 7 740 × 360–9 540	6 060 × 240–6 300 × 360–7 740	Senior Pharmacist 4 740 × 180–5 100 × 240–5 820
Pharmacist 5 340 × 240-6 300 × 360–7 380	4 380 × 180–5 100 × 240–5 820	Pharmacist 3 450 × 150–4 200 × 180–4 560
—	1 740 × 120–2 700 × 150-3 300	Pharmacist (Unqualified) 1 530 × 90–1 620 × 120–2 700-2 850
—	3 000 (fixed)	Trainee Pharmacist (Male) 2 460 (fixed)
—	2 850 (fixed)	Trainee Pharmacist (Female) 2 340 (fixed)

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Hansard 2

District surgeons

24. Mr. L. F. WOOD asked the Minister of Health:

(1) Whether there is a shortage of district surgeons in the Republic; if so, what is the shortage of (a) full-time and (b) part-time district surgeons in each province;

(2) How many (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) full-time and (ii) part-time district surgeons were employed by the State and undertook their own dispensing in connection with their State services during 1975;

(3) How many patients were treated by district surgeons during 1974;

(4) How many district surgeons are in receipt of a drug allowance.

The MINISTER OF HEALTH:

(1) Yes.
The shortages are as follows.

(a) Full Time:

Cape	16
Transvaal	29
Natal	8
O.F.S.	17
Total	70

(b) Part Time:

Cape	25
Transvaal	14
Natal	1
O.F.S.	7
Total	47

(2) (i)

Full Time	Employed	Own Dispensing
(a) White	136	—
(b) Coloured	—	—
(c) Indian	—	—
(d) Bantu	—	—

(ii)

Part Time	Employed	Own Dispensing
(a) White	341	287
(b) Coloured	1	
(c) Indian	3	2
(d) Bantu	3	2

(3) Patients treated during 1974.

	Patients
Full-time district surgeons	3 960 904
Part-time district surgeons	3 306 444
Total	7 267 348

In the past no statistics were kept in respect of patients who were treated by full-time district surgeons, but since 1974 these figures are also available.

(4) 291.

93

Black medics get less pay

NM 3/2/76

Political Correspondent

CAPE TOWN — Racial discrepancies still exist between the salaries laid down by the Government for medical personnel in South Africa. This was revealed in the House of Assembly yesterday when the Minister of Interior, Dr. C. P. Mulder, replied to a question tabled by Mr. L. F. Wood (U.P. Berea).

A White professor or chief specialist is paid R15 600 a year, whereas his Coloured or Indian counterpart receives R13 200 a year and his Black counterpart R11 250 a year.

Similar racial discrepancies exist in the salaries paid to specialists, dentists, medical officers and pharmacists although they have the same qualifications.

A White Government medical officer, for example can earn up to R11 700 annually, while a Coloured or Indian person in a similar position can earn up to R9 900 and a Black person in the same position up to R8 460.

A Coloured or Indian pharmacist can eventually earn more than the starting salary of a White pharmacist, but a Black pharmacist cannot do so. The White pharmacist begins at R5 340 a year and rises to R7 380 a year, while a Coloured or Indian begins at R4 380 a year rising to R5 820 a year and a Black pharmacist begins at R3 450 and rises to R4 560.

In another question by Mr. Wood, the Minister of Transport Mr. S. L. Muller, revealed that the average annual salary paid to Whites in the South African Railways was R6 097, while Coloureds earned an average of R1 419, Indians R1 524 and Blacks R1 153.

93

Hansard 2 col 84 4/2/76

Medical/dental training institutions

122. Mr. L. F. WOOD asked the Minister of Indian Affairs:

(1) Whether his Department has established or intends to establish medical and dental training institutions; if so, (a) when and (b) where;

(2) (a) to what universities and hospitals will such institutions be attached and (b) for which race groups will training facilities be available;

(3) whether training facilities will be available to Indians residing outside the Republic;

(4) what is the estimated (a) initial cost to establish and (b) annual administrative cost of training facilities for Indian medical and dental students, respectively;

(5) what is the estimated annual (a) intake of medical and dental students and (b) output of graduates in medicine and dentistry at these institutions;

(6) when is it expected that the first such students will (a) graduate and (b) complete their internship.

The MINISTER OF INDIAN AFFAIRS:

(1) Yes, the Department of Indian Affairs intends to establish medical training facilities. No decision has as yet been taken in regard to dental training facilities.

(a) When practically possible.

(b) At Durban.

(2) (a) It will be attached to the University of Durban-Westville. No decision in regard to other institutions has as yet been taken.

(b) Indians.

(3) If and when applications from Indians residing outside the Republic are received, it will in the light of the circumstances be considered on merit. The facilities are in the first instance, however, aimed at providing in the needs of Indian South Africans.

(4) (a) and (b) In view of the fact that no decision has as yet been taken as to how and when the facilities will be provided no figures are available.

(5) (a) and (b) Not available.

(6) (a) and (b) fall away.

93

Hansard 2.

Medical/dental training facilities

121. Mr. L. F. WOOD asked the Minister of Bantu Education:

(1) Whether his Department has established or intends to establish medical and dental training institutions; if so, (a) when and (b) where;

(2) (a) to what universities and hospitals will such institutions be attached and (b) for which race groups will training facilities be available;

(3) whether training facilities will be available to Africans residing outside (a) the Republic and (b) the Bantu homelands;

(4) what is the estimated (a) initial cost to establish and (b) annual administrative cost of training facilities for Bantu medical and dental students, respectively;

(5) what is the estimated annual (a) intake of medical and dental students and (b) output of graduates in medicine and dentistry at these institutions;

(6) when is it expected that the first such students will (a) graduate and (b) complete their internships.

The MINISTER OF BANTU EDUCATION:

(1) It is the intention to establish a university for the training of medical doctors, dentists and veterinary surgeons.

(a) Legislation is now being prepared to provide for the establishment of such a university.

(b) Near Ga-Rankuwa.

(2) (a) The University will be an autonomous institution and the Ga-Rankuwa Hospital will form an integral part of the university.

(b) Blacks.

(3) (a) Yes, applications will be considered on merits.

(b) Yes.

(4) (a) R30 million.

(b) R3 000 per year per medical student and R4 000 per year per dental student.

(5) (a) 200 medical and 50 dental students.

(b) 150 medical doctors as from 1982 and 35 dentists as from 1983.

(6) (a) Medical doctors: 1982. Dentists: 1983

(b) 1983.

Hansard 3 col 154 10/2/76

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Enrolment figures for medical/dental students: Training facilities

120. Mr. L. F. WOOD asked the Minister of National Education:

(1) What are the latest enrolment figures available for each year of study at each university in respect of (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) medical and (ii) dental students;

(2) whether medical training facilities at universities were (a) introduced or (b) extended during the past 10 years; if so, (i) at which universities and (ii) when;

(3) what is the present maximum annual intake of (a) medical and (b) dental students at each university.

The MINISTER OF NATIONAL EDUCATION:

(1) 1975:

(i) Medical

		Year 1	2	3	4	5	6
UOFS	(a)	81	69	51	39	40	—
UP	(a)	200	200	207	187	188	204
US	(a)	186	142	115	83	89	66
UCT	(a)	122	169	152	138	127	127
	(b)	21	12	5	10	11	16
	(c)	6	8	7	8	8	7
UW	(a)	183	172	177	152	127	162
	(b)	5	4	0	0	2	3
	(c)	12	18	28	31	22	25
	(d)	0	5	1	0	1	0
UN	(b)	2	5	6	8	6	5
	(c)	35	67	59	49	34	42
	(d)	43	56	39	35	25	12

(ii) Dental

		1	2	3	4	5	6
UP	(a)	91	72	77	66	56	67
US	(a)	63	36	24	19	17	—
UW	(a)	53	53	40	38	39	47
	(b)	0	0	0	0	2	0
	(c)	2	1	0	5	1	2
	(d)	2	2	3	1	0	1

(2) (a) Yes.

(i) UOFS.

(ii) 1971.

(b) (i) (ii)

(i)	(ii)
UCT	1965-'66 and scheduled for completion in 1976.
US	1965-'66 and scheduled for completion in 1976.
UP	1965-'66 and scheduled for completion in 1976.
UW	1965-'66 and completed in 1972. A new medical school approved in 1972.
UN	1970-'71.

(3)

	(a) Year 1	2	(b) Year 1	2
UP	225	225	80	72
UW	200	200	60	60
US	200	150	70	50
UCT	180	190	—	—
UOFS	80	80	—	—
UN	80	120	—	—

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Medical/dental training facilities

123. Mr. L. F. WOOD asked the Minister of Coloured, Rehoboth and Nama Relations:

(1) Whether his Department has established or intends to establish medical and dental training institutions; if so, (a) when and (b) where;

(2) (a) to what universities and hospitals will such institutions be attached and (b) for which race groups will training facilities be available;

(3) whether training facilities will be available to Coloureds residing outside the Republic;

(4) what is the estimated (a) initial cost to establish and (b) annual administrative cost of training facilities for Coloured medical and dental students, respectively;

(5) what is the estimated annual (a) intake of medical and dental students and (b) output of graduates in medicine and dentistry at these institutions;

(6) when is it expected that the first such students will (a) graduate and (b) complete their internships.

The MINISTER OF COLOURED, REHOBOTH AND NAMA RELATIONS:

(1) Yes.

(a) Medical—Being planned at present.
Dental—1973.

(b) Bellville, Cape.

(2) (a) University of the Western Cape. A training hospital is to be erected and in the meantime accommodation is being rented from the Tygerberg Hospital.

(b) Coloureds.

(3) Yes.

(4) (a) Medical—Not available yet.
Dental—Initial costs spread over three years R2 036 130.

(b) Medical—Not available yet.
Dental—R450 000 p.a.

(5) (a) Medical—Not available yet.
Dental—±22 second year students.

(b) Medical—Not applicable as yet.
Dental—±16.

(6) (a) Medical—Not applicable.
Dental—1978.

(b) Not applicable as yet.

93

Doctors' pay call

14/2/76 NM.

Political Correspondent

CAPE TOWN—A review of doctors' salaries which discriminated on racial grounds was long overdue, Mr. Graham Mills, U.P. MP for Pietermaritzburg North, said yesterday.

He had earlier questioned Dr. Connie Mulder, Minister of the Interior, on whether he intended recommending equal pay for equal work for all State doctors.

Dr. Mulder replied: "The matter is receiving the attention of the Government."

Mr. Mills said that Dr. Mulder seemed to give the impression that changes could be expected.

"There is no doubt that this Nationalist policy of legislated colour discrimination which permeates South Africa is detrimental to our image and acceptance in the Western fold."

Mr. Mills said that he had been heartened by the Pietermaritzburg City Council's decision to equalise pay for Black and White doctors in its Department of Health.

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Action likely on doctors' wage gap

ARGUS 18/2/76

The Argus Political Staff

EQUAL pay for all State doctors was receiving the attention of the Government, the Minister of the Interior, Dr C. P. Mulder, said.

Dr Mulder, who was replying in Parliament to a question by Mr Graham Mills (U.P., Maritzburg North), would not expand on his statement in an interview later.

He said it would be premature to say anything in the country's present financial state, but he said the issue was being considered by the whole Government and not just his department.

Mr Mills said later that Dr Mulder had given the impression that changes could be expected in the disparity in pay between Black and White medical doctors in the service of the State.

'I can only say that such an investigation and review of the policy is well overdue.'

STAR 19/2/76.

93

Black doctor scores a first

Own Correspondent

DURBAN — A senior specialist at the University of Natal's Medical School at King Edward VIII Hospital, Dr Ephraim Mokgokong, has become the first African doctor elected to a local branch council of the South African Medical Association.

He has joined eight other medical men elected to the council of the Natal coastal branch.

Dr Mokgokong was at the centre of a controversy 17 months ago when he was overlooked for a top post at the Medical School.

The job of acting head of the Department of Obstetrics and Gynaecology went to a doctor he had trained through post-graduate studies.

Last December Dr Mokgokong was promoted to deputy head of the department.

He has 14 years' experience including 11 as a senior specialist. Trained at the Natal University Medical School, Dr Mokgokong (42) was the first African lecturer in South Africa to reach the rank of senior lecturer and principal specialist.

The new president of the Natal coastal branch of the Medical Association, Dr Barry Stacey, said he was "absolutely delighted" to have an African doctor on the council.

Last year a senior lecturer at Natal University's Medical School, Dr Y K Seedat, became the first Indian member of the Federal Council of the South African Medical Association.

S. Times. 7/8/76.

Equal pay for doctors is the first hurdle

POLITICAL CORRESPONDENT

EQUAL pay for Black and White doctors will receive top priority when the Government moves to close the wage gap in the public service. Doctors, irrespective of colour, could receive the same salaries — possibly by the end of this year.

This was learnt on reliable authority after the disclosure by the Sunday Times last week that the Government had devised a single key salary scale for all public servants which would eventually eliminate the wage gap.

The introduction of the scheme has been delayed until there is a recovery in the South African economy. Economic conditions at the moment are such that even normal cost-of-living adjustments for public servants have been ruled out.

The key salary scale would cost about R95-million, but to achieve Black-White pay parity within the scheme would cost a further R400-million, the Minister of the Interior, Dr Connie Mulder, revealed this week.

The introduction of a key salary scale would not mean immediate pay parity between the race groups because workers would be locked into it, according to experience as well as education and special qualifications, Dr Mulder said.

It would mean that there would be no discrepancy between the wages of men who shared the identical experience and qualifications.

It had always been the policy of the Government to close the wage gap — but this could not be done overnight. It was dependent on productivity and economic conditions, he said.

It is believed that the Government is looking seriously at the question of equal pay for doctors — a group where the discrepancy is most glaring, and where the cost of parity would not be too high.

Last week Dr Mulder said that the introduction of equal pay would start "at the top" — which would mean that doctors would be the first to benefit.

Factors which are delaying immediate equal pay for Black doctors are believed to be:

- The coming independence of the Transkei.
- Pressure from Blacks in other professions.

The granting of equal pay to Black doctors before the Transkei achieves independence on October 26 could, Government sources said, place the Transkei in the position where it would have to pay "South African salaries".

South African pay rates could be uneconomic for the Transkei, yet it would have to match them. After October, however, the Transkei could draw up pay scales to match its own economy.

93

One doctor serves 24 locations at Bizana

DD. 26/3/76.

There is a shortage of medical practitioners in the Transkei. This was confirmed by the Secretary for Health, Dr D. D. Arbuckle.

He was commenting on complaints by people in the Bizana district.

One black doctor serves the district which has more than 24 locations.

Dr Arbuckle said there was no resident medical practitioner at St Patrick Hospital but there was medical coverage for the vast population.

In the rural clinics patients were examined by sisters who had to decide whether to treat a patient or send it to a doctor.

In more serious cases patients were sent to Greenville Hospital in the same district.

Mr W. T. Damoyi said there were more than 60 nurses at the hospital but there was the problem of the shortage of docters.

He appealed to the Transkei Government for help because of the number of cases in the district.

(1) ~~103~~

(2) 93

93

Only six new black doctors qualify in year

1/5/76 D.D.

HOUSE OF ASSEMBLY — Six blacks out of a total of 693 qualified as doctors in South Africa.

This means that only 0,87 per cent of South Africa's new doctors last year were black. All graduated from the University of Natal.

The information was given yesterday to the Progressive Reform Party MP for Houghton, Mrs Suzman, in a written reply to questions put to the Minister of National Education, Dr Koornhof.

DR KOORNHOF

Other figures given by Dr Koornhof showed that 601 (86,7 per cent) of the new doctors were white, 65 (9,4 per cent) were Asian and 21 (three per cent) were Coloured.

Seventeen of the 21 Coloured doctors graduated at the University of Cape Town and the other four at the University of Natal.

Nineteen Asian doctors graduated at the University of the Witwatersrand, seven at the University of Cape Town and 39 at the University of Natal.

The University of Pretoria produced the largest number of white doctors — 199, the University of the Witwatersrand 170, the University of Cape Town 169 and the University of Stellenbosch 63. — PC.

(i) ~~Education~~ – University

(2) 93

Mercury, Tuesday, May 4, 1976. 13

Wood on Black doctors

NM

CAPE TOWN — The shortage of African doctors in South Africa clearly indicated that training of Africans at the University of Natal's medical school should not be curtailed, Mr. Lawrence Wood (U.P., Berea) said in the Assembly yesterday.

Speaking during the Third Reading Debate on the Medical University of Southern Africa Bill, Mr. Wood said that more than half the estimated 400 African doctors now operating in the country had been trained either at Witwatersrand University, UCT or Natal University.

The Minister of Bantu Education, Mr. M. C. Botha, had claimed that the Cabinet had been considering establishing the new African university for the past 10 years.

"It seems it did not consult with the University of Natal, since the decision not to take more African students at the university from this year was conveyed to the university only in December last year," said Mr. Wood.

This decision was being carried out in spite of the fact that the Minister himself had admitted that the number of African practitioners was completely inadequate. — (Sapa.)

(1) Educatn – Univsy
(2) 93

'Don't shut out Black medics

Profs in protest over all-White plan for school

By DIANA POWELL

TWENTY of South Africa's leading professors of medicine, including Chris Barnard, this week protested strongly against the Government's plan to phase out Black students at the University of Natal Medical School.

Apart from Prof Barnard, the doctors include Prof B. Bromilow-Downing, Dean of the Faculty of Medicine at the University of Cape Town, and 15 heads of departments at UCT Medical School.

The professors are signatories to a letter published in the current Medical Journal in which they urge their colleagues at other universities to support Natal in its attempts to continue admitting Black medical students.

"We view with grave concern the possibility that the Medical Faculty of the University of Natal may be prevented from admitting Black undergraduate medical students from 1977," the letter says.

"We find it difficult to believe that at a time when more Black doctors are urgently needed anyone should act to reduce the potential number of Black medical graduates.

"We do not criticise the establishment of additional facilities, the Faculty of University of South Africa, but we cannot agree that, because of these additional facilities, the Faculty of Medicine at the University of Natal should be closed to Blacks.

"Surely both faculties should be allowed to develop their full potential in view of the acute shortage of Black medical practitioners."

In another letter the Medical Students Council of the University of the Witwatersrand calls on the Government to rescind its decision to close the University of Natal to Blacks, to remove the enforcement of discrimination at medical schools — including Wits — and to remove all discrimination in medical practice.

The appeal to the Government forms part of a resolution taken at a mass meeting of medical students at Wits, the letter says.

93

Call for more Black doctors

STAR 21/5/76.

DURBAN — Annual graduations from the University of Natal's medical school—South Africa's only Black medical faculty — provides just about one African doctor to a million Africans.

In contrast the White output of doctors from medical schools elsewhere in the country provides 110 doctors to a million Whites.

Comparative ratios of doctors to population are one to 400 in the White group, one to 900 in the Indian group and one to 40 000 in the African group.

These are some of the figures contained in an article in the autumn edition of the Natal University News.

There are fewer than 200 trained African doctors in practice throughout the country, the article says.

"The position regarding African medical care is particularly desperate and the establishment of a new medical school for Africans at Ga-Rankuwa is much to be welcomed."

The standard of African education has improved and increasing numbers of Africans have been applying for medical school places.

According to university estimates, there will be 300 well-matriculated Africans looking for medical school places in 1983. The new Ga-Rankuwa school would be able to admit only about 200 second year students.

With the phasing out of the Natal medical school over the next few years, this means that about one-third of these "desperately needed potential doctors," will be lost.

93

DD 16/6/76

Only 400 black doctors in SA 16/6/76

PRETORIA — There are only about 400 black medical doctors, one black dentist and no veterinary surgeons in South Africa at present, according to an editorial in the Department of Bantu Educations's official journal published here yesterday.

Referring to the establishment of a R30 million medical university at the Bophuthatswana town of Ga-Rankuwa, near Pretoria, the editorial points out that there is a ratio of one black doctor to 4 500 possible patients in the Republic. — SAPA.

93

Black doctor sought for a top job

1/7/76 STAR

Science Editor

The first high-level administrative post for a Black doctor in a Transvaal hospital — that of deputy superintendent of Baragwanath Hospital — is being advertised by the Department of Hospital Services.

The advertisement calls for applications from Black, Indian or Coloured doctors.

The incumbent will be one of four deputy superintendents.

The superintendent of Baragwanath, Dr P J Beukes, is delighted with the step.

"I am sure such a man will be able to make a valuable contribution towards good relations and the efficient running of the hospital," he said today.

ADMINISTRATION

"I believe it is essential that we have a non-White doctor in our administrative setup. Even the best White doctors do not entirely understand the Black patients. We have our non-White doctors in the wards already and now we will have one involved in hospital administration."

Dr Beukes said the hospital was merely extending accepted national policy in training non-Whites to work among their own people.

This was being done in all categories of medical and nursing services, and hospital administration was merely an expansion of this trend.

It is understood that the only other hospital administrative post in South Africa being held by a non-White is that of a Coloured superintendent in the Cape.

93

Cape Times 27/7/76

Pay discrimination at hospitals deplored

Staff Reporter

A TOTAL of 196 White medical posts in four large hospitals in the Western Cape had been filled by Coloured, Asian and African Staff, Mr Herbert Hirsch, Progressive Reform Party MPC for Sea Point, said last night.

In a pre-release of a report back speech delivered in Sea Point, Mr Hirsch said existing salary differences between White, Coloured and African medical staff in the Cape were "totally unjustifiable".

The top salary for White medical officers was R11 700, for Coloured and Asian, R9 900, and for African, R8 640.

"What is incredible is that this policy continues although many Coloured, Asian and African medical staff are employed in posts classified for Whites.

"At Groote Schuur, Tygerberg, Red Cross Memorial and Somerset hospitals, a total of 196 White posts were filled by Coloured, Asian and African people, according to a reply in May, 1976 by the MEC in charge of hospital and health services."

Discussing education in the Province, he said the education authorities were "dragging their feet" about introducing subjects such as road safety, environmental conservation and family planning. These should be taught as additional subjects at the appropriate school level.

While acknowledging the necessity for the nuclear power station to be built at Koeberg, Mr Hirsch said some pertinent questions had not been answered. These included the vulnerability of the station to foreign attack and how and where the waste would be stored.

93

Medical fees up 10 pc — backdated

3/8/76 STAR

Pretoria Bureau

The Federated Council of the Medical Association of South Africa has agreed to a 10 percent increase in all fees from July 1.

This increase will affect only the patients of doctors who have contracted out of medical aid schemes.

It will nevertheless have far-reaching effects on the public, as about 14 percent of the country's doctors have contracted out. Neither the Medical Association nor the registrar of Medical Aid Schemes could give the figure for Johannesburg.

The increase comes two years after a fees increase that caused dissatisfaction throughout the country. Dr B M Buchan, president of the Medical Association, claimed today, however, that the new increase is "justified by the rising cost of living."

"NOT BINDING"

The announcement, in the latest issue of the South African Medical Journal, states that the federal council, at its meeting in May, agreed that all fees would be increased by 10 percent from July 1.

Dr. Buchan said this meant that the increases were not binding on doctors.

"Doctors can, of course, charge as little as they like. This latest increase is simply a guide to maximum charges," h? said. "There is nothing to stop them from charging the maximum although few of them do, to my knowledge."

93

16/9/76. nm

Doctors to ask for rise in fees

PRETORIA — The Medical Association of South Africa is to ask the Government to raise the fees of the country's 10 000 medical practitioners.

A spokesman said in Pretoria yesterday that the Association would ask the Minister of Health in November to appoint a remuneration commission to re-assess the statutory tariffs.

The Medical Schemes Act makes provision for a remuneration commission to sit once every three years.

However, an amendment to the Act last year permits the Association to make an interim application for a commission.

The statutory fees were raised last in January 1975.

However, since then doctors' costs, like the costs of all other professions, have risen sharply. It is likely that the claim will be for an increase of at least 20 percent.

The last increases varied from two percent for radiologists to 42 percent for neuro-surgeons.

When the 1975 tariffs were announced there was a strong reaction from doctors who claimed that the increases were unrealistic when matched with the rise in the consumer price index.

Doctors claim that since January 1975 inflation has eroded more than 20 percent of the purchasing power of their earnings.

The fear is that unless the statutory tariffs are raised soon more doctors will opt out of the Medical Schemes Act.

93

Doctor watched patient die

25/11/76
DD

WINDHOEK — A Windhoek doctor, who thought the worst side-effect of his tapeworm treatment would be vomiting, watched his patient die within minutes, a disciplinary committee of the South African Medical and Dental Council heard yesterday.

Relating the events which led to the death of of 15-year-old Elizabeth Freeman two years ago, was Dr P. Poolman, who pleaded guilty to a charge of disgraceful or improper medical conduct here yesterday.

The girl was brought to Dr Poolman by the police after she fell ill in custody.

"I did not examine her," Dr Poolman said. "She looked healthy to me, but from what she told me I gathered her trouble was a tapeworm in the abdomen. I knew our chemist was not there and not wanting to bother him for tablets, I recalled I had seen a sample of quinicrine which I knew was used for the treatment of tapeworm."

Dr Poolman admitted giving the girl an intravenous injection after preparing a solution out of quinicrine in its powder form.

"I thought it was too much for an intravenous injection, but was naive enough to think I could administer it slowly to the patient.

"One minute she was still sitting there, and then she developed extensive spasms. I got her onto the examination table, but by then there was no breathing or pulse. All my efforts to revive her were in vain. At that stage not even specialised help could have saved her, he said.

Two other doctors appeared at the same hearing charged with disgraceful or improper medical conduct arising from an incident three years ago when a woman sustained extensive brain injuries after falling off an operating table after a back operation.

The woman, Mrs M. A. Viljoen, died last year.

Dr R. Nilssen was charged with failing to supervise the removal of the patient from the operating table and his colleague, anaesthetist Dr C. Crohin with cutting bandages or plasters by which Mrs Viljoen was tied to the operating table.

The case continues. — DDC.

93 Star 22/12/76

Medical aid fees up 25 pc?

Doctors in pay move

The Medical Association of South Africa is expected to seek increases of up to 25 percent in medical aid fees early next year.

The association is to ask the Minister of Health next month to set up a remuneration commission to review doctors' fees under the Medical Schemes Act.

Dr Elset Prinsloo, assistant secretary of the association, said today it was hoped the commission would sit by March.

The percentage increase to be requested by the association had not been determined, she said.

Reasonable

The chairman of the Association of Medical Schemes, Mr J D Erntzen, said today the doctors' request was "not unreasonable."

"Their first increase became effective in January 1975 and if their request is granted, it will become effective only towards the end of 1977.

"This means it will be their first increase in three years."

Mr Erntzen could not say how the increase, it it is approved by the remuneration commission, would affect the 3 500 000 medical aid members.

Higher fees

"It is possible that medical schemes would be forced to increase their subscription charges," he said.

Mr Erntzen said doctors who had contracted out of medical aid schemes could be expected to increase their fees in the light of the commission's findings.

At the moment, most doctors not incorporated in medical aid schemes are charging about 50 percent more than those who are contracted.

● The Dental Association has not applied for the setting up of a remuneration commission and

Reasonable

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Higher fees

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Doctors want fee review

28/12/76

JOHANNESBURG. – The assistant secretary of the Medical Association of South Africa, Dr Elset Prinsloo, said here yesterday that the association would ask the Minister of Health next month to set up a remuneration commission to review doctors' fees under the Medical Schemes Act.

She said it was hoped the commission would sit early in March.

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93

Doctors asked to aid equal pay fund

Cape Times 25/12/76

Staff Reporter

A NUMBER of local doctors connected with the University of Cape Town medical school are to be sent a letter requesting them to contribute to a fund which will help to even out the disparity between their salaries and those of their Black colleagues.

The letter will be a sequel to an appeal made by the class representative of the 1976 medical graduates at their oath-taking ceremony.

In his address, the class representative said everyone agreed that the system of paying Black and White doctors different salaries for the same qualifications was wrong. He felt the whole medical profession could rectify the situation by contributing the salary differences to a fund.

On a previous occasion UCT medical graduates took part in such a pay-levelling scheme.

The representative said last night he had had a response from six housemen so far. Soon, however, a letter restating his proposals would be sent to members of the 1976 graduating class as well as to other medical men connected to the medical school.

93

Doctors draw up list for higher prices

RDM 6/12/76

By ARTHUR ROSE

DOCTORS are drawing up a new price list for all types of medical treatment which will put up medical aid contributions next year.

Their price list will determine, in detail, what medical aid societies will pay for treatments — from simple consultations and injections to major heart operations.

The chairman of the Association of Medical Schemes, Mr J. D. Ernstzen, said yesterday that monthly medical aid payments would have to be increased. But it was impossible to say by how much.

The Medical Association is to ask the Minister of Health for a remuneration commisison to review doctors' fees next month and in the meantime it has engaged a team of accountants and economists to help draw up a complete list.

"We realise that fees will have to go up," Mr Ernstzen explained. "But the association and the Government are leaving it to the medical profession to divide the slices of the cake between them."

They were drawing up a list in which each type of treatment would be given points on a scale from one to 100. A tonsil operation may be given 10 points, for instance, and a heart operation 90 points.

"It will then be for the commission to decide only how many rands a point is worth on the scale. For the first time it will not have to go into each branch of medicine separately."

The medical aid societies would be represented at the commission, which is to sit before the end of March.

"We will try to keep fees at a level the public can afford," he said. "But it is in our interests to see that the tariffs are fair to the doctors as well."

Many doctors had opted out of the tariff agreement because fees were set too low and they were charging more than double the agreed price.

Medical aid societies could only pay the agreed fee and this meant members often had to pay large amounts themselves.

93

SAMA is undecided on birdshot probe

RDM 29/12/76

Staff Reporter

THE South African Medical Association (Sama) has not decided whether to ask the Minister of Justice, Mr Jimmy Kruger, to investigate reports that children were allegedly blinded by police birdshot pellets during the riots.

Dr Jonathan Gluckman, the spokesman for the Southern Transvaal branch of the association, was reported in a Sunday newspaper as saying the association had established there had been cases of birdshot blindings. The matter would be referred to the national body, Dr Gluckman said.

Last night, the general secretary for the association, Dr C. E. M. Viljoen, said details of Dr Gluckman's investigations had not been sent to his office and the matter had not been discussed.

"Whether the association will formally ask the Minister to investigate, I cannot say," Dr Viljoen said.

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Pessimism causes doctors to quit S.A.

NM 2/1/77

Mercury Correspondent

JOHANNESBURG — Lack of confidence in a peaceful solution to South Africa's political problems is believed to be the cause of the present mass exodus of doctors from the country.

Large groups of doctors — including a couple of hundred who have organised a block booking on a plane — will fly to the United States this week to beat the January 9 deadline for them to practise there.

Many of them — including the head of the Department of Radiology at the Johannesburg General Hospital — will register in the United States and then return to South Africa until later this year.

OPPORTUNITIES

In the past, doctors have furthered their studies in the States and Britain because opportunities in South Africa are limited, but most of them have returned to this country.

Because of the unrest since June last year and the bleak political outlook, it is doubtful whether those leaving to study will return. Doctors feel that much depends on the state of the country in the future.

Most of those leaving are younger doctors who fear for the future of the country.

Exodus of SA doctors to the US

Cape Times 7/1/77

Own Correspondent

JOHANNESBURG. – The USA has "severely depleted" the number of South African doctors, says the United States consul in Johannesburg, Mr J Segars.

In Cape Town 66 doctors had been granted immigration visas since November, the US consul general, Mr Ray White, said.

About half would return to South Africa after "clocking in" before the January 9 deadline for doctors to enter the United States on immigration visas. They would emigrate later during the year.

An official at the US consulate in Durban said about 50 doctors had been granted immigration visas but 20 had changed their minds, leaving about 30 emigrating.

Overtime

Staff at the consulate in Johannesburg have been working overtime at weekends for the past fortnight to cope with the flood of applications for visas, mainly from doctors hoping to meet the deadline.

Mr Segars would not disclose an exact number but it is estimated that 130 immigration visas have been granted to doctors in Johannesburg, with more in the pipeline.

"We have severely depleted your doctors and I hope they are good doctors because many American citizens will be dependent on their care," Mr Segars said.

Travel agents said doctors had been flying out of the country in groups on airlines this week, with more leaving tonight and tomorrow.

Disbelief about a peaceful solution to South Africa's political problems and the bleak outlook since the June unrest were cited by two doctors at Johannesburg's General Hospital as main reasons for the medical migration. Both are leaving the country permanently.

Mr White said that whereas 100 immigration visas were usually granted to people from various professions in the Cape every year, in the past couple of months 110 had been granted, bringing last year's figure to 300.

Professorships

Doctors fear that a stricter medical exam may prevent them from working in the United States after the deadline.

Dr Jonathan Gluckman, spokesman for the Southern Transvaal branch of the Medical Association, said the association had no means of knowing how many doctors were leaving.

"I know a handful of quite senior people leaving, some to take up professorships, others because of the political situation. Younger doctors are going mainly because they are concerned about the future in this country.

"My impression is that an abnormal number of doctors are leaving. It is bound to affect medical services adversely in the future. It is very worrying and I am concerned. I think the Government should know how many doctors are leaving."

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ARGUS 10/1/77

Minister calls for probe on doctor exodus

The Argus Political Staff

THE Minister of Health, Dr S. W. van der Merwe, has instructed his department to investigate allegations of a large-scale 'exodus' of doctors from South Africa.

This was confirmed today by a spokesman at the Minister's office.

The spokesman said no further information was available as the Minister was away on holiday.

Dr van der Merwe was quoted by the Afrikaans Sunday newspaper Rapport yesterday as saying he regarded the issue of doctors leaving South Africa as having been exaggerated.

There were many reasons why people went overseas.

The Minister was quoted as saying that he had confidence in the medical profession and did not believe that doctors were leaving the country because of imagined or real dangers.

RELIABLE FIGURES

As no reliable emigration figures for doctors were available, an analysis would be made of applications for visas to determine how many doctors had left the country.

Various Press reports about an 'exodus' of doctors have been published in recent months. Some individual doctors who said they were leaving have been quoted as saying they were doing so for political reasons.

One report, publisehd in a Sunday newspaper in September last year, said more than 100 South African doctors, including specialists, were planning to leave the country.

A SURVEY

On the other hand it has been said that South Africa's medical 'brain gain' was bigger than its 'brain drain.'

A survey showed that between 1970 and 1975 South Africa gained two foreign medical graduates for every one it lost.

A spokesman for the Southern Transvaal branch of the Medical Association of South Africa has been reported as saying his impression was that an abnormal number of doctors were leaving.

But Dr J. Gilliland, co-ordinating director of Health Services, has rejected reports of a medical 'brain drain.' He said it was normal procedure for doctors to train and to work overseas to gain experience, and then to return.

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Doctor exodus report is due

Pretoria Bureau

A Department of Health investigation into reports that doctors are emigrating from South Africa in large numbers should be completed this week.

Dr James Gilliland, Under Secretary of the Department of Health said today that a clear assessment of the rumours of a mass doctor exodus was not expected because statistics, supplied by the Department of the Interior, could not easily distinguish between doctors leaving the country for holidays or study and those emigrating.

The Department of Health had experienced no outflow of doctors, which convinced him there was no such exodus, he said.

FAITH

The Minister of Health, Dr van der Merwe, was not available for comment today but his office in Cape Town said it was hoped he would issue a statement following the receipt of the inquiry's report.

On Sunday Dr van der Merwe was reported as saying that indications were there was no exodus of doctors.

He said he had sufficient faith in the medical profession to believe members would not flee the country in the face of supposed or real dangers.

The country did not need those who might leave out of fear.

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RDM 10/1/77

Fear drives White doctors from Soweto

By MIKE LOUW

LAST YEAR'S unrest in Soweto has caused an acute shortage of White doctors in the area. Most have resigned from their health service jobs or given up their practices, because they fear for their safety.

Dr P. J. Beukes, superintendent of Baragwanath Hospital, is negotiating with a number of doctors to treat patients at Soweto clinics.

All clinics in Soweto have been working on reduced staff since the disturbances. Only maternity cases have been attended to.

All other cases have been treated at Baragwanath Hospital, which was working under heavy pressure.

The hospital has started a training scheme for senior nurses. After qualifying they will be posted to the clinics and do some of the work previously done by doctors.

Dr Beukes said Diepkloof Clinic will start treating children up to the age of 10 from today in addition to maternity cases. He hoped to have all clinics functioning fully soon.

Many outpatients now being treated at Baragwanath found it hard to pay taxi fares to the hospitals.

The Mayor of Soweto, Mr David Thebahali said he was delighted that the health service might soon be fully restored. He would ask all Black doctors who have private practices in Soweto to spend a few hours a day at the clinics."

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Fly-away doctors back

Johannesburg's "fly-away" doctors are flying back again already.

Many of the estimated 200 medical men who left last week for the United States simply wanted to fulfil that country's immigration and professional requirements by registering with US immigration authorities by January 9.

Less than a week later, some of them have returned to Johannesburg, having met the deadline for doctors wishing to practise in America sometime in the future.

According to one private hospital, their doctors were away for only five days.

"They have clocked in and clocked out," said a spokesman.

Dr John McMurdo, superintendent of the Johannesburg General Hospital, said the fly-away doctors were not having any effect on his services.

He understood that some doctors who were at present on leave had gone over to America.

"I am not concerned about it, though I do not quite yet know what all this means."

A large removal company which specialises in overseas shifts said it had experienced a significant increase in business over the last six months covering a cross-section of South African society. But another company said it had had no recent boom in business.

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No doctor exodus, says health man

RDM 10/1/77

Staff Reporter

THE Department of Health is investigating reports of an exodus of South African doctors, although there have been no indications that this is an outflow.

Confirming this yesterday, Dr James Gilliland, deputy secretary for Health, said there had been no exodus of doctors from the Department of Health.

Dr Gilliland said that medicine was very international and there was a continual ebb and flow of doctors between countries.

"More often than not, [we are on the re]ceiving end with hundreds of overseas doctors coming here for experience.

There had definitely been an upsurge lately with doctors from South Africa flying to the United States to beat that country's deadline for examination entries.

"But that upsurge has been taken out of context. Who is to say that these men have no intention of returning?" Dr Gilliland said.

Richard Walker in New York reports that a last-minute, one-year reprieve on the curb on South African doctors going to the US is expected to be announced.

The tight new restric[ti]on on the immigration [o]f foreign physicians is to [c]ome into force on Mon[d]ay.

US hospital authorities [h]ave reacted with alarm [a]nd warned the impact [w]ould be "devastating". In [N]ew York, where 52 per[c]ent of hospital staff are [f]oreign-trained, a senior [h]ealth official predicted [t]hat "patients are surely [g]oing to die."

Dr Theodore Cooper, Assistant Secretary for Health at the Department of Health, Education and Welfare, has announced he was recommending dropping the restrictions "this year only".

But he cautioned that a four-year phase-out of foreign recruitment was still the goal.

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ANGEL OF LIFE

THEY call her "Nkoskasi"—mother of our children — and to her 40 000 patients at the Thornhill refugee camp in the Ciskei Dr Barbara Seidler is the angel of life in the disease-ridden hell-hole they call home.

"We call her that because she is like Mother Mary to us. She is the only one who is trying to save us and our children from dying," one of the refugee women told me this week.

The woman fled to Thornhill from Transkei late last year.

Dr Seidler, 42, blonde, and always desperately tired, is the only doctor at the vast refugee camp, South Africa's Lady with the Lamp.

Assisted by a team of 24 black nursing sisters, she has immunised more than 10 000 refugees against tyhphoid and measles during the past week.

At the same time she has fought for more than 18 hours a day to save thousands of babies from death through malnutrition, dehydration and gastro-enteritis.

And now, with that battle nearing the beginning of the end, she is facing the onslaught of a measles epidemic.

I watched her for one day this week at the crumbling old farmhouse where she has set up an emergency treatment centre for the camp.

'Office'

There is almost no furniture in the old house, and patients who turn up in their hundreds, long before dawn, sit patiently on the floor or in the dust outside.

Dr Seidler's "office". where the only phone in the area is installed, is a corner of what was once the lounge.

She hunches on the floor as she pleads with the authorities for drugs and food and portable toilets and water carts and an unending list of essentials which could mean the difference between life and death for many thousands.

But most of the time she is flitting from one room to the next.

- Checking on the progress of a woman in labour.
- Examining the drips attached to the veins in the heads of up to 10 babies at a time.
- Or making a snap diagnosis among the long queues waiting in the dust sending the most urgent cases to the front of the line.

The centre has no electricity and Dr Seidler's day starts before seven in the morning when she collects her drugs from the cold storage rooms of a dairy more than 40 km from the refugee camp.

When she arrives at the centre there is a loud murmuring of welcome from the waiting crowd, most of them women with babies on their backs.

And, desperately busy as she is, Dr Seidler has a moment to smile and talk encouragingly to each one, particularly the children, whom she soothes in Xhosa.

As soon as she has seen to the bulk of the patients and attached the drips to the children, she slips away for a few hours.

Accompanied by a translator, she drives her little white car across the veld stopping every few hundred yards to summon the people in the area with loud blasts on the hooter.

Then, with the aid of a portable loudspeaker, she pleads with the mothers to bring their children to the centre for treatment.

I listened as she tried to explain, time and again, that one injection or one course of tablets was not enough to cure the children; that the mothers had to bring them back for repeat visits so that they could be properly cured.

As long as the daylight lasts she is busy with her patients. When they eventually carry their infants home in the dark she tries to catch up with administration.

Then she draws pictures on child care and breast feeding which are pasted on the wall in the so-called waiting room, so that while the mothers are awaiting for their children to be seen to they can be taught the essentials of child care and hygiene by members of her nursing staff.

After announcing in a newspaper interview last week that four to five babies were dying at Thornhill each day, mainly from gastro-enteritis and malnutrition, Dr Seidler, who is employed by the Ciskei Government was banned from speaking to the Press by the Minister of Health, Mr L F. Siyo.

Report and picture by Nic van Oudtshoorn

'They're losing control'

16/1/83 ST

THE Ciskei Minister of the Interior, Mr S. Siyo, is expected to the area urgently to attempt camp soon because of reports to his Government that the tribal chiefs are losing control over the 40 000 people in the camp.

Late on Friday the Chief Minister of the Ciskei, Mr Lennox Sebe, was told that the three chiefs ruling the camp had lost the support of up to half of the people.

It is understood that officials at the camp suggested to Mr Sebe that he send Mr Siyo to the area urgently.

Measles could wipe out the children like flies

A MEASLES epidemic which could "kill children like flies" is feared by medical authorities associated with the refugee camp at Thornhill, in the Ciskei, where about 40 000 people are living in tents and tin shanties in the veld.

A ban on Press statements by medical personnel on the spot has been imposed by the Ciskei Government, but I was told reliably on Friday that the situation was very grave.

It is feared that if measles strikes on a large scale the area may have to be sealed off to prevent the disease spreading to neighbouring areas.

"Most of the children are so weak from malnutrition — near starvation in fact — and dehydration that they do not have a great hope of recovering from diseases such as measles," I was told.

"What we fear most now is that our inoculation programme may not have been started in time — and many people have still not been inoculated."

Officials also feel that the delivery of vital food should be speeded up to improve the general health of the refugees, and to enable them to build up enough resistance against disease.

"In the condition that they are now they do not have a hope," one worried official said.

Equal pay for ← all doctors likely

ARGUS 19/1/77

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The Argus Correspondent

JOHANNESBURG. — South Africa's health authorities are expected to abolish racial discrimination in their salary structure for full-time doctors soon, probably this year.

The general secretary of the Medical Association of South Africa, Dr Marais Viljoen, said today the association had every hope that this issue, for which South Africa had been repeatedly criticised by the medical profession overseas, would be resolved soon.

'We have reason to believe that the matter is receiving the serious attention of the authorities,' Dr Viljoen said. 'We trust that the justice of our case is fully appreciated.

EXPERIENCE

'It has always been our policy that salaries for doctors should be based entirely on qualifications, experience and service rendered — not on colour and race.'

The Government and the provinces closed the gap to some extent when the salaries of White doctors were increased last year by 10 percent, those of Coloured and Asian doctors by 15 percent and those of Black doctors by 20 percent.

UP TO 90 PERCENT

In broad terms, this means that whereas Coloured and Asian doctors previously received about 85 percent of the salary of a White doctor in the same category, they now get up to 90 percent.

Previously, Black doctors received about 72 percent of the salary of Whites. Now the percentage has been increased to about 79 percent.

Recently, both the Minister of the Interior, Dr C. P. Mulder, and the Minister of Health, Dr Schalk van der Merwe, have indicated that the ultimate aim is equal salaries for all doctors, irrespective of race.

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Cape Times 20/1/77

Doctors expect equal pay soon

PRETORIA. – South Africa's health authorities are expected to abolish racial discrimination shortly in their salary structures for full-time doctors.

The general secretary of the Medical Association of South Africa, Dr Marais Viljoen, said yesterday he had every hope the issue would be resolved soon.

"We have reason to believe the matter is receiving the serious attention of the authorities. We trust the justice of our case is fully appreciated," he said.

The Government and the provincial administrations narrowed the gap when the salaries of White doctors were increased last year by 10 percent, those of Coloured and Asian doctors by 15 percent and Blacks by 20 percent.

This means that at present Asian and Coloured doctors get up to 90 percent and Black doctors about 79 percent of the salary of a White doctor in the same category. – Sapa

Doctors hit wrong dept

13/11/73 Star

Science Editor

The State Health Department is under fire from doctors for making disparaging remarks about the medical profession — and it is entirely innocent.

The statement came from another department.

Two weeks ago The Star published a report on the expected increase in fees for medical aid patients.

A "leading medical authority for the State" was quoted as saying that doctors did not deserve an increase.

"The Hippocratic Oath is a thing of the past. Try to get a doctor after midnight and see what response you get," he said.

Dr James Gilliland, co-ordinating director of health services for the department, said:

"Letters are appearing in the Press from irate doctors attacking the department for making such a statement.

"Others telephone us to object. But we did nothing. This statement did not emanate from anyone in this department."

Dr Gilliland is correct.

In the original report the word "State" slipped in by mistake. The words were used by a prominent medical authority outside State employ, but one in an official post.

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Equal pay for doctors coming

Star 19/1/77

Marais Malan, Science Editor

South Africa's health authorities are expected to abolish racial discrimination shortly in their salary structures for full-time doctors, probably even this year.

The general secretary of the Medical Association of South Africa, Dr Marais Viljoen, said today the association had every hope that this contentious issue, for which South Africa had been repeatedly criticised by the medical profession overseas, would be resolved soon.

For the past 10 years the association has been urging the Government to do away with discriminatory salaries for medical full-timers.

"We have reason to believe the matter is receiving the serious attention of the authorities," Dr Viljoen said. "We trust the justice of our case is fully appreciated."

The Government and the provinces partly closed the gap when the salaries of white doctors were increased last year by 10 percent, those of coloureds and Asians by 15 percent, and blacks by 20 percent.

In broad terms, this means that where coloured and Asian doctors previously received about 85 percent of the salary of a white doctor in the same category, they now get up to 90 percent.

The Minister of the Interior, Dr Connie Mulder, and the Minister of Health, Dr Schalk van der Merwe, have indicated that the ultimate aim is equal salaries for all doctors, irrespective of race.

93, 131

STUDY STAFF NEEDS SAYS DOCTOR

Mercury Reporter

A DURBAN medical practitioner, Dr. Stephen Thomas, yesterday advised businessmen to pay more attention to the needs and ailments of their African staff.

Dr. Thomas, who spent 25 years attending to sick Africans in the rural areas before moving to Durban, said Africans had a traditional fear of the supernatural and were strongly under the influence of their witch-doctors.

These attitudes should be taken into account by employers who had their well-being at heart.

"An African man reigns supreme in his kraal. Even if he is the office messenger don't let the girl on the front counter order him to fetch her a meat pie. They are men and must have the respect they are entitled to," said Dr. Thomas.

Other do's and don'ts were:

Address him by his surname; shake hands with him on his first day at the office; sit down with him and talk to him; give and receive only with the right hand — it is disrespectful to use the other; if you are drinking with him at his home let him drink first; if he needs two weeks off to go home and plough give him unpaid leave; don't let a junior clerk handle his workman's compensation claim if he is injured on duty. Make sure he is attended to promptly.

Dr. Thomas said many people thought African causes and cures for sickness very funny, but he reminded guests attending a Chartered Institute of Secretaries' luncheon that some notions and misconceptions Whites had about diseases were equally laughable.

RDM 27/1/71

375 Zm 98

Doctor refused to do autopsy on detainee

By MIKE DUTFIELD

AN independent pathologist, commissioned by the family of a dead detainee, refused to perform the post mortem when he fou..d major incisions had already made in the body.

Dr Jonathan Gluckman was commissioned by the fa. ly of Dr Nabaoth Ntshuntsha, who was said by polic. .o have hanged himself .n a police cell at Leslie on January 9.

Dr Gl.ckman was asked to represent the family at the post mor..m but decli.ed to take .art in the autopsy when the body w.. found to have been cut already by a mortuary attendant policeman.

Dr G uckman said yesterday .e had been appalled to learn that the incisions had been carried out by the attendant, entirely on his own, without a doctor being present.

"This is contrary to all recognised conduct in mortuaries and infinitely more so in cases of unnatural death. In a lifetime of practising pathology I have never heard of such a practice," Dr Cluckman said.

The body of Dr Ntshuntsha had a major incision from the throat to the groin, and another from ear to ear across the top of the skull.

Dr Gluckman yesterday listed his reasons for declining to perform the au.opsy as being:

- Any interference of such a nature might well have altered appearances in the regions of the incisions;
- The top of the main incision was such as to make impossible the special dissection of the neck which is mandatory in cases of this nature;
- Dr Gluckman was in no position to know the exact nature of the incisions, not having been present.

"It was therefore impossible for me to carry out a thorough and complete examination and rather than give an incomplete report, I declined to take any part in the di..ection.

"Any conclusions I might have drawn would have been based on features which may have been ma.ked and wou'd therefore be unreliable," Dr Gluckman said.

Dr Gluckman said that when he first saw the body of Dr Ntshuntsha the mortuary attendant from Springs, where the body was first take., was present.

This week Mrs Helen Suzman, MP for Houghton, asked the Minister of Police, Mr Kruger, in Parliament about rumours that mourtuary staff had made an incision in Dr Ntshuntsha's body before the post mortem examination.

Mr Kruger replied that an incision ha. been made. "Initial investigation indicate the incision was done without expilict authority following a practice that has apparently developed in some mortuaries," Mr Kruger said.

...a Hutmacher

...NDON — The ... thereafter ...hiding impres... ...ts of Dr Bar... ...ler is her ex... ...y capacity for

...ks she was the ...r at the con... ...refugee camp at ... near Queen...

... herself also ... controversial ... a tug-o-war ...e Ciskei Chief ...r L. Sebe and ...rican govern... ...h officials.

...nd stem the ... illness that ...er arrival at ..., Dr Seidler ... hours a day in a makeshift clinic set up in the old, bare farmhouse.

The slim, blue-eyed blonde woman, about 5ft. 6inches in height is assisted by a team of 24 black nursing sisters. She reportedly fled from Transkei last year and since then has been employed by the Ciskei government. In December she was at Mdantsane Hospital where she supervised the setting up of a house to house health education campaign.

A member of the staff at the East London hotel where Dr Seidler lived said she was "from overseas" and had been "adamant that nothing be said concerning her." She said Dr Seidler had moved out of other local accommodations because "she had been hounded." In spite of Dr Seidler's orders that she would not see anyone, the hotel spokesman describes the doctor as "very sweet."

Dr. J. Klopper, assistant Secretary of Health in the Ciskei, said: "She's done a magnificent job. Without her efforts we'd have been in a real mess."

Dr Klopper described Dr Seidler as a "tremendously dedicated" woman with "the interests of her patients at heart." He said: "She works under tremendous pressure. Praise is unstinting from me personally and from our office. Professionally I have the highest regard for her."

Dee Kallaway, reporter for the Queenstown newspaper said she had met Dr Seidler on two occasions. She describes her as approachable, nice-looking but "not your usual chocolate-box face."

"The first time I met her," said Miss Kallaway, "she spotted me and came pushing through a crowd of blacks towards me. She said: 'Come with me and I'll show you the sort of thing that's going on here'."

In Queenstown she rose before six, took breakfast in a parcel from her hotel, drove off in her ambulance — her only transport — via the local creamery where she drew each day's refrigerated supply of drugs from storage the creamery made available.

If she did return for dinner, it was in time only to take a wash in her bedroom, change clothing and come down to eat and then read.

Thereafter it was back to her room to make the drawings needed to demonstrate graphically to illiterate mothers how to feed their babies and the proper foods.

Dr Barbara Seidler checks a patient in the clinic at Thornhill.

TELEVISION

6.00: KONSERTSAAL: marionette friends from Civic Theatre entertain th...

6.10: KRAAINES- programme present... Keuzenkamp.

6.35: SPORTFOKUS: —

7.00: VERSLAG: — In... news.

7.25: DOKTER, DOKT... Danny Totsiens.

8.05: DIE NUUS.

8.27: BOEKEVAT.

8.30: SPECTRUM: — ... programme.

9.00: TELETIME: ... petition.

9.02: MANHUNTER: Barrett, played by Ken Ho... vestigator criss-crossing th... Bonnie and Clyde era of bring dangerous criminal Death watch.

9.57: GALAXY: — Arts

10.22: GOOD VIBR...

... on January 7.

#93, 95

27/1/77 NM

At death's door

THE EXPERIENCES of nearly 2 000 doctors and nurses who between them were present at the deathbeds of about 50 000 people in the U.S. and India are the subject matter of a five-year survey entitled At The Hour Of Death, which is due to be published shortly.

The authors of the survey, Dr. Karlis Osis and Dr. Erlendur Haraldsson, conclude that the experience of dying is basically the same, regardless of culture, race, education, sex or what one believes in.

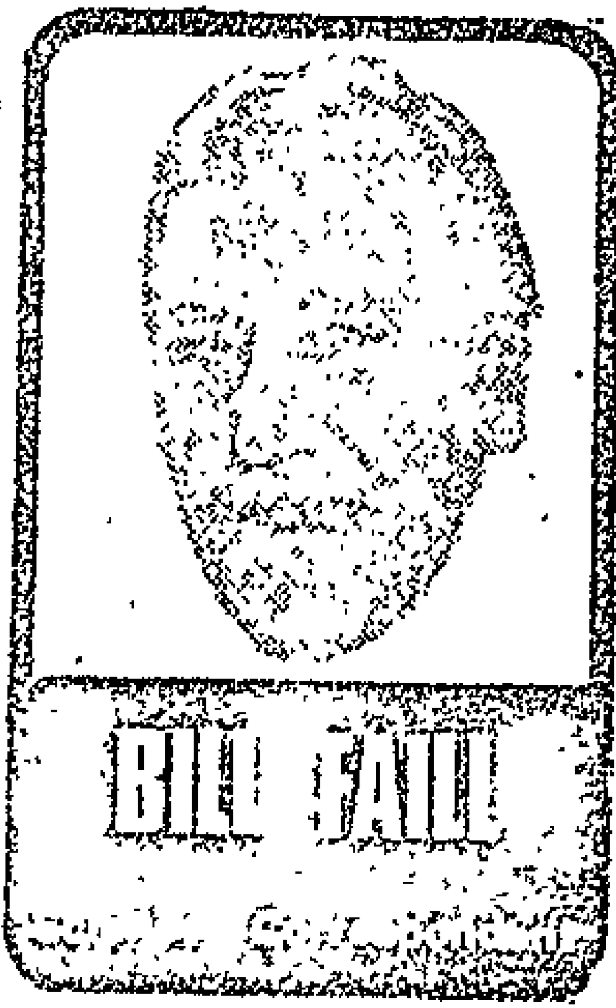
Far from being a mere submergence into unconsciousness, there were similarities in the vast majority of cases that indicated survival of death and a definite social structure to the afterlife.

The present study is a follow-up to one published in 1960 by Dr. Osis. Called Deathbed Observations By Physicians And Nurses, it was considered a classic in its field but was limited to the experiences of Americans.

"We wanted to see if dying people in another culture, with different religious beliefs, had similar experiences to those observed in the American study," said Osis in a recent interview.

The experiences reported from both sides of the world were similar and were made up of a number of distinct features.

In many cases the patients became happier just when the doctor was saying the end was nigh. They died with feelings of serenity and peace but the mood change was not due to medication, sedation, lack of oxygen to the brain or the nature of the illness.



BILL FAIRE

Another characteristic was the appearance of visions, in which the dying saw dead relatives and friends coming to aid their passing into the next world.

The apparitions were invariably invisible to the others present at the deathbed and the doctors and nurses knew about them only because the patient talked about what he saw. That they might be real happenings rather than hallucinations resulting from wishful thinking was indicated by the fact that, usually much to their surprise, they were seen by people who did not expect to die but subsequently did die shortly afterwards.

A third feature was that the dying patient saw his immediate surroundings as if it was another place, a different reality. Usually it was a beautiful landscape.

"The hell - and - brimstone sort of place with devils carrying pitchforks simply didn't appear," said Dr. Osis in the interview.

One difference did show up between the Indians and the Americans — 18 percent of the former felt very upset.

"They had fearful visions and didn't want to go. It was as if soldiers came to take prisoners — a real fear reaction."

The general conclusion that the scientists drew was that their research did not clinch the answer to the problem of life after death. But it did show that the information from the dying was consistent with the idea of survival.

Up to now, they note, most of this information has come from mediums, psychically - gifted people. The new survey tends to confirm much of the picture gained through mediumship.

Exit at the top

SENIOR MEDICAL MEN QUIT SA — FOR GOOD

By HEATHER McGHEE

A NUMBER of senior medical specialists in Johannesburg plan to leave South Africa for good.

Dr Jonathan Gluckman, spokesman for the Southern Transvaal branch of the Medical Association of South Africa, said this week that the departure of these "doctors of quality" was a serious loss both to the Johannesburg and the South African medical scene.

"That young GPs and specialists have left and are going is not all that serious," he said. "There has always been a flow of young doctors to and from countries.

"But we do not know whether greater numbers have left since the urban unrest than is normal.

Deprive

"The departing senior men that I know of will deprive us of specialists in fields like anaesthetics and radiology; fields where we are already short of specialists."

Dr Gluckman said he knew of the following who, if they had not already left the country, were about to go: five radiologists, nine anaesthetists, seven pathologists, three senior physicians and a number of surgeons.

"Altogether there are 21 men of quality, including two university professors, who are forsaking the Johannesburg medical scene for other countries. And I think this is a serious situation."

He believed that many doctors who had left for countries like America and Australia were going to have a fairly hard life unless they were "very special" and at the top of their profession.

Dr J. GLUCKMAN
Serious situation

"Many of the doctors who have rushed off to America may end up working in a hospital," he said.

"I am not saying that South African doctors are not hard working, but in America the demands are greater.

"I know that many doctors in American hospitals begin work at eight in the morning and finish at midnight. Their pay is less, too."

Dr Gluckman said that Australia was a popular alternative for doctors who failed to get into America.

Less pay

One of 21 senior specialists leaving soon said his decision to leave was an "agonising" one.

He was 40 and the first time in [illegible] life was financially successful. He was also able to work with really top specialists.

"And I am giving all this up. My pay in Australia will be a third less than I am earning here. But I am doing so for the sake of my four children."

He decided to go after the Angola civil war.

Dr David Kritchevsky, top United States scientist, who is doing research in close collaboration with scientists at the South African Institute for Medical Research in Johannesburg.

'Don't be a martyr to your diet'

Science Editor

What should you eat, or not eat, to prevent your arteries from clogging up and possibly causing your early demise from a coronary heart attack or stroke?

"Don't be a martyr to diet — eat a well balanced diet but in moderation. At the present stage of our knowledge, this is my advice to the public," says Dr David Kritchevsky, of Wistar Institute of Biology, Philadelphia, USA.

CHEAPER

And he should know, for since the late 1960s he has been shuttling backwards and forwards between Johannesburg and the United States to see his "patients" whose arteries he has been doing his best to silt up by feeding them different — and hopefully wrong — diets.

The "patients" — a troop of baboons and vervet monkeys.

Dr Kritchevsky is doing the research in association with his colleagues at the South African Institute for Medical Research headed by Professor Dennis Mendelsohn, the chemical pathologist.

Why research at long-range?

"It's cheaper for me and my staff to travel regularly to South Africa than to export animals to the States. Besides, the climate is better for the animals here and the local people know how to handle them.

"In addition, I have full confidence in the ability and judgment of my colleagues here. In this institute you have a facility which is difficult to duplicate anywhere in the world."

The overall aim of the project is to determine the role of diet as a cause of atherosclerosis — narrowing and hardening of the arteries which has become virtually an epidemic in affluent Western populations.

Because humans cannot be used experimentally, animals have to suffice. And because the metabolism of primates is so close to that of man, these animals, particularly vervet monkeys, have been chosen.

For about a year different groups of animals are fed controlled balanced diets. But each group gets in addition a type of food not present in their normal diet.

Then the arteries are examined to see whether they show signs of atherosclerosis compared with a control group which ate a normal monkey diet.

Different sugars have been tested in this way. Then followed a diet containing added cholesterol — as high blood cholesterol levels have been strongly implicated as a cause of atherosclerosis and coronary heart disease.

The present study concerns fibre, or lack of it, in the diet to find out whether modern refined foods play a role in atherosclerosis. More research will follow, such as the effect of different types of proteins.

PROGRESS

Dr Kritchevsky does not believe that a single dietary factor is to blame for the rash of atherosclerosis.

"We try to cover all metabolic possibilities," he explained in an interview. "The result is that the outcome of one experiment usually leads to more questions, and so the experiments go on."

The answers are slow in coming as the scope of the project is wide and the problem complicated, he says. But progress is being made and he is sure the problem will eventually be solved.

93

200 SA doctors are now in US

3/2/77

The Star Bureau

NEW YORK — About 200 South African doctors are reported to have entered the United States in the past fortnight to beat the February 17 deadline for exemption from US immigration restrictions.

After February 17, a Department of Labour spokesman said, all foreign doctors, nurses and pharmacists will be subject to the same tight restrictions and regulations as apply to other prospective immigrants.

"For some years, doctors and other medical personnel were treated as schedule 'A' immigrants, which meant that they simply had to prove that they had the necessary qualifications in order to get an immigration visa.

"This was done because of a shortage of medical personnel in the US. That shortage has now eased sufficiently to remove the measures that were taken to encourage medical personnel as immigrants," the spokesman explained.

Because there are now thought to be sufficient doctors in the US, the 200 South Africans who have entered the country ahead of the February 17 deadline will probably find difficulty in getting suitable jobs.

The February 17 deadline, he pointed out, did not necessarily mean that foreign medical personnel would be barred from entering the US as immigrants.

"It simply means that each case will be treated on its merits according to the supply of jobs and the people to fill them.

Hansard 2 col 108 3/2/77.

(93)

District surgeons

21. Mr. L. F. WOOD asked the Minister of Health:

(1) Whether there is a shortage of district surgeons in the Republic; if so, what is the shortage of (a) full-time and (b) part-time district surgeons in each province;

(2) how many (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) full-time and (ii) part-time district surgeons were employed by the State and undertook their own dispensing in connection with their State services during 1976;

(3) how many patients were treated by district surgeons during 1974 and 1975;

(4) how many district surgeons are in receipt of a drug allowance.

The MINISTER OF HEALTH:

(1) Yes.

(a) Full time

Cape	18
Transvaal	31
Natal	7
O.F.S.	17
Total	73

(b) Part time

Cape	23
Transvaal	12
Natal	3
O.F.S.	8
Total	46

(2) (i)

Full time	Employed	Own dispensing
(a) White	130	Nil
(b) Coloured	Nil	Nil
(c) Indian	Nil	Nil
(d) Bantu	Nil	Nil

(ii)

Part time	Employed	Own dispensing
(a) White	338	282
(b) Coloured	1	Nil
(c) Indian	3	2
(d) Bantu	2	1

(3)

Full time district surgeons	3 112 750
Part time district surgeons	3 330 500
Total	6 443 250

(4) 285.

Pay disparity of doctors revealed

3/3/71

CAPE TOWN — White, professionally qualified doctors in State and Provincial employment earned about one-third more than their black counterparts last year.

And the salary scales of Coloured and Indian doctors were midway between those for blacks and whites.

Details of the wide disparity in salaries paid to the different race groups were disclosed yesterday by the Minister of the Interior, Dr Mulder, in reply to a question by Mr Dave Dalling (PRP Sandton).

It was revealed that a black professor or chief specialist (R11 250 a year) earned considerably less than a white principal medical officer (R12 600). A white chief specialist was paid R15 600 and a Coloured or Indian R13 200.

The salary scale for specialists was fixed at R12 600 (white) R10 800 (Coloured and Indian) and R9 180 (black).

For senior medical officers at R11 700 (white), R9 900 (Coloured and Indian) and R8 460 (black).

Commenting later, the PRP's health spokesman, Dr Alex Boraine, said the figures were a "shocking indictment" of Government policy.

They were, he said, a further example of blatant discrimination on racial grounds and made a mockery of the Government's promise to move away from discrimination.

"We urge the Minister to introduce the principle of the rate for the job in State and Provincial hospitals and health services," Dr Boraine said. — PC.

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Court told of strange practice at hospitals

CAPE TOWN. — The strange aspect of a case in which a surgeon was accused of fraud was due to the strange system at Karl Bremer and Tygerberg hospitals a Cape Town Regional Court was told yesterday.

Doctors were permitted private practice while being paid salaries for teaching posts said Dr W. Cooper who was appearing for Dr P. G. Joubert, former head of the department of orthopaedics at the University of Stellenbosch, Tygerberg Hospital, who is accused of 72 counts of fraud.

Dr Joubert is alleged to have defrauded the Workmen's Compensation Fund of more than R8 000 by submitting a number of accounts while receiving a fixed salary as professor of orthopaedics. He pleaded not guilty to the main charge of fraud and to the alternative charge of theft.

Earlier, the State prosecutor, Mr F. L. Silbert, said Dr Joubert was not entitled to a brass farthing — over and above his salary for services rendered at the hospital.

It was common cause that the accused had submitted accounts to the Workmen's Compensation Fund.

In certain cases he had submitted claims for work done by his assistants and in others for cases not treated by his department, said Mr Silbert.

Dr Cooper said the accused had shown himself an honest man in his repayment of fees when advised of a possible irregularity.

He had been confronted with a system at the Karl Bremer and Tygerberg hospitals, whereby workmen's compensation cases were admitted which would normally have been referred for private treatment and in which he was allowed a limited amount of private practice.

The State had not proved that Dr Joubert had intent to defraud.

Judgment will be given today.

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UNI[illegible] [illegible]OWN

TELEPHONE: 69-85[illegible]
Director Ext. [illegible]
Secretary Ext. 4[illegible]

[illegible] OF LIBRARIANSHIP,
[illegible] Building,
[illegible]versity of Cape Town,
RONDEBOSCH
7700

4th August, 1976.

APPLI[illegible]

Orthopaedic surgeon is sentenced for fraud

CAPE TOWN — Mr P. G. Joubert, former head of the Department of Orthopaedics in the University of Stellenbosch at Tygerberg Hospital, was yesterday found guilty in the Cape Town Regional Court on 72 counts of fraud and suspended nor three years.

The sentence was suspended for thhhhe years.

Dr Joubert was charged with defrauding the Workmen's Compensation Fund of more than R8 000 by submitting a number of accounts for patients treated while he was receiving a fixed salary as professor of orthopaedics. He pleaded not guilty to the main charge and to the alternative charge of theft.

The offences occurred while he was employed at the Karl Bremer and Tygerberg hospitals.

In passing sentence, Mr A. Cilliers said the system of limited private practice permitted at the hospital had not been examined in depth during the case and he would not comment further on it.

He accepted that Dr Joubert was a man of the "highest integrity" and his ability as both a surgeon and the incumbent of a hospital teaching post was not questioned.

What could not be accepted was the charging of fees for Workmen's Compensation patients treated in a semi-state institution, charges made for treatment carried out by other persons, and the vagueness of a system where such practices were not questioned.

All charges were regarded as one in determining the sentence and further possible proceedings by the medical professions disciplinary body had been taken into account, Mr Cilliers said.

Dr W. Cooper, appearing for Dr Joubert, gave notice of appeal. — DDC.

The School of [illegible] [illegible] reduced in the last 3 - 4 years by the [illegible] previously given on a no-charge basis by former me[illegible] [illegible] library staff. [illegible] subjects were taugh[illegible] by Mr R.E.M. Immelman, Miss L.E. Taylor, Mr G.D. Qui[illegible] still on the library staff. Other subjects were [illegible] of course, were being taught by another three or four. At the present time there are still three people who help with [illegible] two lectures on their [illegible].

During 1975 and the first part of 1976 it has been possible to engage part-time lecturers [illegible] (Miss L.E. Taylor) and [illegible] from City Libraries and the Cape Provincial Library Service). The money to pay them has been obtained by making economical use of the money available for leave replacements during Mrs Russell's absence.* This course of action was suggested by the Staffing Committee when our position was brought to their attention last year.

In 1977 there will [illegible]

The permanent staff are working [illegible] of our work are being neglected for lack of time to deal with them adequately. We need the money not only to continue employing the part-time staff referred to above, but also to engage the people at present paid from Demonstrator money, and other specialists who at present cannot be approached. It is a question of maintaining the existing position as a first priority, and then of improving on it.

A brief account of the work carried out by the present staff of the School of Librarianship should make the position clear. There are at present six undergraduate/2........

* This was in addition to paying three part-time lecturers to do Mrs Russell's work.

Doctor crisis hits Rhodesia

SALISBURY — The shortage of doctors in Rhodesia has become serious, Medical Association president Mr. John Gordon said in an interview published here yesterday.

Mr. Gordon said the country is losing out for three reasons — some doctors are emigrating, others retiring, and newly-qualified doctors are leaving to further their education and experience abroad, although some are expected to return.

He said: "There are doctors leaving for general practice and for the specialities.

"It is the same for doctors as for other people at present — they feel there is no point in staying."

Mr. Gordon said young doctors who left to further their knowledge are returning at a fair rate. But others feel there is no future and are not prepared to work at setting up practices in the uncertain political climate.

There are also tensions, which even high salaries cannot overcome, such as the trouble and delay in getting medical equipment.

Emigrating doctors usually head for South Africa or the United States, although the latter is likely to shut its doors soon. — (Sapa.)

in Southern Africa, No. 5, 1976

series of television films (video-tape)

meant a teaching load of (12 periods ...) p.w., 5 tutorials p.w.

has been brought into action and additional teaching periods in the Laboratory have become

to be published early 1977

MISCELLANEOUS:

intensive coaching necessary for really effective language teaching,

- acting in comedy by Georges Feydeau Mais n'te promène donc pas toute nue

(Cape Town, 1976)

- project: creation of a Center for the study of French civilization

PROF. P. HORN.

ADDRESS: until 1st December, 1976 — after 1st December, 1976 (while

Dr. Pierre PETIT,
French Department,
University of Cape Town,
Rondebosch, 7700,
South Africa.

Mr. Pierre PETIT,
97 rue Mazarin,
33000 Bordeaux,
France.

2 encls.

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Doctor is refused permit

West Rand Bureau

An Indian doctor and her husband have gone to practise in Natal because she could not get permission to open rooms in her home town.

Dr Farida Nanabhai, who was born in Krugersdorp in 1946, qualified at the University of Natal in 1972. Her husband, Dr A G Bera (34), is a graduate of the Cairo University.

They bought a R40 000 home in Azaadville, the West Rand Indian township, but there are already six doctors for the 400 families and Dr Nanabhai wanted to open rooms in Krugersdorp.

"A permit was refused by the Department of Community Development and I then applied personally to the Minister, Mr Marais Steyn, who promised to go into the matter, but there is still no answer," said her father, Dr M A Nanabhai, a member of the Indian Consultative Committee.

SOME LEAVE

He said he knew of a number of Indian doctors and others who had professions and had left the country because of this sort of treatment.

"What are South African Indians to do who take professions in this country? When they qualify they find all doors closed to them," he said bitterly.

He said this happened even after the President of the Senate and cabinet ministers advocated relaxing restrictions affecting trade for Indians and coloureds.

He said the couple were more or less forced to go to Natal even though his daughter wanted to stay with her family here. They were only eking out a living in Krugersdorp because they had no permission to work.

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Lorna Marshall: The Kin ... !Kung Bushman, Africa XX...
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" " Sharing, ... Relief of Social Tension a... ...shmen, Africa XXXI, 1961
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G.B. Silberbauer: Bushman ... and Government
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Marriage ... ...uberty Ceremony of the G/wi ... XXXIII, 1963.
(Both of ... ...ports deal with the G/wi of ...

P.V. Tobias: "Bushmen Hunt... Ecological Studies in Southern A... Davis, 1964.

M. Wilson: "The Hunters and ... 2, Vol. 1, of Wilson and Thomp... History of South Africa.

The following two books should be ... 1977:

L. Marshall: The !Kung of N...
R. Lee & I. De Vore: Hunter... Kalahari

Bantu-speaking Peoples

General

W.D. Hammond-Tooke: The Bant... ...s of South Africa
I. Schapera: The Bantu Speaki... ...h Africa (Rather old fashioned)
" " Government and Politics in Tribal Societies
Wilson & Thompson: Oxford History of South Africa (vol. 1 for traditional societies, vol. 2 for changing societies).

/Whisson ....

93

Doctors among 300 granted entry to US

Cape Times 23/2/77

Chief Reporter

IMMIGRATION visas to enter the United States were granted to 300 family members of professional people — many of them doctors — in the Cape last year. This figure is three times higher than the annual average.

In Cape Town more than 60 doctors were granted US immigration visas in the last two months of 1976. And in the Republic as a whole the indications are that more than 200 members of the medical profession have left or are planning to leave for other countries, either permanently or temporarily.

The US Consul-General in Cape Town, Mr Ray White, confirmed yesterday that there had been a rush for visas towards the end of last year. But he said this could be accounted for by the large number of doctors wanting to beat the January 9 deadline for acceptance in the US of foreign medical graduates on the former ECFMG examination standards.

New legislation had been enforced on January 10, providing for new and stricter acceptance examinations that would ensure that foreign doctors who want to practice in the US conformed to the same high standards required of members of the medical profession in the United States and Canada.

Mr White said these new examinations were still being drafted and there had been no intimation when they would become operative. In the meantime the issuing of US immigration visas to foreign doctors had virtually come to a standstill. The only exceptions were for doctors who qualified by having immediate relatives in the US who were willing to sponsor them.

The exceptionally large number of South African doctors who had applied for and been granted immigration visas in the last few months of 1976 included many who had intended going to the United States this year anyway, for specialist training or experience. It was therefore not possible to say how many of the applicants intended staying in the US permanently.

Mr White said reports that the new US legislation was aimed at keeping foreign doctors out of the US was correct only in that the stricter acceptance examinations would ensure that foreign doctors who did not measure up to the higher standards required would be debarred from practising in the country. "And my own feeling is that with the high standards that have been maintained in medicine in South Africa, doctors from this country should have little difficulty in meeting the stricter US requirements."

93

11/2/77.

In the Provincial Council

Key to easing doctor shortage

Pretoria Bureau

The way in which the shortage of doctors could be eased all over South Africa had been shown by Dr P J Beukes, superintendent of Soweto's Baragwanath Hospital, arising out of last year's riot emergency, Mr Sam Moss (PRP, Parktown) told the Transvaal Provincial Council yesterday.

It involved training nurses to do much of the work normally done by doctors, without in any way infringing against regulations designed to maintain medical standards.

In a tribute to the work done by Dr Beukes, Mr Moss described the already difficult task which Baragwanath Hospital had in filling the medical needs of the million-strong population of Soweto, and the auxiliary role which the eight clinics under its control played.

These clinics had been staffed largely by highly-competent retired white doctors.

But when the riots erupted in Soweto, it became unsafe for these doctors to enter the area, and the medical situation of its inhabitants became desperate.

Casting round for a solution, Dr Beukes recalled that about 40 percent of the hospital ward work normally done by doctors was being done by black nurses in the emergency, which proved their capability.

So he organised a three-month crash course for them, qualifying them to do medical work, including some diagnosing and treatment.

The first clinic reopened at Diepkloof at the start of this year, and in the first month handled more than 3 000 outpatients. Of these, only 22 percent had to be referred by the nurses to doctors, and of those referred, 5 percent were admitted to hospital.

330, 93

Doctor drain trickles off

Staff Reporter

THE issuing of United States immigration visas to South African doctors has come to a virtual standstill, according to the United States Information Service.

Exceptions are made nly for those doctors who ave close relatives in America willing to sponsor them.

Legislation aimed at keeping foreign doctors out of the US went into effect last month.

The new regulations exclude all foreign doctors from immigrating unless they have passed an American examination.

93

Moves to aid jobless doctors

15/2/72

Mercury Reporter

THE PLIGHT of many Cairo-trained doctors, some of whom are "walking the streets" because the South African Medical and Dental Council has refused to recognise their degrees, has been taken up with the Minister of Indian Affairs, Mr. Marais Steyn.

In a letter to Mr. Steyn, an Umzinto civic leader, Mr. Ismail Moolla, has asked for help for the doctors.

Mr. Moola pointed out that Cairo degrees were recognised in almost every country, including Britain and the United States.

"I cannot see why South Africa should deny recognition of these doctors."

He said there was a shortage of doctors and a number were also leaving because of better prospects in other countries.

"I understand that more than 140 South African Cairo-trained doctors who are working outside South Africa want to return to this country if their degrees are recognised in South Africa," he told the Minister.

Replying to Mr. Moola, the Minister said South African Indian Council was well aware of the problems of medical graduates from the University of Cairo.

"The matter was taken up some time ago with the South African Medical and Dental Council and discussions were subsequently held with the Minister of Health and the chairman of the Medical Council," he said.

"The matter is still being pursued actively and it is hoped that a satisfactory solution will soon be found."

Ex-Wits professor to go on 'trial'

Science Editor

A "trial" at which a former Wits professor of medicine will be "charged" with plagiarism will be held in Johannesburg next week.

It is not a Rag stunt. It's dead serious. Professor Leo Schamroth, professor of medicine at Baragwanath Hospital, will act as counsel for the defence in an effort to vindicate the reputation of Dr William Craib, now 82.

About 50 years ago Dr Craib made a momentous discovery which has since revolutionised the practice of electrocardiography in diagnosing heart disease.

But he was publicly castigated for his views when he presented them to his peers, because they conflicted with dogmas of the time.

Later they were accepted — but were attributed to the very people who so vehemently criticised him.

The occasion will be the A J Orenstein memorial lecture, held under the auspices of the Adler Museum of the History of Medicine.

Professor Schamroth, who will give the lecture, said today: "Until about 1926 everyone believed that when the heart muscle was activated, it became electrically negative.

"Craib's experiments showed that the electric current passing through the heart had a positive head and a negative tail and he termed this a doublet.

"This finding enabled the rational, logical, deductive interpretation of the ECG and revolutionised the practice of diagnostic electrocardiography."

Dr Craib presented his work to a group of doctors in Stockholm. Professor Eindhoven, the inventor of the ECG and one of the greatest authorities of his time, told him he spoke a "lot of nonsense" and refused to discuss it any further.

He added: "It is a disgrace and I am ashamed of you."

Eventually the doublet hypothesis was accepted and attributed to Eindhoven.

Professor Schamroth has for long been a champion of Dr Craib, who has lived in retirement in Somerset East since 1946.

In his inaugural lecture in 1974, Professro Schamroth said: "It will not surprise me if one day he will be awarded a Nobel Prize."

And now he will present a fullblown trial on what he calls "issues of scientific plagiarism and integrity."

Dr Craib will be present at his "trial" and is expected to give a short address at the end.

The lecture is open to the public and will be held in the University Great Hall at 8.30 pm on Wednesday, February 23.

Professor Schamroth hopes to give the same lecture later in Britain and the United States.

taalstruktuur te laat ontwikkel ... faktore tot die veranderings op die gebied van die woord... fonologiese en morfologiese struktuur, en die sinsbou bygedra. Wanneer ons ons bronne versigtig bestudeer, sien ons dat nie die een of ander taal in die besonder of een spesifieke faktor vir die wording van Afrikaans verantwoordelik was nie, maar dat die Afrikaanse taal die produk is van baie eksterne en interne faktore. Besonder belangrik was die dialektiese skakerings van 17de-eeuse Nederlands; soos uit die oorsig blyk, is die meeste „kenmerke" van Afrikaans voortsettings van die een of ander dialekvorm of tendensie in 'n dialek wat in Nederland self deur beskawingsfaktore teëgewerk is of verdwyn het. Daarnaas het die invloed van die talle vreemdelinge aan die Kaap 'n rol gespeel. Ook hier kan ons net by uitsondering een groep sprekers isoleer en vir die wording van 'n bepaalde taalvorm verantwoordelik hou. Ons kan bv. nie aantoon in hoever die Franse of Duitse immigrante die Afrikaanse sinsbou direk beïnvloed het nie, of in hoever hulle die vereenvoudiging van die vormstelsel veroorsaak het nie.

1. Teorieë oor die ontstaan van Afrikaans

Vroeër is daar wel aan die een of ander beslissende taalinvloed gedink. Dit was die geval voordat 'n taamlik groot hoeveelheid direkte gege-

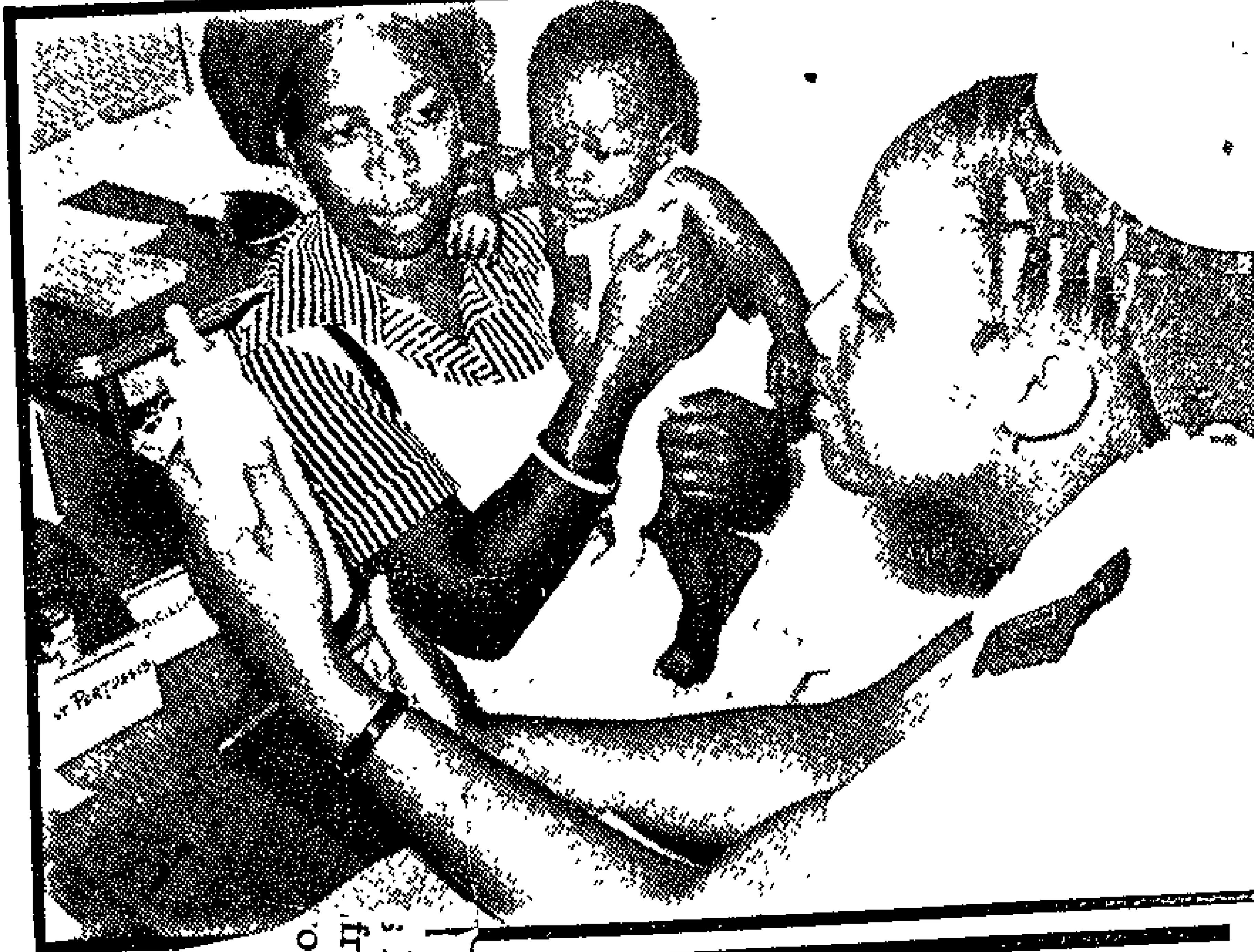
...Kaapse taal in die Argief in Kaapstad gevind is. Kort ... in die herkoms en ...

tussen die 17de-eeuse Nederl... tenare en die taal van die Oosterse slawe wat Maleis ... gebroke Portugees gepraat het, of 'n vermenging van albei („Maleis-Portugees"). In 1658 en daarna het 'n groot aantal slawe wat gebroke Portugees gepraat het, Kaap toe gekom; dit sou volgens Hesseling 'n skielike kommunikasieprobleem veroorsaak het wat tot 'n vinnige verandering van Nederlands gelei het. Die resultaat was 'n sterk vereenvoudigde taal met 'n reduksie in sy grammatika. Wanneer 'n kultuurtaal in 'n bepaalde kontaksituasie deur 'n botsing met 'n sosiaal laerstaande taal binne 'n kort tydperk 'n drastiese reduksie, struktuurverandering en vereenvoudiging ondergaan, praat 'n mens van kreolisering. Hesseling moet egter self erken dat die tipiese kenmerke van kreolisering in Afrikaans ontbreek, daarom kom hy tot die konklusie dat Afrikaans beskou moet word as Nederlands wat halfpad bly staan het om 'n Kreoolse taal te word.

Ongelukkig het Hesseling destyds nie oor die nodige direkte taalgegewens beskik nie; hy kon sy teorie feitlik net op sosio-historiese gegewens baseer wat bowendien nie volledig en korrek was nie. Daarom was ook sy teorie ontoereikend en eensydig; dit het 'n hipotese gebly wat hy nie kon bewys nie.

Nurses come to doctors' rescue

Fear on the part of White and Indian doctors after last June's riots brought Soweto's curative health clinics to an abrupt halt. But now a White woman doctor and a band of specially-trained Black nurses have gone to their rescue.



COMMUNITY HEALTH
Vicki Rosenthal

WOMANPOWER IS setting Soweto health clinics back on their feet.

The first township curative clinic to re-open since last year's June riots is now back in operation — thanks to a White woman doctor and a team of specially trained Black nurses who have taken over the bulk of diagnosis and treatment.

Were it not for Dr M. (she does not want to be identified) and her veteran sisters Soweto's four curative clinics might well have become derelict monuments to Black rage and White fear.

For the 34 doctors — none of them Black — who previously sallied forth into Pimville and Diepkloof took to heart Dr Edelstein's death and now elect to remain within the laager of Baragwanath.

The only one prepared to venture down the desolate, littered streets is a woman, a freshfaced fifty-year-old who sweeps all before her in a whirlwind of efficiency and dedication.

In place of scowls and stones she is met with smiles.

But simmering resentment against Whites may erupt at any time. That's a chance Dr M. has decided to take.

"I am South African and if I am going to live here the thought of allowing fear to dictate my movements is intolerable," she told me. "However, I realise that if a mob starts throwing stones a White is a White is a White."

The idea of nurses taking over doctors' duties was mooted even before June '76, but the unrest forced a training programme into being.

During their three months' course the nurses, who all have several years' practical experience over and above their four or five year qualification, undergo intensive in-service training, primarily in diagnosis.

The greater responsibility and demands of their new role have not yet been reflected in a salary increase.

One sister I spoke to has a three year basic training, a year's maternity course, a year's pediatrics course and 20 years' experience to her credit. She earns R270 a month, before deductions.

According to the superintendent of Baragwanath Hospital, Dr P. J. Beukes, the course graduates are doing "extremely well".

Eighteen are already in the field and 12 are undergoing training.

At this rate it will be some time before all four of Soweto's curative clinics re-open.

Dr Beukes explained he could not increase student numbers because it was impossible ... doctors to the training programme. Four doctors have to be deployed full-time for each batch of 12 students.

In the meantime the residents of sprawling Soweto face transport difficulties and long queues at Baragwanath.

Were it not for the newly-trained sisters their problems would be much greater.

During their first month in '77 they treated 3 087 cases. 601 at Diepkloof clinic and 2 486 at Soweto's temporary clinic headquarters at Baragwanath. Only 22 per cent were referred to a doctor. Formerly all 3 087 cases would have been handled by a doctor.

One advantage of the new system is that patients communicate far better with Black sisters than they did with White or Indian doctors.

What's more, one doctor's work load is now divided between three or four sisters, allowing more thorough examination and more detailed instruction in what to do with pills and potions.

"This is not an alternative service," said Dr M. "It's a supplementary service. These sisters are valuable health workers in their own right."

Cape doctors blow out

Mercury Correspondent

CAPE TOWN — Visas to enter the United States were granted to 300 relatives of professional people, many of them doctors, in the Cape last year, three times more than the annual averages.

In Cape Town, more than 60 doctors were granted U.S. immigration visas in November and December.

And in the entire country the indications were that more than 200 doctors had left or were planning to leave, permanently or temporarily.

The U.S. Consul General in Cape Town, Mr. Ray White, yesterday confirmed a rush for visas towards the end of last year.

But he said this could be accounted for by the many doctors wanting to beat the January 9 deadline for acceptance in the U.S. of foreign medical graduates on the former examination standards.

Legislation enforced on January 10 provided for new and stricter acceptance examinations to ensure that foreign doctors wishing to practise in the U.S. conformed to the same standards required of doctors trained in the United States and Canada.

Mr. White said these new examinations were still being drafted.

The issue of U.S. immigration visas to doctors had now virtually come to a standstill. The only exceptions were for doctors who had close relatives in the U.S. willing to sponsor them.

Training

The exceptionally large number of South African doctors who applied for and were granted visas in the past few months included many who intended going to the United States this year for specialist training or experience. It was therefore not possible to say how many applicants intended staying there.

Mr. White said reports that the new U.S. legislation was aimed at keeping foreign doctors out was correct only in that the stricter acceptance examinations would ensure that doctors who did not measure up would be debarred from practising in the country.

"And my own feeling is that with the high standards that have been maintained in medicine in South Africa, doctors from this country should have little difficulty in meeting the stricter

hier, soos die Nederlandse taalkundige J. L. Pauwels aantoon, met 'n oorgeërfde verskynsel te make.

J. A. VERHAGE, „Deftige en gemeensame vorme in die sinsverband van ou Kaapse taal", *Tydskrif vir geesteswetenskappe*, jg. 5, nr. 3, 1965, pp. 307–323.
J. A. VERHAGE, „Die herkoms van die verbinding *as wat* na 'n komparatief en sy verbreiding in Afrikaans", *Tydskrif vir geesteswetenskappe*, jg. 7, nr. 1, 1967, pp. 328–342.
J. DU P. SCHOLTZ, *Taalhist. opstelle*, pp. 162–168.
J. L. PAUWELS, „De volgorde van verbogen verbale vormen in het Nederlands", in *Dietse studies*, pp. 105–110.

9.5 Slotopmerkings

In hierdie beknopte oorsig ... dat in die besonder of een spesifieke faktor vir die wording van Afrikaans verantwoordelik was nie, maar dat die Afrikaanse taal die produk is van baie eksterne en interne faktore. Besonder belangrik was die dialektiese skakerings van 17de-eeuse Nederlands; soos uit die oorsig blyk, is die meeste „kenmerke" van Afrikaans voortsettings van die een of ander dialekvorm of tendensie in 'n dialek wat in Nederland self deur beskawingstaalvorme teëgewerk is of verdwyn het. Daarnaas het die invloed van die talle vreemdelinge aan die Kaap 'n rol gespeel. Ook hier kan ons net by uitsondering een groep sprekers isoleer en vir die wording van 'n bepaalde taalvorm verantwoordelik hou. Ons kan bv. nie aantoon in hoever die Franse of Duitse immigrante die Afrikaanse sinsbou direk beïnvloed het nie, of in hoever hulle die vereenvoudiging van die vormstelsel veroorsaak het nie.

1. Teorieë oor die ontstaan van Afrikaans

wens van die Kaapse taal in die Argief in Kaapstad gevind is. Kort na die stigting van die GRA het die belangstelling in die herkoms en ontstaan van Afrikaans by taalgeleerdes begin posvat en aanleiding gegee tot die ponering van verskillende teorieë oor die ontstaan van Afrikaans. Th. Hahn se *Hottentots-teorie* van 1882 was die eerste poging tot 'n verklaring van die karakter van Afrikaans. Hoewel hy vasstel dat Afrikaans „phonetically teutonic" is, d.w.s. sy Germaanse struktuur behou het, is dit volgens hom „psychologically an essential Hottentot idiom". Maar hierdie vae stelling kan hy nie bewys nie. Kort ná hom kry ons die belangstelling van Nederlandse geleerdes soos M. de Vries en J. te Winkel, wat die *Frans-teorie* voorstaan. Volgens dié teorie sou Afrikaans onder die invloed van die Franse Hugenote ontstaan het, maar D. C. Hesseling het die teorie in 1897 al weerlê. In 1885 wys Hugo Schuchardt, die beroemde Duitse geleerde en kenner van Kreoolse tale, op twee belangrike faktore wat by die wording van ... eeuse Nederlands ... tenare en die taal van die Oosterse slawe wat Maleis en 'n vorm van gebroke Portugees gepraat het, of 'n vermenging van albei („Maleis-Portugees"). In 1658 en daarna het 'n groot aantal slawe wat gebroke Portugees gepraat het, Kaap toe gekom; dit sou volgens Hesseling 'n skielike kommunikasieprobleem veroorsaak het wat tot 'n vinnige verandering van Nederlands gelei het. Die resultaat was 'n sterk vereenvoudigde taal met 'n reduksie in sy grammatika. Wanneer 'n kultuurtaal in 'n bepaalde kontaksituasie deur 'n botsing met 'n sosiaal laerstaande taal binne 'n kort tydperk 'n drastiese reduksie, struktuurverandering en vereenvoudiging ondergaan, praat 'n mens van kreolisering. Hesseling moet egter self erken dat die tipiese kenmerke van kreolisering in Afrikaans ontbreek, daarom kom hy tot die konklusie dat Afrikaans beskou moet word as Nederlands wat halfpad bly staan het om 'n Kreoolse taal te word.

Ongelukkig het Hesseling destyds nie oor die nodige direkte taalgegewens beskik nie: hy kon sy teorie feitlik net op sosio-historiese

DR SEIDLER . . . conditions are chaotic.

Seidler says many may die

QUEENSTOWN — Conditions at the Thornhill resettlement camp, accommodating 30 000 Herschel emigrants, are reaching chaotic proportions.

Dr Barbara Seidler, in charge of the Ciskei-backed operation, said malnutrition was rife and the camp was disorganised.

She said if something was not done soon, thousands could die with winter looming. Dr Seidler said with the exception of breast-fed babies, nearly 90 per cent of the children were undernourished and consequently underweight and had little resistance to infection or disease.

Dr Seidler said the problems of malnutrition and disorganisation were linked and both were of equal urgency.

Until employment could be found food had to be provided.

"Vast quantities of balanced foodstuffs are an urgent necessity," she said.

"On January 15 I was told by Ciskeian authorities that Pretoria had promised delivery of 1 200 pockets of potatoes a day to Thornhill. That is 36 000 pockets a month. To date I have received 5 500 pockets."

She said she had received mealie meal, soup powder, powdered milk, vitamin tablets and salt.

But there were no supplies of meat, fresh vegetables or fruit and water was in critically short supply.

Most supplies of fresh water had to be carted in

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But there were no supplies of meat, fresh vegetables or fruit and water was in critically short supply

Most supplies of fresh water had to be carted in tankers from the village of Whittlesea, about 20 km away. The erection of 200 emergency water tanks was promised over a month ago, she said, but this contract had had to be put out to tender and the tanks had not yet been installed. — DDC.

... Nederlands ... tenare en die taal van die Oosterse slawe wat Maleis en 'n vorm van gebroke Portugees gepraat het, of 'n vermenging van albei („Maleis-Portugees"). In 1658 en daarna het 'n groot aantal slawe wat gebroke Portugees gepraat het, Kaap toe gekom; dit sou volgens Hesseling 'n skielike kommunikasieprobleem veroorsaak het wat tot 'n vinnige verandering van Nederlands gelei het. Die resultaat was 'n sterk vereenvoudigde taal met 'n reduksie in sy grammatika. Wanneer 'n kultuurtaal in 'n bepaalde kontaksituasie deur 'n botsing met 'n sosiaal laerstaande taal binne 'n kort tydperk 'n drastiese reduksie, struktuurverandering en vereenvoudiging ondergaan, praat 'n mens van kreolisering. Hesseling moet egter self erken dat die tipiese kenmerke van kreolisering in Afrikaans ontbreek, daarom kom hy tot die konklusie dat Afrikaans beskou moet word as Nederlands wat halfpad bly staan het om 'n Kreoolse taal te word.

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False report: doctor rebuked over fees

Science Editor

A doctor has been sharply rebuked by the Medical Association of South Africa for prematurely increasing his fees after an incorrect report that general practitioners had decided on higher fees.

The association publicly repudiated such an increase and has said it will not support it.

The Southern Transvaal sub-group of the National General Practitioners' Association — a body of the Medical Association — recommended tariff increases of between 21 and 28 percent to general practitioners who have contracted out under the Medical Schemes Act, according to a weekend report.

The Medical Association issued a statement today in which the chairman of its federal council, Professor J N de Klerk, the general secretary, Dr Marais Viljoen, the National General Practitioners' Group and the Southern Transvaal branch all deny knowledge of the alleged increase.

The association investigated and found the sub-group had considered increasing fees and intended recommending this to Southern Transvaal.

WRONGFULLY

"But one member of the group acted incorrectly and wrongfully by circularising their patients and advising them that the increased fees had been adopted by the sub-group and would become applicable on March 1," says the statement.

"It is stated unequivocally that the proposed increased fees were not considered or approved by the Medical Association and will not be supported by it.

"Doctors who have contracted out may themselves decide on the fees they wish to charge for a particular service, always subject to the proviso that they will have to be able to justify such fees as being reasonable if a complaint should be submitted to the Medical Council."

93

SA doctor joins UN varsity team

Science Editor

INSISTENCE on academic freedom by the United Nations University has made it possible for a South African doctor to take part in its world hunger programme.

Professor John Hansen, head of the department of paediatrics at the University of the Witwatersrand and a leading nutritionist, was recently invited to attend a workshop of the UN University in Costa Rica with nine other world experts.

The university, which is not a teaching institution in the accepted sense, has its headquarters in Tokyo and was established by the Japanese Government.

"It is determined to keep itself free of the bureaucracy and politics that bedevil the World Health Organisation and other UN agencies," says Professor Hansen. "It was this principle that made it possible for me to attend."

Estimating that between six and 12 million people die every year of starvation or malnutrition, the university with its associated institutions in different parts of the world are workng on various aspects of nutrition, food conservation and technology, and agriculture.

"The workshop I attended concerned nutritional need, particularly during infections," says Professor Hansen.

"Prolonged infections often lead to severe weakness and muscle wasting which have been found to be much more serious than in simple starvation."

Hansard 7 Q col 599 9/3/77

(93)

Non-White doctors/nurses: Salary scales

(577) Mr. D. J. DALLING asked the Minister of the Interior:

What is the estimated annual cost of raising the salary scales of Black, Coloured and Asian (a) doctors and (b) nurses employed by the State to the scales applicable to White doctors and nurses.

The MINISTER OF THE INTERIOR:

(a) R1,4 million.

(b) R14,19 million.

Stiffer indecency penalty

HOUSE OF ASSEMBLY — Medical doctors committing acts of indecency with minor girls would have their names deleted from the list of practitioners on the first offence in future, the Minister of Health, Dr S. van der Merwe, said yesterday.

Introducing the second reading debate on the Health Amendment Bill, he said the names of such doctors could only be deleted on the third offence under existing provisions.

"I believe such a doctor must be deleted on the first offence in order to safeguard the public against such unscrupulous practitioners," he said.

The Bill also provides for restraints on certain commercial and other organisations to expand in the retail pharmacy sphere.

The Bill was read a second time with the support of all the opposition parties. — SAPA.

93

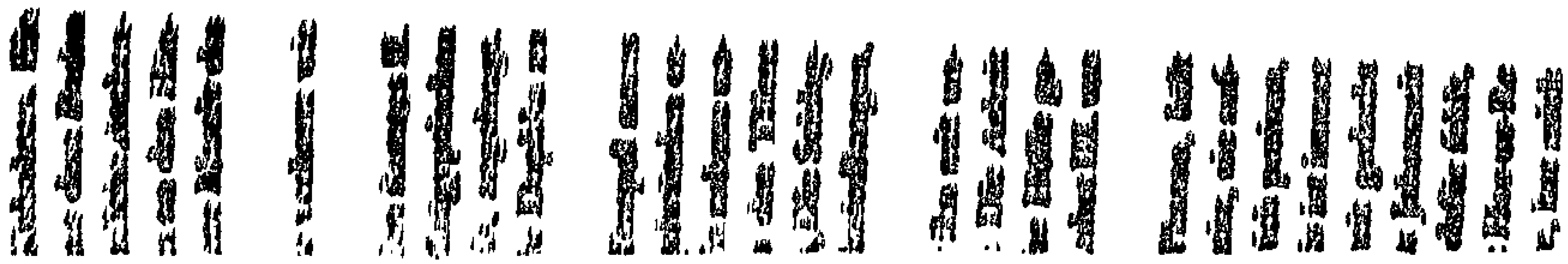
10/3/77 RDM

Cost of equal pay

CAPE TOWN — The Minister of Interior, Dr Mulder, said yesterday it would cost R1,4 million a year to raise the salaries of black, Coloured and Indian doctors to the same level as white doctors.

The Minister also said it would cost R14,19 million a year to level the salaries of all nurses.

The Progressive Reform Party MP for Sandton, Mr D. Dalling, said afterwards this was "a small price to pay in the interests of both being fair and winning the goodwill of highly qualified professional people concerned." — PC.



DOCTORS TO EASE CRISIS IN KWAZULU

African Affairs Reporter (93) NM 17/3/77

A 188-BED KwaZulu hospital at Melmoth which ran for more than two weeks without a doctor now has two—one from England and the other from the Cape.

The doctor crisis at St. Mary's Hospital had reached such proportions that serious cases were being transferred to Eshowe.

A Dr. Kammence from England will soon take up the post of superintendent, and Dr. L. Lane from the Cape is already at work.

A doctor from Empangeni who has been assisting the hospital left yesterday.

ARGUS 18/3/77

93

UCT man gets a top post in U.S.

The Argus Bureau

NEW YORK. — A senior lecturer in the University of Cape Town's Medical School is leaving South Africa to take up a top post in the United States.

From July 1, Dr Julien F. Biebuyck is to become professor and chairman of the Department of Anaesthesiology at the Pennsylvania State University College of Medicine and the university hospital at the Milton S. Hershey Medical Centre.

South African-born Dr Biebuyck is a senior lecturer in the Department of Anaesthetics at UCT's Medical School, and principal consultant at Groote Schuur Hospital.

He received his medical education at UCT, and a doctorate in philosophy at Oxford University, where he studied under Nobel Laureate Sir Hans A. Krebs.

Dr Biebuyck then went to the United States to Harvard Medical School, but returned to South Africa in 1975 to assume his current post.

Dr Biebuyck has earned an international reputation for his research and has been a guest speaker in several countries.

In Cape Town today, Dr Biebuyck said the post would provide a challenge to continue to develop the academic and scientific basis of anaesthesia, and an opportunity to do research in his field.

93

THIS IS NOT MY CHRIS, SAYS DR MARIUS

Tribune Reporter

DR MARIUS Barnard has replied to his brother's newspaper statement on the Cape Town squatter problem by declaring: "This is not the Chris Barnard I know."

The doctor told the professor: "I have read your statement many times and if you really mean what you wrote I cannot believe you are the Chris Barnard I know."

The Barnards have been involved in a public debate prompted earlier this year by Professor Barnard's open letter to President Jimmy Carter.

Referring to statistics his brother quotes on the number of Coloured houses built since 1920, Marius told him: "You must give both sides of the story. Please show me the statistics for the number of houses that are still needed."

In his statement, Professor Barnard compared South Africa's squatter problem with that of other countries. South Africa compared favourably with many places where shanty towns had become an accepted way of life.

In his reply, Dr Barnard said this was the type of argument the Nationalists used. "How can I tell a squatter woman not to worry. . . . that things are worse overseas?" he asked.

93

I'm going for good says Dr Babs

SUN. TRIBUNE 3/4/77

By BILL KRIGE

BARBARA SEIDLER, the woman doctor who fought a lone battle against death and disease at the Thornhill refugee camp near Queenstown, is leaving South Africa for good because she is not being allowed to continue her work among blacks.

This week she handed in her resignation to the Department of State Health in Pretoria giving, in terms of her contract, three months' notice of her intention to leave.

Yesterday she received a reply advising her that

Dr Barbara: An offer she couldn't refuse

24 hours' notice was all that was required. This "offer" she accepted.

"I will be leaving South Africa in July and I can't see myself coming back. I'm needed somewhere else, either in India or in Africa. But come back here? No, thank you. I'm sorry," she said.

Ordered to leave Thornhill after the Ciskei Government disputed her assessment that conditions at the camp had deteriorated to the point that a major disaster was possible, Dr Seidler was told to report for duty in Port Elizabeth where her work would be confined to treating white patients.

"This I could not accept," she said. "I only came to South Africa for the specific purpose of serving the black community.

At Thornhill, where Dr Seidler spent the first two months of this year, an estimated 45 000 refugees from the Transkei are crowded on to two farms. Many have died and malnutrition is rife.

93

4/9/77 DD

Seidler tells why she quit

EAST LONDON — Bureaucratic bungling on the part of State health services, combined with Government policy, must shoulder the responsibility of the now-increasing loss of overseas doctors to South Africa.

This was the opinion of Dr Barbara Seidler, who fought a lone battle against death and disease at Thornhill refugee camp near Queenstown.

Dr Seidler has resigned from the Department of State Health in Pretoria because she was not allowed to continue her work among blacks.

She was officially notified that her 24-hour notice was all that was required and Pretoria accepted her resignation.

Commenting on a weekend report that she was leaving South Africa in July, Dr Seidler said: "That may be true as it is highly improbable that the authorities will allow me back".

Because of bureaucratic bungling, State health services could no longer see the wood for the trees. In this way, overseas medical assistants and doctors would not want to come to South Africa, Dr Seidler said.

Commenting on Thornhill, Dr Seidler said: "Frankly I had to make a self-sacrifice because all along I knew perfectly well that they would try to get rid of me.

"I weighed it up carefully before I started talking to the press, but as a doctor in this stricken area, the lack of toilets, water, food and equally, the poor housing, had to be made known to the public.

"I tried to play it straight with State health, but they did not want me to do so. It was absolutely plain that when they notified me that I would be attached to the district of Port Elizabeth health services, I would be confined to treating white patients only."

Dr Seidler said if State services suddenly saw their way clear to allow her to work with blacks and regard her as purely humanitarian and not political, then she would continue with the work she had in mind.

Dr Seidler said she went to Thornhill purely to help the people.

While she is not yet decided on what she will do, Dr Seidler revealed that until July she would make her services voluntary to the blacks in South Africa. — DDR.

93

Warning on blood tests

Science Editor

Doctors have been warned to make sure that they do not commit legal assault when they take blood from a child for paternity testing.

For example, writes a doctor in the South African Medical Journal, if a husband contends that he is not the father, he is not the legal guardian and cannot agree on behalf of the child that the child's blood be taken.

When a child is born in wedlock there is a legal presumption that it is born of the marriage and the onus of proof is on the parent who alleges the contrary to prove it.

Evidence can include lack of opportunity, such as the case of a prisoner of war who has been absent for more than a year, impotence or sterility, and blood tests.

Hansard 17 Q cols 1169 - 1170 23/5/77

(93)

Doctors/nurses employed by Department of Health

911. Dr. E. L. FISHER asked the Minister of Health:

How many (a) full-time and (b) part-time (i) doctors and (ii) nurses are employed by his Department in (aa) the Republic and (bb) each of the homelands.

The MINISTER OF HEALTH:

(a) (i) (aa) 33.

(a) (i) (bb)

Bophuthatswana	30
Caprivi	1
Ciskei	18
Gazankulu	7
Lebowa	52
QwaQwa	0
Venda	6
Swazi	7
KwaZulu	137

(a) (ii) (aa) 6833.

(a) (ii) (bb)

Bophuthatswana	21
Caprivi	5
Ciskei	3
Gazankulu	14
Lebowa	33
QwaQwa	2
Venda	13
Swazi	128
KwaZulu	2707

(b) (i) (aa) 744

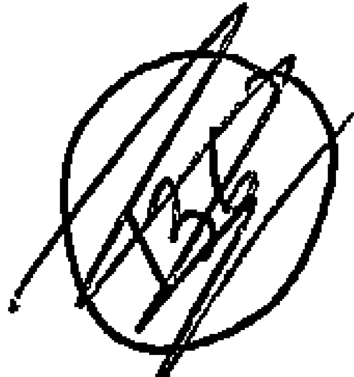
(b) (i) (bb)

Bophuthatswana	13
Ciskei	22
Lebowa	21
Venda	2
KwaZulu	45

(b) (ii) (aa) 266

(b) (ii) (bb)

Lebowa	1
Gazankulu	1
Venda	1



RDM 28/5/77

Medical fees have Nieuwoudt up in arms

Staff Reporter

THE president of the Rightwing Confederation of Labour, Mr Attie Nieuwoudt, says he will mobilise 500 000 white workers to oppose any effort to raise doctors' fees.

A remuneration commission under the chairmanship of Mr Justice R P B Erasmus, is sitting in Pretoria investigating claims for higher fees from the Medical Association of SA.

It is feared that increases will average at least 20%.

The expected increases, Mr Nieuwoudt said in Pretoria yesterday, taken with the steep rise in provincial and private hospital fees, were putting adequate medical attention beyond the reach of the average wage and salary earner.

A statement to Sapa from the MASA secretary-general, Dr C E Viljoen, said: "If the president of the Confederation of Labour has been quoted correctly in the Press, the MASA must state that it regards his statements as irresponsible and improper, if not illegal, as the whole matter of medical fees is under consideration by a remuneration commission and is therefore sub judice."

Inquiry urged into hospital doctors' pay

STAR 30/5/77

Science Editor

The Medical Association has called for an investigation into the salary structure of hospital and other fulltime doctors, either by the Public Service Commission or a statutory commission.

This appeal follows an article by a senior doctor, head of a hospital department in Johannesburg, who says he has reached "crisis point" in his life and has no option but to consider an overseas post.

His salary is only 15 percent more than that of his junior colleagues, and because it is fixed he cannot keep up with rising living costs, he writes in the South African Medical Journal.

COMPLAINT

By working 16 hours a week overtime he can boost his basic salary by four-elevenths. But as he gets this for clinical work only, he has, in fact, to work much longer overtime on administrative duties.

In any event, he says, his income in no way compares with men holding equivalent positions in commerce, or with doctors in private practice.

He also complains that, unlike juniors, senior doctors except professors are not entitled to sabbatical leave. Fulltimers may not even visit an overseas institution' while on leave without permission from the authorities.

Professor J N de Klerk, chairman of the federal council of the Medical Association, says he fully agrees with the doctor. The future of the medical profession in South Africa is so dependent on a satisfactory academic infrastructure that the legitimate grievances as expressed in the letter must receive the highest priority from the Government.

Doctors freeze own pay

PRETORIA — The Administrator will be asked in the Transvaal Provincial Council this week to accept a pay sacrifice from 100 white doctors at the Johannesburg General Hospital to make possible equal pay for black colleagues.

The doctors have offered to have their salaries frozen to provide funds for levelling black and white doctors' pay.

The MPC for Hillbrow, Mr David Epstein, said yesterday although it had been Government policy for several years to close the black-white pay gap, no significant progress had been made.

He praised the 100 doctors for their sacrifice.

"I will ask the Administrator and the MEC in charge of hospitals if they are not prepared to close the gap to agree to the unselfish gesture of the Johannesburg doctors."

The Medical Association of South Africa has repeatedly called for equal pay for doctors with similar qualifications and responsibilities.

There has been no move by the Government yet to apply this principle, either with doctors or in any other profession. — DDC.

93

93

Doctors in sacrifice for pay equality

STAFF REPORTERS

ONE hundred white doctors at the Johannesburg General Hospital have offered to have their salaries frozen to make equal pay for their black colleagues possible.

And the Administrator of the Transvaal is to be asked this week to accept the white doctors' pay sacrifice.

The MPC for Hillbrow, Mr David Epstein, said yesterday that though it had been Government policy for several years to close the black-white pay gap, no significant progress had been made.

There has been no move by the Government to apply this principle, either to doctors or to any other profession.

Mr Epstein praised the white doctors for their offer to sacrifice pay increases so that there could be justice for their black colleagues.

"I will ask the Administrator and the MEC in charge of hospitals, Mr De Haas, if they are not prepared to close the gap by agreeing with the unselfish gesture of the Johannesburg doctors," Mr Epstein said.

At a recent survey in the department of medicine at the General Hospital, 100 out of 119 doctors put their names to the proposal.

The Medical Association of South Africa has repeatedly called for equal pay for doctors with similar qualifications and responsibilities.

But the chairman of the federal council of the Medical Association, Professor J N de Klerk, said yesterday stop-gap methods of closing the black-white pay disparity were not the solution.

Professor De Klerk said: "The only answer is the elimination of professional salary discrimination. Professional groups must be taken out of the civil service salary structure and placed in a separate category where salaries will be equalised."

This way, there would be no ripple effect or disruption in the rest of the civil service salary scale. "We have already taken up the matter at a higher level," he said.

Prof De Klerk said the sacrifice proposed by the General Hospital doctors was well-meant but they were only a small section of full-time doctors making the gesture.

"Black doctors are not interested in haphazard attempts at handouts by small groups. What they want is Government recognition of their professional status as doctors."

Prof De Klerk also called for the reconsideration of the way fulltime doctors generally were remunerated.

At present they receive a set salary and overtime pay, a concession granted by the Department of Health following previous Medical Association representations.

"This method is unsatisfactory and an alternative must be found," he said. "The Department of Health is aware of the great disparity between salaries of full-time doctors and their private counterparts.

"Time is an iniquitous way of measuring the ability of a doctor. Doctors think in terms of quality, not time. Training, background and ability should also be taken into account," Prof De Klerk said.

transfer to farms where they were required were unsuccessful - practically all Natives who moved going to such places as they pleased" (26).

As a result of these obstacles, Lagden by June of 1904 was beginning to have serious doubts about the efficacy of the 1895 Law. As he wrote to ~~H~~ Native Commissioner for the Eastern Transvaa

> If this law ... own in the Transvaal is not capable of ... without bloodshed then I think the l... should be amended (27)

It also seel ... of this doubt on Lagden's part was due, to ... degree, to the fact that there was conside... istance to the attempts to enforce the Squat... ative Commissioner for the Northern Divisior ..., for example, reported in November 1904 tha... was being experienced in getting African s... into any agreements with White landowners ... nts were of a verbal and not of a written ... addition, by 1902 there was at least one impor... vement amongst Africans in the form of the Zc... Vigilance Association, which was formed by Levi ... 04 it was to form the basis of the Transvaal N... sociation. The T.N.V.A. in 1904 had a recor... 226 (29) but, despite its tiny size, undoubte... ve Affairs Department some cause for concern in that it held a meeting of chiefs from all over the Transvaal on 1st May 1904 (30). This worried Wheelright, Native Commissioner for the Northern Transvaal, since the meeting was being held at Pietersburg, which he felt demonstrated that the Association was being run on independent lines (31). In

/addition ......

Cape Times 4/6/77

R186 000 would close gap — MPC

IF THE Cape Province were prepared to spend another R186 000 a year it could eliminate the gap which at present exists between the salaries of white and black doctors.

Mr Herbert Hirsch (PRP, Sea Point) said he based this statement on replies to his questions during the present session of the Cape Provincial Council.

The money

He was speaking during the committee stage of the budget for the Hospitals Department. He was sure that if Mr P J Loubser, MEC in charge of Hospital Services, tried he would be able to find the money.

Mr Hirsch said he realized that such a move would not solve all the problems but the important thing was that it would make considerable impact and do a lot of good.

Nationalist members said the same would have to be done for nurses and it would be unfair to equalize the salaries of doctors only.

Mr Loubser will reply to the debate on Monday.

93

Hansard 20 Q col 1295 14/6/77

(93)

Investigation into salary scales of doctors in State employ

*3. Mr. R. M. DE VILLIERS asked the Minister of the Interior:

Whether a request has been received from the Medical Association for an investigation into the salary scales of doctors in State employ, if so, what was the reply.

†The MINISTER OF THE INTERIOR:

No.

24/6/7 DD (93)

Specialists top money-makers

JOHANNESBURG — South Africa's doctors, pressing for an increase in medical fees, are not starving. And their specialist colleagues are even more safely ensconced in the caviare class.

Statistics on the earnings of the medical profession are particularly relative at a time when they are pressing for increases in fees — and when there is mounting public criticism of the reluctance of medical men to do house calls.

Figures obtained from the Human Sciences Research Council show that more than half the country's medical specialists are earning in excess of R23 000 a year each — from their practices alone.

More than half the country's general practitioners are earning R18 000 a year — plus.

An investigation by the council has revealed that the specialists are the country's top earners. However, general practitioners are a bit down in the list, in sixth position, following chartered accountants, barristers, engineers and attorneys.

The council says that, in the field of self-employment, chartered accountants on average earn R20 000 a year; barristers R19 500; engineers R19 000; attorneys R19 000; doctors R18 250; building surveyors R17 500; architects R17 000; dentists R15 750; land surveyors R15 500; veterinarians R12 000; pharmacists R12 750; and farmers R12 000.

Interesting facts came to light when comparisons were made in the field of wages of professional people as employees.

The council surveyed 27 professions, and found that teaching, as a profession, is near the bottom, in 22nd position.

Topping the field here are employed medical specialists, at an average of R13 750, followed by company secretaries, with R12 000, chartered accountants with R11 750, and public relations officers with R8 750.

About half the country's teachers earn under R8 000 a year and the other half more, to lesser or greater extent according to service. — DDC.

STAR 4/7/77 (93)

SA doctors are flocking to Australia

Own Correspondent

BRISBANE — Growing numbers of South African doctors are making quick sorties into Sydney simply to get their names on the New South Wales medical register.

These doctors and ones from Asia are thought to be using Australia's easy registration laws as an insurance policy against possible political and economic upheavals in their own countries.

Last year there were only 14 South Africans among the 800 foreigners who recorded their names on the New South Wales medical register.

This year the figure is expected to leap to many times that number.

Several weeks ago a flight from South Africa brought a contingent of doctors and 47 registered in one day.

Dr J Martin, assistant medical secretary of the New South Wales branch of the Australian Medical Association, believes Asian and African doctors are "using Australia as a possible place to flee to."

He said influx of foreign graduates now posed a "major problem."

"We estimate that of the 12 000 doctors on New South Wales register only about 8 000 are practising."

The medical association is now asking for changes to laws on medical registration to bring about a limit on the number of doctors admitted.

IMMEDIATE

On one day last year 400 Hong Kong doctors flew into Sydney to register.

Said Dr Martin: "There should be no automatic registration of foreign graduates of certain countries which we have now. We want an immediate stop to registrations of convenience without proof of residence and we believe all doctors coming in should have to sit an examination regardless of their qualifications."

Dr Martin said in January the United States had stopped accepting foreign doctors.

"This means that European doctors who would have gone to the United States will now be looking toward Australia as a possibility with resultant bad unemployment problem for our own graduates," he said.

N. Mercury

3 DOCTORS GET MEDALS

Mercury 14/7/71
Correspondent

JOHANNESBURG — Three Johannesburg doctors were yesterday presented with medals by the Secretary for Health, Dr. J. de Beer, for their achievements in cancer research.

The Oettle Memorial medals were presented to Doctors J. S. Harington, J. J. Alexander and G. Macnab.

(93)

N. Mercury 16/7/77

Award for Dr. Stott

(93)

Mercury Reporter

DR. Halley Stott, chairman and founded of Natal's Valley Trust, has been awarded a doctorate in medicine by Edinburgh University.

He attended a graduation ceremony at the university.

Dr. Stott, who founded the trust 25 years ago, was awarded his doctorate for his thesis: Valley Trust a socio-medical project for the promotion of health in a less developed rural area.

(93)

Now doctors write essays to win prizes

By JENNIFER HYMAN

REPORTS of doctors writing essays for prizes in competitions organised by pharmaceutical companies are among further claims of "unethical" practices made to the Express this week.

The reports, which have angered organisations concerned with maintaining standards in the medical and pharmacy professions, follow the Express investigation into several pharmaceutical companies.

One of them, Pharmethica, was accused by doctors of offering them cash payments and air tickets in return for prescribing its products.

This week Mr P R van der Merwe, director of the Pharmaceutical Society of South Africa, said this practice had "virtually ceased" as a result of the Express report.

Chemists also reported a return to normal — after a period in which certain doctors had been prescribing Pharmethica products as if they were "the miracle drugs of the century".

Mr Van der Merwe told the Express of another incident in which a pharmacist had offered a free holiday to customers who purchased R100 worth of goods.

"We checked to see if this included prescription medicines. When we found that it did, we warned the pharmacist that we would report him to the Pharmacy Board."

Other cases reported to the Express include:

- A pharmaceutical company which held cocktail parties for doctors, who were asked to fill out a questionnaire on patient trends and then given a cheque each;
- A company which offered to pay half the cost of any of their products which doctors prescribed. This would have saved patients a considerable amount;
- A pharmaceutical company which ran an "essay competition" for doctors who had to write about the company's product. Winners received air tickets.

Mr Van der Merwe said his society strongly condemned "collusion" in the promotion, prescription and dispensing of medicines.

The Express has also received strong reaction to a report about three pharmaceutical companies which are controlled by 235 doctors.

One of the companies has 63 gynaecologists among its 66 shareholders, another has 33 specialists, and the third has 139 doctors on its shareholder list.

The Express has since discovered that none of the companies appears to employ medical representatives to promote their products.

Mr J J Clark, chairman of the Pharmacy Board's practices committee, stressed that doctors should consider only the therapeutic value of medicines they prescribed.

He added that if the Pharmacy Board believed "disruptive" practices had arisen and it did not have an ethical rule to cover them "we would ask the Minister of Health to promulgate one".

Companies share offices

Express Reporter

IT WAS stated in the Sunday Express on June 26 that a pharmaceutical company, Pharmethica, also operated under the names Biopharm and JAT.

The Express has now established that Biopharm and JAT, which also trades under the name Pharmethica, are separate companies, although they have directors in common and share the same head office and telephone numbers.

Products manufactured by Biopharm are distributed by Pharmethica, while entries in official registers of drugs list either Biopharm or Pharmethica as the manufacturer.

The Express also stated incorrectly that Biogesic — a pain-killing drug marketed by Pharmethica — was selling at almost twice the price of its equivalent, Stopayne.

The Biogesic capsule is in fact 51% more expensive.

The price comparisons which the Express should have quoted are: 200 Stopayne capsules — R15.04. 200 Biogesic capsules — R24.00.

D.D. 26/7/77

Race drives doctor out

(93)

JOHANNESBURG — Constraints imposed by separate development in South Africa are prompting a leading Johannesburg geneticist, Dr George Nurse, 49, to emigrate to Papua where he will have greater freedom in his research.

The senior lecturer in genetics at the Institute for Medical Research feels that Government restrictions hinder in-depth genetic studies of tribal blacks.

He leaves South Africa on Friday to take up a research post at the Institute of Medical Research in Papua, New Guinea, in October.

INSIDE

DAILY DISPATCH, TUESDAY, JULY 26, 1977 — 11

93

Army trainees can't see private doctors

JOHANNESBURG — A military trainee who falls ill during service cannot opt for private medical treatment — he must be seen by army doctors and treated at military hospitals, the Surgeon-General in charge of military affairs said yesterday.

Dr C. R. Cockcroft was commenting on the case of Frikkie Botha, 18, shown by X-rays to have cancer within a week of discharge from Voortrekkerhoogte Military Hospital with a diagnosis of a "virus in his stomach muscles."

Shortly after admission to a Johannesburg nursing home for emergency treatment, Frikkie was ordered back to Voortrekkerhoogte, where he underwent an operation on Wednesday. He did not want to return, according to his mother, Mrs H. Botha, of Heidelberg.

Frikkie, who has been in the army for a year, was examined at Potchefstroom and Windhoek before being transferred to Voortrekkerhoogte because his mother wanted him closer to home.

After six weeks in Voortrekkerhoogte he was discharged.

"A trainee is our responsibility until his service is over," Dr Cockcroft said yesterday. "We are liable for any sickness which occurs during training or any condition aggravated by training."

Asked why army doctors had failed to diagnose Frikkie's cancer, Dr Cockcroft said an X-ray could be negative one weekend and positive the next week.

Mrs Botha said yesterday her son's condition was reasonable. "The pain is far less," she added, refusing to comment further. — DDC.

N. Mercury 6/8/77

DOCTOR BACKS 'DEATH PILL'

93

Mercury Correspondent

LONDON—A doctor has advocated a death pill to get rid of geriatrics and prophesied a "demise pill" will be available before the end of the century.

"If civiliasation continues it will become obligatory," said Dr. John Goundry in Pulse medical magazine.

But Mr. David Hobman, director of Age Concern, said the article seemed totally inconsistent with the Hippocratic Oath.

"The doctor sounds neither humane, sensible nor civilised," he said.

Dr. Goundry said a fatalistic acceptance of death could help people improve the quality of their lives, and that there was gross indecency in becoming old and decrepit.

ARGUS 1/9/77

'Bonding' urged to retain SA doctors

93

The Argus Correspondent

JOHANNESBURG. — Bonding medical graduates immediately after qualification for 10 years' service in health care should be introduced to curb South Africa's alarming brain drain, a Wits University medical professor said in Johannesburg today.

Professor H. Seftel, Professor of African medicine at the University of the Witwatersrand, was speaking at a seminar at the university's medical school.

He said medical students were privileged people who were committed to serving community suffering. The community paid for the students to study at a medical school.

'I have no hesitation in calling for a system of bonding for graduate students to a period of 10 years' service in health care,' Professor Seftel added.

'Bonding graduate students might be the best way of selecting medical students who really cared,' he said.

Dr George Beaton, director of the division of continuing medical education at the university, said two surveys were conducted in 1973 and 1976 to find out how many Wits medical graduates had remained in South Africa.

The survey showed that about 46 percent of students who graduated between 1960 and 1973 had left South Africa and South West Africa.

Most had gone to the United States, Australia, New Zealand, Israel and Britain.

Since last December when the second survey was carried out, the brain drain had worsened.

TABLE 21. NUM[...] BE IN THE CITY

AREA [...] .A.R. MEN

1. Milnerton Munic[...] (farm labourers [...] Kilarney area) [...] Stable 'boys' M[...] [...] own 4,315 [...] 1,719
2. Bakoven to Port[...] (domestics, car[...] etc.)
3. Portwsood Road [...] Gate (domestics [...] takers, etc.)
4. Toll Gate to Ne[...] (includes Clare[...] Athlone, Lands[...]
5. Kenilworth to H[...]
6. Retreat to Kalk[...]
7. Salt River Brid[...] Paarden Island-[...] Industries
8. Fishhoek Munici[...]
9. Pinelands Munic[...]
10. Simonstown Muni[...]
11. Thornton
12. Bergvleit
13. Bishops Court
14. Constantia
15. Kirstenhof
16. Ottery

TOTAL [...] L 6,034

CITY COUNCIL TOTAL: 9,489

(93)

RDM 5/9/77

Doctors battle to beat rare germ

Staff Reporter

DOCTORS are still battling to eradicate an antibiotic-resistant germ which has spread among patients in a few hospitals in Johannesburg and Durban.

The rare organism, which can cause pneumonia, meningitis and other illnesses, has so far killed a patient at the Consolidated Main Reef infectious diseases hospital on the West Rand and caused serious infection in several others.

It spreads by inhalation, but not as rapidly as other infectious diseases.

Yesterday Dr H J Koornhof, head of the department of microbiology at the South African Institute for Medical Research, said patients and carriers were being isolated and treated to prevent the germ from spreading.

"Pneumococcis has not yet appeared among the general public outside hospitals," he said.

"We have tested enough people, particularly children, to be pretty sure that the multi-resistant germ is not widespread at this stage."

He said there was no cause for alarm and it was not necessary for doctors to change their conventional treatment.

There were at least three antibiotics which could still be used to treat patients infected by the resistant organism.

These include rifampicin, fusidic acid and novobiocin.

Dr Koornhof said the extensive use of antibiotics in hospitals could have prompted the appearance of the antibiotic-resistant organism.

It was less likely to spread as rapidly outside hospitals.

He said patients were not discharged until the germ had been completely eradicated.

"We have informed the Department of Health and the Department of Hospital Services. They are helping us to eradicate the organism," Dr Koornhof added.

Fight against germ

5/9/77 (93)

Mercury Correspondent

JOHANNESBURG — Doctors are still battling to eradicate an antibiotic-resistant germ which has spread among patients in a few hospitals in Johannesburg and Durban.

The rare organism which can cause pneumonia, meningitis and other illnesses has so far killed a patient at the Consolidated Main Reef Infectious Diseases Hospital on the West Rand and caused serious infection in several others.

It spreads by inhalation but not as rapidly as other infectious diseases.

Yesterday, Dr. H. J. Koornhof, head of the department of Microbiology at the South African Institute for Medical Research, said patients and carriers were being isolated and treated to prevent the germ from spreading. "Pneumococcis has not yet appeared among the general public outside hospitals.

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ot only an offence
n outside Rhodesia)
main urban areas)
in employment.
men, but the Minister
. The 69 000 foreign
ld appear to be those
hey constitute 35
workers in 1975.

YEAR	Foreign			All Workers		
	Male	Female	Total	Male	Female	Total
1972	203 658	18 130	221 788	696 663	105 177	801 840
1973	201 987	18 461	220 448	733 497	119 487	852 984
1974	199 333	18 418	217 752	766 055	123 373	889 428
1975	195 725	18 296	214 021	861 482	127 158	928 640

TABLE 7.

FOREIGN AFRICAN WORKERS IN RHODESIA
1956-75

Year	Number	% of Total
1956	309 775	50,8
1961	278 373	45,4
1969	229 154	34,0
1972	221 788	27,7
1975	214 021	23,0

Source: Rhodesia, Final Report on the September 1961 Census of Employees, C.S.O., Salisbury; Rhodesia, 1969 Census of Employees, C.S.O., Salisbury, (mimeo);
C.S.O., African Employees By Country of Origin, DL/978/15, Salisbury, (mimeo)

As an ....

400 doctors write to quit

8/9/77

JOHANNESBURG — At least 400 doctors from all over South Africa gathered at Rand Afrikaans University here yesterday morning to start writing the first United States visa-qualifying examination to be held in this country.

The two-day examination is now a necessary qulification for the admission of alien physicians to the United States for either permanent residence or participation in graduate medical education training programmes.

When a reporter asked doctors on their feelings about emigration, in a break between examinations, only one out of 30 said he was not considering leaving South Africa. — SAPA.

The [illegible] minor fluctuations in rainfall. The area i[illegible] nuary causing damage to the vegetation and crops [illegible]

Approximat[illegible] in, including hail, in this area falls with an inte[illegible] per 15 minutes and is accompanied [illegible] (farmers' commen[illegible] on) and generally falls between midday and 22h00 [illegible] 17h00 and 18h00 (Weather Bureau, 1965) [illegible] before 1902 (duration 1 to 3 minutes).

1.5 Soils

A reconnaissance soil survey of the Eastern Orange Free State has been undertaken using the classification designed for the soils of the Tugela Basin in Natal (Van der Eyk, MacVicar and de Villiers, 1969), and now accepted as the standard soil classification by the Soils Research Institute of the Agricultural Technical Services. (The soil forms referred to in this section have been defined in Appendix I). Past surveys by Van der Merwe (1962) classed the soils as gley-like pseudo-podsolic Highveld soils. A soil classification of the North West Orange Free State (Loxton, 1970) and of the whole Orange River Catchment area showed some similarities to the Eastern Orange Free State.

It has been established that there are certain soil catenas in the Eastern Orange Free State where landform and site factors are regularly associated with certain soil forms as in Fig. 1. The most recent soil survey in the Ficksburg-Clocolan area (Mulder, n.d.) gives the following soil forms; he does not describe the soil series.

1.5.1 Soils of the Cave Sandstone mesa surfaces

On the well drained hillocks of the mesa surfaces the major soils are sandy Hutton forms which have high potential for agriculture but, due to the inaccessibility of the mesa surface, are mainly used for grazing. On the lower slopes of the hillocks the Clovelly soil form occurs. This is similar to the Hutton and Avalon forms but is a more shallow type. Drainage lines on the mesa

We thank you for your [illegible] the Performer's Diploma [illegible] also applied for admi[illegible] degree course, please note that admission to the [illegible] to the Performer's Diploma [illegible]

In order to be consid[illegible] South Africa. [illegible] should prepare the fo[illegible]

1. [illegible]
2. An excerpt fro[illegible] 1 to 3 minutes[illegible]
3. A contrasting excerpt from a modern play (duration 1 to 3 minutes).

Improvisation and reading [illegible]

We recommend that you [illegible]

Please send to us as soon as possible a certified copy of your matriculation or matriculation exemption certificate and proof of symbols obtained in the matriculation or equivalent examination. Rhodesian students are asked [illegible] and a matriculation exemption certificate if available. These documents must reach the Registrar's office as soon as possible, and in any case not later than the third week in January.

Acceptance [illegible] to a University residence. If you have applied for admission to a University residence you will be informed of the result of your application by the Residence Officer of the Registrar's staff.

for Registrar

FR.4.77

my companion [illegible] no [illegible] one's eyes up [illegible] part of [illegible] the handsomest person I had [illegible] was a large quiet woman, who [illegible] type, yet wonderfully rich [illegible] Though she was not really o[illegible] she was very grave, even a little sad. She had the dignity of a Roman matron[illegible] and she handled coppers as if they had been [illegible] Trastevere who were perhaps as handsome as she; but even the head-dress of the Roman contadina contributed less to the dignity of the person born to wear it than the sweet and stately Arlesian cap, which sits at once aloft and on the back of the head; which is accompanied with a wide black bow covering as much as possible of the crown; and which, finally, accommodates itself indescribably well to the manner in which [illegible]

for a five-franc piece. She [illegible] again; of an intensely feminine type [illegible] a certain physical nobleness.

Patients hit as doctors quit

Sunday Times 18/9/77

(93)

THE MASS exodus of doctors from South Africa is beginning to hit patients.

All over the country patients are having to wait up to four months for appointments with specialists in fields such as ophthalmic surgery and dermatology.

By SUZANNE VOS

The exodus has now reached proportions of "considerable magnitude which can no longer be discounted", says Dr G. R. Beaton, director of the Division of Continuing Medical Education at the University of the Witwatersrand.

In a recent survey, Dr Beaton found that of the 1 252 doctors who graduated from Wits between 1960 and 1973, more than a quarter are now living and working overseas.

And in the past year alone more than 100 general practitioners and specialists have left the country.

Taxpayers contribute more than R20 000 to educate a medical student, so the "brain drain" — apart from much-needed manpower — is costing the country millions of rands.

At the University of the Witwatersrand's once-proud Medical School, the radiology department has been "badly hit" by the emigration of the professor, Dr Errol Levine, and four of his colleagues, say staff members.

At the University of Natal, the cardiology department has lost its professor, Dr Elliott Chesler, to America — four years after losing its previous professor to Israel.

At the University of Cape Town, the head of the Gastroenterine Unit at Groote Schuur hospital, Professor S. Bank, has left for England.

Large numbers of coloured and Indian doctors have already left, and they include Dr Barbara September, Dr Tony Grantham and Dr John Rampano, from Durban, who are all now working in Australia.

Leading Durban doctors who have recently left include paediatrician Dr Roger Hindle (New Zealand), dermatologist Dr Peter Lane (Canada), neurologist Dr A. Barnett (United States), orthopaedic surgeon Dr Len Simon (United States), anaesthetist Dr Ben Rogoff, (United States), radiologist Dr S. Gentin (United States), physician Dr M. Berger (Israel) and surgeon Dr S. Kaplan (United States).

In Johannesburg, biochemist Professor J. Balinsky has gone to the United States, together with surgeons Dr D. Nathanson, Dr Ian Drew and Dr Tony Hedley.

Accelerating

A well-known thoracic surgeon is also about to leave.

Several black doctors at Baragwanath Hospital are also known to be looking for posts overseas.

In Cape Town, orthopaedic surgeon Dr Eric Kref has gone to Tasmania and ear, nose and throat specialist Dr Derek Lipman to the United States.

According to one specialist physician the exit rate is accelerating.

"Things aren't going to get better — they're going to get worse," he said.

There is just one — ironic — glimmer of hope. Some British doctors unhappy with the National Health Service are emigrating — to South Africa.

Sun. Exp. 4/9/77

(93)

Medical exodus now stampede

THE medical exodus from South Africa is rapidly growing into a stampede — and tens of millions of taxpayers' money go with the doctors who are quitting the Republic to settle elsewhere.

400 SIT US EXAM, 12 QUIT A SUBURB IN MASS FLYAWAY

By KITT KATZIN and PETA THORNYCROFT

An extensive Express investigation has uncovered fresh evidence to show that more doctors than ever — from every branch of the medical profession — are packing their surgical bags, ready to leave for good.

Inquiries show that:

- Nearly 400 doctors from all parts of the country will gather in Johannesburg next week to write a stiff two-day "visa qualifying" examination that will help them to emigrate later to the United States.
- Forty-seven doctors registered in ONE day with the New South Wales Medical Board.
- Earlier this year 220 doctors flew to America in a desperate bid to beat the registration deadline for foreign graduates.

"It was a fantastic day." — Australian medical official who registered 47 South African doctors in one day.

To train these 667 doctors cost South Africa's taxpayers at least R20 million.

But Australia, it seems, has become the new haven for South Africa's "flyaway" doctors.

In the past few months:

- Twenty-one set up practices in Canberra.
- Twelve in Perth, Western Australia.
- About 150 have registered or made inquiries with the Australian Medical Association in Sydney;
- "Scores" of inquiries have been made in South Australia, Queensland and Victoria.

"It was a fantastic day," commented an Australian Medical Association spokesman when he described this week how 47 South African doctors queued up within a few hours to register.

The doctors, he said, mostly from the Transvaal, were all well-established and middle-aged practitioners.

Qualifications of South African medical men are recognised automatically in Australia, but the spokesman issued this warning:

"Taxpayers have a right to a return on their money," — Wits professor.

"Only general practitioners and anaesthetists are needed in Australia right now. We don't have any room for specialists or surgeons."

Doctors are also emigrating to New Zealand, Canada, France and England. But statistics are not available.

In Johannesburg, where the one-way brain drain is in full cry, an incredible 400 doctors will begin writing an American entrance examination next week.

The examination is controlled by the Educational Commission for foreign medical graduates, based in Philadelphia, which is the first step doctors can take towards eventually being granted a visa to emigrate to the United States.

"Obviously we are concerned about the matter." — secretary of the South African Medical Association.

In Johannesburg:

- Twelve doctors packed up and left from one northern suburb.
- Pharmaceutical representatives, in daily contact with doctors and consulting rooms, report that the shortage is critical.
- One medical man said this week: "Just show me 12 young doctors still in private practice in the city."

There are also reports that the emigration pattern has spread to dentists, psychiatrists, psychologists and a wide spectrum of specialists.

Figures, however, could not be obtained.

But with the outflow of medical men, the taxpayer is left holding the baby.

To the tune of tens of millions.

It costs roughly R30 000 to train one doctor in South Africa, which means the country will lose a minimum R20-million when 667 doctors finally leave for the United States and Australia.

The outflow has led to an appeal by some doctors that graduates should be subjected to State service to repay national, moral and financial debt.

"Taxpayers have a right to a return on their money," certain Wits medical school professors argue.

But the Department of Health does not favour compulsion.

This week the Deputy Secretary, Dr James Gilliland, dismissed claims that doctors were leaving in large numbers and said there had certainly been no exodus from his department.

"There has always been a constant ebb and flow of doctors between countries.

"Our health services have not been affected, although I concede more doctors may be leaving than before. Many of them, however, may have gone to study further and will return."

The secretary of the South African Medical Association, Dr C E M Viljoen, said there was no statistical evidence showing the exodus of doctors had increased.

However, he believed personally the figures were higher than usual, "and obviously we are concerned about the matter."

'No future here for me, my kids'

4/19/77

Express Reporter

"IT WAS a major emotional decision to leave South Africa, the land of my birth, my elderly parents, a city in which I am already established, and start all over again."

Those are the words of a young 28-year-old psychologist who leaves this country at the end of the month. He will settle, like hundreds of his colleagues, in America.

He doesn't want to go, and is losing financially by emigrating.

He started renovating his pretty Norwood cottage just after the Soweto riots of June last year. He sold it last month, in a hurry, and at a loss.

"I'm only staying because my wife won't leave her family." — Physician.

Earlier this year his only sister, a medical practitioner, also left South Africa and also settled in America.

"My future here is precarious. It has been a ghastly, traumatic and emotional upheaval.

"My sister and I are our parents only children and we are leaving them behind.

"I don't think there is a solution to our problems in South Africa. Perhaps the only chance would be if the Government changed, and fast, and undertook a massive education programme to equip people for that quick change.

"There is no political party at the moment who could engineer this kind of solution however.

"The Progrefs are full of hot air, and the other parties are incompetent. Perhaps there are Black leaders who have a solution, but as they are all either banned or in jail, the average White South African like myself doesn't know what their potential is."

This young psychologist told me that nearly 50% of his class who graduated in Johannesburg in 1969 have already left South Africa. A specialist physician in Johannesburg told me that the only reason he was staying on in this country was because his wife was close to her family and did not want to leave them behind.

"There is no future here for me or my kids. A situation like the one in Ireland is bound to erupt, and I know that we should leave now while we still have time, before I get any older.

"We are not giving fast enough, and I have no faith in the way the country is heading.

"The Black leaders of yesterday were moderate, and they were taken advantage of. Since Soweto they have lost power and the extremists are the ones who control our future now.

"I hope by the time I persuade my wife to leave it won't be too late."

Another doctor, a specialist in a unique position, head of a costly and vital unit in a provincial hospital is also leaving South Africa — but at this stage not for good.

He is going to America on a year's study leave, but he admits he will be looking around at possibilities, while he casts a wary eye at political developments in his country.

Speak to one doctor about his agonising decision to pack his medical bags and quit, and he will tell you about several others who have left, are leaving, are selling their practices, are in America, have settled in Australia, and the story is always the same.

"I don't think there's a solution to our problems." — Psychologist.

No future for their wives and young children — must make the move while they are young enough to adapt, hate to go, unstable future, urban terrorism on its way, the Government's desultory changes, and a new Black political power which is sweeping through the country.

"There is a seething Black majority who will rule no matter what, and the situation is now beyond control, even that of the Nationalist Government. The bitterness of the Blacks is too deep now, and things can never get back to what they were," said one young doctor who is leaving shortly.

Doctors' fees to rise by ten pc

D.D. 14/10/77

(93)

PRETORIA — The medical aid scheme fees of doctors will rise from November 1 by between eight and 10 per cent, the Minister of Health, Dr Van der Merwe, said here yesterday.

Doctors who have contracted out of the Medical Schemes Act are also expected to raise their tariffs. About 75 per cent of doctors have not contracted out.

The Minister said the increases would mean a rise in members' subscriptions to medical aid funds.

Subscribers in the lower income groups will pay about 35c more a month. Subscribers earning R1 000 a month will pay about R2 extra.

Dr Van der Merwe said he had an undertaking from the Medical Association of South Africa that doctors would adopt a responsible attitude in applying the new tariff of fees.

In determining the new tariff of fees, the remuneration commission had used a system of a schedule of relative unit of values for the first time. A unit was set at 80 cents.

The Minister said the new tariff of fees was substantially lower than that asked for by the profession.

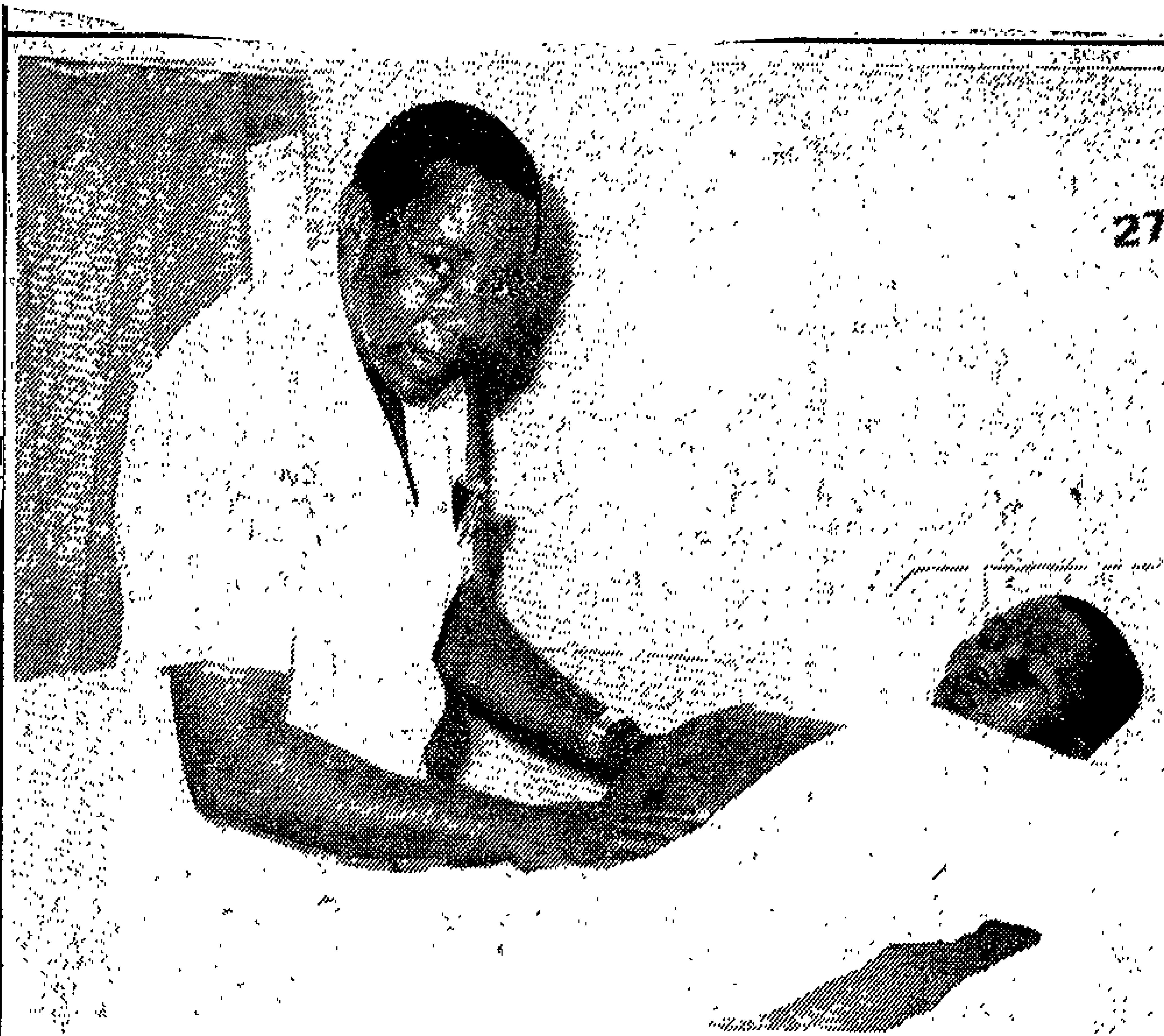
There was no limitation on what doctors who had contracted out could charge for their services, except that if they were excessive the Medical Council could act against them.

The chairman of the Representative Association of Medical Schemes, Mr J. D. Erntzen, said the increases would raise the costs of schemes by about four per cent.

Most schemes had found 1977 a heavy year — a year of increasing costs. Private hospital charges had been raised and provincial hospital fees had gone up substantially.

"Schemes will now have to raise their subscriptions. If they don't do this immediately the majority will be unable to hold out beyond the beginning of next year," Mr Erntzen said.

The chairman of the Medical Association of South Africa, Prof J. N. de Klerk, said from Cape Town the new tariff of fees meant the profession would carry the brunt of the substantial cost increases since fees were last raised. — DDC.



DR. E. T. Mokgokong in the wards at King Edward VIII Hospital.

African will head medical faculty

Mercury Reporter 27/9/77 (93)

THREE years after being overlooked for the post of head of the department of gynaecology and obstetrics at the University of Natal, Dr. E. T. Mokgokong has become head of the same department at the new Black Medical University of South Africa.

But in 1974 he was recommended for the posts of acting head and permanent head of gynaecology and obstetrics.

After discussions between the Province and the university, a doctor whom Dr. Mokgokong had helped train was made acting head and then Professor R. Philpott was appointed permanently.

Dr. Mokgokong received the M.B., Ch.B. and Dipl. Mid. (S.A.) at Natal Medical School.

Dr. Mokgokong, principal gynaecologist and senior obstetrician lecturer at the University of Natal, will become the first Black to head a South African medical faculty.

He takes the post at Medunsa, in Garankuwa near Pretoria, on July 1 next year. It will be the latest of many firsts for him.

Dr. Mokgokong was the first African to join the fellowship of the South African College of Obstetricians and Gynaecologists.

He was the first African to reach the rank of senior lecturer and principal specialist and the first elected to a local branch council of the Medical Association.

NATIONAL CERTIFICATE FOR TECHNICIANS OR NATIONAL CERTIFICATE IN :

Electrical
Mechanical
Mechanical
Structural
Building Fo
T O T

Doctors up in arms over tariff rises

Star 14/10/77

(93)

Marais Malan, Science Editor

Doctors are bitter about an eight to 10 percent average increase in medical aid tariffs. They regard the increase totally unrealistic.

And senior members of the profession foresee large-scale contracting out and an escalation of the brain drain.

"Certain disciplines will have no option but to contract out as they will not be able to keep their heads above water," a doctor said today.

Professor J N de Klerk, chairman of the Federal Council of the Medical Council. said doctors had absorbed a 42 percent rise in their expenses in the past three years.

Mr John Ernstzen, chairman of the Representative Association of Medical Schemes, said today it was difficult to determine exactly how the new tariffs would affect medical aid.

But if 10 percent was regarded as an average increase then medical schemes would have to pay only an additional three to four percent since doctors' fees constituted about 40 percent of the total benefits.

NO OPTION

"Sooner or later schemes will have to increase subscriptions as we have been faced with escalating costs apart from the new increase in medical tariffs," he said.

"For example, private hospital fees as well as physiotherapists' fees have increased this year."

The Medical Association of South Africa has so far declined to comment officially on the new tariff structure.

Dr Marais Viljoen, general secretary of the association, said the findings of the commission would be considered by the association's federal council on November 11 and 12.

A doctor said the increases would be a great incentive for more doctors to leave the country.

TURMOIL

"I agree with the Minister of Health that something should be done to prevent doctors from emigrating — but the tariff structure for contracted-in doctors is one factor that contributes towards the process," he said.

A specialist commented: "By and large this remuneration commission finding is going to create turmoil in the profession."

Medical fee rises gazetted

Pretoria Bureau

The tariff for a general practitioner's consultation, in his rooms, has been increased from R4 to R4,40 for doctors who are contracted in to medical aid schemes.

This was gazetted in Pretoria today, in a schedule containing more than 5 000 services rendered by the medical profession.

The new tariffs set for other common general practitioners with the former tariff in brackets:

CONSULTATION

Consultation at home, nursing home or hospital R6,80 (R6,05), maximum weekly fee for visits at home, nursing home or hospital R47,60 (R30,15) night visits R9,60 (R7,35) and weekend visits R8,80 (R7,35).

There is provision for an additional fee of R3,60 per quarter hour, in the case of emergency calls lasting more than half an hour.

The tariff for a first visit to a gynaecologist in his rooms has dropped from R11,30 to R11,20, with subsequent visits up marginally from R5,40 to R5,60. The maximum weekly fee chargeable is up from R26,90 to R39,20.

The fee for a first consultation with a psychiatrist in his rooms remains the same at R16, with subsequent visits up from R7,40 to R8.

The specialist's fees for an appendicectomy will rise from R68,80 to R72.

ON 3.10.77.

RS' REPORT

RAND DAILY MAIL, Friday, October 14, 1977. 3

(93)

Flight of doctors has Govt worried

IT WAS disturbing that during the first half of this year three times the usual number of doctors left South Africa, the Minister of Health, Dr Schalk van der Merwe, said yesterday.

In an SABC interview he said that if the drain on the country's medical resources continued the Government would have to instigate an urgent investigation.

The training of a medical student cost the taxpayer R30 000 and a responsibility rested on newly-qualified doctors to serve the country for at least a limited period.

Dr Van der Merwe said discussions on the admission of foreign students to medical faculties in South Africa would be held with the Committee of University Principals.

If it was found that students were abusing the privileges they enjoyed in the country preventative measures would have to be taken. — Sapa.

DOCTORS' FEES

FM 14/10/77

(93)

How big an increase?

As the *FM* went to press, the Minister of Health, Schalk van der Merwe, was about to present the Remuneration Commission's prescription for doctors' and physiotherapists' fees.

The last tariff took effect on January 1 1975 and was to be operative for three years. In some cases, fees were raised by as much as 42%. Since then the CPI has jumped by a third and the question now is how much the new scales will go up to follow it.

The Minister has no power to alter the tariffs proposed by Mr Justice R P B Erasmus' commission. The fees are in effect a maximum for doctors who have not contracted out of medical aid schemes.

The commission was appointed in April, and submitted its findings to the Minister on July 14. He is obliged to publish them within three months. Hence this week's announcement.

An earnings survey by the Human Sciences Research Council put the annual earnings of doctors at R18 250, and of dentists at R15 750.

Doctors' aid fees up by 8-10 percent

(93)

Mercury Correspondent 14/10/77

PRETORIA — The fees of doctors in medical aid schemes would rise from November 1 by between 8 percent and 10 percent, the Minister of Health, Dr. van der Merwe, said in Pretoria yesterday.

Doctors who have contracted out of the Medical Schemes Act are also expected to raise their tariffs. About 75 percent of doctors have not contracted out.

The Minister said the increases would mean a rise in members' subscriptions to medical aid funds.

Dr. van der Merwe said at a Press conference in Pretoria yesterday that he had an undertaking from the Medical Association of South Africa that doctors would adopt a "responsible attitude" in applying the new tariff of fees.

Powerless

He stressed that in terms of the relevant legislation the Minister of Health had no power to amend or reject the fees recommended by the Remuneration Commission.

Some fees had been raised by as little as 2 percent. Others had been increased by up to 12 percent.

They averaged out, however, at between 8 percent and 10 percent.

The minister said the new tariff of fees was substantially lower than those asked for by the profession.

There was no limitation on what doctors who had contracted out could charge for their services, except that, if they were excessive the Medical Council could act against those doctors.

He added that he was not wholly satisfied with the present system of determining fees, and said it was his intention to amend the legislation.

The chairman of the Representative Association of Medical Schemes, Mr. J. D. Erntzen, said the increases would raise the costs of schemes by about 4 percent.

Eragrostis chloromelas.

There appears to be some biotic factor which results in strong replacement of other species by Sporobolus fimbriatus. Sporobolus fimbriatus is not a common species and is found only in degraded veld on the north and west faces of talus slopes in the Clocolan area but Roberts (1973) notes that it is associated with partially overgrazed veld or disturbed areas where it acts as a sub-climax species. It grows tall and forms almost pure stands resulting in a photo image which is particularly uniform, smooth in texture and a light-grey (lgy) hue.

5.3.2 (v) Aster filifolius - Themeda triandra - Aristida diffusa co-dominant grassed dwarf shrubland community as represented by plots 20, 31, 32, 54 and 56 These plots are associated with dolerite rock either in the form of the steep sill edge, as in the case of Prynnsberg, or in the form of a dyke cutting through, or forming part of a talus slope in the Molteno Red Beds.

Sill talus slopes are characterised by a cover of less than 10 per cent tall shrubs such as Rhus dentata, Diospyros austro-africana, Rhus erosa and trees of Celtis africana. These species are not as common on the dyke situation.

On the sill situation Aster filifolius is the dominant species giving a dwarf shrub physiognomic type. This is largely due to the biotic factor of overgrazing resulting in grass basal covers of under 2 per cent. The climax of Themeda triandra, Eragrostis chloromelas, Elionurus argenteus and Heteropogon contortus

D.D. 15/10/77

Doctors reject fees

(93)

PRETORIA — A large body of South Africa's doctors have rejected the increases in the tariff of fees handed down to them by the Erasmus Remuneration Commission as totally unacceptable.

The chairman of the Medical Association of South Africa, Prof J. N. de Klerk, said: "Quite obviously we are disturbed by the commission's findings. We felt we had presented the commission with a well balanced and justified case."

Asked if the association had any recourse, Prof De Klerk said the issue could be taken on review to the Appeal Court.

However, he emphasised no such decision had been taken.

He did not believe there would be a medical brain drain.

According to the new tariffs announced by the Minister of Health, Dr S. van der Merwe, and gazetted yesterday, patients will now pay R4,40 instead of R4 for a consultation with a general practitioner.

General practitioner consultations at a patient's home, hospital or nursing home have been raised from R6,05 to R6,80, and night or weekend visits have jumped from R7,35 to R9,30.

In the schedule, containing more than 5 000 services rendered by the medical profession, the tariffs for specialist fees vary and in some cases are lower.

The tariff for a patient's first visit to a gyneacologist has dropped from R11,30 to R11,20 and consultation with a paediatrician has dropped from R16,25 to R16.

The inclusive fee for a normal confinement has jumped from R104,80 to R139,20 and a Ceasarian birth has gone up from R130,60 to R163,20. Specialist fees for an appendectomy will rise from R68,80 to R72. — DDC.

Higher doctors' fees start today

RDM 15/10/77

(93)

INCREASES of between 8% and 10% in the fees of doctors "contracted in" to medical aid schemes were announced by the Minister of Health, Dr Schalk van der Merwe, yesterday.

The amended tariffs were published in the Government Gazette yesterday and they come into effect today.

Dr Van der Merwe said there might be an increase in the public's contributions to medical aid schemes as a result of the higher tariffs, but in his opinion the increase would be "minimal."

About 75% of private doctors are "contracted in" to medical aid schemes.

The amended tariff of fees does not affect doctors working for the State or Provincial authorities.

Mr Van der Merwe said doctors who had decided to "contract out" of medical aid schemes were not affected. They could charge what they liked.

"I have consulted leaders of the medical profession and found their attitude to be understanding and constructive. They have undertaken to exercise restraint in the present economic circumstances. Some of them might even ask less than the prescribed tariffs," Dr Van der Merwe said.

"I cannot believe the medical profession has a purely materialistic view as far as this matter is concerned and I am confident that the appeals made to them will not fall on deaf ears."

Dr Van der Merwe said he was not entirely satisfied with the present system of determining doctors' fees and he would soon propose amending the law.

The new tariff system was based on a "relative system of unit values," the monetary value of such a unit being 80c.

Under the Medical Schemes Act, the Minister of Health was compelled to appoint a remuneration Commission last April.

The Act required the Minister to amend the tariff of fees as proposed by the Remuneration Commission within three months of receipt of the commission's report.

"In terms of Section 30 (1) of the Act, the Medical Association of South Africa directed a request to me at the beginning of this year to appoint a Renumeration Commission to review the tariff of fees for medical practitioners.

"Because two years had elapsed since the appointment of the last Remuneration Commission in respect of fees for medical practitioners, I was obliged to make such an appointment," Mr Van der Merwe said.

"Since the Act leaves the Minister no discretion I am also now obliged to publish the tariff of fees for medical practitioners according to the proposals of the Remuneration Commission."

The tariffs for medical practitioners who had, in terms of Section 29 of the Act elected not to render services to members of registered medical schemes at the tariff of fees, were not affected by the proposals of the commission, he said. — Sapa.

D.D. 17/10/77

Doctor hits at critics

(93)

CAPE TOWN — Prof J. N. de Klerk, chairman of the federal council of the Medical Association of South Africa, and head of the department of urology at Tygerberg Hospital, has criticised trade union leaders and medical-aid scheme representatives for "dictating" to the remuneration commission on doctors' fees and has appealed for a new deal for doctors of all races in fulltime hospital service.

In the latest issue of the South African Medical Journal Prof De Klerk said he was "heartily sick" of hearing that doctors were indifferent to the welfare of patients.

"I am no longer prepared to stand by and see the profession continually sneered at as if they were only interested in money and in enriching themselves at the expense of their patients," he added. — SAPA.

93

Star 20/10/77

Medics against strikes

The SA Medical and Dental Council has backed a proposal on measures to ban disruptive activities—such as strikes — by people registered with the council.

The proposal, an amendment to a motion put forward by the Secretary for Health, Dr J de Beer, was passed by a large majority of the council during its meeting in Johannesburg, which ended yesterday.

The council resolved to recommend to the Minister of Health "that measures be considered to prohibit anybody registered in terms of the Medical, Dental and Supplementary Health Service Professions Act from taking part in a strike, boycott or other action aimed at disrupting public health services and thereby endangering the lives and health of patients."

It also recommended similar measures to prevent any person inciting somebody registered according to the Act to take part in such disruptive action.

The council has accepted in principle a Bill to amend the Medical Schemes Act, 1967, and another to amend the Medical, Dental and Supplementary Health Service Professions Act (1974). Both Bills are expected to be published soon.

STAR 20/10/77.

(93)

Medical men hit on pay secrecy

Science Editor

The Medical Association of South Africa has been sharply criticised for its lack of co-operation and secretiveness over doctors' incomes and expenses in its evidence before the recent remuneration commission.

The commission, appointed by the Minister of Health to fix a new medical aid tariff, released its report last week.

The tariff has evoked large-scale dissatisfaction among doctors. An overall eight to 10 percent increase has been allowed but, in many instances, fees had been reduced — for some procedures as much as 20 percent or more. In some cases, for example consultation fees, increases have been as little as 15c.

Doctors had asked for a 34 percent increase.

But the commission, in its report, claims that it was hampered in its deliberations by lack of co-operation from the Medical Association.

It expresses its "displeasure" with the association for not taking it into its confidence on doctors' incomes and expenditure. Lack of such evidence may be fatal to its findings, the report alleges.

INCOME

As a result of this uncertainty the association of medical aid societies submitted that doctors kept their income and expenditure secret because they already earned enough money. This may be one reason, but not the only one, says the report.

Another possible reason is this: As long as doctors have the right to contract out and apply a tariff other than the statutory "medical aid tariff," the association can effectively paralyse the proceedings of a remuneration commission, mainly by neglecting to give relevant evidence.

"If the tariff suits them they remain contracted in, if not, they contract out and charge their own fees," the report says.

"Under the present Act, a remuneration commission can come to the correct and best conclusion only while it enjoys voluntary co-operation.

A spokesman for the association said today that the allegations of the commission would be fully answered in a supplement to the South African Medical Journal which is to appear on Saturday.

Medical men hit back on tariffs

Star 24/10/77 (93)

Science Editor

The medical profession, which has been sharply criticised for being "secretive" about its income and expenses in its evidence before the medical aid tariff commission, has hit back.

The Medical Association maintains that it was the duty of the commission to ask for the information, but it never did.

And its economic consultant, Professor J A Lombard, economist of Pretoria University, alleges that the commission made a subjective attack on the medical profession. In addition it did not meet the necessary standards of economic insight, objectivity and relevance.

These comments are contained in a supplement to the latest issue of the South African Medical Journal.

The association says no corroboratory evidence was led to support the commission's contention that doctors' incomes were the highest of all professions in the country.

FIGURES

Yet the commission regarded as unacceptable figures on doctors' earnings obtained from the Human Sciences Research Council and the Department of Statistics.

The association says it has no right to demand statements of income and expenditure from its members. Even if it could, various important factors would not be reflected, such as hours of work, sources of income, and costs of practice.

This association says its claim for an increase was based solely on economic arguments. It asked that the tariff be increased only to make provision for a true increase in the costs of practice plus a 10 percent increase in the net income of doctors (the amount given to public servants).

The association claims that the commission's statement that doctors negated the value of remuneration commissions by merely contracting out when the tariff did not suit them, was not based on the evidence.

There was, for example, no breakdown in the number of doctors who had contracted out who were in fulltime service or who had retired.

A draft Bill to abolish remuneration commissions and the right to contract out will be published soon. Tariffs are to be fixed by the Medical and Dental Council.

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In both course I and II the focus is on ... agriculturalists rather than on the more recent large-sc... ilizations such as those in Greece, Egypt and the near East ... e legitimate branches of archaeology, they are not taught at p... partment of Archaeology.

Archaeology III was introduced for the first time in 1976, changing the Archaeology major from two years to three. The course is offered in both the Arts and Science faculties and focusses on the investigative techniques of the archaeologist in the field, in the laboratory, and in writing prehistory. The course includes some practical training in museum methods, photography, mapping, and the like, but has a heavy emphasis on the applied science techniques employed by archaeologists. Fieldwork is required.

In Additional Archaeology (taken simultaneously with or subsequent to Course III) students with exceptional aptitude and interest pursue individual original research projects involving scientific applications in the analysis of archaeological materials, and participate in a research seminar. Laboratory and fieldwork are carried out as each project requires.

COMPARATIVE AFRICAN GOVERNMENT AND LAW I:

The material for this course is derived largely from Southern Africa with comparative reference to case studies in the political systems of East and Central Africa. The course includes an introduction to the comparative study of the politics of race, class, and ethnicity.

Comparative African Government and Law I may not be taken in the first year and Political Science I must be completed beforehand. It is suggested that the following course or courses should be taken prior to or concurrently with Comparative African Government and Law I. The suggested courses and their times of meeting are given below:-

Political Science I	meets at 9.25 a.m.
Economics I	meets at 10.20 a.m.
Sociology I	meets at 11.15 a.m.
African History I	meets at 8.30 a.m. (this course cannot be taken by a first year student)
Social Anthropology I	meets at 8.30 a.m.

Jo'burg man was link for recruiting

30/10/77

Sunday Times Reporter

A JOHANNESBURG doctor now in Texas was the South African connection between an American medical recruitment firm and local doctors eager to emigrate.

A Sunday Times investigation into the massive medical brain drain also revealed that:

- Four hundred doctors have left the country this year, though many ostensibly for study purposes. It is known, however, that at least 169 emigrated between January and July.
- Beween 10 and 15 doctors inquire each week about opportunities in America.
- Because of the exodus many GPs now see up to 50 patients a day and put in an 80-hour week to cope with the volume of work.

The secretary of the South African Medical Association, Dr C. E. M. Viljoen, said this week there was great concern about the number of doctors who were leaving the country.

"The Minister of Health has indicated that legislation may be passed to force doctors to stay in South Africa for a certain period after qualifying.

"As yet the Medical Association hasn't formulated a policy on the matter.

"There is a definite shortage of doctors. However, we can do nothing to prevent local doctors from operating an information service for overseas recruitment agencies."

Dr Viljoen was commenting on the case of Dr A. E. Mircea, who practised in Jeppestown until he emigrated to America about three weeks ago.

For nine months Dr Mircea acted as go-between for the Hospital Corporation of America, based in Nashville, Tennessee, which has an interest in 93 hospitals.

The Sunday Times traced him to the Bayshore Hospital Medical Centre at Pasadena, near Houston, Texas.

He said: "I maintained a post office box in Jeppestown for the corporation. Doctors who saw its advertisements in the South African Medical Journal wrote to the number.

"I collected the letters once a week and sent them, unopened, to Nashville.

"I regarded my role as a pure exchange of information. I was not recruiting and I did not make any money out of it.

"Nor do I know of any other South African doctor who was paid for recruiting."

Since he left for America, doctors have written directly to Nashville.

UALTY POSTS IN THE U.S.A.
international medical recruiting firm with U.S.A. who require experienced Physicians

OPHTHALMOLOGIST — CANADA
Take over established ophthalmological surgical practice in Winnipeg, Canada. Owner retiring. Reasonable Terms.
Contact: Dr J. Margolis, 312-388 Portage avenue, Winnipeg Man., Canada, telephone office: 204-943-3856, residence: 04-489-6672.

HOSPITAL CORPORATION OF AMERICA
DIVISION VII, TEXAS, U.S.A.
Offers opportunities to General Practitioners nd Specialists to open and establish independent rivate practices affiliated to ultramodern hospi als in Texas. No strings attached.

PHYSICIAN — TARANAKI HOSPITAL BOARD — NEW ZEALAND
Applications are invited for the whole-time or substantially whole-time position of Specialist General Physician to the Taranaki Base Hospital in New Plymouth.
It is preferred that applicants have a special interest in Gastroenterology or Neurology.
Salary will be within the scale NZ$15 111 to $19 467 a

MATER PUBLIC HOSPITALS
SOUTH BRISBANE, QUEENSLAND, AUSTRALIA
DIRECTOR OF RADIOLOGY
Applications for this position are invited from Specialist Radiologists who are able to register in this discipline in Queensland

(93)

Doctor ... Doctor ...

LITTLE JO'BURG IN LITTLE OLD HOUSTON

SPECIAL REPORTS: Wynter Murdoch in Johannesburg
David Langworthy in Houston

UP TO 50 South African doctors have settled this year in the Texan boom city of Houston. The South African colony is known as "Little Jo'burg".

They are drawn by uncertainty over South Africa's future, financial inducements and the city's extensive medical facilities.

Most are from Johannesburg and seem intent on washing their hands of any connection with South Africa.

Many refused to be interviewed and none would agree to their names being used.

One said: "I imagine we're regarded at home as traitors or rats leaving a sinking ship.

"Nearly all of us have relatives still living in South Africa. If we identify ourselves there could be the risk of eventual reprisals by people who resent our leaving.

"South Africa, after all, is on a war footing."

Another said: "I just want to forget South Africa. I don't feel I owe anyone any explanations."

Those who spoke to me listed these reasons for leaving:

- Fear for their children's future. One told me: "I didn't want my children to live under either the Nationalists or black majority rule." Another said: "I don't want any son of mine fighting for a system of apartheid I don't believe in."
- Political frustration: "I didn't vote for the policies of the present Government and I cannot change them," said one.

"I couldn't stay because I couldn't bear to live with them any longer."

- Financial gain. A general practitioner explained simply: "I am a capitalist. I can make more money here for the same or less work."

Few feel they have betrayed their country or express any regret. Several who practised for a number of years before leaving South Africa say they repaid any debts to their country by paying heavy taxes.

One said: "South Africa is a country of immigrants — people who settled there in search of a better life. They should understand our reasons for going."

Two or three of those I spoke to said Houston had not come up to expectations, but none said they would return to South Africa.

Early this year about a dozen South African doctors had been engaged by the big Memorial City Hospital on Houston's wealthy West Side. However, all but three moved out rather than compete with one another.

Today a number of South Africans are in private general practice together and others, including specialists, can be found on the staffs of other hospitals in the city.

One recent arrival said Houston was put on the map for South African doctors late last year by advertisements in the South African Medical Journal offering free office accommodation for a year, a guarantee of $5 000 gross billings a month and financial help in moving and settling in.

Hospitable

The doctors say these promises have been kept, with only minor exceptions.

The doctors I spoke to say Houston has been hospitable and they have encountered few adjustment problems. Told of reports in South Africa of widespread discontent, he said: "I can't imagine how that story started. We are all as happy as we could be away from home."

A GP's wife said she found little change in life style. "Houston has the pulse of Johannesburg and the humidity of Durban — and the people are just as warm."

Doctors are in great demand in Houston, whose 40 hospitals include internationally recognised centres for the treatment of cancer and cardiovascular diseases and for rehabilitation therapies.

More than 8 000 doctors practise in the area. In addition there are many places for medical students and housemen. South Africans can be found among them.

The doctors who have come to Houston form part of a larger South African colony of about 80 families in a variety of professions.

They are all part of a huge influx which has brought about 8 000 new residents a month to Houston and made it one of the fastest-growing cities in the United States.

Change

The sudden surge of interest in immigration to the US in late 1976 and early 1977 can also be explained by changes in the American immigration

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Change

The sudden surge of interest in immigration to the US in late 1976 and early 1977 can also be explained by changes in the American immigration laws which took effect this year from January 9.

Foreign doctors are no longer automatically placed in unrestricted employment categories but must satisfy immigration officials that they are not taking a job that could be done by an American.

All foreign doctors applying for immigration since then have had to pass a stringent visa qualifying exam. The first was in September. No results have been published.

The stricter entrance requirements have slowed the pace of new arrivals considerably. A spokesman for the Texas Employment Commission, the clearing house for job applicants under the new law, says only one South African doctor has applied for residence since February.

While the South Africans are happy with Texas, not all Texans are happy with them.

An American doctor said: "Some of them have come here expecting things on a silver platter. They're not prepared to put up with the slightest inconvenience. They seem to think they're a class apart."

Star 19/11/77

93

Bill may cause new exodus of doctors

Marais Malan, Science Editor

The medical pot in South Africa is on the boil. And it may boil over within the next few months unless the draft Bill which will force doctors to charge medical-aid tariffs without the right to contract out, is amended.

The effect, some doctors believe, may be disastrous for the future provision of health services and that the emigration of doctors, already a growing problem, may become an avalanche.

The removal of the right to contract out would mean the introduction of a system of bureaucratically controlled socialised medicine — but one which is not Government subsidised as in other countries with such a scheme, they say.

In most of these countries too, private arrangements may exist between doctor and patient.

Doctors are already up in arms over the tariff of fees introduced by the latest remuneration commission which, while laying down an overall increase of some 10 percent, is regarded as totally inadequate in view of rising costs of practice.

In many instances fees have actually been reduced.

The new Bill will abolish the remuneration commission, and instead appoint an enlarged Medical and Dental Council which will lay down the medical-aid tariff in future.

BIGGER DRAIN

But doctors point out that only nine of the 35 proposed members will be elected doctors, while the others will be Government appointees or those who are members by virtue of their position.

Senior members of the medical profession are convinced that if the proposed legislation is adopted in its present form the medical brain drain will increase.

They maintain that there are still plenty of opportunities for South African doctors to practice overseas, particularly as South African medical training is of the highest standard.

Sunday Times 20/11/77

'Odd' medical system defended

By LEONARD PORT

PROFESSOR Andries Brink, dean of the medical faculty at the University of Stellenbosch, this week defended a controversial system of private practice which has long been a bone of contention in medical circles.

Under the system, some senior Stellenbosch medical faculty members are allowed to treat patients privately at Tygerberg, the university's teaching hospital, which is financed by the taxpayer through the Cape Provincial Administration.

A Cape Town court this week called the system "strange" and "vague".

For private work in this semi-State institution some Stellenbosch academics are entitled to fees over and above their teaching salaries.

PROF ANDRIES BRINK
Good system

DR P. G. JOUBERT
Appealing

Crystal clear

No other South African medical faculty permits this. But, said Prof Brink, there was nothing either strange or vague about the system as suggested during the trial of Dr P. G. Joubert, former head of the university's department of orthopaedics, who is appealing against his conviction and sentence for fraud.

It was "a crystal clear" system similar to those in operation in teaching hospitals in the United States, Australia and much of Europe, said Prof Brink.

The system was established at Stellenbosch more than 20 years ago as an inducement to specialists interested in returning to academic life.

Academics wishing to treat private patients had to apply to a committee comprising the university rector, dean of the medical faculty, principal medical superintendent at Tygerberg and the Cape Director of Hospital Services.

But only those who had earned the right through outstanding academic achievements and contributions were granted permission, said Prof Brink.

With the introduction of a non-pensionable allowance scheme involving additional pay for university doctors, three years ago, the private patient system was "frozen".

No new applicants have been considered since then. Some of the doctors opted for the new scheme, making themselves eligible for overtime pay but giving up all rights to private practice.

Ten faculty members, including Prof Brink, remained within the old system and are still treating private patients. One has a standing allocation of six beds.

Prof Brink said the system was above reproach. Criticism was unjustified because full-time private practitioners had the "same opportunities and facilities in a large number of hospitals throughout the country."

Dr Joubert's appeal began in the Supreme Court, Cape Town, this week. It was postponed until next month.

Dr Joubert was sentenced in February this year in the Cape Town Regional Court to two years' jail suspended for three years after being found guilty on 72 counts of fraud involving more than R8 000.

'Improve pay, service deal for doctors'

STAR 29/12/77

(93)

Science Editor

Unless conditions of service and salaries of doctors in fulltime hospital and other posts are improved, the academic brain drain in South Africa will continue, says Professor J N de Klerk.

Professor de Klerk, chairman of the federal council of the Medical Association of South Africa, also said that compared with other Western countries, these conditions leave very much to be desired.

He was replying in the SA Medical Journal to a letter from Dr I W P Obel.

Dr Obel said fewer people were remaining in fulltime service and more and more were leaving the country.

Emigrating doctors were largely motivated by frustration with employment conditions in hospitals.

Dr Obel suggested that the situation would improve if a certain amount of private practice was allowed, salaries made negotiable, the salary structure reviewed and research facilities improved.

He also criticised the "totally iniquitous and growing gap" in the salary structure of white and black doctors.

Professor de Klerk says in reply that the Medical Association is not satisfied with the situation and will continue to press for essential reforms, including a proper salary structure for all members of the fulltime group.

DD 14/1/78 (93)

Doctors pull out of medical aid schemes

JOHANNESBURG — Private Doctors throughout South Africa are protesting against proposed Government legislation by contracting out of medical aid schemes.

This was confirmed yesterday by the secretary of the Medical Association, Dr C. Viljoen. Doctors have also written an open letter to the Minister of Health against a proposal which will abolish the right to contract out if passed by Parliament.

Many doctors had contracted out previously, not because they wanted to charge more than the set tariff for doctors who are contracted in, but because they objected to interference in their affairs, Dr Viljoen said.

A Johannesburg surgeon said yesterday he would give up his practice if the Bill became law." I am quite sure such legislation would accelerate the brain drain in the medical profession," he said.

Another doctor said the proposed legislation was the first step towards complete State control of all medical services.

If passed there would be nothing to stop the medical aid societies dictating what forms of treatment they would pay for and what they wouldn't, to the detriment of individual patients.

"The danger is that a financial institution will decide on a statistical basis what operation may be more successful, whereas for an individual patient another type of operation may be better," the doctor said.

It was not possible to establish yesterday how many doctors had contracted out of medical aid schemes in protest. — DDC.

... badly shaken woman told police ...

DOCTOR EXIT SLOWS DOWN

NM 20/1/78 (93)

Mercury Reporter

THE doctor exodus from South Africa is slowing down but there are still shortages of certain specialists, according to the chairman of the Natal Coastal branch of the S.A. Medical Association, Dr. F. Clarke MPC.

Psychiatrists, skin and eye specialists, specialist physicians and neurologists were in short supply, he said yesterday.

Patients were waiting up to six months for appointments with the few specialists available in these fields in Durban.

Another area where a shortage was being felt was in partnerships. Doctors were having difficulty getting good partners, an essential prerequisite for an efficient practice.

But there was no problem with locums, Dr. Clarke said, for many specialists did them between research and other activities.

Difficult

He said that it was difficult to calculate the number of doctors who had left permanently.

The figure of doctors absent from the doctors' roll was not a good indication as medical men travelled a lot for research or overseas experience, but many returned.

He estimated that the exodus had begun to slow down since America had stopped registering overseas doctors and Australia and New Zealand had tightened foreign entry.

Professor T. L. Sarkin, head of medicine at Natal University said the medical school and the provincial hospitals were "very full."

He said Durban had been less affected, probably because there had been less unrest here than in the rest of the country.

Dr. D. L. Gilliland, co-ordinating director in the State Health Department said the so-called exodus had not affected State hospitals acutely.

"We do not have a full complement in the remote areas like Northern Natal and Zululand but then we never have had. Doctors just don't like going there," he said.

Mdantsane doctor guilty over drugs

1/2/78 (93)

EAST LONDON — An Mdantsane doctor was found guilty of disgraceful conduct involving the drug Pethidine when he appeared before the Disciplinary Committee of the South African Medical and Dental Council at a sitting here yesterday.

The committee will recommend to the council that Dr W. B. Ntshona be suspended for six months, but that this sentence be suspended for three years. The council will decide on the sentence when it meets in April.

Appearing pro forma for the complainant, a Pretoria attorney, Mr W. du Plessis, told the hearing Dr Ntshona's use of Pethidine on some or all of a list of 65 patients was unnecessary, excessive, not in the interests of the patients concerned, not in accordance with good medical practice and harmful or potentially harmful to the patients concerned and that in one or more of the cases, the Pethidine did not find its way to the patients for whom it was prescribed.

The former president of the Border Coastal Branch of the Medical Council, Dr J. R. van Heerden, told the committee he had been alerted to prescriptions for Pethidine by chemists in the city.

He had discussed the matter informally with Dr Ntshona who had told him that a Mr Yako had appeared in court and had been found guilty of theft and forgery after he had stolen a prescription pad from Dr Ntshona.

Dr K. T. Goldswain told the committee Pethidine was an addictive drug that was used in private practice mostly as an analgesic and that he would hesitate to give more than 150 mg at one time.

An East London pharmacist, Mr A. E. de Wet, gave evidence of several prescriptions for Pethidine he had filled under Dr Ntshona's name, but under cross-examination by Mr L. L. Mtshizana, who appeared for Dr Ntshona, Mr De Wet said he could not be fully sure of Dr Ntshona's signature.

Another pharmacist, Mr G. Schlachter, said Dr Ntshona appeared to issue more prescriptions for Pethidine than other doctors.

Dr Ntshona said he had been practising medicine for 26 years and denied he was guilty of disgraceful conduct. He agreed that some of the prescriptions for Pethidine were his, but said the others had been forged.

During cross-examination, Dr Ntshona admitted some of his records and his drug book had only been filled in over the past two weeks, after the summons had been issued to him.

He also agreed that some of the Pethidine prescriptions were not always used on the patients for which they had been prescribed.

He said he kept a close check that his patients did not become addicted to the Pethidine.

After Dr Ntshona had been found guilty of disgraceful conduct, Mr Mtshizana told the committee Dr Ntshona had stopped issuing scripts for Pethidine and had taken his son into his practice so that the irregularities were being eliminated. — DDR.

3 000 doctors contract out

Marais Malan
Science Editor

The number of doctors in South Africa who are contracted out under the Medical Schemes Act has in one fell swoop, doubled since the beginning of the year.

This means they are not bound by the statutory tariff laid down for medical aid patients and can charge patients within ethical limits, what they like.

While medical aid benefits remain the same, patients themselves have to pay the difference.

This brings the total number of contracted-out doctors to just over 3 000 — an increase of 1 555 of whom 216 practise in the Johannesburg area.

This move is seen to follow directly on a recommendation by the federal council of the Medical Association of South Africa in November to doctors to contract out, mainly as a result of dissatisfaction with the findings and tariffs laid down by the fifth remuneration commission, published shortly before.

Doctors only had a few weeks in which to react to the association's call as notification of intention to contract out had to be submitted by the end of November to become effective by January 1.

Doctors who now wish to contract out have to wait until the end of March. It is feared the number who have contracted out now may be only the beginning of what may become an avalanche later this year.

Medical scheme administrators say the increase in the number of contracted-out doctors will increase their administrative problems.

For example, contracted-out doctors are inclined to omit the tariff number from their accounts. This causes delays as the schemes then have to contact the doctors concerned to obtain the information without which accounts cannot be paid or members reimbursed.

In November, I predicted that a stormy time lay ahead in medical politics. Not only is the medical profession bitterly disappointed in the new tariff.

The federal council of the Medical Association has rejected outright a provision in a draft Bill which abolishes the right of doctors to contract out.

The federal council maintained that such a measure was unnecessary as there were only a few doctors who exploited the public and the provision would not curb their activities anyway.

HANSARD No. 2 COLS, 52, 53, 54 8/2/78 (93)

Salary scales for doctors/dentists/pharmacists

10. Mr. N. B. WOOD asked the Minister of the Interior:

What are the salary scales laid down for (a) White, (b) Coloured, (c) Indian and (d) Bantu (i) doctors, (ii) dentists and (iii) pharmacists in State and provincial hospital services?

The MINISTER OF THE INTERIOR:

(a) to (d)

Rank	Salary scale (R per annum) White	Coloured/ Indian	Bantu
(i) Specialists			
Chief Specialist/Professor	17 490 (fixed)	14 850 (fixed)	12 870 (fixed)
Principal Specialist	16 170 (fixed)	13 530 (fixed)	11 910 (fixed)
Senior Specialist	14 850 (fixed)	12 390 (fixed)	10 950 (fixed)
Specialist	14 190 (fixed)	11 910 (fixed)	10 560 (fixed)
(ii) Medical Officers			
Chief Medical officer	14 850 (fixed)	12 390 (fixed)	10 950 (fixed)
Principal Medical officer	14 190 (fixed)	11 910 (fixed)	10 560 (fixed)
Medical officer	8 610 × 390–10 950 ×480–12 870	7 440 × 390–10 950–11 430	6 630 × 270–7 440 × 390–10 170
Intern	5 820 (fixed)	4 650 (fixed)	3 930 (fixed)

(iii) Dentists: As in respect of Medical Officers.

(iv) Pharmacists

	White	Coloured/ Indian	Bantu
Chief Pharmacist	10 950 × 480–12 870	9 390 × 390–10 950	7 830 × 390–9 390
Senior Pharmacist	8 610 × 390–10 560	7 7170–7 440× 390–9 000	6 090 × 270–7 440
Pharmacist	6 090 × 70–7 440 × 390–8 220	5 010 × 270–6 900	4 110 × 180–5 010 × 270–5 820
Trainee Pharmacist	4 470 (fixed)	3 570 (fixed)	2 454 (fixed)

The above-mentioned scales do not include allowances payable to the personnel.

Statistics on SA's loss of doctors

Political Staff

HOUSE OF ASSEMBLY. — There was a net loss of 100 doctors during the first 11 months of 1977 and 149 during 1976, the Minister of Statistics, Dr Schalk van der Merwe, said yesterday.

A judge, who has not been named, also emigrated. Another judge settled in the Republic.

Dr Van der Merwe was giving details of the number of professional people who had left South Africa and who had settled in the Republic, in reply to a written question by Mr David Dalling (PFP, Sandton).

Mr Dalling said afterwards that the figures "give he to much of the adverse rumours which have been circulating in the country about a mass exodus of professional people".

"It seems to me that the vast bulk of professional people are opting to stay in South Africa and make it their permanent home. This is a vote of encouragement which indicates a faith, that I share, in the future of our country," Mr Dalling said.

In 1976 228 doctors left South Africa and 79 immigrated. During the first 11 months of 1977 205 doctors left and 105 settled in the Republic.

Dr Van der Merwe

Altogether 2 028 professional people left the country in 1976, while 5 971 settled in the Republic — an inflow of 3 943.

During the first 11 months of last year there was a net loss of 423 professional people. A total of 3 342 left South Africa, while 2 919 settled in the Republic.

The minister said there had been a net gain of 24 dentists in 1976 and a net loss of 10 dentists during the first 11 months of last year: a gain of 44 veterinary surgeons in 1976 and 10 in 1977: a gain of 12 attorneys in 1976 and a loss of 12 in 1977; a gain of 175 teachers in 1976 and a loss of 64 in 1977; a gain of 68 architects and townplanners in 1976 and a loss of 43 last year.

In reply to another question by Mr Dalling the Minister of Immigration, Mr Alwyn Schlebusch, said 3 466 Rhodesian citizens had applied for residence permits during 1976 and 3 434 last year.

In his capacity as Minister of the Interior, Mr Schlebusch told Mr Dalling that 63 of the 1 955 people who applied for South African citizenship during 1977 had their application turned down.

Only the healthy should pay!

Star 11/2/78 (93)

The medical profession has certainly been making the headlines lately. Doctors contracting out, and open letters to the Minister . . . arguments about remuneration commissions that go back and forth!

Doctors feel that they are being hard done by, but others think that they are being paid too much. And so the controversy goes on, while the public are mystified by the whole proceedings.

But I wonder whether the correct issues are being discussed. Is the present way of establishing a doctor's fee the ideal? Let us take a look at the system.

The doctors have prepared a list of services to be rendered by the profession and have attached a price to each service. The present argument is about the price. I say that the argument should be about the system.

Is it right that those who draw up the price list should then be able to decide which items to charge for and therefore establish how big the fee should be? It is rather like a shopper going to the supermarket with an empty basket and having it filled up with goods by the manager, and then being made to pay for them, whether he needs them or not.

This, surely, is unsound economic practice. The customer (patient) has no say whatsoever in the amount of money which is to be spent. Rather, he is at the mercy of the professional who is supplying the service.

And, of course, the fees have to be paid, irrespective of the result. There is no discount for the unsuccessful operation or the wrong diagnosis. On the contrary, the patient is liable to be involved in more expenses to restore the situation.

This brings me to my point. Would it not be better for the patients if doctors were paid not for the things they do (which the patients have no idea of knowing whether they are necessary or not) but rather for the results they achieve.

With the present set-up, it undoubtedly benefits the doctor have a lot of sick patients. He gets no income from healthy people.

I say the situation should be reversed. Let the healthy people pay the doctor, because they are healthy, and let the sick be treated free of charge, without doctors referring to their price lists for services rendered. In this way, the incentive will always be to heal those that are sick as quickly as possible.

Doctors will now earn their money by keeping people healthy, which is, after all, their real function.

(93)

Schalk takes his medicine over Medaid Bill

Sun Times 12/2/78

By FLEUR DE VILLIERS

THE Government has backed away from its controversial proposal to prevent doctors and dentists from contracting out of medical aid schemes, National Party sources revealed in Cape Town this week.

The proposal, in the draft Medical Schemes Amendment Bill published late last year, led to an immediate clash between the Government and the Medical Association of South Africa, which recommended that its members contract out in protest against the clause.

Many doctors followed the association's advice, and this year the number of medical practitioners who declared that they were no longer bound by the medical schemes tariff was reported to have reached 3 000.

Bitter

Bitter exchanges between the association and the Minister of Health, Dr Schalk van der Merwe, were followed by intense lobbying.

Before last year's election many doctors are understood to have threatened to vote for the Progressive Federal Party if the Government did not change its stance.

This is believed to have led to heavy caucus pressure on Dr Van der Merwe to scrap the controversial clause.

Now, sources say, the Minister has yielded and the clause will go.

As in the past, doctors who regard the medical schemes tariff laid down by the Medical Remuneration Commission as too low will be allowed to contract out — and charge medical schemes patients as private patients.

'Hysterical'

National Party sources said that the reaction of the doctors to the draft Bill — which was published merely to elicit comment — had been "excessive and hysterical". The Medical Association, they said, had behaved "like a trade union".

Asked to comment, Dr Van der Merwe said he had met representatives of the medical schemes, the Medical Association and the Dental Association this week.

"Much progress was made and we came to an agreement," he said.

The Minister, who said the Bill in its final form could be tabled in two or three weeks would not disclose whether

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2. Have yo[...] n refused?

If yes, [...]

3. What pr[...] ur work?

4. What do[...] blems?

Do you [...] h workers on this or on othe[...]

Have [...] g together to get something chan[...]

To occa[...] only

Will you [...] farm?

Why/Why

Schalk takes his medicine over Medaid Bill

By FLEUR DE VILLIERS

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Asked to comment, Dr Van der Merwe said he had met representatives of the medical schemes, the Medical Association and the Dental Association this week.

"Much progress was made, and we came to an agreement," he said.

The Minister, who said the Bill in its final form could be tabled in two or three weeks, would not disclose whether he intended to drop the controversial clause.

He did, however, concede that "on some things we have had to think again and some slight changes will be made."

The draft Bill had simply been a working document designed to elicit comment, and the Government had received and considered comment from everywhere — not only from the three groups he met this week.

STAR 15/2/78

(93)

It's not what SA doctors ordered

Own Correspondent

BRISBANE — South African doctors who have been making flying visits to Australia in numbers of up to 45 a flight to become registered as potential Australian practitioners may soon find Australia less attractive than they believed.

It is estimated that by 1991 there will be a surplus of more than 1 000 doctors.

Fears of such a surplus have sparked a demand for both a drastic cut in the number of medical students accepted and a stricter control over the influx of foreign doctors.

The Australian Medical Association has recommended both these measures. It wants a cut of 10 percent in the number of first-year admissions to medical schools and in addition to a demand that the number of foreign doctors should be subject to quota, insists they should sit an examination and should be required to live permanently in Australia to become registered.

An official of the association, Dr George Repin, said the surplus of something like 1 000 doctors in 13 years would come about even if no more foreign doctors were accepted between now and 1991.

Chairman of the Health Commission, Dr Roderick McEwin, said for the first time in his experience Australian doctors returning from overseas could not obtain posts for non-specialists in hospitals at registrar level.

Doctors refute criticism of nursing homes

NM. 17/2/78

SIR, — Mr. Thys van Lingen has recently aired his views regarding private hospitals, and this resulted in your editorial comment dated February 8, 1978.

We feel that there is an opposite point of view which should be presented. Before labelling the costs incurred in private hospitals as disgusting, some facts should be considered.

Basically beds in provincial hospitals are subsidised by the tax-payer. These are expensive and cost about R50,00 per bed per day to maintain. They are not freely available to the private patient (the person who pays the lions share of the cost of the hospital bed by means of his income tax), who is thus forced to rely on private nursing homes and hospitals when he becomes ill.

Service

By and large private hospitals provide a good service at a bed cost below R30,00 per day, inferring that there is overall better and more economic management than in provincial bureaucratically run equivalents.

That the private hospitals or members of the medical profession who use them, should be sniped at by political opportunists, is as unjust as your rather biased comment of February 8.

The disparity in essential bed costs has not been publicised, nor has the fact that the Natal Provincial Administration charges high fees for the use of equipment in provincial hospitals, that has already been paid for by the tax-payer in the first place. e.g. A CAT brain scan at Wentworth Hospital, using a very expensive machine is subject to a further fee to the private patient.

In Natal the tax-payer must again pay for the use of the artificial kidney, radioactive isotope scan, and ultra-sound equipment which has already been indirectly purchased through his taxation.

These facts are difficult to reconcile with Mr. Van Lingen's attack on private hospitals, and his championing of the provincial hospital cause.

Remedy

One remedy would be for the provincial authorities to take over the privately run nursing homes in their entirety. Informed politicians should be gracious enough to acknowledge that the Province could not afford to do this, and should, therefore, be grateful for the role played by these institutions in serving those members of the public who are denied access to provincial institutions. There is no need for maintaining two separate camps of private and non-private medicine.

All hospital beds should be partly subsidised to care for both rich and poor alike. In this way the often overworked medical practitioner would be able to do his bit for the underprivileged in his community without having to travel the many miles to public or provincial hospitals, which in Durban, are located in such inaccessible places as the Beachfront and the Bluff.

The final point that should be asked is whether or not the public wishes to have a non-competitive homogenous hospital set-up, which may indirectly cost them more than the present situation of private and provincial hospitals.

PRACTITIONERS

HANSARD NO: 4
Col. 191, 192.
21/2/78

Skeerder.

Vraelys aan boer

93

1. Distrik

2. Aantal skape

3. Nommer van plaas

4. Gebruik u 'n skeerspan?

Indien wel,

5. Gebruik hulle meganiese of h

6. Hoeveel a) skeerders

b) dagsmanne is daa

7. Hoe lank werk hulle op u pla

8.

9.

10.

11.

12.

District surgeons

13. Mr. N. B. WOOD asked the Minister of Health:

(1) Whether there is a shortage of district surgeons in the Republic; if so, what is the shortage of (a) full-time and (b) part-time district surgeons in each province;

(2) how many (a) White (b) Coloured, (c) Indian and (d) Bantu (i) full-time and (ii) part-time district surgeons were employed by the State and undertook their own dispensing in connection with their State services during 1977;

(3) how many patients were treated by district surgeons during 1977;

(4) how many district surgeons are in receipt of a drug allowance.

The MINISTER OF HEALTH:

(1) Yes.

(a) Full-time

Cape	15
Orange Free State	12
Natal	10
Transvaal	24
Total	61

(b) Part-time

Cape	8
Orange Free State	1
Natal	3
Transvaal	3
Total	15

(2)

(i) Full-time	Employed	Own dispensing
(a) White	75	Nil
(b) Coloured	Nil	Nil
(c) Indian	Nil	Nil
(d) Bantu	Nil	Nil

(ii) Part-time	Employed	Own dispensing
(a) White	324	279
(b) Coloured	1	Nil
(c) Indian	3	Nil
(d) Bantu	2	2

(3) 4 810 000. This figure has been estimated, as all annual reports have not been received.

(4) 262.

ander: hoeveelheid

waarde aan boer

waarde aan skeerder

Dagsmanne: kontant ander: hoeveelheid

waarde aan boer

waarde aan skeerder

13. Hoe word die betalings bepaal?

Hansard 5, cols 295-6, 1/3/78

93

X

District surgeons

201. Mr. H. E. J. VAN RENSBURG asked the Minister of Health:

(1) Whether there were any vacancies for (a) full-time and (b) part-time district surgeons in the Republic at the end of 1977; if so, how many in each province;

(2) whether there was any increase in the salary scales of full-time district surgeons during 1977; if so, what are the present scales.

The MINISTER OF HEALTH:

(1) Yes.

(a) Full-time:

Cape	15
Orange Free State	12
Natal	10
Transvaal	24
Total	61

(b) Part-time:

Cape	8
Orange Free State	1
Natal	3
Transvaal	3
Total	15

(2) No.

Hansard 6 col 342 7/3/78

93

Students qualified as doctors

298. Mr. J. F. MARAIS asked the Minister of National Education:

How many students in each race group qualified as doctors at each medical school at the end of 1976 and 1977, respectively.

The MINISTER OF NATIONAL EDUCATION:

Figures for 1976—

	Whites	Coloureds	Asians	Blacks
U.O.F.S.	45	—	—	—
U.P.	186	—	—	—
U.S.	88	—	—	—
U.C.T.	128	11	7	—
U.W.	128	2	22	1
U.N.	—	3	32	22

Figures for 1977 are not yet available.

Ciskei pays all doctors the same

9/3/78 DD

KING WILLIAM'S TOWN — Black doctors employed by the Ciskei Government are receiving salaries which are on a par with salaries paid to their white counterparts in the homelands.

The Ciskei Government decided last December to upgrade the salaries involving nine doctors. Two of the doctors, Dr L. Piliso and Dr M. Pemba, are permanently employed at Mount Coke and Celilia Mkiwane hospitals.

The Medical Superintendent at Mount Coke, Dr L. Mzimba, was not affected by the upgrading as his salary from the outset was not affected by racial considerations.

Chief A. N. Mqalo, Ciskei's Minister of Health, said yesterday he was worried by the few black doctors in the Ciskei and the homeland had made available to some students' scholarships for medical studies.

"We have 15 students at medical school this year and we hope we shall keep on sending more to medical school, depending on the availability of funds for such an undertaking."

It was also announced yesterday by the chairman of the Ciskei Public Service Commission, Rev J. P. Ncaca, that salaries of public servants in the homeland had been raised with effect from January 1, 1978.

He said the 20 per cent allowance which the public servants have been receiving since July 1, 1976, would partly be consolidated in the revised salary structure.

Salaries for Ciskeian teachers, however, would not be raised for some time. — DDR.

14/3/78 (13)

Nearly 250 doctors quit Republic in 1977

CAPE TOWN — Confirmation of the medical brain drain, continuing discrimination in pay scales between black and white doctors in Government employ, and a further call for mass contracting-out of the medical aid schemes form the theme of the latest report to the Medical Association of South Africa.

The report, by the chairman of the federal council, Prof J. N. de Klerk, appears as an insert to the latest issue of the South African medical journal.

Masa records showed that 225 doctors left South Africa for overseas practice in 1977, but as not all doctors are members, the real total was nearer 250, Prof De Klerk said.

He reported "with regret" that the association's requests for the removal of pay and fringe benefit discrimination between black and white doctors in full-time service had still not been realised.

"I repeat the call by the federal council to all doctors to contract out for the present until such time as the question of the new draft legislation and practical problems in the application of the new statutory tariff are satisfactorily resolved," Prof De Klerk said. — DDC.

farm?

rmal or informal) between you district on wages or working ify.

l annual costs is taken by labour

2. Employment

1. Is there a shortage of labour in your district? If yes, what sort of labour?

2. If you wanted to, say, double your labour force, would you be able to find extra workers?
   If yes, how long would it take?

   How would you go about attracting them?

   Where would they come from?

   Do you think the farms around you could simultaneously double their labour forces?

or

2. If you wanted to increase your labour force, how many extra workers could you hire at your current starting wages?

PARLIAMENT

14/3/78 (93)

Bill won't peg doctors' fees

THE ASSEMBLY — The Government has dropped proposals which would have prevented any doctor charging fees higher than those laid down by the Medical and Dental Council.

Provisions in draft legislation published last year which would have meant doctors could not contract out of the Medical Schemes Act have been omitted from a Bill introduced here by the Minister of Health, Dr Schalk van der Merwe.

The Medical, Dental and Supplementary Health Services Professions Amendment Bill lays down that the set tariffs will be binding only on members who have not contracted out.

Draft legislation is published for information and comment before any final decision on a matter has been taken. Last year's proposals drew strong protest from the medical profession.

In terms of the new measure, tariffs — at present laid down by the Government after investigation by a remuneration commission — will be set by a tariffs committee to be established by the South African Medical and Dental Council.

The Bill also prohibits strikes or go-slow strikes by registered medical personnel which are intended or likely to disrupt state, provincial or local authority health services.

The provision carries a maximum penalty of a R1 000 fine or six months' imprisonment, or both. Convicted offenders will be struck off the medical register. — SAPA.

225 doctors left SA last year

Star 15/3/78

About 225 doctors left South Africa last year, according to the records of the Medical Association of South Africa.

But as all doctors are not members of the association, the true figure may be about 250, says Professor Guy de Klerk, chairman of the association's federal council, in his annual report.

"This is certainly not a mass exodus as some newspapers have implied, but it is undoubtedly many more than in previous years," he writes.

"South Africa cannot afford such a loss of its medical manpower."

Professor de Klerk says the ratio of doctors to population in South Africa is about one to 2 000, with the ideal set at one to 750 or 800. At the moment about 700 doctors qualify every year.

IMPLICATIONS

Most doctors who are leaving are academics or specialists.

"Seen in the light of the fact that it takes about 13 years and costs between R30 000 and R50 000 to train such a doctor, the implications of the situation are clair to us all.

"South Africa desperately needs every doctor in the service of the country," writes Professor de Klerk.

He appeals to the authorities to remove points of friction,and to his colleagues to think carefully before deciding to settle overseas.

Among these friction points he mentions salaries and conditions of service of fulltime doctors in State or provincial employ.

Other reasons why doctors are leaving include political considerations and concern over proposed legislation which tends towards socialism — in the view of the Medical Association.

(Professor de Klerk apparently refers here to a proposal to remove the right of doctors to contract out under the Medical Schemes Act. This has

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1. Name (f
2. Age.
3. Race
4. Home (t
5. Work ty
6. School:
7. Team
8. Number
9. How lon
10. How did you learn to do it?
11. Have you ever done any other work?

    If yes, brief employment record:

Place	Period	Type of work	W...	...asons for leaving
1.				
2.				
3.				
4.				
5.				

12. Have you ever thought of doing differen

    If yes, why don't you?

13. How much of the year do you spend doin
14. How many farms do you visit each year?
15. When you are not doing this work, do y... do other work?

    What?

n

Questionaire to workers (2)

been refused?

your work?

roblems?

.th workers on this or on

.ng together to get something

s onl

s farm

Star 15/3/78 (93)

Doctors welcome new fee rulings

Marais Malan
Science Editor

The Medical Association of South Africa has won its battle — the threat of what it regards as a form of socialised medicine has been averted and a medical aid tariff is not to be enforced by law.

A proposal which would have abolished their right to contract out under the Medical Schemes Act — and thus to charge their own fees — has been dropped.

Dr van der Merwe . . . most welcome.

The elation felt in medical circles at this turn of events is not reflected in the terse statement yesterday by the general secretary of the association, Dr Marais Viljoen:

"This is in accordance with the representations we have made to the Minister of Health, Dr van der Merwe and the move is most welcome."

Everyone is most careful not to appear to gloat over what can only be seen as a back-pedal by the Minister.

Last year he published draft amendments to the Medical Schemes Act and the Medical, Dental and Supplementary Health Services Act in an effort to improve a situation that had become intolerable.

NOT WORKING

The Medical Schemes Act was just not working. Remunerations commissions appointed under the Act to set a medical aid tariff were not satisfying doctors and more and more were contracting out so that they would be no longer bound by the statutory tariff.

The draft legislation proposed to remedy the situation in two ways:

- Abolish the remuneration commissions and empower the Medical and Dental Council to draw up a tariff, thus giving doctors a direct say in the process;
- Abolish the right to contract out.

The Medical Association, with reservations, could see the merit in the former. On, the latter it dug in its heels, and this was where the allegation of "socialised medicine" came in.

Representations were made to the Minister and this provision was dropped from the amendment Bills tabled in Parliament this week.

Late last year the association recommended to its members that they contract out as a mark of dissatisfaction with the tariff laid down by the recent remuneration commission.

Many responded and by the end of January the number of contracted-out doctors had almost doubled to 3 000.

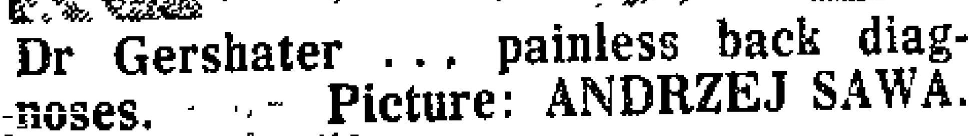
PROTEST

It seems a fair deduction that they contracted out, not only on account of the new tariff, but also in protest against the proposed abolition of their right to contract out.

Whether the trend continues remains to be seen.

It may well be that doctors who are still contracted in, will wait to see how the new system of tariff fixing by the Medical Council is going to work before deciding whether they, too, will join the ranks of the opted-out.

Medical first for South African



Dr Gershater . . . painless back diagnoses. Picture: ANDRZEJ SAWA.

A PAINLESS, simple and effective way of investigating back pain, sciatica and slipped discs has been perfected by a South African doctor.

It replaces one of radiology's most unpleasant investigations, myelography, which is painful, costly, and can have serious side effects.

The radiologist responsible for this medical breakthrough is Dr Raziel Gershater, a Pretoria Medical School graduate, now working at the North York General Hospital in Toronto, Canada.

It is a quick procedure with no side effects. The patient can be back at work within two hours. It has proved 98 per cent accurate compared with between 84 and 85 per cent for myelography.

By DOREEN LEVIN

Dr Gershater, who was in Pretoria this week on a brief visit, said: "Myelography is a very unpleasant and painful examination involving a dye being injected into the spinal canal.

"In many of the cases, blinding headaches follow, and the patient can be hospitalised for up to a week. Other complications, including arachnoiditis, a doctor-induced disease, can also occur.

"For these reasons I was looking for another procedure I worked on an idea formulated by some Swedish doctors 20 years ago, which they were technically unable to accomplish.

"I have shown this technique to be considerably more accurate in the diagnosis of slipped discs. This has created a great deal of interest all over the world

"Any radiographer can learn it quickly. It has already replaced myelography in many Canadian and American hospitals, and is spreading rapidly to other countries," Dr Gershater said.

He had lectured about the technique at Pretoria University, but it was not yet being done in South Africa.

"Although it is a much simpler procedure for the patient, it is more complex for doctors. Myelography is much easier to do," Dr Gershater said.

SA takes up case of fired Ciskei doctor

Sun Times 26/3/78

(93)

By ROB HUDSON

THE South African Government has taken up the case of Dr Rod McDade, who was instantly dismissed in January from his post as medical superintendent of the Ciskei's second-largest hospital.

The chairman of the federal council of the Medical Association of South Africa, Professor J. N. de Klerk, confirmed this week that the Government had taken up the matter with the Ciskei Government after approaches by the association.

Dr McDade had worked at Mount Coke Hospital, near King William's Town, for four years.

He was appointed medical superintendent 20 months ago, before Chief Minister Lennox Sebe's Government was elected under a constitution leading to independence.

On being dismissed, Dr McDade was told never to set foot in the building again.

He told me this week that he had been asked by the Medical Association to write a letter detailing the events leading up to his dismissal.

"My professional integrity has been questioned and I'm very upset," he said from the King William's Town hospital where he is now working.

Prof De Klerk told me: "This matter has to be handled delicately. White doctors in the homelands should have security of tenure; and this sort of incident encourages members of the profession not to take up these posts.

"If it happened that white doctors did not take up such appointments it would be to the detriment of the homelands as there is a great shortage of doctors there."

The Ciskei's Secretary for Health, Dr Jack Klopper, told me that the homeland Government was unaware of the latest turn of events.

"I would have heard if the Ciskei Government had been approached. I find this very strange," he said.

"All white posts here are temporary as they will be Africanised.

"We are all seconded and must accept that we have to go. We are only here to help train the people."

Vraely
Nommer
Landdr
Groott
Soort
wat
asie van plaasinkomste
skrywe moet word):
Aantal
is
Aantal
vroue
Aantal
"
Aantal
Afstan

Fired doctor's case to be probed

EAST LONDON — Dr Rod McDade who was dismissed from the Mount Coke Hospital in January has had his case taken up by the South African Government.

According to Sunday newspaper reports, Dr McDade was asked by the Medical Association of South Africa to write a letter detailing the events up to his dismissal by the Ciskei Government.

The chairman of the federal council of the association, Professor J de Klerk, has confirmed that the Government had taken the matter up with the Ciskei Government after approaches made by the association.

Dr McDade had worked at Mount Coke Hospital near King William's Town for four years, and was appointed medical superintendent nearly two years ago.

He was quoted by the newspaper as saying "My professional integrity has been questioned and I am very upset."

Dr McDade, who is now working at Grey Hospital in King William's Town, could not be contacted yesterday for comment. DDR.

DR McDADE

Skeerders

Vraelys aan boere

1. Distrik
2. Aantal skape
3. Nommer van plaas
4. Gebruik u 'n skeerspan?

   Indien wel,

5. Gebruik hulle meganiese of handskere
6. Hoeveel a) skeerders

   b) dagsmanne is daar in die

7. Hoe lank werk hulle op u plaas elke
8. Waarvandaan kom hulle?
9. Hoe werf u hulle?
10. Hoeveel keer het die span reeds op u
11. Hoeveel skape skeer hulle weekliks?
12. Betaling

    Skeerders: kontant ander: ho

    wa

    wa

    Dagsmanne: kontant ander: hoe

    waa

    waa

13. Hoe word die betalings bepaal?

4 — DAILY DISPATCH, THI

93

30/3/78 DD

De Beer hits at Amnesty

CAPE TOWN — The Secretary for Health, Dr J. de Beer, yesterday rejected as false and contemptible allegations by Amnesty International that certain details of the health of detainees are withheld or covered up by doctors.

Addressing the fifth South African International Symposium on Forensic Medicine at Tygerberg Hospital, Dr De Beer said Amnesty International was campaigning against South African doctors practising forensic medicine.

From letters received from the international body, it seemed South African doctors "are now alleged to be accomplices in malpractices involving even torture of the persons under their medical care.

"A terrible aspect of these allegations is that Amnesty International regrets that it is not able to supply any details of the accusations, but expects the doctors to supply these details themselves."

"I wish to state emphatically that I reject these accusations and insinuations with all the contempt at my command," he said.

South African doctors had never allowed themselves to be used for purposes other than the welfare of their patients "and, in keeping with the highest traditions and ethical standards of the medical profesison, we will never allow this to happen.

"I say this to the world: these allegations are devoid of all truth." — SAPA.

Hansard 8 31 March 1978
Question 11 Cols. 474 & 475.

93

Salary scales for State-employed doctors/nurses

*11. Dr. A. L. BORAINE asked the Minister of the Interior:

Whether the differences in salary scales for State-employed doctors and nurses, respectively, in each race group were decreased during 1977; if so, what is the present ratio of scales; if not, why not.

†The MINISTER OF INDIAN AFFAIRS (for the Minister of the Interior):

The differences in salary scales for State-employed doctors and nurses, respectively, in each population group were not decreased. The salary increases which be-

came effective on 1 January 1978 only constitute a general relief measure and did not provide for narrowing of the salary gap.

Hansard 9 5 April 1978
Question 203 -49- Cols. 540.

93

EDA AQUACULTURE PROJECT

by Ross Duncan Brown

March 1978

EDA has built up [illegible] ning information and articles on f[illegible] e is a vast quantity of aquac[illegible] have been selective to some extent, f[illegible] than scientific papers.

Much of the resea[illegible] late primarily among research wo[illegible] tion of such material into projects tha[illegible] earch work. At the same time through [illegible] "Link", the EDA magazine, we are [illegible] a potential rural development.

Patients treated by district surgeons

203. Mr. H. E. J. VAN RENSBURG asked the Minister of Health:

How many patients in each race group were treated by (a) full-time and (b) part-time district surgeons in each province in 1976 and 1977, respectively.

The MINISTER OF HEALTH:

(a)	1976	3 112 750
	1977	2 746 000
(b)	1976	3 330 500
	1977	2 064 000

The records of the Department are not kept according to population groups.

Children treated for malnutrition

290. Mr. N. B. WOOD asked the Minister of Health:

(a) How many (i) White, (ii) Indian and (iii) Coloured children have been treated for malnutrition in the last year for which figures are available and (b) what is the estimated cost of such treatment.

The MINISTER OF HEALTH:

Malnutrition is not a notifiable disease and no reliable information on malnutrition conditions is available.

(a)(i), (ii), (iii) and (b) falls away.

Practical Experin[illegible]

Two projects are [illegible] Town. One is a viability study [illegible] d the other involves more or less con[illegible] dams. EDA's emphasis has been on fish [illegible] needs of areas experiencing pro[illegible] eveloped areas. Bearing this in mind we have utilised existing dams for our projects rather than constructing made-to-order fish ponds. We believe that if fish farming catches on at a grassroots level it will bear little resemblance to the model rectangular pond with sloping bottom, monks weir, and demand feeder.

There are two aims to these experiments. Firstly, there is a shortage of people who know anything about fish farming. It's a mistake to assume that the personnel at the Government Hatcheries are experts on fish farming. In fact it is generally not within their field at all. We've therefore aimed at interesting voluntary workers in our programmes and given them a chance to actually handle fish. This gives them some insight into the fish farming process so that they do not advertise fish culture as a rural development without understanding some of the practical problems themselves. It is important to realise that fish farming by itself is no panacea for nutrition problems. At best it is merely one element, albeit an important one, of our integrated development approach.

The second aim of EDA's experiments was to experience the practical

Hansard 9 -51- 5 April 1978
Question 317 Cols. 542 & 543 (93)

After a lot of trial and error I've found that very good results can be achieved with a throw net for sampling, and a gill net for harvesting.

District Surgeons

317. Dr. A. L. BORAINE asked the Minister of Health:

(1) What is the present salary scale for full-time district surgeons;

(2) when did this scale come into operation.

Cage Cul[...]

This pro[...] f Cape Town in conjunction with the Envi[...] is a section of the student's environm[...] sists of a frame 5m x 6m which floats o[...] n the water, suspended from the frame.

543 WEDNESDAY,

The MINISTER OF HEALTH:

(1) Chief district surgeon: R14 850 (fixed).

Principal district surgeon: R14 190 (fixed).

District surgeon: R8 610 × 390–10 950 × 480–12 870

(2) 1 January 1978

We got go[...] have 100 Tilapia in the cage now and w[...] winter. Before next summer we'll hav[...] s a control. I'm very interested to hear fr[...] out cage culture.

Future Pla[...]

At the end[...] an Aquaculture Conference to discuss th[...] ern African and work out a strategy for fisheries development in the future. One of the things that emerges from this survey is that people involved in the field need to get together on a person to person basis and swap information and skills. A conference of this nature is long overdue, and I think it could answer a lot of pressing questions and interchange of ideas.

For the scientist there will be the challenge of relating scientific research to practical goals. For the layman and the farmer there will be an opportunity to meet and discuss fish culture with experts. We expect this conference will be very fruitful.

The conference is still in the planning stages, venue and dates have yet to be finalised. We would welcome suggestions on any aspect. Interested parties should contact the EDA Cape Town Office.

Doctors' share in hospitals criticised

Political Staff

CAPE TOWN — The Senate was told yesterday of a Durban man being forced by his doctor to go into a private hospital at high cost — only to find that the facilities required for his treatment were all available at Addington Hospital.

Senator Eric Winchester (PFP) described doctors holding shares in private hospitals as being on a par with doctors holding shares in graveyards.

Speaking in the third reading of the Medical Schemes Amendment Bill, he called on the Minister of Health, Dr Schalk van der Merwe, to bar doctors from holding these shares.

"Very often doctors persuade their patients, who are probably at that stage so ill that they cannot think clearly, to go to a private institution instead of one of the provincial institutions."

Senator Winchester, said Addington was a very well-equipped and well-run provincial hospital.

"The patient was admitted to a private institution, and after a couple of days, he found that the fees were so high, that they nearly caused his death anyway.

AVAILABLE

"He then discovered that the facilities required for his treatment, as well as a bed, were available at Addington Hospital.

He said doctors often held shares in the private hospitals.

"I am not saying that is the reason why they direct their patients there, but one suspects that it is the reason.

"As far as I am concerned it goes against the grain that a doctor should have shares in a private institution and then direct his patients to that institution when they can get that same treatment in a government institution which, generally speaking — I cannot speak for them all because I lack the knowledge — is highly motivated and well-equipped, with a highly-trained staff."

"As far as I am concerned it goes against the grain that a doctor should have shares in a private institution and then direct his patients to that institution when they can get that same treatment in a government institution which, generally speaking — I cannot speak for

6/4/78 DD (93)

Mdantsane doctor dies after flu

EAST LONDON — The deputy head of the gynaecology department at Cecilia Makiwane Hospital, Mdantsane, Dr Xola Pemba, 30, died at his flat in Zone Seven, Mdantsane, yesterday morning.

Dr Pemba, who is believed to have died of pneumonia, had a heart ailment.

He was born in Port Elizabeth, the first of nine children of the late Mr and Mrs Jimmy Pemba, of Red Location, New Brighton.

He qualified as a doctor at the University of Natal and served for some time at Livingstone Hospital before moving to Mdantsane to start a private practice. For some time he was on the staff of Frere Hospital and also served at Grey Hospital, King William's Town.

He joined the staff of the Cecilia Makiwane Hospital on a permanent basis late last year.

Dr Pemba had been writing examinations for a senior degree in gynaecology at the time of his death.

DR PEMBA

A friend said he complained of influenza on Monday and was shivering on Tuesday.

He got up in the early hours of yesterday morning and ordered some injections and died at about 1 am.

Funeral arrangements had not been finalised but it is expected he will be buried in Port Elizabeth.

Dr Pemba was unmarried. — DDR

7/4/78 (93)

Death: phone service blamed

EAST LONDON — A friend of Dr Xola Pemba, the deputy head of the gynaecology department at the Cecicila Makiwane Hospital, Mdantsane, who died on Wednesday morning, has claimed he could have been still alive if the telephone system in Mdantsane was reliable.

Mr Major May, an electrical contractor, who was one of the first people who got to Dr Pemba's flat when an alarm was raised, said a woman had tried to raise his number for more than an hour.

The woman then walked to the hospital to get an ambulance because she could not drive.

Mr May was taken to Dr Temba's place by ambulance and they arranged to call Dr L. Msauli, who certified Dr Pemba dead. Dr Pemba, who died of pneumonia, had a heart ailment.

"If the staff who worked at the exchange that night had done their work, Xola would probably be still alive because if they had acted on calls booked, Dr Msauli would have got to Xola's place in good time," Mr May said.

He said efforts had been made to raise his number and the operator had answered only after an hour and did not get back to say what was wrong.

When they tried to raise Dr Msauli's number they did not get a reply and had to drive to his place.

"And to add insult to injury, when we tried to raise Xola's relatives in Port Elizabeth the man who replied said: 'Is it you again, kwedini?' Mr May said. Efforts to get comment from the Post Master at Mdantsane, Mr S. Ngcaba, failed yesterday. He was reported to be out for the afternoon.—DDR

SUNDAY TRIBUNE, APRIL 9, 1978

(93)

Interest in private hospitals under fire

DOCTORS' SHARES: NEW PROBE

By TONY SPENCER and PENNY SWIFT

THE MEDICAL and Dental Council is to probe the controversial issue of doctors holding shares in private hospitals.

This follows sharp criticism of the practice by the Minister of Health, Dr Schalk van der Merwe, who believes it could lead to abuses.

Until this week, the emotive issue of whether doctors should have financial interests in private hospitals, nursing homes and clinics has been avoided by the Government.

Although it has been discussed by top Department of Health officials, it is said by the Secretary of Health, Dr Johan de Beer, to be a sensitive matter which is difficult to solve.

Dim view

During the third reading in the debate of the Medical Schemes Amendment Bill in the Senate this week, Dr van der Merwe said he took a dim view of the practice. But he would not take legislative measures to prevent doctors holding shares.

It was difficult for the Government to intervene in what was an ethical problem, he said.

He did not believe the Medical Council took too good a view of doctors having shares in private hospitals, and it was for this body to exert its influence over professional medical men.

He was replying to a question from Senator Eric Winchester who complained there was a clash between a doctor's duty and his pocket when he sent patients to hospitals where he had an interest, and where fees were high.

The Senator had asked whether there was a way to bar doctors from sending patients to hospitals where they had shares when the patients could be properly treated in provincial hospitals at lower cost.

A **Sunday Tribune** investigation last month found the practice of doctors having shares in private hospitals, nursing homes and clinics to be widespread. In Durban alone, almost 100 doctors, dentists and specialists hold shares despite the fact that the De Villiers Commission of Inquiry, which investigated private hospitals several years ago, found it inadvisable.

Usual

According to a Department of Health spokesman, last week's Senate debate will be referred to the Medical Council as is the usual procedure when matters involving professions are debated in Parliament.

He said the council would discuss the issue and according to the council registrar, Mr Willem Barnard, it will be the first time the Medical Council has considered the matter.

Mr Frank Martin, Natal MEC in charge of hospitals, welcomed a Medical Council probe into what he said had caused confusion and unhappiness over the years.

"Even if doctors send patients to private hospials where they have shares for the very best reasons, people are still suspicious."

The public would always have doubts about a doctor's motive, and this was the quickest way to destroy the patient-doctor relationship.

Ethical

"The sooner the Medical Council looks at this, the better it will be for doctors and patients.

Mr John Ernstzen, chairman of the Representative Association of Medical Schemes, agreed that the issue should be examined by the Medical Council. It was an ethical matter and legislation should not be introduced.

And Mr Barney Hurwitz, a director of two of Durban's private hospitals St Augustine's and Parklands — angrily countered Senator Winchester's criticism.

"Mr Winchester should get his facts right," he said. "He does not realise that the taxpayer — you and I — is subsidising patients at the provincial hospitals."

About 14 doctors hold shares in Parklands Nursing Home (Pty) Ltd. and most of them are specialists. Another eight doctors are directors of companies which hold shares. Among them, the doctors and their companies hold 35 920 of the 163 405 ordinary and preferential shares.

No doctors appear to have shares in St Augustine's Hospital (Pty) Ltd or the major shareholder — St Augustine's Holdings (Pty) Ltd.

Hansard. 10 – 14 April 1978
Question 393 Col. 598 a 599.

(1) 93

Vrolys aan plaaswerkers (2)

m die probleme op te los?

Persons in health service professions who emigrated

393. Mr. N. B. WOOD asked the Minister of Statistics:

(1) How many (a) Whites, (b) Coloureds, (c) Indians and (d) Bantu in the different professions associated with health services emigrated from South Africa during the last 12 months for which figures are available;

(2) what is the number of each race group in each such profession.

The MINISTER OF STATISTICS:

	(1) Emigrants 1977 (a) Whites
Doctor	213
Dentist	25
Veterinarian	5
Pharmacist	30
Pharmaceutical Assistant	10
Dietitian	3
Professional Nurse	215
Nursing personnel not elsewhere classified	26
Optometrist/Optician	7
Physiotherapist	46
Radiographer	16
Health worker not elsewhere classified	15

Figures in respect of (1)(b) Coloureds, (1)(c) Asians and (1)(d) Bantu not available.

(2) Figures for the last 12 months are not available. The latest figures available are those compiled according to the 1970 Population Census.

Population Census 1970

	(a) Whites	(b) Coloureds	(c) Asians	(d) Bantu
Doctor	7 929	139	514	175
Dentist	1 202	2	10	5
Veterinarian	502	2	—	1
Pharmacist	2 557	6	32	5
Pharmaceutical Assistant	579	71	34	119
Dietitian	227	4	1	23
Professional Nurse	20 512	3 573	527	17 127
Nursing personnel not elsewhere classified	6 210	2 314	444	9 367
Optometrist/Optician	502	21	11	22
Physiotherapist	1 054	13	13	41
Radiographer	1 106	54	45	57
Health worker not elsewhere classified	2 505	151	108	8 111

NM 12/4/78 (93)

Young doctor quit after death

Mercury Reporter

A YOUNG doctor left general practice after an incident in which a five-year-old Zululand girl, Ruth Coetzee, died after swallowing a 2c coin, a committee of the South African Medical and Dental Council heard in Durban yesterday.

The committee was sitting to hear charges against Dr. Stefan Swanepoel of St. Lucia and Dr. William van der Merwe, a locum at the Riverview clinic.

Appearing for the parents of the deceased child Mr. W. J. du Plessis said Dr. van der Merwe had been consulted on April 26 last year to examine the child but the advice given had been incomplete and insufficient.

Dr. Swanepoel had been requested to examine the child in the early hours of April 27 but had asked a fifth-year medical student staying with him to carry out the examination as he was not feeling well.

Mr. du Plessis said the doctors could in no way be responsible for the death of the child and that allegations were against conduct in carrying out the examinations.

Evidence was that the parents had brought the child to the Riverview clinic about 4.15 p.m. on April 26 saying she was "choking on a 2c coin."

Appearing before the three-man committee with the president of the council, Professor H. W. Snyman presiding, Dr. van der Merwe said he had been standing in the corridor of the clinic shortly before closing time when the father rushed in carrying the child, followed by the mother.

"The child was sobbing and crying and the parents were shouting at her," Dr. van der Merwe said.

He had told the father to hold her upside down while he thumped her between the shoulder blades.

He then stood her up and examined her chest thoroughly and found no sign of a coin lodged there, Dr. van der Merwe said.

The child had calmed down and responded to instructions normally, he added.

Dr. van der Merwe said he had concluded there was no obstruction in the bronchial tubing and told the parents the coin must have passed to the stomach.

He told the parents to contact him immediately if there were further problems, and the child left the clinic walking normally.

Early the next morning, the committee heard, Mr. Coetzee knocked on the door of Dr. Swanepoel in St. Lucia.

After examination by Mr. Otto Nel, a fifth-year medical student, the child was rushed to Empangeni Hospital where she was put on to a ventilator.

She died on May 3.

According to Dr. Louis Fourie, the district surgeon, cause of death was bronchial pneumonia although there were three possible causes of death. These were anoxia or hypoxia (total or partial loss of oxygen to the brain) pneumonia, or tubular damage to the kidneys.

After evidence from both sides the committee submitted the verdict of improper conduct. In mitigation of sentence Mr. J. Immermann (instructed by Myers Lindsay and Co.) appearing for Dr. van der Merwe, said the doctor had left general practice as a result of the incident.

Both doctors were cautioned and reprimanded.

13/11/78 R.D.M.

Doctor faces suspension

93

DURBAN. — The South African Medical and Dental Council is to be recommended to suspend Dr K. Singh of Red Hill from practice for six months with the sentence not implemented for three years provided he is not found guilty of any offence during that period.

Dr Singh's appearance before the disciplinary committee yesterday followed a complaint of overcharging. — Sapa.

Black earns fellowship in psychiatry

By G. R. NAIDOO

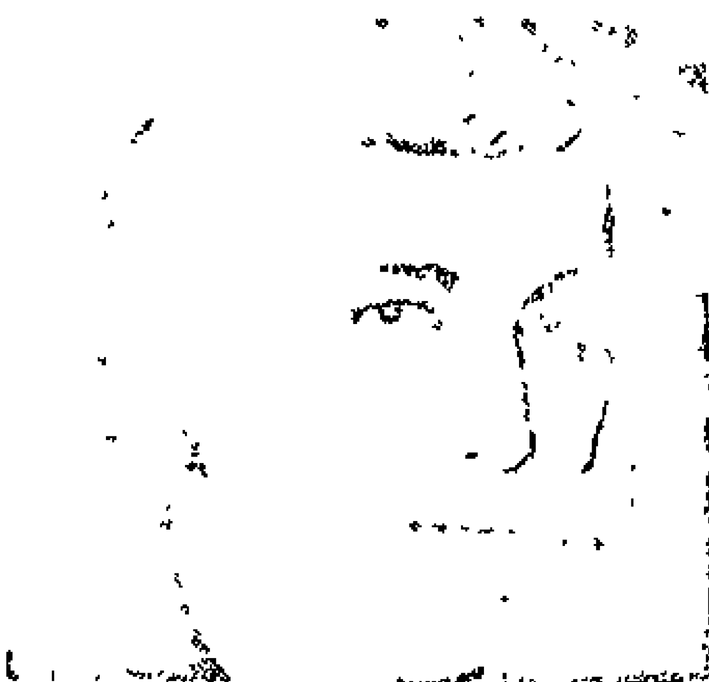
AN Indian, Dr Ashwin Valjee, has become the first black South African to have a fellowship for psychiatry by the College of Medicine of South Africa conferred on him.

A graduate of the University of Natal, Dr Valjee became involved in mental health in 1972 when he was a part-time general practitioner attached to the Mental Health Clinic in Durban.

A year later he took over as acting medical superintendent of the Springfield Sanatorium, which catered for 250 Indian patients. This he did while running his own private practice.

"The patients became more demanding, and I more apprehensive, as I did not know enough about psychiatry to treat them," Dr Valjee said.

"I found that white psychiatrists were inadequate in their treatment of Indians as they did not understand our culture. Psychiatry is people — you have to know people from their social, medical and psychological standpoints," he said.



DR ASHWIN VALJEE
Psychiatry is people

Dr Valjee worked for two years, the minimum period in which one could be awarded a fellowship.

"During the two years, I slept for only five hours a night and put in hundreds of study hours each month with the encouragement of my wife, Sheila," he said.

Dr Valjee, now employed by the State, is keen to do research on the effects of depression.

"Recent research in America has shown that depression is one of the main causes of cardiac artery disease which results in heart attacks. I am keen to do research in this field and relate it to our own people," he said.

Swiss doctor on fraud charges

STAR 20/4/78

A Swiss doctor appeared before a Johannesburg Regional Court magistrate yesterday on 21 charges of fraud involving nearly R400 000.

Dr Henri Rene Haenggi (39) pleaded guilty to eight counts involving R64 153 and not guilty to the 13 other counts. The State accepted pleas of not guilty to five of the counts, involving R249 574, but is leading evidence on the eight remaining counts involving R85,442.

Dr Haenggi, former managing director of Pentec Services (Pty) Ltd, admitted submitting to Pentec accounts for which he personally was liable.

The magistrate, Mr J L de Villiers, acquitted Dr Haenggi on five of the counts to which he pleaded not guilty. These related to the alleged payment of R249 574 to Design Draughting and to an alleged application for foreign currency, under another name, for R60 073,48.

The remaining eight counts allege Dr Haenggi, or an accomplice, opened a bank account in a false name at the Civic Centre branch of the Standard Bank, and that a total of R85 442 was payed to the account by Pentec.

The case continues tomorrow.

23/4/78 (93)

SUNDAY TRIBUNE, APRIL 23, 1978 (93)

'There are people in SA charging exorbitant

DOCTORS ...

THE NEED...

By Marion Cox

ACUPUNCTURE practitioners, unless medically qualified, are breaking the law and should be reported to the police, says the Registrar of the South African Medical and Dental Council, Mr Willem Barnard.

"We do not keep a register of acupuncturists and in my view they are doing acts which call for police action," he said.

The Department of Health confirmed acupuncture was not registered by any law and that an unregistered person treating illness for gain was breaking the law.

"There is no provision made for the technique of acupuncture but it is difficult to state the actual legality of what they do," said a spokesman for the department.

A Durban doctor who practises acupuncture spoke out against the growing numbers of unqualified practitioners and the need to tighten laws to control them.

"It's time something was done to prevent this kind of thing mushrooming as it has in other countries," he said. "Anyway how can anyone treat a patient unless he is medically trained and able to make an accurate diagnosis? There are people in South Africa who are charging exorbitant fees — as high as R50 a session — for unqualified treatment."

The technique of inserting fine needles at various angles and depths has been used for more than 3 000 years in China where the implements were formerly made of bamboo or stone. There are more than 1 000 points on the body where needles are inserted, 150 in the ear alone, but the reasons for the technique's ability to cure are still not fully understood.

Stimulates

"Inserting the needles drains away the tensions and stimulates the circulation," says Mr Thomas Ah Sun, a Chinese acupuncturist who has recently set up practice in Durban. He studied acupuncture in Hong Kong after being successfully treated by it for chronic rheumatism in Pretoria where other medicine had failed.

"We are busy forming an association of acupuncturists so we can become registered," he said. "It is perfectly legal to practise as long as we do not diagnose illness or treat cancer. We cannot mend what is broken but there is no doubt that acupuncture is very effective for asthma, migraine, muscular disorders and the relief of pain."

Mr Ah Sun's patients are mainly karate experts who come to him for treatment of painful muscular injuries. One of his patients, Mr Bruce Anthony, who has a joint disorder, claims he has been helped by having needles applied to his ear.

Painless

"I'm completely free of pain for the first time in four years," he said.

Mr. Pieter Breytenbach, a Durban city councillor, was successfully treated by acupuncture after a calcified shoulder made his arm practically useless.

"I had an operation on my shoulder but my arm was still virtually useless, it was so weak," he said. "After three acupuncture treatments from a qualified doctor, I felt tremendous."

The medical profession is cautious about expressing an opinion on the merits of acupuncture though most doctors agree there is something in it.

Effective

"Scientific evidence suggests that acupuncture is effective in some areas of medicine," said Professor Theodore Sarkin, Dean of the Faculty of Medicine of Natal University. "The insertion of needles has been used by orthodox surgeons in treating muscular ailments and childbirth and it is undoubtedly effective as an anaesthetic in some cases. But in my opinion it is necessary to have a medical background in order to be able to use acupuncture and eventually this technique will be a part of the orthodox medical man's training."

Black earns fellowship in psychiatry

By G. R. NAIDOO

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"Recent research in America has shown that depression is one of the main causes of cardiac artery disease, which results in heart attacks. I am keen to do research in this field and relate it to our own people," he said.

Doctor may be struck off register

Pretoria Bureau

A DOCTOR who fled South Africa after being convicted of conspiring to commit an illegal abortion, Dr Sarantos Tsalavoutas, may have his name struk from the SA Medical register.

A disciplinary committee of the SA Medical and Dental Council yesterday recommended that the doctor's name be erased from the roll. They found him guilty of disgraceful conduct.

Dr Tsalavoutas fled South Africa in 1976 with Mrs Aliki Michaelides. At the time they were awaiting sentence on their conviction.

Mrs Michaelides returned to South Africa last year and was fined R200 by a Pretoria magistrate.

At the same council hearing in Pretoria yesterday, the committee recommended that the name of Dr Raman Ramjas be suspended from the register for four months

Dr Ramjas, 41, of Jerusalem Street, Pretoria, was convicted last year by a Pretoria magistrate of buying 690 grams of unwrought gold in a police trap.

He was then fined R1 000, or 500 days' jail, and sentenced to a further 12 months' jail suspended for three years.

27/4/78 D.D.

(93)

Animal fat no killer — doctor

DURBAN — There was no evidence that eating animal fats would shortern one's life, a Natal nutritionist, Dr D. G. Campbell, told a milk symposium here yesterday.

Dr Campbell said some of his most grateful patients were those he had restored to eating animal fats after coronary thrombosis, and this was certainly not affecting their life span.

"As long as intakes of refined carbohydrate foods are drastically curtailed, there is no evidence that eating animal fats will shorten one's life."

He said the dairy industry the world over was facing a crisis precipitated chiefly by medical evaluation of its products.

He said the private sector of the dairy industry in South Africa should found a dairy public relations secretariat, totally divorced from the Milk Board. — SAPA.

Eight top doctors to quit SA

Sun Times 28/5/78

By NIC VAN OUDTSHOORN

AT LEAST eight medical professors and top specialists attached to Groote Schuur Hospital — including some members of the famous cardiac unit — are quitting South Africa to settle overseas.

The shock move could be the beginning of another brain drain.

The doctors are all involved in teaching at the University of Cape Town's medical school, which uses Groote Schuur as a training hospital.

It is understood from very reliable medical sources that the main reasons for their decision to leave are:

- Poor salaries which have not kept pace with the cost of living.
- The abolition of many financial rewards, like travelling expenses for doctors who have to visit patients after hours.

"Doctors received a so-called overtime allowance some years ago but this, in fact, gave the authorities the excuse to start cutting other allowances," one source told me.

"The result was that doctors who have chosen an academic career at a teaching hospital such as Groote Schuur have become progressively poorer."

- It is felt that doctors who are doing such top-level research that they are invited to read papers at conferences abroad are penalised because they lose about 25 per cent of their salaries when they are away.

"The only other way is to use regular vacation times for such conferences, but that is not fair because that is really part of an academic's job," one doctor told me this week.

'Those who have chosen an academic career have become steadily poorer'

- The disparity in salaries received by white and black doctors at provincial hospitals.

"Doctors in private practice are not nearly as closely involved with the harsh realities of this wage gap as are those in academic positions.

"Black and white students pay the same fees, attend the same lectures, write the same examinations — and yet the day after they qualify those with black skins earn less than their white colleagues," said one source.

The South African Medical Association has also taken a strong stand against this disparity over the years, but has received only promises that the wage gap is to be eliminated when money is available.

"Many doctors have given up believing these promises. They just cannot stand this irrational discrimination based on race any longer. That's why they are leaving," said one senior doctor.

- The freezing of posts for economic reasons which has prevented natural growth of departments and cut back promotional opportunities.
- Lack of more and better equipment at the hospital due to a shortage of money allocated by the Cape Provincial Administration.

"One of the advantages of an academic career in medicine is the opportunities for research and the first-rate equipment which should be available," one source told me.

"But, because of financial constraints, new and better equipment is being bought on only a very limited scale. Most of the time doctors are told just to make do with what they ..."

- Some of the doctors are also understood to be concerned about the political situation in South Africa.

The doctors who are leaving have apparently all obtained academic posts in the United States, New Zealand and Australia.

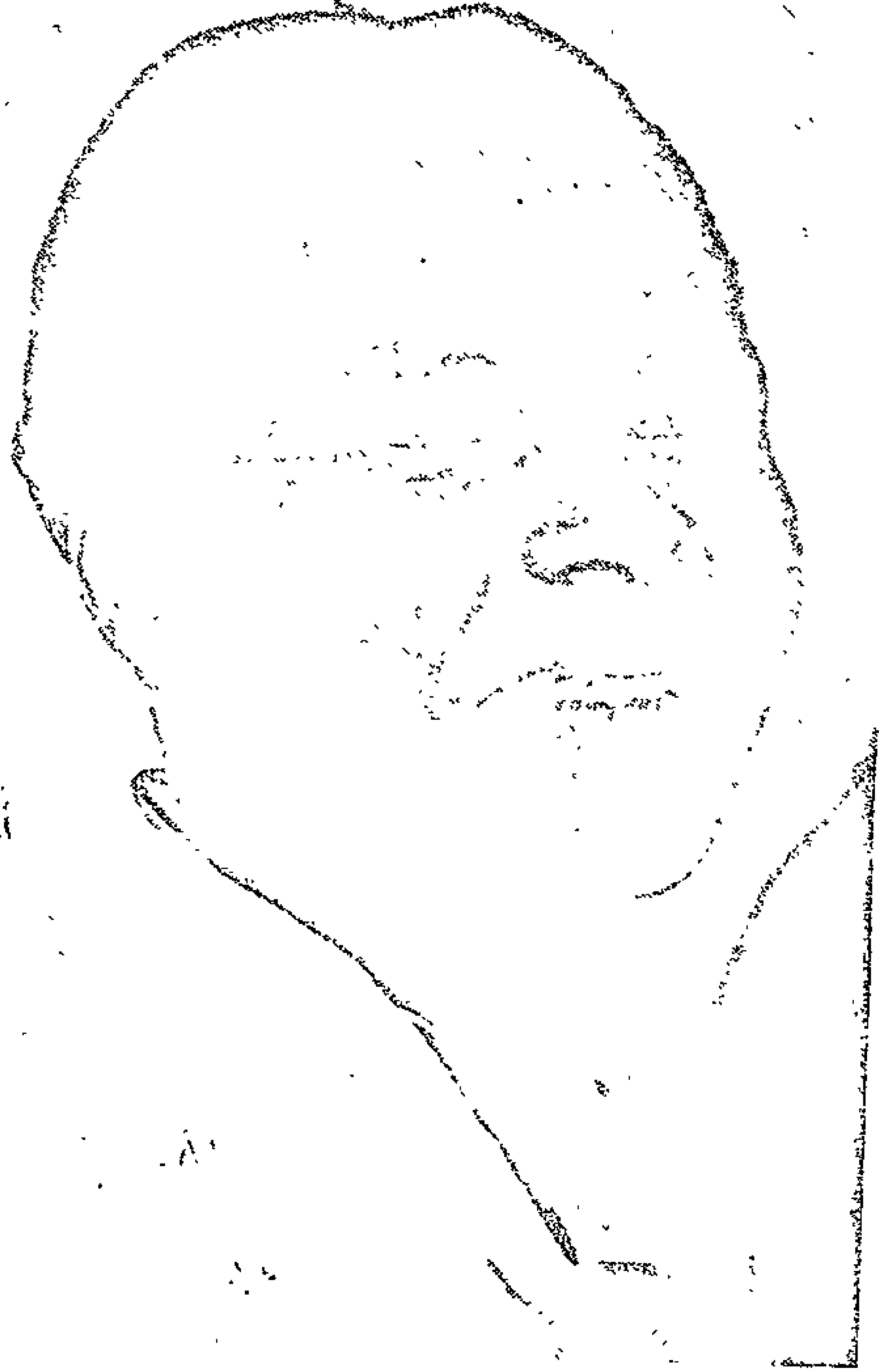
The medical superintendent at Groote Schuur, Dr Reeve Sanders, referred the Sunday Times to the Director of Hospital Services for comment. But the director, Dr L. M. Kotze, was not available.

RDM 4/5/78

(93)

In Naphuno this doctor is just 'nurse'

ZWELAKHE SISULU



Dr Ramphele ... banned to the far north.

THERE are no doctors in Lenyenye township in the district of Naphuno east of Tzaneen east of Pietersburg, the locals will attest. There is only one special nurse — nurse number 4224454.

The locals are also likely to tell you in low, mournful tones that the special nurse, a pert pretty figure of mysterious manner, is to be seen fluttering in her white dust coat every morning at the crack of dusty dawn.

Her name, Dr Mamphela Ramphele and her identity Number, 4224454. It is a number that has played an important part in her life, as in the lives of other black people.

It is a number which once caused red faces in Parliament and in the offices of the Security Police in East London.

Dr Ramphele was banished in May last year to the district Naphuno which forms part of the scattered homeland of Lebowa. It's a place to which she has no attachment.

Lenyenye is in the north-eastern Transvaal. Green hills reveal themselves in undulating furrows and frowns. A spirit of animated freedom pervades, except for Dr Ramphele.

When the local people speak about the special nurse, it is with awe. No, they don't know where she came from, nor do they know her name. But she is an important person, said the man responsible for the big water tanks outside the township.

When Dr Ramphele was banished to Naphuno, she was the medical superintendent of Zanempilo Clinic in King Williams Town. The clinic was founded and run by the Black Community Programmes (BCP) until its banning in October last year.

Amongst other things, her banning order requires that:

- She should not treat some of the patients who come to her home in the dead of night, they might constitute a gathering. Of politicians, presumably, not of patients.
- She should obtain permission from the magistrate of Naphuno if she needs medical supplies from Tzaneen, the nearest town.
- The permit must be renewed every week.

However, she has legally broken her banning order thousands of times. Because Naphuno is a scattered district, to get to some of her out-stations she has to criss cross the area several times.

Is she can obtain permission to leave Naphuno, she attends church on Sunday. It's a day she looks forward to, says her brother, Mr Tommy Ramphele, who teaches at a nearby school.

Dr Ramphele epitomises what happens to many young, articulate blacks. In retrospect, her banning was one of the tragic events which attended the black consiousness movement before the various black organisations were banned. First there was the death of Mapetla Mohapi, who died in detention, then her banning and those of several other colleagues and the death of Steve Biko.

She attended medical school with Steve Biko at the University of Natal. They were young, the movement was young, and they were to nurture it.

After qualifying as a doctor she went down to King Williams Town — "King" to her circles — to head the clinic there.

One morning in April last year Security Police served her with a banning order restricting her to a remote part of the Transvaal of which she'd never heard.

Something was not quite right with her order. Her name had been wrongly spelt and her identity number was incorrect. It took her four or five hours on arrival in Tzaneen to get legal opinion on her order. She was told that the errors rendered it invalid. Back to King Williams Town she went until her brief reprieve ended 10 days later with the correct order.

Back in Naphuno, and with the help of friends, she raised enough money for medical supplies and started a practice.

According to her brother, Tommy, scores of people come to the house seeking help and unwaveringly she attends to them. Her life revolves around her home and surgery. On an ordinary day she will work from 9 am to 6 pm with a break for lunch at home.

Her modest four-roomed house is a hub of activity. Foreign journalists and diplomats are just some of the people who drop in, one by one for a tete-a-tete.

Vol (93) 7/8/78

Blacks for hospital boards–call

Pretoria Bureau

A call for the appointment of black, Indian and coloured practitioners to the boards of their own hospitals was made in the Transvaal Provincial Council yesterday.

The appeal came from Mr Sam Moss, PFP councillor for Parktown, who has served for years on the board of Baragwanath Hospital in Soweto.

With a "new dispensation" in South Africa eligible black and coloured practitioners should be appointed as board members at Baragwanath and Coronation Hospital respectively, Mr Moss said.

Similar provisions should be made for Indians in Lenasia.

He asked the MEC charged with hospital services, Mr K S de Haas (Standerton) to start "slotting in" members of these communities as soon as vacancies appeared in the appropriate hospital boards.

such an application was made. Unless the city council in turn gave its permission the Minister of Community Development, Mr Marais Steyn, would not consider the application. This had happened in the case of Pretoria's Breytenbach Theatre, he said.

Mr van Niekerk denied there was any difference between his policy and that of the Government.

Previously permits had been issued for a series of performances or single shows. Now permits could be issued for multiracial performance on a semi-permanent or annual basis.

"Internation" hotels and theatres, granted multiracial status, were the exception, he said.

Doctor faces suspension

17/5/78

A Honeydew doctor was yesterday found guilty of "scandalous conduct" by the disciplinary committee of the South African Medical and Dental Council for signing prescriptions to rectify an incorrect drug register.

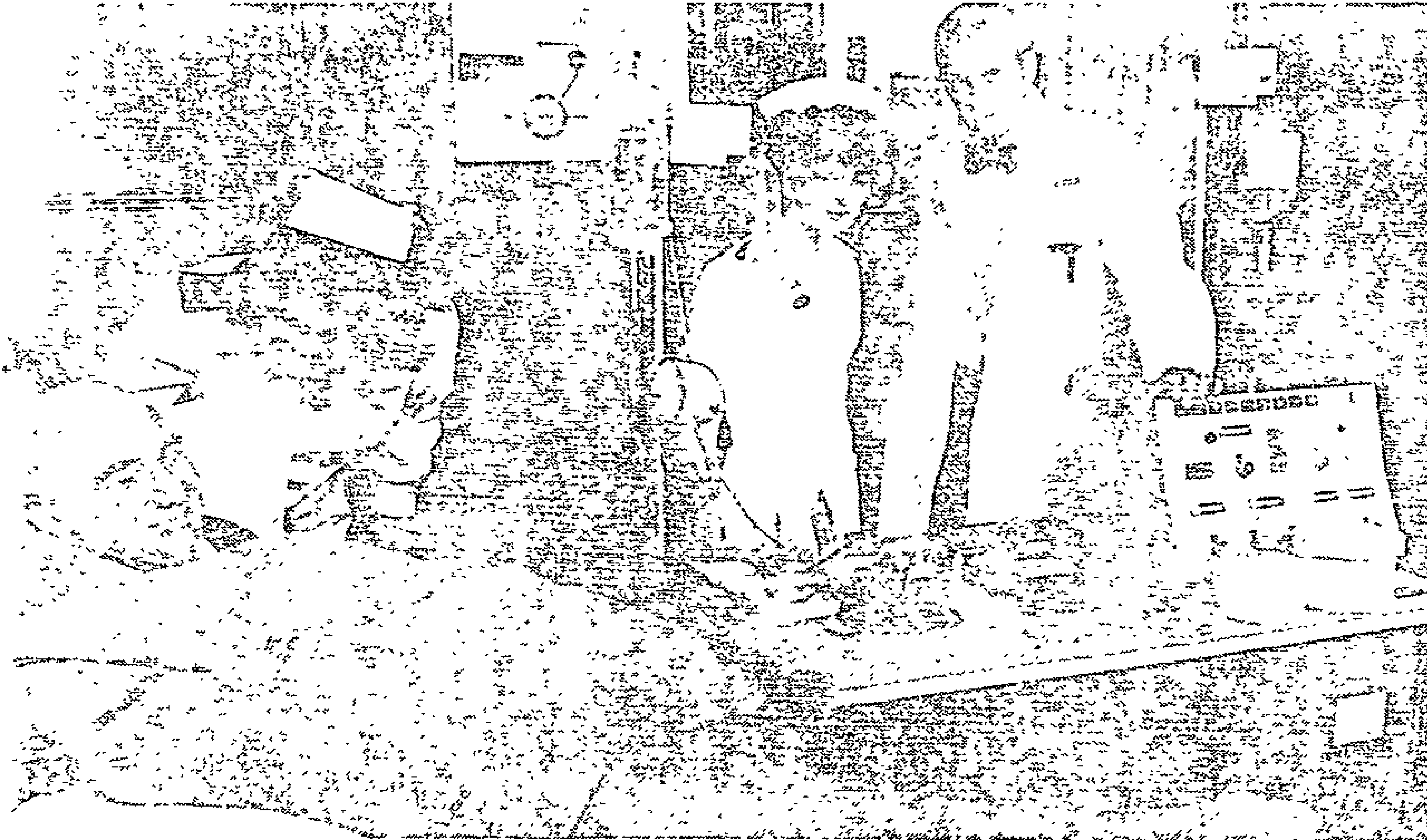
The committee recommended Dr Tertius Viljoen be suspended from practising for nine months.

This sentence was to be suspended for three years.

The hearing followed the conviction of Dr Viljoen by a Randburg Regional Court magistrate for issuing false prescriptions.

Dr Viljoen, a part-time district surgeon, said he had been asked to sign two prescriptions for a chemist whose drug register showed a shortage of 60 Mandrax tablets. He said he thought the shortage was a "technical fault," but it later turned out that the tablets had been stolen by an assistant.

Cape Times 15/5/78



ty of Cape Town's department of pathology held its inaugural research day in the Nico Malan Hall at Groot ital yesterday. Co-operating in an exhibition of a continuous blood flow fraction separator were, from left: the Ian Wilson; Sister Ray Smit; Sister Jackie Byrne and Professor Peter Jacobs, head of the department of haematology.

UCT losing its best staff — prof

PROFESSOR M C BERMAN, head of the division of pathology at the University of Cape Town, said yesterday that his department was faced with the loss of some of its best academic staff to overseas institutions.

Speaking at the inaugural research day in pathology, held in the Nico Malan Hall at Groote Schuur Hospital, Professor Berman said loss of staff had always been a problem in the Republic, "but there can be little doubt that recent political events have had a deleterious effect.

"Even in the present climate, encouragement and availability of adequate research facilities, along with a satisfying commitment to patient care, would be a potent counter to what could otherwise lead to a serious crisis," said Professor Berman.

The exhibition of research, which was opened by the dean of the Faculty of Medicine, Professor David McKenzie, included a number of papers and poster displays by the departments of anatomical pathology, bacteriology, chemical pathology, clinical science and immunology, and the department of haematology.

Two special displays showed the action of a continuous blood flow separator in use by a patient with a blood disorder, and a chemical pathology laboratory computer system developed by the department and operated at one-fifth of the cost of a commercial system.

RDM 3.5.78

Administrator slams quitting SA doctors

(93)

CAPE TOWN. — Doctors leaving the service of the Cape provincial administration for overseas were politically frustrated and were "like rats leaving a sinking ship", the Cape Director of Hospital Services, Dr R L M Kotze said yesterday.

A number of the 2 000-odd doctors — both part-time and full-time — employed by the provincial administration had resigned recently or planned to resign.

Among their grievances were poor salaries, the disparity in salaries received by doctors of various races, lack of equipment, the abolition of allowances and other privileges and the political situation.

In an interview, Dr Kotze said he believed the political situation was the main cause of the resignations.

"But this is not a mass exodus. We have received letters and have heard rumours for some time," he said.

"This will certainly not affect our services. I am not impressed by their reasons for leaving, and have no sympathy for them.

"We are not concerned about the situation. In fact, I have a long list of overseas doctors who want to come and work for us.

"Politically these people are unhappy, and they are just looking for a whip to hit us with," he said.

Dr Kotze would not disclose salaries paid to white, black, Indian and coloured doctors. "That is a political thing, and not my job."

Salaries were constantly being reviewed. Doctors were paid overtime and when they attended congresses overseas, a contribution was made to their travel expenses. They also received full pay while away, he said.

Dr Kotze declined to disclose how many doctors had resigned recently. "Doctors come and go all the time and I cannot give you a figure."

A number of allowances had been done away with, but the overtime allowance compensated for that, he said.

"I cannot see what they are on about. There is no country in the world that treats its doctors as well as we do in the Cape Province," Dr Kotze said.

A senior member of the medical profession closely involved with the problem said he believed many of the grievances listed by doctors were "very real". — Sapa.

DOCTOR TELLS OF BATTLE FOR RIGHT TO LIVE WITH HUSBAND

~~82~~ 93 ~~206~~

Fighting for her family

Argus 3/6/78

REUNITED with her daughter in Cape Town this week, Dr Lucky Ramadas and five-year-old Thenelli. Mother and daughter last saw each other two years ago.

By Derryn Deavin

A SOUTH AFRICAN doctor who has lived apart from her daughter for five years so the child would not lose her South African citizenship, returned home this week to try to find work and fight for her right to live with her husband in the land of her birth.

Slim and attractive, Dr Lucky Ramadas, 30, who went to India 12 years ago to study medicine, said: 'I love South Africa and really want to settle here but everything seems to be working against me.'

At the home of her parents, Mr and Mrs S Govender of Rylands Estate, Dr Ramadas told of her year-long battle to get permission for her husband, who is also a doctor, to work and live in South Africa.

Dr Ramadas matriculated in Durban and went to India in 1966. After a pre-university course in Madras which she passed with two distinctions, she was granted a scholarship by the Indian government to study at Tanjore University.

'I chose that university with a view to returning home to work because it is recognised by the SA Medical Council.'

Dr Ramadas met and married her husband while they were both still students and came to South Africa in 1972 to have her first baby, Thenelli. She was persuaded to leave her two-week-old daughter with her parents so the child would not lose her South African citizenship.

The first time her husband saw his daughter was when she visited India with her grandparents at the age of three.

'Although my parents have shown five-year-old Thenelli pictures of my husband and I constantly, and she knows we are her parents, she is much closer to her grandparents,' said Dr Ramadas sadly.

Real trouble started for the Ramadas when they qualified in 1976 and tried to get resident and work permits in South Africa.

After unsuccessful applications were made for her husband's entry to South Africa, they had also applied to settle in Sierra Leone, Zambia, Nigeria, Botswana, Swaziland and Lesotho, but were turned down.

Dr Ramadas believes they were turned down because she is a South African national.

'As a last resort I applied for a job for my husband in Transkei. I thought I could go and work in Port Elizabeth and we could see each other at weekends,' she said. She is still waiting for a reply from Transkei.

Dr Ramadas is an only child. Her mother is a teacher at Rylands State High School and her father a sales representative and a former amateur featherweight champion.

During her studies in India she came home six times and her parents made four trips to India.

'My father is not a well man. Neither of my parents wants to leave South Africa and want their daughter and grandchild near them,' said Dr Ramadas.

Dr Ramadas's husband has now taken out French nationality in the hope of making immigration easier. His mother is a French national and he has an aunt and uncle who are both practising doctors in France.

'I am desperately trying to find a job myself in Cape Town. If I can, we will make another attempt to get my husband to South Africa and hope that we will be able to get a work permit for him,' she said.

Mr Govender, Dr Ramadas's father, said: 'I worked terribly hard to give my daughter a good education. All I ask now is that I can grow old in the country where I was born with the family I love around me.'

Tribune MEDICAL FILE

THE QUITTERS

Many UCT student doctors plan to leave South Africa after they qualify, survey shows

A SURVEY at the University of Cape Town Medical School has shown that one-third of final-year students questioned want to leave South Africa after they have qualified.

And a further 21 percent are undecided about whether they will stay in South Africa.

The findings of the survey were published last week in Pulse, a new UCT medical student publication. Fifty-two percent of the final-year students and 78 percent of first-year students responded to the voluntary questionnaire.

The percentage of students who wanted to stay in South Africa after graduation dropped slightly from the first to the final year.

Two-thirds of those who wanted to leave South Africa said they would do so immediately after graduation. The rest said they would spend up to five years in practice before leaving.

Publication of the survey coincides with a warning to Parliament that the medical brain drain could accelerate if the Government does not give more money for medical research.

Politics

The warning was given by the president of the Medical Research Council, Professor A. J. Brink. In his annual report, he said research money was needed urgently because the quality of health care was at stake.

Meanwhile, a senior spokesman for the Medical Association has disputed a claim by the Cape director of hospital services, Dr R. L. M. Kotze, that doctors who leave the country are "rats leaving a sinking ship".

Commenting on a newspaper interview in which Dr Kotze slammed doctors planning to leave the Cape Provincial Administration to settle overseas, Dr Marais Viljoen, secretary general of the association, said it was not true that all doctors left South Africa because of the political situation.

And Professor David McKenzie, dean of the faculty of medicine at the University of Cape Town Medical School, said most doctors who left the joint service of Groote Schuur Hospital and the medical school did so because they had got senior posts overseas — in other words because they had been promoted.

"We produce a high standard of medical postgraduate and they go to head departments, start new medical schools and so on."

Dr Kotze caused an uproar with his "rats leaving a sinking ship" statement.

Dr John Sonnenberg, PFP MPC for Green Point and a medical practitioner, said in the Cape Provincial Council it was not true that all doctors wanting to leave the country were unpatriotic. There were valid grievances.

Dr Kotze admitted in the interview that more doctors than usual had resigned recently or planned to resign from the

Professor A. J. Brink
A warning

Cape Provincial Administration and he rejected their complaints about conditions of service.

He said: "Politically these people are unhappy and they are just looking for a whip to hit us with."

There was not an exodus of doctors. "There are always comings and goings. Up to last year I think more doctors came here from overseas than left the country. They are mainly from the UK.

"Last year the doctors leaving and those coming in were about even. So all this talk about how much it costs the South African taxpayer to educate a doctor — one hears this pretty arbitrary figure of R30 000 a doctor — tends to ignore the fact that even last year this was about balanced by overseas-trained doctors coming in."

Professor McKenzie said he doubted whether doctors left the medical school purely because of the political situation, though it might play a small role.

"We are not the only country to suffer from a loss of medical personnel. Britain, for instance, has supplied virtually the whole Western world, including South Africa, with doctors."

Doctors in the joint service of the Cape Provincial Administration and the medical school had two main grievances.

One was the discrimination in salaries paid to doctors of different races, which the administration had undertaken to eliminate as soon as possible.

The other was the difficulty in getting sponsored travel arrangements to attend overseas conferences.

"Each of our people can get funds from the province to go to about one conference overseas in three years. After that funds have to be found elsewhere. This is not the case in many other countries."

Balance

Professor McKenzie said there was no exodus of doctors. Probably fewer had left than in some other professions.

There was no point in trying to restrict doctors leaving. That could lead to a blacklash.

"Up to now the country has been able lat least nearly to balance the number of doctor emigrating and immigrating, but although there has thus been no loss in quantity there could have been a loss of quality."

Professor's new diagnosis for doctors

SPECIAL REPORTS BY TONY SPENCER-SMITH

THE UNIVERSITY of Cape Town's Medical School wants doctors with highly developed social consciences — not bookworms.

The university has formed a committee to examine the current selection system whereby candidates with top marks at school automatically get into the medical school.

While it will probably be a long time before the committee reports, it could lead to a drastic shake-up which cuts out the bookworm with few of the qualities which make a good doctor.

Instead, a breed of doctor who is highly community-oriented, deeply involved in the health of society as a whole, and who is not afraid to be "political where health is concerned," could be created.

This would have far-reaching implications on the entire health system — particularly for blacks.

News of the move came in a speech last week by Professor Ralph Kirsch, Associate Professor of Medicine and Principal Physician in the Department of Medicine.

Professor Kirsch, speaking on health needs in Southern Africa, said there was an urgent need for medicine, to place more emphasis on fighting the social factors which produce high disease rates.

He said the School of Medicine at Ben-Gurion University in Israel had already adopted a system whereby a student need only obtain a university pass at high school with B grades in two subjects to be eligible to be considered for admission.

Values

All such candidates took a psychometric examination, narrowing the field to 300 candidates who were then interviewed to find if they were suitable for the approximately 50 posts.

At the interview, students were queried on intellectual characteristics; their values, such as the desire to assume responsibility for providing help to people in distress and interest in community health service; and personality characteristics including interest in people, sensitivity to their suffering, and humility.

He said later the current selection system at medical schools in South Africa was based purely on school results.

"So the bookworm who had been spoonfed at school, just sitting at home working away to get good marks and doing nothing else, can get in purely on the basis of his results," he said.

"And the person who may already have shown all the right qualities to be a good doctor except exceptional school marks, cannot get in.

"So here, and indeed all over the world, the question is being asked: Are we picking the students who have the right qualities?

"In a survey of UCT final year medical students and their equivalents at a London university, as well as some staff members at these institutions, it was found that things like the recognition of the limitations of one's knowledge and abilities, integrity, dedication to the job and enjoyment of it, and an inquiring mind, were considered among the most important characteristics of a good doctor.

"Which of these have anything to do with top marks at school?"

In his speech, Professor Kirsch also suggested several other changes.

These include:

- Having students spend part of their period of medical education in rural hospitals, and so have a chance of deciding whether they would like to work there.
- The teaching of African languages to medical students.
- That preventative medicine be given a far more important role to medical school curricula to overcome the ignorance about this field among doctors.
- Increased expenditure on preventative medicine, which currently ran at only two percent of the total expenditure on health services.
- A new emphasis on the patient. The word "patient" appeared only about 10 times in South Africa's Health Act.

Service

He said: "An examination of health from the consumers' point of view will show that adequate nutrition, housing, employment, and education, form the cornerstones of good health.

"It follows, therefore that health development is essentially a political and social process that should start off with the acceptance of the social function of health and should ensure that health technology is developed and applied in harmony with the social function.

"Unfortunately, most doctors remain loathe to involve themselves, in what others may call political matters, and this, when added to the lack of education to which I have referred, probably accounts for the lack of interest which most practitioners have towards promoting health."

He told me later: "We need more doctors prepared to go into the rural areas. We need to see that medical students don't just go to train with GPs in posh areas like Bishopscourt, but also to deprived areas like the Crossroads squatter camp — an area which essentially has not got a single doctor.

Professor Kirsch said in his speech: "I work in a hospital, Groote Schuur, where few, if any, of t[...] doctors believe th[...] discriminate betwe[...] patient or anoth[...] where we can ne[...] this objectively [...] yes, our studen[...] patients, until [...]tients lie side [...] the same war[...]

TABLE 13 ACCOMMODA... UGULETU & KEY TO STATISTICAL DATA

Key to employers' dormitories	ALLOCATE... No. of hostels	...TED No. of beds	NOT BUILT No. of hostels	No. of beds
1. Cementation		–	1	30
2. Clifford Harris		120	–	–
3. Fred Pike Cape Grc Construction		30	–	–
4. G.H. Burchell		–	1	30
5. Gorrie & Findlay		60	–	–
6. Industrial Sand &		30	–	–
7. Kara Construction		60	2	60
8. Lupini Bros.		30	1	30
9. Prebuilt Products		30	–	–
10. Cementation		60	–	–
11. N.J.J. Dekkers		30	–	–
12. Murray & Stewart Transferred to Pre Products.		60	–	–
13. National Meat Supp		60	–	–
14 R..Lway Constructic		–	4	120
1 einforcing Steel	1	30	–	–
1 R.H. Harris	2	–	2	60
. R.J. Southey (Natal)	3	92	1	30
18. R.H. Morris	4	120	–	–
19. S.A. Woolen Mills	1	–	1	30
20. Simcor Construction	4	60	2	60
TOTAL	43	1,...872	15	450

Zulu doctor denies drug allegations

22/6/78 Nm 93

Mercury Reporter

NEWCASTLE — A member of the KwaZulu Legislative Assembly, Dr. Simon Phillip Maseko (31), said yesterday he had a strong suspicion that his wife was addicted to pethidine.

He further claimed that he had not freely and voluntarily made a statement to a magistrate because his prime consideration was his wife who, he feared, would be jailed. He made the statement believing that if he did so it would help her to get treatment.

Dr. Maseko is facing a charge of dealing in dangerous, dependence-producing drugs, and four other charges. He is appearing before Mr. J. J. Muller.

He is charged with dealing in morphine and/or pethidine, or, alternatively, administering these drugs for other than medicinal purposes.

Other charges allege failure to enter prescribed particulars in a register of morphine and/or pethidine sold between January, 1974 and January, 1978; failure to balance this register to show the quantity of substances in stock; attempting to defeat or obstruct the ends of justice by hiding the register from the police; and hiding and/or destroying a number of patient cards.

The fifth count alleges failure to give an explanation, particulars or information required by an inspector, or giving false or misleading information.

Dr. Maseko has pleaded not guilty.

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23/6/78 Kin (93)

Armed farmer 'halts' doctor

Mercury Reporter

A South Coast sugar cane farmer held up a doctor who was rushing to assist a dying patient. "It is no concern of mine if the b . . . dies," he told the doctor, refusing to allow him further along his private farm road.

This evidence was heard at the trial of Mr. David Joshua Landers of Montevideo Farm, Ellingham, who pleaded not guilty to two counts of pointing a firearm and one of assault when he appeared before Mr. G. Dehning in the Magistrate's Court at Scottburgh yesterday.

Dr. Jacoob Kadwa, a registered medical practioner at Umzinto, said he was rushing to assist a critically ill patient on the night of January 27.

The road to Park Rynie had been blocked by a truck which had jack-knifed across the road.

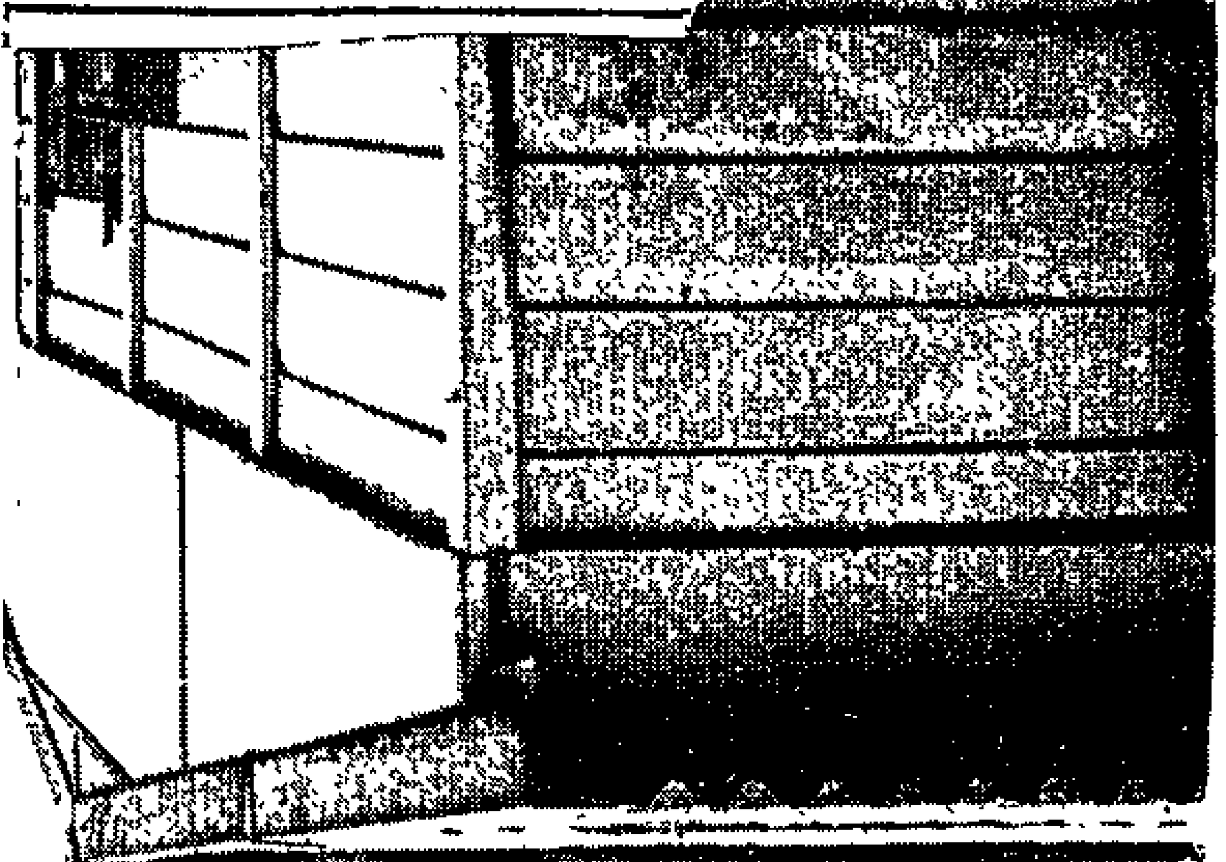
Stopped

A bystander had offered to show him an alternative route which unknown to them took them along a road which was on Mr. Lander's farm. Other cars followed.

The doctor said Mr. Landers had approached in his truck and stopped the convoy.

Mr. Landers was holding a shotgun which had a torch attached to it.

"I identified myself but he just swore at me. I pleaded that I had a patient who was extremely ill and Mr. Landers told me he couldn't have cared less if the b . . . . died," said Dr. Kadwa.



The doctor walked to his patient who had died when he arrived.

Mr. Landers told the Court he and his wife had been woken by car-lights shining in their bedroom window shortly after 11.00 p.m.

He went to his safe to get a shotgun and went out to investigate.

"I was not prepared to listen to any explanations because I was only interested in protecting my wife, our 20-month-old child and my property," said Mr. Landers.

Mr. Landers said he had not believed that Dr. Kadwa was a doctor. Dr. Kadwa had been wearing a pyjama jacket and had not produced any acceptable evidence that he was a medical practitioner.

Judgment was postponed until Monday.

Mr. A. Brookbanks is appearing for the State. Mr. T. M. Smithers for Mr. Landers.

NEWEST EMPLOYERS, DORMITORY-SHEDS GUGULETU

Star 7/7/78 (93)

'Foreign brain gain' at hospital

Pretoria Bureau

The H F Verwoerd Hospital in Pretoria is experiencing a "brain gain" with about 30 foreign doctors working there by the end of the year.

This was revealed by its superintendent, Dr Exert van Wyngaard, at the arrival yesterday of another qualified doctor.

"We are getting more applications from local and foreign doctors than we can use," he said. Posts for doctors at most of the hospital's departments were filled.

Dr van Wyngaard said the flow of doctors to his hospital had strengthened noticeably in the last three years. Asked why foreign doctors were attracted to the H F Verwoerd Hospital in particular, he said:

"I am convinced one of the main reasons is the excellent training facilities here. Another is that this is the largest medical and paramedical training hospital in the country."

He went on to say Dr Peter Meulyzer was the first of six Belgian doctors to start work at the hospital this year.

The others working there or expected to arrive within the next few months were from Argentina, Australia, Poland, Czechoslovakia, Great Britain, the Netherlands, Rhodesia and Sweden.

Four English students are also due to join the hospital, two in the obstetrics department, shortly.

The 'doctor' is a nurse

PAT SIDLEY

THE "anaesthetist" and intensive care unit "specialist" at Bophelong hospital is not a qualified doctor — she is a nurse.

The two "psychiatrists" running the 800-bed psychiatric section are nurses.

The hospital, in Mafeking, near BophuthaTswana, is a typical rural hospital, with too qualified doctors for its 1 150 beds and 14 outside clinics, and too little sophisticated equipment, or money.

But it has nurses — specially trained Advanced Clinical Care nurses — who are the "human gadgets" the hospital must rely on.

To reach a rural population most hospitals use a clinic system run by nurses and visited weekly by doctors, but because of the team of "doctor-nurses" at Bophelong, the clinics need only monthly visits by a qualified doctor, whose role then becomes one of consultant-teacher.

Bophelong's Dinokana Clinic sees some 350 patients a month. They are examined and treated by the nurses. The doctor only comes to advise the nurses — and to reassure a conservative patient population.

"We ask the nurses to wear their stethoscopes dangling visibly from their pockets so they look like doctors," said the hospital superintendent, Dr Patrick Mokgobo. The "doctor-nurses" are his brainchild.

If a patient goes to the hospital instead of a clinic, hoping to see a doctor, he will probably be disappointed. Nurses give out-patients a thorough physical examination. In the wards they take blood, put up drips, order X-rays, take electrocardiographs, connect respirators, give drugs intravenously and perform lumbar punctures.

Dr Patrick Mokgobo — superintendent of Bophelong Hospital. The "doctor-nurses" are his brainchild.

Nurses would not be allowed to perform some of these services in South Africa, but BophuthaTswana is an independent country.

Nurses also treat all the psychiatric patients. Certifying of patients has, however, to be done by "somebody from Pretoria every now and then," Dr Mokgobo said.

The Advanced Clinical Care nurse at Bophelong is in effect a general practitioner. She has to be. The hospital has no surgeon, no anaesthetist, no psychiatrist and only two physicians among its seven qualified doctors.

The superintendent, Dr Mokgobo, trained at the University of the Witwatersrand, specialised as a physician at Baragwanath, was for a time the only physician in Swaziland, and is an expert in his field of African rural medicine.

Appointments of doctors to the hospital still have to go through Pretoria and, says Dr Mokgobo, "somehow if the applicant is black he will have to be Tswana-speaking to be posted here". So the problems of a rural black hospital are exaggerated by South African political problems.

The Bophelong nurse's most important task is the continual screening of cases and the spotting of emergencies which she is empowered — and expected — to treat.

A six-page set of standing orders describing the full scope of her authority is issued by the hospital superintendent.

There is a superficial resemblance to the Chinese barefoot doctor system, but this is more sophisticated.

"These nurses are not village health workers, with elementary first aid knowledge. They are doctors," says Dr Mokgobo.

Nurse Intumeleng Mochekele is an "anaesthetist" and intensive care unit "specialist". She was born in Lesotho and trained at Baragwanath. When Lesotho's only anaesthetist left the country, she was forced in six weeks to learn to "dope" — which she did.

"One copies the experts — that's how you learn. I've had to do closed heart operations and train our housemen," she says. A houseman has to administer 50 "dopes" before he may register. "I've trained one so far. He's doing fine — I think he can dope."

An elderly man died one afternoon when I was at the hospital. He was in the intensive care unit, following a stomach operation. He went into shock and his lungs collapsed.

Dr Mokgobo, Nurse Mochekele — as the intensive care unit specialist — and two medical officers connected him to a respirator, and pumped his failing heart. But he died.

The man need not have died — if he had been in the Johannesburg General Hospital, said Dr Mokgobo. There the intensive care unit would not have been equipped with makeshift or human gadgets. The man would have been monitored in a well-equipped unit for at least a week after the operation. The unit at Bophelong is makeshift. It can hold only one patient at a time, so the man died.

His death was a pointer to the realities that remain in an otherwise remarkable system of coping with a desperate situation by desperate measures.

Test for foreign medical degrees

Staff Reporter

ABOUT 70 doctors and dentists — mainly Indian —with qualifications from Egyptian universities will have to pass a special examination before being allowed to practice in South Africa.

The chairman of the SA Medical and Dental Council, Professor H W Snyman, said yesterday the council maintained a register of foreign degrees recognised in South Africa.

"If the degree is not recognised here, then graduates will have to write a special examination. This system is not unique to South Africa. There is a similar situation in the United States and the Scandinavian countries," he said.

In 1975 the council withdrew its recognition of Egyptian degrees, but reversed its decision in April this year on condition that the graduates passed its special examination.

About 20 doctors with Egyptian degrees are said to be practising in neighbouring countries. Another 50 are reported to be planning to leave South Africa because, they say, it could take months before the new regulations become law.

Most of the doctors graduated from the universities of Alexandria and Cairo.

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4 SUNDAY EXPRESS July 16, 1978

Impatient doctors plan to join brain drain

ANOTHER SUNDAY EXPRESS EXCLUSIVE BY JEAN LE MAY

AT LEAST 50 doctors and dentists are planning to quit South Africa for good because of delay in recognising their foreign qualifications.

They are South African-born Indians, most of whom have qualified within the past two years — some very recently — at the medical schools of the Universities of Cairo and Alexandria, in Egypt.

Many are working in shops or are being supported by their families.

Another 28 are already practising in Swaziland, Botswana, Rhodesia, and Zambia, while 30 final-year students still in Egypt will qualify shortly.

Most say they have no intention of returning to South Africa because of the difficulties their colleagues are having.

And this comes at a time when the "brain drain" from South Africa included 249 doctors in the previous 18 months, the Minister of Health, Dr Schalk van der Merwe, said in February.

The SA Medical and Dental Council withdrew recognition of Egyptian qualifications in 1975 — without warning or explanation.

At the time there were 185 South African Indians at Egyptian medical schools — including the 70 who have since qualified.

In April this year the council reversed its decision and once more decided to accept Egyptian-trained doctors and dentists, provided they wrote a special examination.

At a meeting in Pretoria this week the council decided on the form the examination should take, but it will be months before the regulations are gazetted, says council chairman Professor H W Snyman.

None of the doctors to whom I spoke was prepared to be named, fearing publicity could prejudice their final acceptance by the Medical and Dental Council.

Middle East countries are prepared to accept immigrants from South Africa, I was told, provided they relinquished their South African citizenship.

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STAR 19/7/78

(93)

Why the young doctors go away

Inadequate research facilities, and conditions of service contribute more than racial tension to the exodus of doctors from South Africa, believes the Director of Alumni Affairs at the University of the Witwatersrand. ROGER DEAN reports.

Professional frustration rather than political expediency is chasing some of South Africa's best medical brains overseas — and it may not be altogether such a bad thing.

That is the view of Professor S S Israelstam, Director of Alumni Affairs at the Witwatersrand University, who has just returned from an extensive tour to set up alumni clubs in Israel and North America.

After talking to a good many of the 1 500 or so Wits graduates now settled overseas, Professor Israelstam insists that racial tension in South Africa has very little to do with their leaving. The main goad, among medical men in particular, is the old complaint about inadequate research facilities and meddlesome conditions of employment.

"They are simply frustrated by the kind of civil service atmosphere they find here," the professor said. "By comparison, working somewhere like the United States opens up a whole new world.

"A doctor working in hospital service finds research facilities are available as a matter of course, and he is expected to use them. For the first time he believes he is making a real contribution to medicine."

He cites the case of a young graduate who went from Johannesburg to the D M Anderson Hospital in Houston. Here he waited three months after ordering a simple piece of equipment costing only a few rands — and still didn't get it. There he can go to stores and requisition equipment costing thousands of dollars and it will be delivered the next day.

"Other grouses are the inadequate pay here and the pettiness of some conditions of service. Just as school principals may not leave the premises without an inspector's permission, some doctors found they could not leave their posts even for a few minutes."

Professor Israelstam does not altogether condone this sort of attitude; he feels those who stayed behind deserve a good deal of credit not only for their service to the community, but also for helping to bring about changes in South African society at large. But paradoxically he believes the expatriates may be repaying some of their debt in pure personal ambassadorship.

Professor Israelstam . . . a vicious circle.

"Contrary to what some people would have you believe, these men are not virulently anti-South African or in any way bitter about the country. Most retain a very strong sense of loyalty, and this expresses itself in relations with their colleagues.

"In their everyday lives they do a great deal to redress misconceptions and distortions about this country at what is after all a fairly influential level. I'm damned sure they do a better job of it than our own information officials."

The paucity of research funds in South Africa is readily acknowledged by the Medical Research Council. Its annual report published last month said it had been unable to pursue a number of "worthwhile and meritorious" projects.

"The last few years have seen a marked decline in available resources," said the president, Professor A J Brink. "The council has approached not only a situation of financial stagnation, but actually one of negative growth."

This is reflected in the current year's allocation from Parliament, which has been cut by four percent. Professor Brink warns that progress will have to depend increasingly on support from the private sector.

He cites the exodus of highly trained personnel as a major factor inhibiting research. It is of course a vicious circle: as money tightens more doctors leave; as the number of doctors drops, so more are pressed into teaching and direct clinical care; and as this happens so research is further neglected.

Professor Israelstam sees the basic problem in terms of the underlying philosophy applied by hospital administrations. They draw too broad a line, he feels, between research and medical care.

"To put it simply, they seem to feel their function is just to look after so many patients, and finding better ways of doing it is not their responsibility. They forget that every rand spent on research will benefit the patient in the long run."

RDM 21/7/78 (93)

Natal pledge on black doctors

Own Correspondent

DURBAN. — Black doctors may soon be treating patients of all races at Natal's provincial hospitals, according to Dr Fred Clarke, the New Republic Party MPC for Umhlanga.

Dr Clarke told a report-back meeting in his constituency on Monday night that it was already policy for private white patients to be treated by black doctors in provincial hospitals.

He said Natal had recently appointed a "brilliant" Indian professor of paediatrics and an Indian professor of cardiology, and he believed another appointment was in the pipeline.

"These people have been appointed because they are the best available specialists — they were appointed on merit."

Dr Clarke, chairman of the provincial council's hospital services committee, said barriers were being broken down in Natal and there could be no practical or moral objection to these moves.

"I believe that in the near future, when professorial grand rounds are carried out at our hospitals — that is, case examinations by the top academic experts of difficult medical or surgical cases — these grand rounds will be multiracial."

Any patient would have the right to refuse treatment from a black doctor, he said — but this would be "sickening".

The patient concerned would thus be denied treatment by the best medical men available.

30/7/78 R.D.M.

(93)

Green light given to hospital dumping

Staff Reporters

THE City Engineer's Department has decided to allow hospitals to dump drug phials and used medical instruments again at the municipal tip in Newlands, Johannesburg.

But the department yesterday laid down fresh regulations for acceptance of the materials, which will now be buried at the tip.

On Tuesday, the city Medical Officer of Health, Dr Baldwyn Richard, announced that the tip would be closed to hospitals following the discovery that children in the area had taken quantities of potentially lethal drugs and syringes from the dump.

The liaison officer of the engineer's department, Mr John Bates, said yesterday hospitals would have to package medical items and separate them from ordinary refuse.

"Hospitals will have to make prior arrangements with the supervisor of the Waterval depot. Bulldozers will be used to bury the packages. In this way we aim to prevent children from getting at them," Mr Bates added.

Earlier, the superintendent of Coronation Hospital, Dr Carl Kniep, said he did not accept the "no dumping" ruling. Disposal of materials from the hospital, he said, was a municipal function.

STDR 25/7/78

Black doctors for Natal hospitals

(93)

Own Correspondent

DURBAN — Dr Fred Clarke, the New Republic Party MPC for Umhlanga, last night hinted that senior black doctors might soon be treating patients in all categories at Natal's white hospitals.

Dr Clarke, who is immediate past-president of the Natal Medical Association and chairman of the Natal Provincial Council hospital services committee, said it was already policy to allow private white patients to have black doctors.

He told a report-back meeting in his constituency that in terms of his proposed metropolitan scheme, which he mooted last month, black professors from the Natal Medical School at the University of Natal would be able to treat patients of any race group — private or otherwise — in any metropolitan hospital.

All the hospitals in the Greater Durban area would be placed under the medical school as teaching hospitals.

Dr Clarke says that not only would this result in increased efficiency, but it would also enable the province to build a new hospital at Pinetown.

Doctor forced out in row

OB Supplement Indaba 28/7/78 (93) (103)

UMTATA — The only doctor at a Flagstaff hospital has left after nine years, following a dispute with tribesmen.

Now tribesmen who held an unauthorised meeting at the hospital, Holy Cross have been reprimanded by the Minister of Health, Mr G T. Vika.

Dr W. I. Jardin, was given leave by the Department of Health when the situation at the hospital became tense

There is no doctor at the hospital and the department is trying to get doctors from the United Kingdom to take up posts there.

Mr Vika and his deputy, Chief D.D.P. Ndamase, held a meeting with tribesmen and staff members of the hospital.

Mr Vika told the tribesmen they had no right to interfere with hospital administration and to hold unauthorised meetings on the hospital grounds. He told staff members it was against government regulation to disseminate distorted information to the public for their selfish ends and to cause unrest.

When the matter was reported to his department an official addressed the tribesmen at two separate meetings but the situation remained tense.

During the meeting with Mr Vika tribesmen demanded that Dr Jardin leave the hospital at once.

Mr Vika told the tribesmen that if there was any maladministration they should report to the authorities concerned

"You have no right to hold unauthorised meetings on the hospital grounds and pressure the doctor to leave," Mr Vika said. They should make any complaints to the proper authorities.

When Mr Vika announced Dr Jardin had been transferred the tribesmen clapped hands in jubilation.

Mr Vika said plans were underway for four doctors from United Kingdom to assume duties at the hospital at the beginning of August.

social and economic problems, who were usually far more interested in artisans and craftsmen of the traditional type than in industrial wage-earners. The fact that many of such large-scale industrial enterprises as existed—the Ural ironworks in Russia are a leading example—were geographically remote from any large town also helped urban life to retain its predominantly mercantile and handicraft character almost everywhere to the end of this period.

The still largely traditional and static society described in this chapter was doomed to rapid decay. The network of communities, orders, privileges, peculiarities and exemptions, of which it was composed, could not hope to withstand indefinitely the forces of change which were growing stronger throughout this period. From the [illegible] of the century at latest it was being steadily though very slowly [illegible] by the demands of governments for larger revenues and greater ad[illegible] trative efficiency. It was also being undermined, more rapid[illegible] perhaps more fundamentally, by the development of Europe's ec[illegible] life. For a society based on customs and traditions which were [illegible] where different was slowly being substituted one based on ide[illegible] economic pressures which were everywhere the same. Yet it wou[illegible] great mistake to describe eighteenth-century society entirely [illegible] mainly in terms of 'progressive' forces. Like so many other aspect[illegible] continent's life during this period, it must be studied with an ey[illegible] past as much as to the future.

SUNDAY TRIBUNE, JULY 30, 1978 (93)

MANY DOCTORS QUIT TRANSKEI

HOSPITALS SHORT OF STAFF BECAUSE OF DISSATISFACTION WITH ADMINISTRATION

TRANSKEI'S health services are ailing — and many doctors are leaving because of disatisfaction with the administration of hospitals in the country.

Medical superintendents in Transkei this week estimated that at least 30 doctors were urgently needed to relieve the shortage.

In some outlying areas hospitals are relying on practitioners in private practice to supply essential services.

A recruitment campaign to relieve the critical shortage is being undertaken in Britain, America, Germany, Switzerland and other European countries

The Transkei Secretary for Health, Dr Charles Bikitsha, said this week there was no crisis.

"But we don't give interview here," he added and put down the telephone.

He was reported earlier saying that Transkei had recruited at least 20 doctors in the United Kingdom.

Medical sources in Transkei this week said that staff had steadily been leaving the hospitals since they were nationalised in 1975.

At one hospital — the Holy Cross — the last

Tribune Reporter

resident doctor has left after nine year's service.

Although the doctor refused to discuss his reasons for leaving, it is understood that he was struggling to carry out the duties normally performed by seven doctors.

Temporary

His attempts to reorganise the hospital to ease his work load met with opposition from the local chiefs.

The hospital is now being staffed by two temporary doctors.

And another doctor this week blamed the Transkei Department of Health and Dr Bikitsha for the shortages.

The doctor who asked not to be identified for professional reasons is now in private practice in South Africa.

He started work in Umtata in 1975 as a medical officer with the South African Department of Health and was later sent back to Umtata by the army as a doctor.

In 1976 he was transferred to complete his training in the Transvaal.

"Just before I left I went to see the hospital authorities. We were renting a house and I needed to make arrangements for my wife to be able to stay on at the house.

"The authorities agreed to this. I had signed a contract as a seconded officer to the Transkei Government so I was entitled to it.

"But in February, 1977, while I was still in the Northern Transvaal, I received a telegram ordering me to evacuate the house.

Transfer

"I eventually had to take special leave from the army and drive all the way to Umtata to sort it all out.

"But the real crunch came when I returned to Umtata to work.

"The superintendent handed me a letter advising that I was transferred to another hospital at the coast and had to report there that day.

"I objected because the hospital where they wanted me to work was a one-man show, I did not have the experience to do the job and the letter of transfer had never been posted to me.

Remove

"Also my wife and young children had never seen the place, which was very remote.

"The Secretary for Health refused to see me.

"After representations at Ambassador level failed, I was withdrawn from the Transkei by the South African Government."

One of the medical superintendents interviewed said he had recently travelled overseas in an attempt to recruit.

"I have about 16 doctors in the pipeline. They should arrive over the next three years. But it is a very leaky pipe.

"I'll be happy if we get ten of them," he said.

GEWONE VERGADERING

S.A. GESTIG: KERKRAADSVERGADERING 27 MEI 1978

HISTORY HONOURS 1978

Southern Africa since 1910

Tutorial 1

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Two black doctors to treat whites in Natal

Sunday Times 30/4/78

(93)

By G. R. NAIDOO

TWO senior black doctors who have been appointed professors will be allowed to treat white patients in Natal's white provincial hospitals.

This was revealed by Mr Frank Martin, Natal MEC in charge of hospital services.

The doctors, Professor A. Mitha, of the department of cardiology, and Professor A. Moosa, head of the department of paediatrics, both at the University of Natal's Medical School, automatically become heads of their departments in all provincial hospitals.

They will be responsible for their departments at all the satellite hospitals attached to the Medical School.

The one reservation is that if white patients refuse treatment from a black professor they may have to resort to second best.

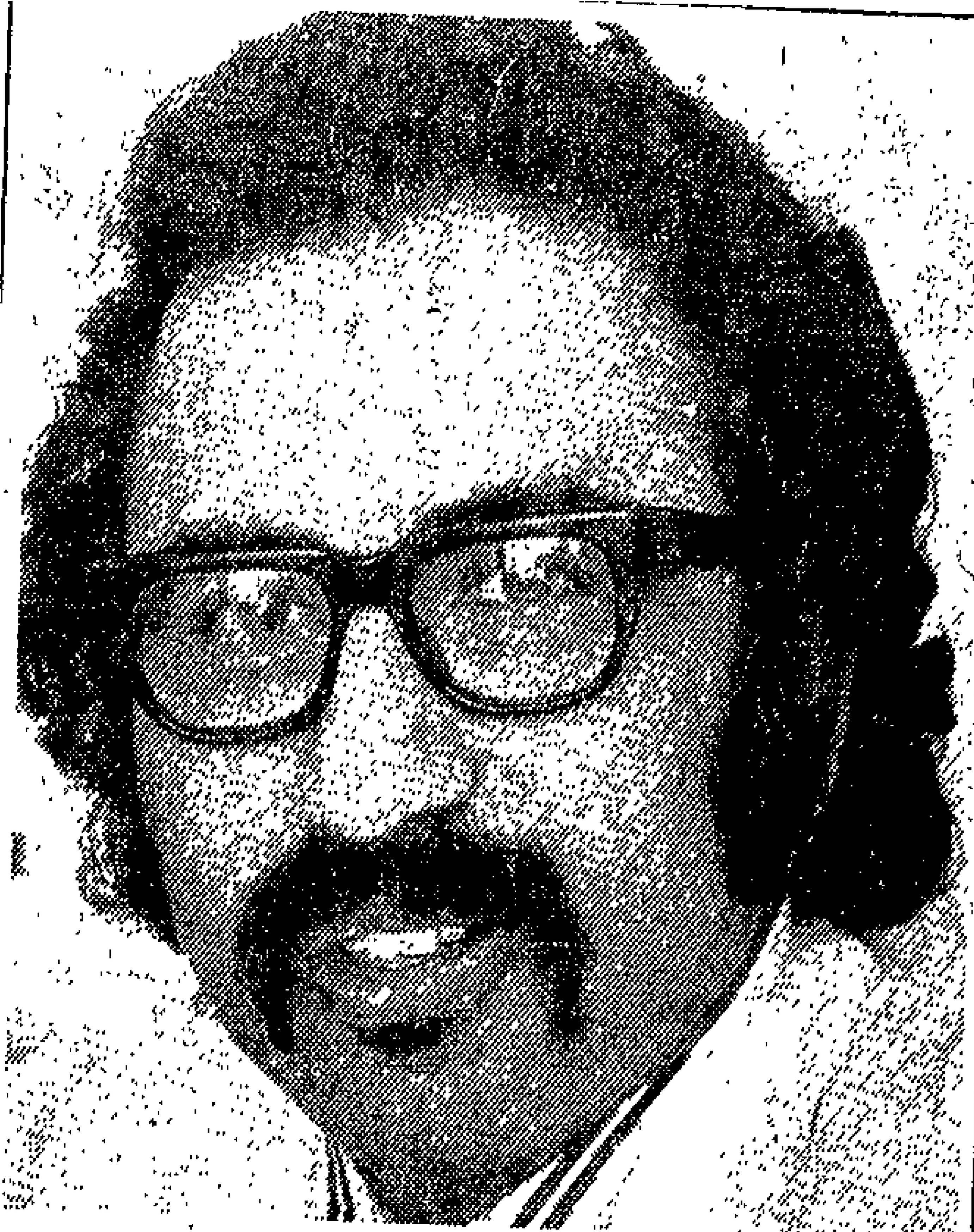
Sickening

Until now, paying white patients at provincial hospitals had the right to choose their own doctors, irrespective of race.

Dr Fred Clarke, MPC and former president of the Natal Medical Association, told the Sunday Times that if a white patient refused treatment from a black professor it would be "sickening", and anyone doing so would be refusing treatment from the best medical men available.

Dr Clarke has proposed a metropolitan scheme whereby the Medical School, which is open to blacks only, should be opened to all race groups and that all hospitals in the greater Durban area should be placed under the Medical School as teaching hospitals [illegible]

He said that talks had already been held between the Medical School, Mr Geoff Oldfield, the NRP MP, and the Government, on this issue.



Professor Allie Moosa

NM 4/8/78

New faces at varsity

(93)

Mercury Reporter

FIVE new professors, including two Blacks, have been appointed at the University of Natal in Durban and Pietermaritzburg and at the Medical School in Durban.

In Durban they are Professor D. R. Sienaert, head of the Department of French, Dr. A. Moosa, head of the Department of Paediatrics and Child Health and Professor A. S. Mitha, head of the Department of Cardiology.

In Pietermaritzburg, Professor J. M. de Villiers has been appointed head of the Department of Soil Science and Agriculture and Professor S. E. Drewes, Professor of Organic Chemistry.

Professor Moosa hopes to establish a research and clinic centre for neuromuscular diseases of children in Durban.

The appointments were effective from July 1.

RDM 93 4/8/78

Doctor, nurse blamed for death

AN 11-year-old boy, who went into hospital for an operation to his broken arm, died after being given carbon dioxide instead of oxygen during the anaesthetic, an inquest court heard in Pretoria yesterday.

Dennis Craig Brimacombe, of Pretoria North, died on April 26 last year. The court ruled that the negligence of the assistant nurse, Mrs Ursula Giannios, and the anaesthetist, Dr Jan Hendrik Lombard, caused the boy's death.

Mrs Giannios told the court she had worked at the Eugene Marais Hospital for seven years. On April 22 last year an emergency case was brought in for an operation.

When she tried to connect the anaesthetic pipes, one pipe would not fit, she said.

Sister Johanna Lottriet, who was called in, said she could see the boy was suffering from a lack of oxygen.

Dr Lombard said the carbon dioxide pipe could be attached to the oxygen pipe although the connections were slightly different. — Sapa.

Minister hits at 'quitters'

NM 5/8/76 (93) (23)

NEWCASTLE — The Minister of Health, Dr. Schalk van der Merwe, told doctors here last night it was possible the main reason for the outflow of medical practitioners "could simply be plain materialism."

Speaking at the annual dinner of the Northern Natal branch of the Medical Association, he said if that were the case, such aspects as service to the peoples of South Africa, or of duty to the country, which bred them and trained them, would be of minor consideration to a prospective emigrant.

"It could follow that rather than admit to base materialism, an emigrant would be tempted to place the blame elsewhere and to join those who find it fashionable to criticism South Africa," Dr. van der Merwe said.

Reasons

A variety of reasons were given why doctors opted to emigrate. One often heard was that the emigrant did not agree with the Government.

"I do not deny that this may be so, but it does seem strange that the vast majority of doctors leaving the country emigrate to affluent Western countries such as Australia, Britain and the United States.

"Clearly their concern for the welfare of the Black people of Africa does not extend to offering much needed medical services to these people either here or elsewhere in Africa."

Equal pay

Another reason mentioned was that the financial remuneration and conditions of service were unacceptable.

Some doctors had claimed that they left because of the differences in salaries of the different race groups.

"To colleagues of all races who feel strongly about this I repeat here what I have stated in the past. As soon as the economic position improves satisfactorily, I see no reason why the salaries and remuneration of qualified practitioners in the service of the State cannot be equalised. I regard this as a high priority." — (Sapa.)

6/8/78

GENERAL BRUSH-OFF FOR DR OLSSON

Dr Caroline Olsson keeps an ear on her husband John's reaction to her latest setback.

'Slave' surgeon is given a frosty reception

DR CAROLINE Olsson, who spent four years under the spell of a London sex-party queen, is no longer working at the Johannesburg General Hospital.

By RIC WILSON

The hospital asked her to leave after the Sunday Times disclosed last week Dr Olsson's secret life as the slave of a notorious London socialite, Mariella Novotny.

"When I went to collect my pay on Monday I got a frosty reception from hospital officials. They asked me to return my stethoscope and parking card," said Dr Olsson, 34.

Technically Dr Olsson was not sacked, since her temporary employment at the hospital's casualty ward ended last month. But she applied for a permanent post and she said the hospital had agreed to keep her on as a locum for this month.

The hospital superintendent, Dr John McMurdo, refused to comment.

"What we do at employer-employee level is the hospital's private business," he said.

But he gave his blunt opinion of Dr Olsson's revelations in the Sunday Times. "Of course I'm annoyed by it. Smutty stories in the newspaper don't do our image any good."

Dr Olsson, who was due back at the hospital from leave on Thursday, said: "They didn't fire me. They just didn't invite me to go back again. My temporary appointment expired at the end of last month, but they were going to keep me on for this month.

"It is not altogether surprising. I thought I would get a bad reception after details of my relationship with Mariella were published."

Dr Olsson is not going to kick up a fuss. "I don't like getting the brush-off and I don't want to contest my right to be there," she said.

"I had hoped my application for a permanent post would be approved and I expected to get the letter when I went in to collect my salary on Monday.

Misery

"It looks as though I will have to look elsewhere for a job. I will just have to find a different hospital."

Dr Olsson and her South African husband, John, 26, fled to South Africa seven months ago to break the Svengali-type spell which enslaved her to Mariella Novotny, who was hostess of the "Man in the Mask" party.

The party was at the centre of the Christine Keeler sex scandal in the 1960s.

Under Novotny's spell, Dr Olsson was driven to misery. "I was mesmerised by her. I felt I was her slave. She was capable of giving any commands and making me carry them out.

"When we went shopping she would stride ahead and I would walk behind carrying all the parcels. Once, when I stayed in her house, she made me make all the beds the next morning."

Dr Olsson, who is a member of the Royal College of Surgeons, said she hoped to settle in South Africa to be out of Novotny's reach.

SUNDAY TIMES, August 6, 1978

93

Bleeper traps bogus doctor

STORES clerk Marlon Paulsen, 23, told a remarkable story this week of how he had posed as a doctor and examined patients for six months at Groote Schuur Hospital, although he had passed only Standard 9.

He was not registered as a medical student at the University of Cape Town's Medical School, but had regularly used its library since last November for his "studies".

Groote Schuur poseur 'taught' medical students

By NORMAN WEST
Picture: TERRY SHEAN

Paulsen said that in January he had bought a book on clinical methods from a student, also not connected with UCT.

He loaned this book to a UCT student who had entered the Medical School library with it to do research.

When this student tried to leave the library, an electronic detector began bleeping and the library doors locked.

"The student said it was my book — which it was," Paulsen said. "I had no idea that the book was stolen when I bought it. But I was arrested and locked up."

He was let out. "Because I was so obsessed with a burning and overpowering yearning to become a doctor, I went back to the Groote Schuur wards dressed in a white dustcoat and with a stethoscope dangling from my neck.

"For instance, a student would do an ECG (electrocardiograph) and ask me where the JVP (jugular Venus pulse) would be. Or I would explain to them where to find the apex beat of the heart.

"I would then give them explanations in the form of short lectures.

"I was also sometimes asked to demonstrate certain procedures — as when one senior student asked me to demonstrate the correct way of carrying out a rectal examination.

"The student I am talking about told the magistrate during my trial how impressed he was with my methods and the demonstration I gave him and his colleagues on the proper way to do a rectal," said Paulsen.

During all the months he had been impersonating a doctor at Groote Schuur he had never been challenged — until there was a specific lookout for him after the book theft.

"I believe that I am ready to sit for at least a third-year medical examination any time to test my theoretical knowledge," Paulsen said. "I also believe I have done nothing wrong against anyone."

Cont. next page

Bogus doctor Marlon Paulsen outside Groote Schuur Hospital this week.

6/8/78

Spotted by guard

"While I was examining the joints of a four-year-old girl, a Groote Schuur security guard spotted me and the police were called.

"That's how I landed in court on three charges: Theft of the book, impersonating a student by attending the UCT Medical School library and impersonating a doctor."

He was sentenced to 12 months' imprisonment, suspended for five years on the impersonation charges and fined R30 (or 30 days) for the theft.

Paulsen told the magistrate, Mr E. Maritz, that he still wanted to be a doctor, but would now work through the correct channels.

He told me that he had a library of about 50 medical books at his Ocean View home. He had made a thorough study of the books since developing an irrepressible urge to be a doctor.

Paulsen built up the medical library by buying second-hand books on the Cape Parade for between R2 and R3. Some of the books he had bought, he said, could be worth hundreds of rands.

Gave "short lectures"

He had soon absorbed all he could from the books and decided to do more "research".

In January he bought three dustcoats at 50c each at a sale. "My stethoscope — it was punctured — I bought from a Stellenbosch student for R4.

"I mingled with students when they moved to the Groote Schuur wards across the way from the library, put on my dustcoat and stethoscope with a badge bearing my name and walked round with them.

"The senior medical students with whom I walked the wards knew I was not a student because I never attended lectures with them. "But they all regarded me as an experienced intern since I often helped them with problems in the library.

"However, when the students found problems in the wards of Groote Schuur, they would turn to me for advice.

Nurse admits theft from husband

11/8/78 (93)

Mercury Reporter

NEWCASTLE — Mrs. Nomfundo Lovedalia Maseko (33) was found guilty on a charge of administering or using Schedule 7 substance drugs for other than medicinal purposes and also on a charge of theft when she appeared before Mr. I. S. Brits in the Newcastle Magistrate's Court yesterday.

She pleaded guilty to the two charges and not guilty to the main charge of dealing in drugs.

Her pleas were accepted by the prosecutor, Mr. C. A. Scott.

Mrs. Maseko is the wife of Dr. Simon Phillip Maseko, a member of the KwaZulu Legislative Assembly.

She was fined R500 or 250 days.

She admitted she had stolen, during the period August 1977 to January 1978 a quantity of ampoules of morphine or pethidine and a quantity of prescription forms from her husband, Dr. Maseko, and Dr. Kumalo.

Mr. Colin White for the defence said in mitigation that Mrs. Maseko was in such a physical and mental state that she stole and used the drugs for other than medicinal purposes.

She stole pethidine from her husband's medical bag and as a nursing sister she knew how to use pethidine.

She had studied at Natal University for a diploma in nursing and that was where she met Dr. Maseko.

There was no doubt she had caused a great deal of trouble [illegible]

DRUGS DOCTOR FINED R500

Mercury Reporter

NEWCASTLE — A doctor who admitted he knew his wife was taking drugs was fined R500 (or 350 days' imprisonment) after he was found guilty on three charges under the Drugs Act yesterday.

A member of the KwaZulu Legislative Assembly and a former Mayor of Osizweni, Dr. Simon Phillip Maseko (31) was found guilty of administering or using dependence-producing drugs for other than medicinal purposes when he appeared before Mr. J. J. Muller in the Newcastle Magistrate's Court.

He was also convicted of failing to make the required entries in a Schedule 7 substances register and failing to balance it at required three-monthly intervals.

Pethidine

In a written statement handed to the Court yesterday, Dr. Maseko admitted that in January he found 10 ampoules of pethidine missing.

He knew his wife was taking drugs but because he thought she was addicted he did nothing to recover the ampoules.

Referring to the two charges of failing to keep a register, he said that when he had supplied morphine and pethidine to patients he had entered particulars on their cards but due to an oversight he had failed to enter 20 to 30 cards in the register.

On a few occasions he

She was detained for four days. She had learnt her lesson.

Mr. White said about 30 ampoules were involved.

Mr. Brits said he took into consideration the mitigating factors but there were aggravating circumstances.

Pethidine was a narcotic not a sedative.

The same charges were withdrawn against Mr. Jackson Maseko (23) a medical student and brother of Dr. Maseko.

On a few occasions he had failed to balance the register within the prescribed time due to overwork.

Labourer

Dr. Maseko was found not guilty on the main charge of dealing in dangerous dependence drugs and attempting to defeat the ends of justice, and also failing to furnish required information to an inspector.

Mr. Colin White, for the defence, told the Court in mitigation Dr. Maseko was the son of a farm labourer.

If it had not been for his wife's indulgence in drugs, Dr. Maseko would not have been charged.

Pressure

"I am happy to inform you his wife on her own has broken the habit and tells me she is no longer taking drugs," said Mr. White.

"Dr. Maseko was seeing, on an average, 120 and up to 200 patients a day. He was working under terrific strain and pressure."

He would have to appear before the Medical Council and "I trust he will not be struck off the roll."

Doctor on murder charge

16/8/75 STAR (93)

Pretoria Bureau

A Pretoria psychologist pleaded not guilty in the Pretoria Supreme Court today to murdering the 25-year-old son of a woman he is sharing a house with.

Dr Willem Lodewyk Roos (46) who works for the Human Sciences Research Council, is alleged to have shot and killed Mr David Donald Madge on September 23 last year.

Mr Madge's mother, Mrs Elizabeth Madge, told the court that about a month before the shooting, there had been friction between her son and Dr Roos over the price paid for the house and property in Garsfontein, Pretoria, where she and Dr Roos were living.

Her son had been the agent through whom the house had been bought and Dr Roos thought the price paid was too high.

On the evening of September 23, her son had arrived at the house while she and Dr Roos were watching television.

He had been drinking and seemed upset. An argument had developed between him and Dr Roos, Mrs Madge said.

Her son smashed a painting by his father, artist Don Madge, which was hanging on the wall.

Mrs Madge said she then heard a sound which sounded like crackers going off and saw that her son had collapsed.

In a statement made to the police after the incident, Dr Roos said he became scared when he saw Mr Madge destroying things in the house and opened fire on him.

(Proceeding)

Doctor could be struck off the roll

93

16/8/78 R.D.M.

Pretoria Bureau

A SOUTH AFRICAN Medical and Dental Association disciplinary committee yesterday recommended that a doctor now serving a five-year jail sentence for dealing in drugs, be struck off the roll.

At its hearing in Pretoria the committee was told that David Cornelius Liebenberg began serving a five-year sentence on March 16, this year, after an appeal to the Supreme Court had failed.

The committee heard Liebenberg was arrested on June 3, 1976, at his home at Hartbeespoort Dam. Lieutenant F Jooste of the police narcotics bureau, told the committee he found ampules of cyclimorph and pethedene, both "schedule seven" drugs, hidden all over Liebenberg's house.

"His wife had many pin pricks on her arms, legs and buttocks," Lieut Jooste said. "Liebenberg was sweating a lot and kept scratching himself while I was questioning him."

Five chemists gave evidence before the committee saying they had sold cyclimorph and pethedene to Liebenberg from May 6, 1976.

Each chemist said that the quantities of each drug bought by Liebenberg far exceeded the amounts normally bought by surgeons.

One chemist said Liebenberg had bought "20 times" the amount of each drug normally purchased.

Dentist in trouble over laughing gas

16/8/78, RDM

(93)

Pretoria Bureau

A DENTIST who admitted inhaling laughing gas (nitrous oxide), was yesterday prohibited from running a private practice for three years by a disciplinary committee of the South African Dental and Medical Association.

Dr Elsias Hendrik du Toit of Pietersburg told the committee he used the gas to relieve tension and because he had marital problems.

He was admitted to the Weskoppies Hospital in December last year.

Dr Herbert Exner, a psychiatrist at the hospital told the committee Dr Du Toit had a low stress level and suffered from amnesia when he drank alcohol.

He had treated Dr Du Toit in November, 1973, for his drinking problem and use of nitrous oxide.

Dr Du Toit said he had undergone treatment for a drinking problem and epilepsy a Weskoppies Hospital in 1964.

Dr Jacob Kruger, a Pietersburg district surgeon, said he had been called to Dr Du Toit's consulting rooms by Dr Jan Van Eeden on December 7, last year.

"I found Dr Du Toit sitting in his dentist's chair inhaling nitrous oxide. He was disorientated and very aggressive," he said.

Dr Du Toit said he used nitrous oxide on all his patients as a matter of routine and demonstrated the effects of the gas to patients on himself on three occasions.

He denied ever having worked on a patient while under the influence of the gas.

"Most patients always came to me because I used this gas," he said.

The committee recommended Dr Du Toit be permitted to practise in a hospital under supervision for three years.

Dr Du Toit would also have to visit a psychiatrist approved by the South African Medical and Dental Association.

Reports from the psychiatrist would be submitted to the board every three months.

Dr Du Toit's case would be reviewed after three years, the committee said.

POLITICAL comment in this issue by Allister Sparks, Benjamin Pogrund and John Ryan; newsbills by Trevor Bisseker; headlines and sub-editing by Colin Thompson; cartoons by Bob Connolly; all of 171 Main Street, Johannesburg.

Doctors seek fee increase

19/8/78

JOHANNESBURG — All sectors of the medical profession are to ask the South African Medical and Dental Council for an increase in fees to meet rising costs.

Representatives from the different groups of the profession — general practitioners, surgeons and specialists — will be holding round-table discussions at the end of this month to thrash out fee increases and acceptable structures.

The Medical Association will then put these proposals to the council for approval. The increases, if passed, will only become effective from the beginning of next year.

The Secretary for Health, Dr Johan de Beer, seemed optimistic this week at a general practitioner's congress, that the profession would get the increases.

A spokesman on medical fee structure said yesterday that since 1967, the profession had had an increase of only 58,3 per cent.

Since the last medical fee increase in October last year, fees stand at R4,40 for a consultation, R6,80 for a house call and R9,60 for a night call. These are the statutary tariffs laid down by the remuneration commissions of the Medical Association who have reviewed price structures in the past. — DDC.

Doctors seek fees hike

19/8/78 (93)

Mercury Correspondent

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The Secretary for Health, Dr. Johan de Beer, seemed optimistic this week at a general practitioners' congress, that the profession would, in fact, get the increases.

58 percent

A spokesman on medical fee structure said yesterday that since 1967 the profession had had an increase of only 58,3 percent. The consumer price index level had risen by 120,6 percent over the same period.

"We will also ask the council to approve an automatic yearly increase of the same amount the consumer price index level rises," he said.

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Doctor deported for barring black baby

By Sydney Moses

UMTATA — Transkei yesterday deported the medical superintendent of a hospital here who refused to admit a two-month-old black baby despite Government requests.

Dr J. H. Hofmeyer of the all-white section of the Sir Henry Elliot Hospital refused to admit Lindelwa Cawe despite requests from the Prime Minister, Chief Kaiser Matanzima, and the Minister of Health, Mr G. T. Vika, because the black section was too full.

The Minister of Interior, Mr H. Pamla, had the head of the Special Branch, Col Martin Ngceba, serve the order on Dr Hofmeyer and he was escorted to the border.

His wife, Mrs Lucy Hofmeyer, followed him in the family car so that he could have transport from the Kei Bridge.

She said from her Umtata home last night her husband was on his way to Pretoria.

"I have nothing further to say," she said.

Col Ngceba said after he had served the order, Dr Hofmeyer demanded to be allowed to consult his legal adviser.

But the deportation order stated that he leave Transkei immediately and Dr Hofmeyer threatened to report the matter to Pretoria.

"The South African Government will take up the matter with the Transkeian Government," Dr Hofmeyer, who practised in Transkei for 30 years, said.

Mr Vika said because of the congestion at the black section of the hospital, he requested Dr Hofmeyer to admit the baby and when he refused, the matter was referred to the Prime Minister.

The Prime Minister made a similar request and Dr Hofmeyer replied the hospital did not fall under the jurisdiction of the Transkeian Government, but under Pretoria. Mr Pamla said: "We came to the conclusion that this man had no respect of the Government and the only thing we could do was to deport him. He was arrogant."

He said Dr Hofmeyer had visited the baby at the black section of the hospital and found her sharing a cot with another child. Dr Hofmeyer said the child was comfortable.

25/8/78 93

(93) R.D.M. 29/8/78

FACE TO FACE

TWO hundred family doctors of all races, including some from Transkei, Rhodesia and overseas, met in Johannesburg recently for a three-day congress aimed at boosting the GP's flagging image and initiating vocational training specifically designed for the family doctor. **BOB HITCHCOCK** put to congress chairman **DR BOZ FEHLER** (left) the sort of questions patients would like to ask.

GP – a very special doctor

HITCHCOCK: On the right of the patient to know the truth about his condition — what was the consensus among delegates?

DR FEHLER: The general feeling among most doctors is that there must be continual and meaningful rapport between the patient, the family and the doctor. As for telling someone he has a illness of a kind he would find frightening — the doctor should decide whether or not to tell the patient after proper consultation with the patient's closest relatives.

One of the papers presented at the congress dealt with sexual counselling in general practice. It is the view of some specialists, including psychologists, that the GP is not qualified to deal with this subject. How do GPs feel about this? Is the subject adequately dealt with in undergraduate training?

It's not dealt with at all at medical student level. It's up to the GP to get to know as much as he can about sexual problems and develop an expertise in dealing with them. When the GP knows the husband and wife well he is obviously the right person to deal with their sexual problems. If necessary he would, of course, consult a specialist before giving treatment or advice.

Another of the papers concerned standards of undergraduate and postgraduate training. Do GPs believe their initial training is inadequate?

Look, the truth is that for training a basic doctor it's excellent. But for those entering the discipline of general practice it's certainly not adequate.

In what way is it inadequate?

Well, the concept of general practice just doesn't feature in undergraduate training.

Are you saying that the basic doctor out of medical school is not competent to practise as a family doctor, in spite of having served a year's internship?

That's right.

What can be done about this?

A young man or woman who intends becoming a family doctor should have a form of training that brings him into contact with home patients rather than hospital patients. Medical students need to see the prospects of general practice as a career and therefore need exposure to family medicine. As it is the medical student is being taught largely by specialists.

Are there any moves to create departments of family medicine at medical schools?

Yes. As a result of the congress, Johannesburg GPs are having talks with the University of the Witwatersrand. And the universities of Pretoria and the Orange Free State and one black university recently introduced departments of family medicine.

One doesn't have to be a doctor to realise that the medical man's image has deteriorated over the years. He is accused today of dealing with too many patients, to the detriment of individuals. He is accused of being no longer interested in patients' families, and of having lost the common touch. And he's accused of not being available when he's needed most — during emergencies in the home. How does the GP react to such criticism? Was this subject discussed?

The whole essence of the congress was to seek to improve our image, not only with the public but with medical students too. There is a shortage of medical doctors and we don't want in our ranks the doctor who falls off the ladder of specialisation. We want specially trained GPs.

Yes, but what have you to say in defence of the GP?

Quite a number of doctors have quit South Africa. This means that those who stay have an additional workload. It's quite impossible to work as we did years ago, visiting every patient who complained of a sore throat. Most of us still visit patients — the very ill, the elderly and infirm. We attend serious emergencies in the home.

Talking of emergencies generally, including road accidents involving people not on your panel, I understand that while it is a statutory duty for doctors to handle such emergencies, standards and responsibilities to the community and to patients have never been defined. Is that so?

Yes, that is the position.

What was decided at congress? Do you intend drafting a definition for the consideration of GPs?

In attempting to delineate the GP's role in emergency care it is essential to have some scientific data on the scope and magnitude of the problem. The College of Medicine at Rondebosch is hoping to do a three-month project in which every emergency treated by a group of GPs will be recorded. For the purpose of the survey an emergency call will be defined as a call requiring immediate response to the exclusion of any activity the GP may be performing.

What did GPs' wives discuss at congress?

Their discussion was on the effect of their husband's practice and patients on their lives. After three hours they concluded that all they wanted was recognition of their place in the home, and that despite the difficulties the husband must communicate with them and their children.

Delegates seemed to be upset that the media generally gave more prominence to the matter of doctors' fees than to any other subject discussed. Don't doctors realise many patients consider they are being overcharged?

When you consider the charges made for medical services in the United States, Canada and Australia, South Africans can count themselves lucky. The personal and continuing service given by South African doctors is something to be proud of.

I see that the R10 000 it cost to hold the congress was partly paid for by a pharmaceutical company. Who paid the balance?

It came from delegates' registration fees.

What happens to your congress findings?

They will be sent to the World Organisation of National Colleges and Academies of Family Medicine. We've broken new ground in this country — this was the first congress of its kind for GPs. The next will be held in Cape Town in 1980.

Finally — did you allow smoking?

No. It was prohibited in lecture rooms and during workshops.

Deported doctor home

UMTATA — The deported medical superintendent who refused to admit a black child into the white section of the Umtata Hospital is back in Transkei.

The Secretary of the Interior, Mr L. Ndesi, has given Dr Jan Hofmeyer three days to wind up his affairs.

Dr Hofmeyer refused to comment yesterday on his deportation.

Dr Hofmeyer refused to admit two-month-old Lindelwa Cawa despite Government requests.

He maintained such permission had to be given by Pretoria who controlled the white section of the hospital.

At the time of Transkei independence, agreements were made with South Africa to govern and regulate the employment terms of staff at hospitals which remained under the jurisdiction of Pretoria.

The agreements guaranteed entrance and exit from Transkei to such staff without hindrance.

However the Government of Transkei may require any non-Transkeian citizen to leave Transkei .... and may refuse entry into Transkei to any person in the service of the department (South African Department of Health), or demand the removal of any person serving in Transkei. — DDR.

When a person has been sick for a long time, and the doctors and the amaggira have been unable to help, he might be advised by a person who had the same sickness and who was helped by the Zionists to come to us.

A person coming to our church does not tell us what kind of sickness (ugula) (s)he has. The spirit will tell us what kind of sickness (s)he has. After the spirit has told us what is wrong, we can heal the person.

I asked him as to the reasons for people joining the church:

Some people come because they see that the church will help them. Others come only for pleasure. What I have experienced is that people come to our church to hear whether we are able to tell them about their difficulties. After they have heard all about what worries them, they often do not come back. Others come being sick. After being healed, they join the church and become a member of the congregation.

I then enquired about specific treatment techniques. He specified that he used a medicine (iziwasho), coloured cords, bathing, sacrifice, specially shaped sticks and dreams. The technique used depended on the person's problem and on what he is told by the spirit.

His concept of sickness is obviously different to the usual Western concept and included, for instance, a person who is unable to secure employment after a long period. Such a person would be given a medicine to cause vomiting and another medicine to hang around his neck. The "patient" will also be given a coloured cord to wear around his head.

The sacrifice of an animal is undertaken in response to the ancestral shades "because most of the peoples ancestors want them to do something". The coloured cords appear to play numerous roles in healing, they may represent different kinds of spirits, they may be tied round specific parts of the body, e.g. wrists, ankels, waist or head and serve a protective function in warding off "enemies".

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Doctor faces Medical Council sentence

(93) [illegible] 9/9/78

Staff Reporter

MEMBERS of a disciplinary committee of the South African Medical and Dental Council which sat yesterday will recommend that a Turffontein, Johannesburg, doctor, Dr Dirk Scheepers, be suspended from medical practice for a year.

They will also recommend that this sentence be suspended for three years.

Dr Scheepers appeared before the council on charges of prescribing several 30 mg capsules of the drug Duromine to a patient, Mrs P Trejier, without a thorough medical examination and without taking the necessary steps to determine whether the use of the drug could be dangerous or harmful to her health.

A second charge related to the fact that Dr Scheepers had refused to tell Mr Trejier the contents of an injection he had given his wife.

Dr Scheepers, 29, pleaded not guilty to both charges but changed his plea on the first charge to guilty after evidence had been led. He was found guilty on both charges.

In evidence Dr Scheepers said that Mrs Trejier had come to him to lose weight after she had seen the results he had achieved in treating a friend of hers.

"She said she was in a hurry and wanted the same pills and injection I had given to her friend," Dr Scheepers said. "She was a young woman of 25 and I did not expect her to have a history of high blood pressure or heart trouble — so I gave her the pills and injection.

"Later, her husband phoned to say his wife was not well."

In defence of Dr Scheepers it was said that Mrs Trejier had suffered no long-lasting harmful effects from the use of the drug.

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Jail would mean early death, judge rules

Own Correspondent

DURBAN.—Sending a seriously ill businessman to jail would be sentencing him to a premature death, a Durban judge said yesterday.

He fined the man R55 000 for contravening exchange control regulations.

Mr Justice Shearer also sentenced Victor Bernard Lapinski, 60, to four years' imprisonment, suspended for five years.

Lapinski pleaded guilty to three counts of contravening the regulations by illegally sending R36 000 out of the country, buying foreign currency from someone not an authorised dealer and failing to make a declaration to the Treasury or a dealer.

Doctors told the court Lapinski had a heart condition and would probably not live more than three years. Imprisonment could be fatal.

Lapinski said he was a company director and owner of the Marine Sands and Impala Holiday Flats and La Goulue and Stax restaurants.

In 1975 his son Leo was divorced. His son was unhappy and wanted to start life afresh in the United States, where a relative had offered him a junior partnership in his business for R50 000.

Lapinski agreed to help his son and began accumulating dollars and travellers cheques to send to the US. Some of these came from visitors to his flats and restaurants.

From January 1976 to March this year the businessman sent R36 000 in dollars and cheques to America, enclosed in letters.

Six of the letters were intercepted by Post Office officials and Lapinski was arrested.

In sentencing Lapinski, Mr Justice Shearer said that in view of the medical evidence he could not send Lapinski to jail. If it had not been for that evidence, however, he would have imposed substantial terms of imprisonment.

He had committed a crime against society and everyone living in South Africa. His actions affected the living standards of all.

The judge accepted that Lapinski had been motivated by solicitude for his son and took into account that the currency had been repatriated.

Medics feel the strain as GP numbers drop off

Sun. Tribune 17/9/78

(93)

Long queues at the doctor's

Tribune Reporter

FAMILY doctors, particularly in Johannesburg's northern suburbs, are being forced to take on more patients because there is a shortage of general practitioners.

The two main reasons for this are the drain of doctors leaving for overseas and they bent towards specialisation.

The problem has been more noticeable in Johannesburg and particularly in winter when doctors have more patients with coughs, colds and flu.

Many doctors are working 12 hours a day to cope.

One northern suburbs doctor inherited many patients from a GP in the area who went overseas.

"I've just had to find time to cope with them," he said.

He starts his calls at 6.45 and is in his surgery by about 9.30. At lunchtime he plays a game of squash — his only relaxation and is back by 2pm to see more patients until he goes home — possibly with a house call on the way at about 7pm. The doctor said he felt he was falling behind in latest medical knowledge because he did not have time to read journals.

He said the crush of patients was forcing doctors to lose personal contact with their patients ... which was an essential part of being a GP.

Another northern suburbs doctor felt the shortage was largely due to budding doctors being attracted into specialising rather than general practice.

He is actively involved in trying to raise money to establish a chair of family medicine at the University of the Witwatersrand. Bloemfontein and Pretoria universities already have similar faculties.

He said during their training, medical students were exposed to the specialities in medicine more than general practice and were lured into them when they graduated. "They don't spend enough time with the coughs and sore throats in casualty. They are exposed to cardiac and lung cases — the dramatic stuff. These make up about two per cent of all patients."

He said the idea of having a chair of family medicine had been agreed to by the university and it was simply a matter of raising R300 000 to finance it.

He did not expect this to happen within the next year.

The idea would be for medical students to spend some of their training in general practices. "We want family medicine to be looked on as a speciality," he said.

Secretary of the National General Practitioners' Group, Dr George Davie, said the shortage of trained GP's had always been a problem.

Doctors were also working longer hours to keep pace with the rising costs as well as taking on patients from doctors who had left the country.

He said it was not a country-wide problem yet. The brunt of the shortage was being borne mainly by Johannesburg doctors.

SUNDAY TRIBUNE, OCTOBER 1, 1978

an alarming trend in South African medicine

Medical students talk of leaving before they even qualify and hospitals face the crunch

THE growing shortage of doctors in South Africa could lead to an "unimaginable" situation at hospitals like Durban's King George VIII and the Transvaal's Baragwanath where doctors are already seriously overstrained.

This frightening warning was delivered to South Africa at the conference on the Economics of Health Care in Southern Africa this week at the University of Cape Town.

It came from Gill Westcott, a research worker with the SA Medical Students Trust.

Increases

She said that Defence spending increases would lead to an overall cut in the resources available to the health sector, "and we may be faced with the twin prospects of a worsening disease situation with unemployed nurses and hospitals and clinics standing unused."

She suggested a series of urgently needed measures to help the country to cope.

She said that 80 percent of the doctors who graduated with top passes from Wits in the last 50 years were now abroad.

Tendency

"The tendency to migrate has accelerated in recent years, both financal and political reasons playing a part.

"According to UCT staff members, undergraduates in their second year can be heard talking about their decision to emigrate once they are qualified, and some clearly regard their medical training as the passport to life in other rich communities.

"The loss of doctors will be aggravated by the increasing need for doctors in military service as years go by, so medical facilities now experiencing a shortage of doctors will be in danger of closing."

"Also, many of the expatriate staff of mission and homeland hospitals could be expected to return to their countries of origin.

"Health facilities in the homelands may therefore be expected to suffer particularly seriously and surgical facilities may become virtually inaccessible to a greater proportion of the population than in the case today.

"A key question is whether preventive medicine will continue: Whether nurses by that time will be sufficiently well-trained to run hospitals as large clinics and to maintain child welfare clinics and school health programmes.

"If this does not happen, large outbreaks of preventable infectious disease — e.g. typhoid, diphtheria, whooping cough — can be expected, and TB will take a still greater toll."

Numbers

In another paper, Dr Tim Wilson, who trains primary health care nurses in Soweto, said that while the numbers of medical students were being increased rapidly, the number of doctors was not rising correspondingly.

He said the maldistribution of doctors in South Africa was "appalling."

In 1962 population to doctor ratios were reported to range from 600 to 1 in Durban 40 000 to 1 elsewhere in the country. Fifteen years later the ratios were largely unchanged.

Estimated

He said: "In the six years from 1970 to 1975 — quiet years politically — it is estimated that 14 percent of all our medical graduates and 50 percent of those from Wits and UCT left the country permanently.

"During the course of 1975 despite the fact that 469 new doctors immigrated into the country, the net gain of doctors to the country was only 111

"During 1977 the country had a net loss of 152 doctors Of the doctors remaining, 20 percent practise as specialists so that counting on even an extra 1 000 doctors working in primary health care in the next five years seems unrealistic"

Gill Westcott said there was already difficulty in filling Cape Town posts in public health services — MOHs and so on — as the present staff retired.

"Many posts may fall empty, so that preventive work in urban townships could also dwindle

"With increasing disorganisation in the townships, more disease is to be expected: influenza, pneumonia, TV, measles, gastroenteritis and malnutrition"

She said the age structure of the population of doctors could be expected to increase as young men left

Unrest

Township unrest would make many urban areas inaccessible to doctors

"However, the consequences of this will very likely be mitigated to a considerable degree by the presence of nurse clinicians who, if present training courses are imitated and expanded, will be available in reasonable numbers for work in decentralised clinics"

Sun. Tribune 15/10/78. ~~103~~ (93) 3

R167 000 for the man who wouldn't admit black child to hospital

DOCTOR JAN STRIKES IT RICH

By PETER MANN

A WHITE doctor, deported from Transkei for refusing to admit a black baby to his hospital, has been paid out R167 493 by the South African Government.

Dr Jan "Hoffie" Hofmeyr was paid more than five times the municipal value for his house in Umtata's plush Delville Road.

The house is now occupied by Mr S. T. Mabovula, a wholesaler from Tsolo. Mr Mabovula is understood to be related to the Prime Minister, Paramount Chief Kaiser Matanzima.

Dr Hofmeyr was paid R130 945 for the house. The municipal value of the property is R25 850. Sources in Umtata estimated the market value of the house at R45 000 to R50 000.

In addition Dr Hofmeyr was paid R36 548 for the building in which his surgery was housed. This is also reported to be an excellent price as the building is a small one.

The South African Bantu Trust, which uses taxpayers' money to buy white property in homelands, is also said to have paid the doctor an undisclosed amount for his practice.

Dr Hofmeyr practised in Umtata for 30 years before his deportation.

He was thrown out in August this year for refusing to admit a two-month-old black girl to the all-white Sir Henry Elliot Hospital in Umtata.

Dr Hofmeyr was part-time medical superintendent of the hospital, which is controlled from Pretoria.

On August 24 he refused to admit Lindelwa Cawe to the hospital — in spite of a request from the Minister of Health, the Reverend G. T. Vika.

He had been asked to admit the girl because the children's ward at Umtata General Hospital was overcrowded.

Dr Hofmeyr, who visited the child in the Umtata hospital and found her sharing a cot with another child, refused the request saying the Sir Henry Elliot Hospital was for whites only.

The matter was then referred to the Prime Minister.

When Dr Hofmeyr persisted in his refusal to admit the child he was served with a deportation order by the head of the security police, Colonel Martin Ngceba, and escorted to the Kei River border post.

The Minister of the Interior, Mr H. Pamla, who issued the deportation order, said Dr Hofmeyr had "displayed arrogance" and had "no respect for the Transkeian Government."

This week he refused to comment on his deportation or the amount he had been paid out.

"You go back to Umtata and find out the true story of what happened. Publish that and then I'll talk to you," Dr Hofmeyr said. He refused to expand.

Sources in Umtata said the price paid for Dr Hofmeyr's house was the highest ever in the town. The transfer had also gone through with unusual speed. Dr Hofmeyr was paid out on September 15 — just 21 days after he had been deported.

TRUST PAYS OUT FOR PLUSH HOME HE HAD TO LEAVE

Dr Jan Hofmeyr, deported from Transkei but paid out R167 493 by South Africa

Transkei calls for doctors

26/10/78
93

QUEENSTOWN — Transkei was appealing to the world community to relieve the new state of a serious shortage of doctors, the Transkeian Minister of Health, the Rev G. Vika, said here yesterday.

Mr Vika said his Government was offering scholarships to young Transkeians to study medicine.

South African medical schools had opened their doors to Transkeians.

The Minister is on a tour of hospitals in Transkei and is having talks with doctors on ways and means of recruiting medical men from other countries.

He is also addressing communities in the areas he is visiting encouraging people to send their children for medical training.

The question of hospital equipment and machinery is also being discussed.

Mr Vika appealed to high-school teachers to submit names of promising scholars.

He said extensions to the Umtata General Hospital had begun to bring it to the Groote Schuur Hospital standard. There were plans to train Transkeians there as doctors and specialists — DDC

(93) 27/10/76

Addict doctor off roll

PRETORIA — The name of a Pretoria doctor, Dawid Cornelius Liebenberg, has been removed from the register of the South African Medical and Dental Council.

The council, sitting here, found Mr Liebenberg bodily and mentally incapable of continuing to practise as a doctor as he was a drug addict.

He is serving a sentence in the Pretoria Central Prison after being convicted of drug trafficking.

Another doctor whose name was removed from the register is Mr S. J. Tsalavoutos of Johannesburg. He left South Africa after appearing in court on a charge that he had conspired to procure abortions.

Dr D. W. Scheepers of Johannesburg was given a 12-month suspension, suspended for three years, for giving a prescription to a woman without examining her.

Dr S. A. van Niekerk of Vanderbijlpark was suspended for four months for leaving a swab in a patient and Dr T. Viljoen of Johannesburg was given a nine-month suspension, suspended for three years, for issuing a false prescription.

The council refused to return the name of Mr J. A. Beneke to the register. It was removed in 1974. — SAPA.

Southern ... elopment Research Unit

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Cape Town

September 1977

Sun. Tribune 29/10/78

93

DOCTORS CAN'T HALT KILLER GERM

MEDICAL officials have failed to prevent the spread of a deadly new supergerm at two Durban hospitals because of inadequate facilities. The bug has already killed 14 children.

At the same time authorities are taking no special measures to curb the menace, which is anxiously being watched by health authorities internationally.

Doctors claim the supergerm is under control to "an extent" but admit they cannot take effective steps to identify and isolate all the carriers.

Dr Frank Hallett, a member of the microbiology team which discovered the supergerm, says that overcrowding and limited laboratory facilities are the main reasons why doctors are having difficulty in eliminating the supergerm at Durban's King Edward VIII and Clairwood Hospitals.

The germ, a pneumonia bug which is highly resistant to penicillin and sometimes to other commonly used drugs, caused a world-wide scare when it was first isolated by the staff of Natal University's medical faculty at King Edward in May last year. It was feared that it would spread to other countries. So far

According to Dr Hallett there are two ways in which the supergerm could possibly be eliminated. Throat specimens could be taken from the 200 paediatric patients at King Edward at least three to four times a week for laboratory tests, and special isolation wards could be established at the hospital.

But neither can be done at the moment because the laboratory is not in a position to cope with the extra tests and King Edward is "always too crowded" for isolation wards to be established for a large number of patients.

The germ has made its appearance only among patients at certain black hospitals. Since May last year it has claimed the lives of 14 African children in Durban, most of them under two years. The most recent death was about a week ago. Several deaths also have occurred in the Transvaal.

Dr Hallett said the team was not able to identify all the carriers of the germ because of the problem of limited laboratory facilities and the absence of isolation wards. And supergerm cases were still being found.

Although it was said last week that the problem was under tight control Dr Hallet said this week: "To an extent it is under control. Our main problem lies in the fact that we haven't been able to eliminate all the carriers, although it is not a big problem."

REPORT BY TICKS CHETTY

New vaccine

Asked to comment, Dr V. A. van der Hoven, Natal's director of Hospital Services, said: "I am not aware of it being a tremendous problem. And I have not been approached to establish special facilities at the hospital."

Dr Hallett said that if the problem continued the team would consider using a special vaccine on all children being admitted to the hospital to give them immunity against the germ.

But there is one problem. The vaccine has never been used on children in South Africa and it is not known how they would respond to it.

"Successful trials of the vaccine have been carried out overseas, but they were on normal, healthy children. We don't know how a malnourished child, for instance, would respond to it," said Dr Hallett.

According to Dr Hallett, doctors in the Transvaal were in a better position to cope with the supergerm when it was first identified there because of the bigger laboratory facilities and the establishment of isolation wards there.

He said though there were fears the germ would spread to other countries, they had not yet materialised.

Internationally, health authorities are worried about germs which are resistant to antibiotics, a problem which seems to be steadily increasing. The World Health Organisation is debating whether a much stricter and more systematic control of antibiotic use may be necessary.

S&D2(a)

The medical empire

Ask anyone what they think is the most important piece of equipment in the doctor's gadget bag and you will get as many answers as there are people. Most would be wrong. The most important item in the medical armoury today is the prescription pad.

Think about it next time you go into the surgery. The pad will be lying on the desk top, conveniently at hand. Some doctors will even reach for it before you sit down. A few may even begin writing before you've stopped talking.

The problem is that your doctor can't give you what you really want and most of the things that can affect your health are being looked after by other agencies. It may be only a temporary phase while the profession adjusts to the new outlook on health but at present most doctors are relegated to the prescription pad and dependence on packaged medicine.

About 90 per cent of all human ailments will cure themselves if left alone. The rest require such a vast armoury of preventive and curative medicine that it encompasses much more than what your family doctor can offer.

Surveys have shown that apart from the chronically sick most people go to the doctor for reasons other than illness, such as boredom, loneliness, depression, fear and other psychological problems that are a product of modern mass living.

Contact with the doctor is a boost to the ego, a kind of metal pick-me-up that charges the patient's batteries and sends him off for another round in the urban jungle. At least, that's what should occur. What happens all too often is the fixed smile, the prescription pad and the "next please, nurse," routine.

Quite simply, doctors don't have time to listen to your problems if your opening words show that you are not actually ill or in pain. Your worries are soothed with a practised dismissal line of the "take-two-after-meals" variety and you are shown out, mollified by the harmless placebo or light tranquilliser prescribed on your magic piece of paper.

Once, not so long ago, the doctor was the be-all and end-all between you and everything that goes bump in the night out there. He advised your parents, tended your birth, saw you through the whole teething, cough and spot performance, whipped out your appendix and anything else that offended you, and generally hung in there with you for as long as you can remember.

No longer. The heyday of medicine and the big daddy era for doctors was probably just after the great discoveries had chased out the quacks and just before technology brought mass-produced instant health for all. In our own time has come the high-cost medical empires bounded by the private consulting rooms of the rich and the high-budget research factories into which the poor are crammed in the belief that they are being hospitalised.

The Chris Barnard column

The emphasis was on cure and to hell with the cost — the state would pay, disease palaces sprang up in every urban centre, bankrolled by the taxpayer, infested by medical students, a godsend to building trade, the drug companies and the equipment makers, and frightening to the patients.

Now, with the knowledge that complete cure of nation's ills is not only unattainable but too costly, the bias is swinging towards prevention of ill-health — a concept already largely achieved by the work of the great 19th century engineers.

It seems strange to think that an engineer can have much control over your state of health but it is a fact that the engineering and architectural departments of any university annually turn out more guarantors of the nation's health than any medical faculty.

Modern sewage, water supplies, housing, transport, agricultural advances and communications have done more to raise the health standards of mankind than hippocrates and his entire pill-pushing crew. A single plumber probably achieves as much in the field of preventive medicine than most medics while the ordinary health inspector, doing a boring routine check of takeaway shops and corner cafes, saves more in terms of the nation's health budget than any topflight, nationally-known specialist, myself not excluded.

The medical empires are being broken down into day clinics, mobile advice bureaus and a host of paramedicals who are taking health out of the consulting room and putting it back on the street where it belongs.

All this of course could, unless well orchestrated, present a considerable threat to the medical profession. The hierarchy, I'm glad to say, is bearing up well and fighting what must be the most successful rearguard action in history.

No sooner does a paramedical or vaguely health-connected occupation appear than it is dragged under the banner of medical control. For the public good of course. If the doctor can't actually do the job himself he will make damn sure that he controls whoever does — as the lengthening list of psychologists, radiologists, chiropractors and masseurs, the latest addition, shows.

They failed with the building trades and never quite got off the ground with the allied professions but that was in the early days before the medical power structure took root. I'd hate to think what would happen today if plumbing were suddenly to appear as a new job category. Can you imagine how the South African Board of Plumbing would look as an affiliated body?

But don't let it provoke you too much — if you should take ill suddenly it is still better to ring a GP than a bricklayer.

Doctor's accounts were 'false'

Mercury Reporter

A DISCIPLINARY committee of the South African Medical and Dental Council yesterday recommended that a Chatsworth doctor be struck off the register for submitting false accounts to a medical aid scheme.

The committee headed by Prof. H. W. Snyman, president of council, found Dr. L. V. Naidoo of Road 1020, Chatsworth, guilty of disgraceful conduct on two counts.

He was found guilty of submitting to the Natal Medical Plan in May 1977 an account for R40,62 for treatment for Mr. Saphiamoorghy Naidoo of Chatsworth and his family when only treatment costing R1,26 for Mr. Naidoo had been given.

He was also found guilty of asking his patient to sign a blank account form which was used to defraud the plan.

An assessor for the plan, Dr. David Martyn, said they had paid Dr. Naidoo R1 662 that month which was well above the average monthly payment of R500.

Accounts

If Dr. Naidoo had submitted accounts for fictitious treatment, he would consider it "most improper conduct."

Mr. S. Naidoo said when he had received notification of a bill itemising treatments his family had not received, he rang Dr. Naidoo who told him to come and collect an amount equivalent to his portion of the bill.

"I told him I don't operate that way and I would have to report him to the plan," said Mr. Naidoo.

In evidence Dr. Naidoo said his receptionist and not himself had asked the patient to sign the blank form. His receptionist had since left the country.

He said he and Mr. Naidoo had conceived a scheme to defraud the plan.

However after Mr. Naidoo had come to his surgery and demanded money from him because he had won a lot of money on the races he had told the plan the billing was a mistake and had refunded the R38,36 to it.

Mr. Naidoo said the doctor and a Mr. L. M. Naidoo, a cousin of both of them, had asked him to sign an affidavit that members of his family had in fact had the treatment.

'Lies'

He refused to sign because it was "all lies".

Cross-examined by Mr. Guido Penzhorn for the complainant, Dr. Naidoo said he knew nothing about the affidavit until he had gone to Mr. Naidoo's house for the signing.

He later admitted, when questioned by Prof. Snyman, that the facts in the affidavit were not correct and that he had been a party to requesting Mr. Naidoo to sign it.

Prof. Snyman said the committee's recommendation that Dr. Naidoo's name be erased from the register would be submitted to council in April.

Doctor loses battle for job and salary

RDM 10/11/78

(93)

BLOEMFONTEIN. — The Appeal Court yesterday allowed an appeal by the Director of Hospital Services, Transvaal, against a judgment which ordered that Dr Navin Vithal Mistry be reinstated in his post as a medical officer at Baragwanath Hospital from August 1, 1976, on full pay, and that the salary which had been withheld from him from that date should be paid.

Dr Mistry was suspended from August 1, 1976.

On August 3, 1976, Dr Mistry had been arrested and had appeared in the Kliptown Magistrate's court. He had not been asked to plead to any charge.

He had understood verbally from the investigating officer that the charges being investigated were fraud and forgery and uttering allegedly committed in the course of his work at the hospital.

After several postponements Dr Mistry and his attorney were told by the prosecutor that he had insufficient information to compile a charge sheet. On the application of Dr Mistry's attorney the case was struck from the roll.

On September 1, 1977 in the Transvaal Supreme Court, Mr Justice Le Roux found that up to date there was nothing on the papers which indicated that a charge sheet had been compiled, or that the State was in a position to compile one. Nor was there any indication of an intention to proceed with a case against Dr Mistry.

Mr Justice Diemont, with the Chief Justice, Mr Justice Rumpff, Mr Justice Rabie and acting Judges of Appeal, Mr Justice Viljoen and Mr Justice Hoexter concurring, said the main argument for the director was that the judge had decided the dispute on an issue which was not raised in the papers before the court.

Mr Justice Diemont said when proceedings were launched by way of notice it was to the founding affidavit that the judge would look to determine what the complaint was.

It followed that Dr Mistry could not extend the issue in dispute between the parties by making fresh allegations in the replying affidavits or by making such allegations from the bar. — Sapa.

Star 18/11/78

(93)

Doctors take top grading in survey

Doctors are held in higher esteem in South Africa than are clergymen, lawyers, engineers, teachers and professors, diplomats, nuclear physicists, business executives, politicians, editors and booksellers.

This Market Research Africa (MRA) conclusion was drawn from a survey of 1 000 white urban dwellers who were asked: "Who do you hold in the highest esteem?"

Seventy-six percent of those interviewed selected doctors compared with an average of 81 percent in similar international surveys.

Clergymen, with 48 percent support scored better than lawyers (43 percent), engineers (42 percent) and army officers (38 percent).

Politicians, with 15 percent of the votes (20 percent in the overseas surveys) were better thought of than newspaper editors (11 percent in South Africa and 13 percent internationally) and bookshop owners who are held in the lowest esteem (six percent here and eight percent overseas).

REVILED

In England and New Zealand surveys have shown that the public has a higher opinion of the legal profession than lawyers have of themselves.

"For many years the English legal profession has seemed to suffer from a chip-on-the-shoulder feeling that it is unjustly reviled and criticised," says De Rebus Procuratoriis, journal of the South African attorneys profession.

More than 47 percent of New Zealanders interviewed said lawyers were honest trustworthy people, only 17,7 percent of lawyers gave an affirmative reply.

A spot survey by The Star has shown South African attorneys have a higher opinion of themselves than their counterparts in England and New Zealand.

the estate was beautifully illuminated. However, since then we have been disappointed that the situation has gradually deteriorated in some areas. The contractor gave us an excellent guarantee of his work for one year including replacement of the globes which failed during that time, but unfortunately we are having no success in getting him to honour his obligation. Sadly this means that parts of the estate are again very poorly lit. The globes are extremely expensive, and our budget does not allow us to replace the globes (which should last up to 2 years) every few weeks. We are doing our best against the contractor, but it is proving very difficult. We are also looking into the possibilities of getting a maintenance contract for the lights from another contractor.

8. PAINTING THE OUTSIDE OF THE HOUSES

This seems to be progressing very satisfactorily, weather permitting, with an average of 3 - 4 houses per month as an onward going project. If residents are dissatisfied with the work in any way when their houses are painted, please could they report this to Mr. D.S. Roberts (Tel. Office: 432086). as Mr. Roberts-

10.

Are you interested in reading? Do you enjoy a cup of tea (or coffee) and an informal chat? If so, kindly contact any one of the persons listed below for further information:-

Jenny Herbert - Hse. No. 90 (Hamlet 1) Tel. 726498
May Bennett - Hse No. 88 (Hamlet 1) Tel. 720027
Hazel Foox - Hse No. 44 (Hamlet 4) Tel. 721718

11. AMENITIES NEARBY

Sports Club - (Membership necessary) - Constantia Sports Complex (near Alphen) - Tennis, Bowls etc.

Walking Permits - Tokai Forest (above Manor) - available from Mr. Bird, Forestry Dept., Tokai Road., or P.O. Box 88, Retreat. Tel. 721331

Library - (small, free, locally situated) - Lismore Avenue Library - off Tokai Road. (larger, but membership fee necessary) - Meadowridge - Tel. 728900

12. IDEAS

Anyone who has any ideas about the improvement of the estate (must be cheap!), the solution of the problems we have discussed in this news letter, or the promotion of good neighbourliness is asked, nay begged, to contract the Directors with his scheme.

If you have managed to get through all this, you have definitely got staying-power. Many thanks for your attention.

Man Greenhalgh
CHAIRMAN

Police disrupt meeting claim

MATATIELE — A Transkei doctor has complained that South African security police here disrupted a meeting of Transkei medical practitioners, searched the house where they met and took away the owner, a widow, for interrogation.

Matatiele is in East Griqualand.

Dr J. Mabaso, president of the Medical Scholarship Group, Transkei, said they were holding a quarterly meeting at the late Dr J. Njongwe's house.

Eight security policemen armed with sten guns came inside while others kept guard.

They said they were looking for a criminal, searched the house, and took Mrs Njongwe to the charge office where she was questioned for more than two hours.

Following inquiries by a local advocate, Mrs Njongwe was taken home.

Dr Mabaso said they were stopped by the same police at a road block on their way home. Clothing and documents in the boot were searched.

The policemen asked for the minute book of the association and paged through all the documents they found.

White motorists were not stopped by the police.

Dr Mabaso said the policemen also took their names, addresses and car registration numbers.

They identified themselves as medical officers, but the police took no heed and harassed them.

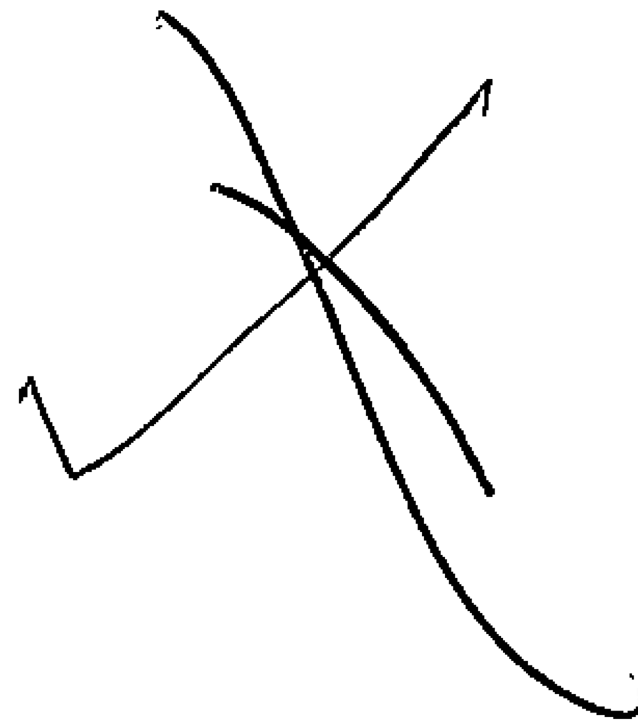
The head of the Security Police in Matatiele, W/O H. F. Steyn, said: "I have no comment to make. Sorry, I can't give any information."

It is believed that Transkei doctors will take up the matter with their Government. — DDR.

HEALTH + DISEASE – Doctors

(93)

5-12-78 – 14-12-79



Star 5/12/78

(85)

(243) (93)

Doctors move to aid hostel families

Severe overcrowding and poverty are threatening the health of scores of families housed by the West Rand Administration Board in Mzimhlope Hostel, Soweto.

The families are among the more than 1 100 moved to the hostel after their houses were destroyed or damaged by floods two years ago.

Their plight is underlined by the inability of Wrab to do anything to help because of an acute shortage of funds.

The families are housed in hostel rooms built for single men and they are paying up to R7 a month for each occupied bed.

These high rentals mean that a family of four with children over 16 pay close to R30 a month for a single room at the hostel.

For children under 16 the charge is R3,50 a month for each bed they occupy.

Black doctors, worried by conditions at the hostel, are clubbing together to attend to the malnutrition which has been found among children there.

However, a Wrab spokesman has strongly denied that the families are faced with any health hazard. He said there was a permanent welfare officer stationed at the hostel who looked after the wellbeing of the people.

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Conclusion

The paper has argued that Botswana can afford and would benefit from a more organic, more experimental, more locally determined approach to rural development than the apparent inappropriate drive for greater precision. The two proposals used as examples of such an approach, the upgrading of the traditional rights to graze to a right over communal land under a communal land company concept and a regular employment guarantee scheme, are both wonderful laborato... local government capacit... group security and initi... effective instruments fo... assets and for the provi...

Doctor accused by council

7/12/78 (93)

Mercury Reporter

WITNESSES at a Medical and Dental Council inquiry in Durban yesterday said they had been given medical certificates by Dr. A. I. Padia, of Kloof, without being examined.

Dr. Padia is appearing on five charges of improper or disgraceful conduct because he allegedly issued certificates between April, 1976 and January, 1977, without satisfying himself by personal observation that the facts on them were correct.

Two people who went for certificates were policeman pretending to be Durban Corporation bus drivers, who were setting a trap for the doctor.

Major G. H. Kruger said on January 21, 1977, he had sent two men with corporation medical certificate forms and R2 each to the doctor.

Marked

When his men returned with the signed forms he had gone into the consulting rooms and found the marked notes on the doctor. There was no entry for these in the doctor's receipt book.

Sergeant Tom Kamanga said the doctor's Indian nurse-receptionist filled in his form using his assumed name.

"She asked me what was wrong and I said I wanted eight days' sick leave. She said there must be something written on the form so I told her I had stomach trouble.

"The doctor came in, signed our forms, gave mine to me and said: 'God bless you'."

Backache

The doctor had not examined him or asked him questions about his illness.

Constable D. L. Ndlovu said he told the receptionist he had backache, but did not say he had 'flu although she wrote "lumbago and influenza" on his certificate.

He too had not been examined.

Mr. Bongkinkozi Zungu said he was a corporation bus driver and in April, 1976, had gone to get a sick leave form filled up as he wanted to go to Mhlabatini.

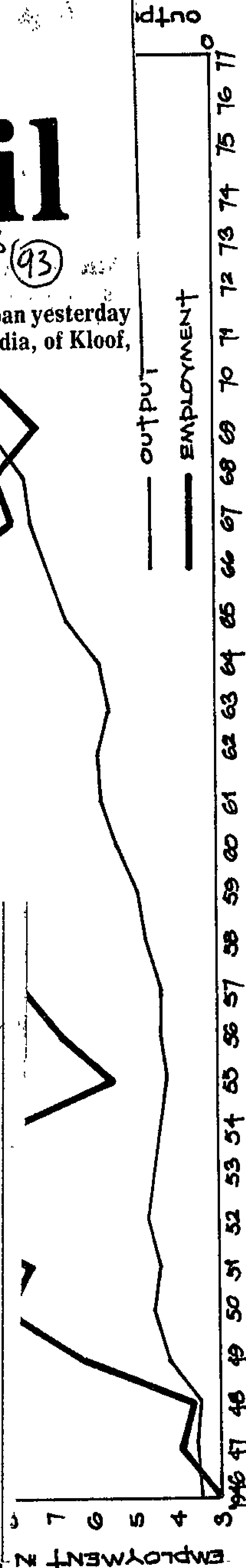
Common

"I said I wanted two weeks.

"After he wrote on the form he said he wanted R2 and I paid him."

Another witness, Mr. S Thusi, said it was the common knowledge among bus drivers that Dr. Padia would sign sick leave forms.

The inquiry was adjourned to February 19.



AD 19/12/78

93

Court warns doctors over prescriptions

JOHANNESBURG — An advocate defending a doctor charged with dealing in drugs told a magistrate here yesterday "doctors were sitting ducks for drug addicts who were determined to get hold of drugs."

Mr A. P. Kruger appeared on behalf of Dr Joseph Salamon, 56, who pleaded not guilty to illegally dealing in seconal tablets and using dependence producing substances for purposes other than medicine.

Finding Dr Salamon not guilty on both charges, the magistrate, Mr E. Brandt, said he accepted the doctor's evidence but that there was a suspicion that Dr Salamon was inclined to issue prescriptions "left, right and centre."

"A word of warning must be spoken to doctors to be more careful in future," he added.

Dr Salamon told the court a new patient consulted him and told he had a sleeping problem and asked for seconal tablets. He did not find it a strange request as many patients asked for different drugs. He prescribed a month's supply.

The man later turned out to be a detective from the drug squad.

"A doctor has to accept in good faith what a patient tells him," Dr Salamon said. — SAPA.

·ery largely concerned with wages and working
ost instances but not in all.

›loying, let us say, 100 African workers, if
resolved upon the introduction of a liaison
: of his employees were resolutely committed
simple mechanism to break the impasse.
.on meeting were to insist from the chair
't ballot in the face of a decided worker preference for voting by
nds, there is no quick, effective instrument for reconciling so
a difference.

Committees

fference between the liaison and the works committee is that the
the former is "to consider ... and to make ... recommendations",
f the latter is "to communicate the wishes, aspirations and
requirement. f the employees in the establishment or section of an establishment in respect of which it has been elected, to their employer and to represent the said employees in any negotiations with their employer concerning their conditions of employment or any other matter affecting their interests". Evidently the legislature envisaged the liaison committee as a consultative body while the works committee was to enjoy negotiating rights limited to in-plant bargaining and thus falling short of collective bargaining as it is generally understood. The chairman of the works committee was to be the intermediary between the workers' elected representatives and the employer.

While the period of office of a liaison committee was not limited by statute, that of a works committee was limited to "not more than two years".

Co-ordinating Committees

As the new system permitted the election of more than one works committee in an establishment, provision was made for a co-ordinating works committee consisting of the chairmen and secretaries of each works committee where two or more such committees had been elected. The appointment of a co-ordinating committee was to be made after consultation with the employer concerned, and its duties were roughly the same as those of a single works committee.

M 27/12/78 (93)

Doctors probe birth monitors

The common practice of electronically monitoring a baby's birth is potentially dangerous to both mother and child, and the risks may exceed the benefits in most cases, according to a US government-funded study.

The report commissioned by the National Centre for Health Services Research said the effectiveness of electronic foetal monitoring (E F M) has not been proven scientifically, even though the procedure has become popular since its introduction in the mid-1960s.

Using this unproven technology could be costing patients more than 300 million dollars (R258 million) a year in medical bills, said the report, which was believed to be the most extensive study done on the subject.

Written by Dr H. David Banta and Dr Stephen Thacker, it was based on surveys of more than 600 articles and books related to EFM, a process in which electronic tabs are kept on the labour and delivery process, so that doctors can intervene if problems arise.

This intervention can involve things like inducing labour, repositioning the mother to take pressure off the baby or surgically removing the baby through a Caesarean section.

"I'm personally convinced EFM is useful, but not as much as proponents say," Dr Banta said in an interview. "About everything in medicine has some benefit, but the problem is that it might not be a benefit for all and it becomes overprescribed and overused."

Hospitals commonly use three EFM methods: an external device using ultrasonic waves to monitor foetal heart rate and uterine contractions, attaching electrodes to the baby's head to follow heart rate and putting a tube into the uterus to check contractions, and taking blood samples from the baby's scalp to check oxygen levels.

"If you look for scientific evidence of EFM benefits, it just isn't there," Dr Banta said. "We should not use a technology until there is proof."

Advocates of EFM say the procedure can save many babies' lives and prevent permanent problems, such as brain damage because of oxygen deprivation during birth. But Dr Banta and Dr Thacker said an analysis of the available literature showed little evidence of EFM preventing death or long-term disability.

Even though surveys showed a high degree of support for EFM among practising obstetricians, "the possibility of preventing brain damage through EFM and caesarean section is purely speculative," the report said.

One reason for the support of EFM from doctors is that the death rate for babies at birth fell steadily in the late 1960s and early 1970s, roughly paralleling the introduction of EFM.

While it is possible that EFM made a small contribution to decreased mortality, Dr Banta said, many other changes in obstetrics that influence deaths occurred at the same time. He cited more extensive family planning programmes, greater emphasis on prenatal care and better prenatal diagnostic tools.

Dr Banta said the direct cost of EFM is about 80 million dollars (about R68 million) a year, including equipment, staff time and the addition of as much as 50 dollars (about R43) to the cost of each delivery.

Indirect costs, such as for additional Caesarean sections, are even greater, Dr Banta said. Some doctors have been questioning the rapid rise in Caesareans during the past ten years, and Dr Banta and Dr Thacker estimated in their report that EFM is responsible for half of the increase.

In 1965 Caesareans were used in 160 000 deliveries, 5,55 per cent of the total. By 1975, there were 353 000 Caesareans, about 12 per cent of all deliveries. The death rate to mothers for this operation is 3,1 per 10 000 procedures, he added.

The added EFM-attributed Caesareans cost the United States 222 million dollars (about R190 million) each year using 1975 figures, the study said. It said EFM posed a risk of pelvic infection to mothers and a risk of bleeding and infection to newborns, and the electronic monitoring procedure posed the additional risk of death because of the higher number of Caesareans. — SAPA AP

...oval of the presumption favouring liaison ...es and provides that a works committee may ...ther a liaison committee already exists. ... shown that some organisations were employing ...at others felt that this was desirable. This ...ess from the African workers point of view.

... are concerned the intention is to extend their ... to a limited form of in-plant negotiation. ...w any employer with more than one establish- ...ngle liaison committee for all the workers ...provided that at least one employee member ...ected.

...r limit of more than twenty employees for ...ct works committees. This would allow smaller ... of representation.

...isaged by the legislation would be the introduction ...roup of liaison, works or co-ordinating works ...ea would be entitled to apply to the Minister ...nt of an industry committee. If the Minister ...esentative of the African employees in the trade ...e application. The relevant inspector or ...area would preside over a meeting called to ...stry committee and would determine the number ...mittees allowed to attend. This obviously ... with broad discretionary powers. Membership ...ld be limited to no fewer than five or more ...l number of alternates. Their period of office ...rs.

...ion would provide for a larger measure of ...trial relations and at a higher level than

Cape Times 2/2/79

The Cape Times, Frid

93

Pressure to cut SA medical ties

Own Correspondent

LONDON. — Pressure is mounting in international medical circles to isolate South Africa further by cutting ties with the Republic.

The latest issue of the journal World Medicine, pulished here, urges that reciprocal agreements between South Africa and other countries concerning doctors be scrapped.

At present, South African-trained doctors may practise in Britain if they are registered with the British General Medical Council.

A radical element within the medical profession here plans to have the matter of medical ties with South Africa raised at the BMA's annual representative meeting in June.

This is the policy-formulating forum of the BMA. Delegates from all parts of Britain attend and motions are put to the vote.

In addition to this, a paper is being prepared detailing medical organizations, of which South Africa is a member, and international medical conferences organized by the Republic.

An attempt will then be made for the expulsion of South Africa from these medical organizations, and also to boycott conferences in South Africa.

Radical and anti-apartheid forces meet here this weekend to plan their campaign against South Africa.

The conference will be addressed by Dr A V Jablensky, who will represent the director-general of the World Health Organization. He is the medical officer for the division of mental health at WHO headquarters in Geneva.

Another speaker will be a South African exile, Dr Nomava Shangase, who will represent the banned African National Congress. She trained and qualified as a doctor in Tanzania and will speak on the health needs of the ANC, which includes the care of refugees.

Mr Hugh Bailey, assistant national officer of the powerful British trade union the National and Local Government Officers' Association (Nalgo), will speak on actions which can be taken in Britain and will press for a boycott of South Africa.

UK doctors move to cut ties with SA

R.D.M. 2/2/79

(93)

Own Correspondent

LONDON. — Pressure is mounting in international medical circles to further isolate South Africa.

The latest issue of the prestigious para-medical journal World Medicine, published in London, argues that reciprocal agreements between the Republic and other countries concerning doctors should be scrapped.

At present, South African-trained doctors may practice in Britain as long as they are registered with the British General Medical Council.

Members of the British medical profession plan to raise the matter of ties with South Africa at the British Medical Association's meeting in June.

The meeting is the policy-formulating forum of the BMA.

A paper is being prepared detailing medical organisations of which South Africa is a member, and international medical conferences organised by the Republic.

An attempt will then be made to press for the expulsion of South Africa from the organisations, and to boycott conferences held in South Africa.

This week-end, a conference has been convened to plan a campaign of action.

Speakers will include Dr A V Jablensky, representing the director-general of the World Health Organisation, South African exile Dr Nomava Shangase, who will represent the African National Congress of South Africa, and Mr Hugh Bailey, assistant national officer of the powerful British trade union, the National and Local Government Officers Association.

Dr Jablensky is the medical officer for the division of mental health at WHO headquarters in Geneva; Dr Shangase will speak on the health needs of the ANC, which cares for many young refugees who have left South Africa since the 1976 Soweto uprising.

Mr Bailey has declared he will press for a medical boycott of South Africa.

A spokesman for the BMA said yesterday that any decision to change reciprocal agreements with South Africa would have to be done through the General Medical Council.

That is a purely medical body, although it does have government representation.

There are strong ties between the GMC and the South African Medical Association and considerable sympathy in British medical circles or the SAMA, considered to be a staunch fighter against apartheid.

"It might seem illogical in medical circles here to try and isolate South Africa further, when the doctors' representative body in South Africa is, in fact, against the apartheid system," the spokesman said.

It is difficult to estimate how effective the campaign will be.

Feelings are certainly strong — particularly among young medical personnel and black doctors.

But there is also a solid body of conservative opinion in the medical profession.

SEPTEMBER, 1978.

Dear Forest Glader,

Half a year has passed since our last A.G.M., and you may like to know what has been, and is, happening in the Association.

1. COMPOSITION OF THE BOARD

We have sadly had to accept the resignations of R.A. Provan, H.S. Rumbelow and G.C. Bunn from the Board.
Mrs. Mary Greenhalgh, who was co-opted to the Board immediately after the A.G.M., was elected as Chairman, J.O. Read as Vice-Chairman, and Mr. E.E. Monk was co-opted as a Director. The Board of Directors now comprises the following:-

Mr- ...

t 2) Tel. 723719
el. 724726

ce) 432086

feel free to contact
tate or matters you would

nged to meet our commitments
5.00 per month per house
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details about this, the
's house - No. 44.

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scheme for Forest Glade.
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f the Board of Directors
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all which have been made must be completely opened up. Barriers or obstructions

2 / ....

Doctor fined R5000 for procuring abortions

7/2/79 Star (93)

A 59-year-old medical practitioner was today fined R5000 (or 45 months) for procuring five illegal abortions earlier this year.

Dr Morris N Gnesin (59) pleaded guilty before a Johannesburg regional magistrate, Mr K K Smith, to illegally procuring five abortions between January 25 and February 5 this year.

His attorney, Mr Raymond Joffe, described Gnesin as a "destroyed man" and said that "all the abortions were performed at the request of the women — three of whom threatened to commit suicide if they were not given an abortion."

Mr Joffe added that the abortions were not procured solely for monetary gain, but also to save the women "degradation, humiliation and embarrassment".

"He (Gnesin) is completely destroyed now. He's got nothing to fall back on and the chances of him committing a similar offence are remote."

Mr Joffe said that Gnesin had received a total of R1500 for the abortions. The lowest he charged was R100 and for one abortion he charged R450.

Gnesin was convicted 25 years ago of illegally procuring an abortion.

In passing sentence, Mr Smith said a factor in Gnesin's favour was that he "did not commit the offences for personal gain only."

Mr Smith said: "You are qualified to perform these acts and there was therefore less danger of injury to the women."

The magistrate also said R1500 could not be described as excessive bearing in mind normal charges."

put on the common area and interferring with the enjoyment and use of the common area by all must be removed.

We quite realise that some people have gone to a lot of trouble and expense to plant on their own or the common area. Thus where enclosures have been made by planting, we hope that they can be opened up by the least possible disturbance and the judicious moving of certain, rather than all, plants. Mr. Roberts, the Architect for the estate, and member of the Board, will be glad to discuss and advise on the possible methods of doing this, and we would suggest that people who have enclosures made by plants should contact him before moving or removing plants themselves.

The Directors have most reluctantly decided that if these enclosures, barriers or obstructions have not been removed by the end of 1978, they must take the necessary steps, possibly through legal action, to have them opened up or removed. While some people have already received requests to open up enclosur and remove barriers, we wish to make it clear that the regulations and policie apply equally to all.

As a general rule, the Directors have decided that they will consider applicat for fences, hedges etc. along the eastern and western boundaries of private e but that none will be permitted on the northern boundaries of any private erf.

4. PLANTING AND GARDENING ON COMMON AREA

We are all very grateful to members who have helped to improve the common area with extra plants, which the Association could not have afforded. Of course once planted they form part of the common area, and so have to be maintained by the Association, and the gardeners on the estate may have instructions, fro time to time, to clip, prune or move the plants for the good of the plants themselves, or to ensure that the common area is kept open for the enjoyment and use of all members.

5. PETS

People are constantly complaining about animals straying round the estate and dirtying area close to houses. Sometimes this is so bad that it is a health hazard. It is extremely difficult to see a solution to this problem, and in t past the Board has felt unable to do anything about it, save ask for considera from dog-owners in cleaning up and generally keeping control of their dogs. T trouble is now becoming so acute that we must remind all members of regulation 4.1.3 which requires permission from the Board for the keeping of animals. Th in future no one may keep a pet without first obtaining the permission of the Board, which can of course be refused. To try to decide on a future policy to contain this problem and be fair to pet-lovers, we wish to have a complete picture of the situation. For this we need details of the pets kept in each household, and we should be grateful if you will complete the attached form and return it to Mrs. Foox, House No. 44 (Hamlet 4), as soon as possible.

6. The Directors have received complaints that quite a few people have washing li up on their balconies in the full view of passersby. All the houses have yard especially to avoid this unattractive feature. Moreover, it is quite possible to put up lines at a very low level on 1st floor balconies so that washing hanging on them cannot be seen from the ground or from other houses. Please would people refrain from putting washing in a place or at a level where it can be seen by others.

7. EXTERIOR LIGHTS

For a glorious few weeks after the repair work on the lights had been completed

3 / ....

Fined for abortion

JOHANNESBURG — A 59-year-old medical practitioner was yesterday fined R5 000 or 45 months imprisonment for procuring five illlegal abortions earlier this year.

Dr Morris Gnesin, 59, pleaded guilty before a regional court magistrate here to illegally procuring the abortions between January 25 and February 5 this year.

Gnesin's attorney, Mr Raymond Joffe, described Gnesin as a "destroyed man" and said: "All the abortions were performed at the request of the women, three of whom threatened to commit suicide if they were not given an abortion."

The attorney said the abortions were not procured solely for monetary gain, but also to save the women "degradation, humiliation and embarrassment."

Sun. Trib. 11/2/77

(93)

11/2/79

DEADLY MUTI KILLS 263 BLACKS

By TICKS CHETTY

Doctors find poison root in herbal medicine has no antidote

Dr Keshavlal Bhoola . . . The use of impila must be actively discouraged

TRIBAL doctors are using a highly poisonous root in the preparations of herbal mixtures which have so far known to have killed 263 Africans — half of them children.

And to date doctors have been unable to treat people who became ill after taking quantities of these mixtures

The deadly toxic content of the root of the plant which the Africans call the impila (callilepis laureola) was discovered recently by researchers in the Department of Pathology of the University of Natal.

[illegible] all the post-mortems p[illegible]formed during this period. the incidence of death due to liver damage from this cause was found to be 1,21 per cent.

"We have no doubt that the incidence of herbal poisoning is much higher as many deaths have been incorrectly diagnosed and the nature of the illness has not been suspected especially in the rural areas," said Dr Bhoola.

Headache

"Our study has shown that 50 percent of these deaths were in children below the age of 15. In many cases the children appeared well nourished and well cared for. In some cases several children in the same family had died of herbal poisoning at the same time.

"The symptoms start soon after the administration of the herbal remedy prepared from impila and consist of severe vomiting, headache and abdominal pains. Convulsions and rapid progression into coma, due to a profound lowering of the blood sugar levels, are nearly always seen. And death occurs within one to five days.

"Treatment with intravenous glucose does not help these patients and the outcome so far has always been fatal."

In their research into impila, doctors employed an African social worker to carry out a survey on the root. The survey showed that 30 percent of the people in Umlazi township used mixtures from the root either orally or as an enema.

Impila is widespread on the Natal and Transkei coasts, the grasslands of south eastern Transvaal and in Swaziland.

Research into impila started in 1973 after doctors at Durban's King Edward VIII Hospital found acute kidney and liver damage in patients who had taken herbal medicine over long periods.

The social worker was then asked to interview relatives of 30 patients suspected of having died from herbal poisoning.

Difficulty

"Although encouraging considerable difficulty in persuading relatives to divulge what remedies had been given to the people who had died, repeated visits and questioning revealed that in nearly all the cases some form of traditional herbal mixtures had been given to the deceased," said Dr Keshavlal Bhoola, who is conducting research into impila.

The Department of Pathology then decided to investigate some of the plants commonly used by tribal doctors for the preparation of herbal cures.

Impila was found to be poisonous in laboratory tests on rats, causing liver and kidney damage identical to that seen in people.

According to Dr Bhoola, from 1958 to 1977 there have been 263 deaths from impila poisoning

(93)

Abortions cost doctor R5 000 — and family

● Dr Gnesin . . . shattered

By PADDI CLAY

AT THE age of 60 this week, Dr Morris Gnesin found his 36-year-old career destroyed by his desire to help women in trouble.

And with little money behind him he faces a bleak future — rejected by his children and without the chance to continue in the only profession he knows.

Dr Gnesin was found guilty in the Johannesburg Magistrate's Court of performing illegal abortions and fined R5 000.

The magistrate, Mr K K Smith, said a factor in the doctor's favour was that "he did not commit the offences for personal gain only".

The shock of his arrest on Monday and the court case on Wednesday still showed on the face of the gentle doctor when the Sunday Express visited him at his Greenside home the day after the court case.

His ex-wife had just left that morning for Israel with his younger son. The embarrassment and stigma of having her son's father branded an abortionist had been too much for her, said a shattered Dr Gnesin.

He spoke to me in the comfortable but modest lounge of his home — the house belongs to his ailing mother. With him were his brother and his brother's family who had flown up from Upington to give him support.

Dr Gnesin said it was hard to accept his rejection by his former wife and his two sons: "I did abortions for women to help save their marriages and sometimes their lives — and it has destroyed my own family and my own life," he said quietly.

"In hospital wards I saw too much of the aftermath of back street abortions to remain unmoved by the pleas of women who begged me to help them end their unwanted pregnancies."

Like his brother and sister-in-law, Mr and Mrs Solly Gnesin, he believes strongly that South Africa's abortion laws should be eased.

"Britain and many other civilised countries allow abortion on demand.

"If the Government is worried that private doctors would make huge profits out of performing abortions willy-nilly they could set up strictly controlled clinics," Dr Gnesin suggested.

He was paid for the abortions he did — but he was not motivated by the money, he said.

"I would have done it for nothing if the woman could not pay," he said.

It had always been his belief that a doctor should alleviate suffering, physical or mental.

"The women who came to me were suffering tremendous anguish," he said. "If they don't get help from a doctor, they will go anywhere for an abortion.

CAREER LIES IN RUINS AFTER CHARGE

"A women came to me recently. When I refused to do an abortion for her she went to someone in Soweto. When things turned septic all I could do was recommend that she go to a hospital and get treatment."

Until the SA Medical and Dental Council sits sometime in March, Dr Gnesin will exist in a kind of limbo. It is likely that the Medical Council will strike him from the roll and he will no longer be able to practise as a doctor.

"If that happens I don't know what I will do.

"I am not a rich man. In my Hillbrow practice I dealt mainly with workman's compensation cases, which are not profitable. I live in this house, which belongs to my mother, and support her."

Dr Gnesin also pays his ex-wife alimony and is helping support his younger son, who has just come out of the army.

He told me he had given very little thought to the consequence to himself of performing illegal operations.

"Because of that I have hurt my family and destroyed my livelihood. I'm too old to start another career. Maybe I will become a caretaker," he said despairingly.

Dr Gnesin's brother is determined that Dr Gnesin, now that he has nothing to lose, should take up the cudgels and fight for some sort of abortion reform.

Dr Gnesin was convicted of performing an illegal abortion 25 years ago.

● Since 1977, a year after the Abortion and Sterilisation Act came into force, six other South African doctors have been found guilty of performing illegal abortions.

Axing for 'disgraced' Kloof doctor?

20/2/79 (93)

Mercury Reporter

A DISCIPLINARY committee of the South African Medical and Dental Council yesterday recommended that Dr. A. I. Padia of Kloof, who was found guilty on three charges of improper or disgraceful conduct, be removed from the register of medical practitioners.

The recommendation will be considered by the council in April.

Dr. Padia was found guilty of issuing three medical certificates in January, 1977, without satisfying himself by personal observation that the facts on them were correct.

He originally faced five charges and pleaded not guilty, but when the hearing resumed in Durban yesterday, Dr. Padia changed his plea to guilty on three of the charges.

The committee subsequently found him guilty on these three charges and withdrew the remaining two.

Mr. W. Booysen SC, with Mr. S. J. Janson, (instructed by Jacobo Meer and Co.) appeared for Dr. Padia. Mr. G. Penzhorn (instructed by Shepstone and Wylie) appeared for the Medical and Dental Council.

Hansard 3(96) 30/2/79 (93)

District surgeons

73. Mr. N. B. WOOD asked the Minister of Health:

(1) Whether there is a shortage of district surgeons in the Republic; if so, what is the shortage of (a) full-time and (b) part-time district surgeons in each province;

(2) how many (a) White, (b) Coloured, (c) Indian and (d) Black (i) full-time and (ii) part-time district surgeons were employed by the State and undertook their own dispensing in connection with their State services during 1978;

(3) how many patients were treated by district surgeons during 1978;

(4) how many district surgeons are in receipt of a drug allowance.

The MINISTER OF HEALTH:

(1) Yes.

(a) Full-time	
Cape	[illegible]
Orange Free State	[illegible]
Natal	[illegible]
Transvaal	[illegible]
Total	[illegible]

(b) Part-time	
Cape	8
Orange Free State	2
Natal	Nil
Transvaal	1
Total	11

(2)

(i) Full-time	Employed	Own dispensing
(a) White	62	Nil
(b) Coloured	Nil	Nil
(c) Indian	Nil	Nil
(d) Black	Nil	Nil

(ii) Part-time	Employed	Own dispensing
(a) White	319	271
(b) Coloured	2	Nil
(c) Indian	6	4
(d) Black	2	2

(3) 6 600 000. This figure has been estimated, as all annual reports have not been received.

(4) 263.

Medical doctors who left the Republic permanently 28/2/79

Hansard 4 (253)

264. Dr. A. L. BORAINE asked the Minister of Statistics: 93

Whether [illegible] the number [illegible] Republic permanently [illegible] years; if so, what [illegible] of these years

The MINISTER OF STATISTICS:

1976 .. [illegible]
1977 [illegible]
January to November 1978 [illegible] (The figure for December 1978 [illegible] able)

2/3/79 (93)

PE doctor acquitted

PORT ELIZABETH — A former doctor at the Uitenhage Provincial Hospital Dr Botyo Stanev Botev 55 was acquitted on a charge of culpable homicide when he appeared in the Regional Court here yesterday.

Dr Botev had pleaded not guilty before Mr A W Meiring that he was responsible for the death of Mrs Margaret Bezuidenhout whom he treated as casualty doctor when a miscarriage was imminent.

The State alleged that Dr Botev was responsible for her death because he had ordered a nursing sister to inject her with a drug called Scolin, and that she had died on March 16 last year.

The State alleged that the application of Scolin was responsible for respiratory collapse which resulted in a lack of oxygen and caused brain damage.

Mr Meiring found the State had not proved beyond reasonable doubt that the application of Scolin caused the woman's death. Many other factors could have done so.

He said medical evidence could also not show that Scolin caused her death.

Dr Botev, a Bulgarian refugee, is due to leave South Africa for Switzerland to put his passport in order. If he does not he can be declared a stateless person. — Sapa

Hansard Question Col. 427

(93)

14/3/79

District surgeons: vacancies

284. Mr. H. E. J. VAN RENSBURG asked the Minister of Health:

Whether there were any vacancies for (a) full-time and (b) part-time district surgeons in the Republic at the end of 1978; if so, how many in each province.

The MINISTER OF HEALTH:

Yes.

(a)	Full-time	
	Cape	25
	Orange Free State	15
	Natal	12
	Transvaal	22
	Total	74
(b)	Part-time	
	Cape	8
	Orange Free State	2
	Natal	Nil
	Transvaal	1
	Total	11

Hansard 6 Question Columns (93)
427 14/3/79

District surgeons: patients

286. Mr. H. E. J. VAN RENSBURG asked the Minister of Health:

(1) How many patients were treated by (a) full-time and (b) part-time district surgeons in each province in 1978;

(2) how many (a) full-time and (b) part-time district surgeons were in the employ of his Department in that year.

The MINISTER OF HEALTH:

(1)(a) and (b) 6 600 000. This figure has been estimated, as all annual reports have not been received. The records of the Department are not kept according to Provinces.

(2) (a) 62.

(b) 329.

19/3/79 CT (93)

Heart surgeon leaves SA to take top US post

By BOB MOLLOY

SOUTH AFRICANS had good medicine cheaply available in spite of tremendous bureaucracy and red tape in the administration of medical services, according to a senior heart surgeon who leaves South Africa this week to take up a top post in the United States.

He is Dr Allan Wolpowitz, the senior surgeon in the Groote Schuur Hospital heart team concerned with the last 11 heart transplants, who has been appointed as head of a new heart transplant unit to be opened at Wayne State University, Michigan.

"It is a tremendous challenge, there are only two other such units in America and altogether four in the world operating as a continuous service," Dr Wolpowitz said yesterday.

Educated at Pretoria Boys' High and a graduate of the University of Cape Town, Dr Wolpowitz specialized in surgery under Professor Chris Barnard before studying for two years under Dr Donald Ross (the first British surgeon to carry out a heart transplant in the UK).

He came back to Groote Schuur Hospital as a consultant surgeon and had been a senior surgeon for the past two years both there and at the Red Cross Children's Hospital.

Asked why he was leaving the world's most famous heart transplant team, Dr Wolpowitz said it was "difficult to turn down the challenge."

"I feel I've got to the top here and there is nowhere else to go. At my age (35) to be asked to head a department of surgery is an unbelievable opportunity. The post includes undergraduate and postgraduate teaching, private practice and almost unlimited research funds and facilities."

The extensive surgery list, intensive care duty and teaching load at the Groote Schuur complex of teaching hospitals had been an opportunity to show what he could do, but now it was time to move on.

This had "little to do" with the fact that doctors in full-time service were civil servants "and treated as such". There was tremendous bureaucracy and red tape involved in the running of doctors' lives and there was not the freedom of movement in medicine that was needed.

Doctors worked long hours and were paid "hopelessly inadequate" additional allowances for overtime. Petty rules were irksome. Attendance at overseas conferences, serving not only to improve one's own skills but to promote the country's medical image, had to be applied for up to a year in advance and leave was not always granted.

"Regardless of what happens, you lose money on the deal. In my case I went overseas on my own initiative and brought back new skills and experience, but I paid my own way. When I resigned they took R100 off my salary as 'overtime adjustment'. Do you blame doctors for being irritated?"

Professor Chris Barnard was a "brilliant" surgeon. "He is also a natural surgeon. By that I mean he is the kind of surgeon who can think on his feet in the operating theatre and either spot trouble before it happens or get out of it without doing too much damage. You don't get many of those. I learned a lot from him."

6 SUNDAY TIMES, March 25 1979 ★

Doctor pay gap ends — And they'll get a rise, too

By IVOR WILKINS

WAGE discrimination among doctors is to be all but eliminated soon, says the chairman of the Medical Association, Professor J N de Klerk. And doctors' salaries are to go up as well.

Apart from the lowest rungs of the medical salary scale — mainly interns — all doctors employed by the State will receive identical salaries, it is understood.

Wage discrimination among doctors has been a particular point of criticism against South Africa for many years.

A delighted Prof De Klerk told me this week:

"This is a major breakthrough. To a large extent salary discrimination among fulltime professional staff will disappear."

Was he excited by this development? He replied:

"If you had been fighting for this as I have for 13 years, how would you feel? Of course I am excited."

The Medical Association has been pressing for salary parity since its 1967 congress in Maritzburg when Prof De Klerk was one of the proposers of a resolution to end the doctors' wage gap.

Improved

Dealing with the question of pay increases for doctors, Prof De Klerk said: "I have received intimation from the Department of Health that they intend adjusting the salary scales.

"It would not be justifiable for me to jump the gun on this, but I can say that conditions of service for fulltime professional staff are to be vastly improved.

"Many of the problems we have been worried about will be ironed out and will disappear."

He could not predict when an official announcement would be made on the matter, but said the Medical Association had been led to believe it would be in the "very near future".

He said he also could not give details of the salary hike.

But it is expected that it will be similar to other public service increases announced recently: 10 per cent for whites, 12,5 per cent for coloureds and Indians, and 15 per cent for Africans.

PROF DE KLERK
Major breakthrough

This follows the publication this week of Prof De Klerk's report as chairman of the Federal Council of the Medical Association of South Africa.

In it he noted that many doctors, whom South Africa could ill afford to lose, had left the country.

Most, he believed, had done so for political reasons, but others, specifically academic personnel, had gone for better job opportunities.

"Most of these doctors have gone to the US where they have been offered salaries and research opportunities far exceeding anything that they could obtain in South Africa," Prof De Klerk wrote.

He added a warning:

"This is an aspect of which our government must take note, namely that we cannot afford to continue to lose our highly trained academicians because of the lack of facilities and the poor salary structure with which they have had to contend during the past years."

In his interview this week, Prof De Klerk criticised doctors who, on leaving South Africa, suddenly issued public statements about conditions here.

"I question their motives," he said.

Salary increases to bridge pay gap

Staff Reporter

PROFESSOR J N de Klerk, chairman of the Federal Council of the South African Medical Association, said yesterday that expected increases for doctors in full-time State employ would wipe out most of the salary differences between blacks and whites in the profession.

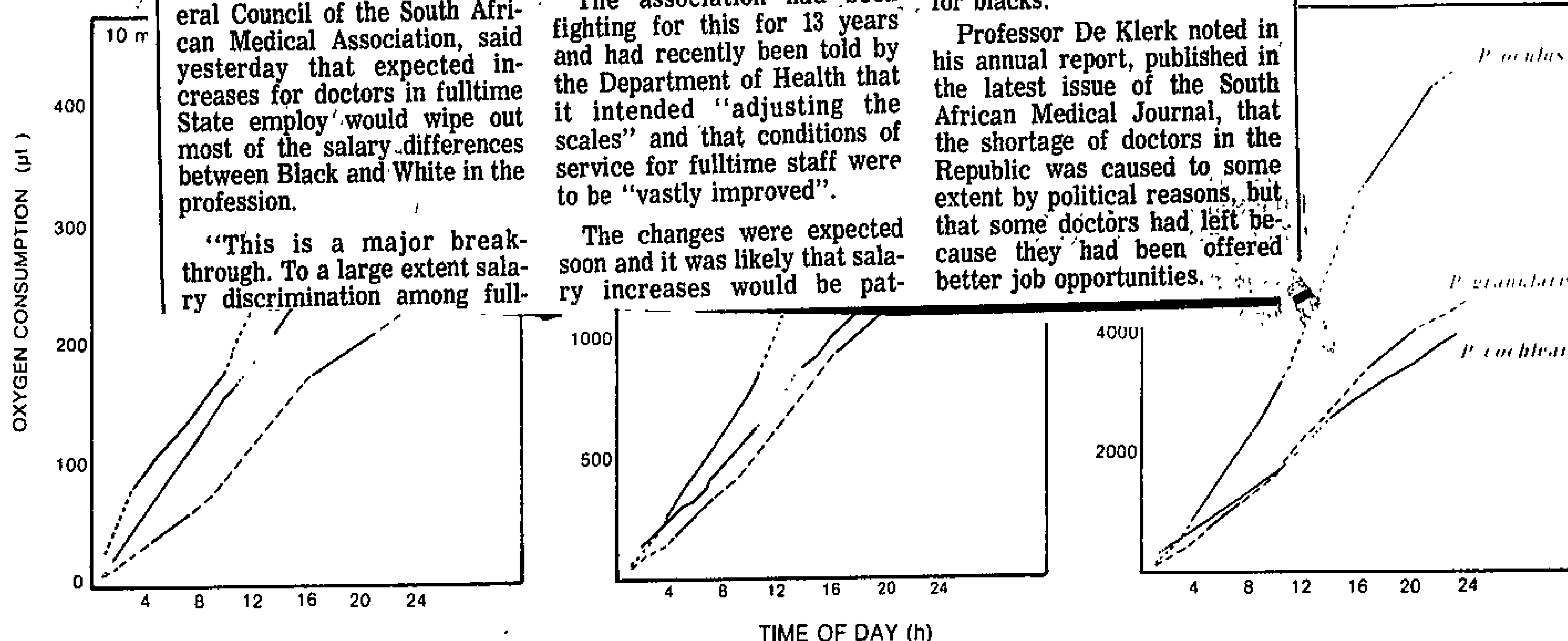
"This is a major breakthrough. To a large extent salary discrimination among full-time professional staff will disappear," said Professor De Klerk.

The association had been fighting for this for 13 years and had recently been told by the Department of Health that it intended "adjusting the scales" and that conditions of service for full-time staff were to be "vastly improved."

The changes were expected soon and it was likely that salary increases would be patterned on those recently given to the public service. These were 10 percent for whites, 12,5 percent for coloured people and Indians, and 15 percent for blacks.

Professor De Klerk noted in his annual report, published in the latest issue of the South African Medical Journal, that the shortage of doctors in the Republic was caused to some extent by political reasons but that others had left because they had been offered better job opportunities.

He warned the government in his report that the country could not afford the steady drain of highly trained academics, lost due to the poor salary structures and lack of facilities in South Africa.



Doctor's pay gap will take knock

Own Correspondent

CAPE TOWN. — Professor J N de Klerk, chairman of the Federal Council of the South African Medical Association, said yesterday that expected increases for doctors in fulltime State employ would wipe out most of the salary differences between Black and White in the profession.

"This is a major breakthrough. To a large extent salary discrimination among full-time professional staff will disappear," said Professor De Klerk.

The association had been fighting for this for 13 years and had recently been told by the Department of Health that it intended "adjusting the scales" and that conditions of service for fulltime staff were to be "vastly improved".

The changes were expected soon and it was likely that salary increases would be patterned on those recently given to the public service. These were 10% for whites, 12,5% for coloureds and Indians, and 15% for blacks.

Professor De Klerk noted in his annual report, published in the latest issue of the South African Medical Journal, that the shortage of doctors in the Republic was caused to some extent by political reasons, but that some doctors had left because they had been offered better job opportunities.

Fig. 6. *Patella* spp. Cumulative plot of oxygen consumption over 24 h in relation to tidal and diurnal cycles. Dotted portions of lines indicate aerial phase of tidal cycle. Data for standard individuals of 10, 100 and 500 mg tissue weight. Energetic cost of metabolism can be calculated by the conversion 5.05 µl O_2 = 1 calorie

of large individuals increases while that of small individuals declines (Fig. 5A). This is predictable in view of the different rates of respiration of small and large limpets in air and water (Fig. 3). Thus, the daily respiration of *P. cochlear* is essentially aquatic and little affected by the brief and mild elevation of rate during the day-time low tides.

In contrast, the mid-shore *Patella oculus* increases its metabolism considerably during the day-time low tide (Fig. 5B). The length of exposure is greater, and body temperatures rise far higher (up to 32°C) on the drier rocks of the midshore. Larger individuals tend to be exposed more than juveniles and they respire faster in air than water, further increasing their respiration during low tide.

Due to migration up the shore, larger *Patella granularis* are subjected to very long periods of exposure, when body temperatures may rise to 32°C, but they minimise metabolic expenditure during this period because their respiratory rates are low in air. The Q_{10} between 17°C in water and 28°C in air is only 1.33. Conversely, there is a dramatic drop in respiration at night from the rate at 17°C in water to that at 15°C in air (Fig. 5C), the Q_{10} being 7.80. Thus, the low rate of aerial respiration not only keeps down day-time rates when temperatures are high at low tide, but results in a considerable saving of energy at night when air temperatures are low.

The data presented above, showing the effects of temperature on aerial and aquatic respiration and the rates of oxygen consumption during simulated tidal cycles for different-sized individuals, allow calculation of budgets of daily oxygen consumption (and hence respiratory energy losses) for the 3 limpet species. These are shown in Fig. 6, from which it is evident that metabolic energy expenditure in the mid-shore *Patella oculus*, which experiences an abundant food supply, is much higher than in the other two species. The lower-shore *P. cochlear* and the upper-shore *P. granularis* both have a much lower metabolic energy expenditure than *P. oculus*, and this is especially evident in the larger individuals.

Conclusions

Patella cochlear occurs very low on the shore where algal growth is potentially high, but under conditions of intense intraspecific competition most algae are eliminated, leaving lithothamnia (which are heavily calcified and have a low calorific value) as the main food. Feeding occurs during submergence and is thus fairly prolonged. Territorial spacing and stacking of juveniles on the shells of adults diminish but do not eliminate competition (Branch, 1975b). Populations are very stable and longevity high: up to 30 years. These circumstances favour a low growth and low reproductive output

Rises will close doctors' pay gap

M (93) 26/3/79

CAPE TOWN — Professor J. N. de Klerk, chairman of the Federal Council of the South African Medical Association, said yesterday that expected increases for doctors in full-time state employ would wipe out most of the salary differences between black and white in the profession.

"This is a major breakthrough," he said. "To a large extent salary discrimination among full-time professional staff will disappear."

The association had been fighting for this for 13 years and had been told by the Department of Health that it intended "adjusting the scales" and conditions of service for full-time staff were to be "vastly improved."

The changes were expected soon and it was likely salary increases would be patterned on those recently given to the public service. These were 10 per cent for whites, 12,5 per cent for Coloureds and Indians and 15 per cent for blacks.

Professor De Klerk noted in his annual report, published in the latest issue of the South African Medical Journal, that the shortage of doctors in South Africa was caused to some extent by political reasons, but that others had left because they had been offered better job opportunities.

He warned the government the country could not afford the steady drain of highly trained academics, lost due to the poor salary structures and lack of facilities in South Africa. — DDC.

400 black doctors get equal pay

(93)

C.T. 31/3/79

Science Reporter

FROM April 1 about 400 black doctors in government service, almost all of them specialists, will for the first time be paid the same salaries as their white colleagues.

An editorial in the latest issue of the South African Medical Journal said this would be the start of a move to end disparity in salaries based on race discrimination.

The editorial added that the government had decided in principle to end salary discrimination but had to face economic problems in doing so. It had chosen to begin with senior members of the profession and work downwards.

Detailing its struggle for equal pay, going back many years, the editorial added that the Medical Association welcomed the beginning of the removal of discrimination, but "it will not be fully satisfied until all medical practitioners in salaried services in South Africa are receiving salaries totally unrelated to their racial origin".

'Doctors making 1 300 pc profit'

Star 18/6/79

(93)

Own Correspondent

DURBAN — Some medical practitioners were making profits of more than 1 000 percent on medicines that they prescribed and dispensed to their patients, it was claimed by a member of the South African Medical and Dental Council at their meeting in Durban yesterday.

Mr J D van Zyl, vice-president of the South African Pharmaceutical Council, said some doctors knew where to get tablets and capsules at greatly reduced prices while pharmacists would have to buy the same tablets at a much higher price.

NO BENEFIT

"In one instance that I know of," said Mr van Zyl, "a pharmaceutical firm was offering certain doctors chloramphenicol tablets at a price of R21 for 1 000 tablets — if the doctor bought 5 000. The doctor could then sell the tablets at R6,50 for 24 and make himself a profit of 1 300 percent on the deal."

Mr van Zyl went on to say the same firm offered the same tablets to pharmacists at a price that was 500 percent higher, thus making it impossible for the pharmacists to make any kind of profit.

NO BENEFIT

"This state of affairs is of no benefit to anyone," he said, "least of all to the patients."

Some members felt that a doctor should be allowed to add an additional charge to the cost of a medicine to make allowance for handling costs and other expenses, while it was felt by others that it could then be construed that doctors were in direct competition with pharmacists.

The matter was referred back to the executive committee.

DAILY DISPATCH, FRIDAY, APRIL 20, 1979 — 11

Council bid to raise medical fees delayed

DURBAN — The South African Medical and Dental Council decided yesterday to cancel proposals for an interim increase in fees and to call a special sitting in August to discuss an increase.

Earlier the Representative Association of Medical Schemes (Rams) threatened to take the SA Medical Council to court if it went through with a 25 per cent fee hike recommendation payable by the medical schemes.

The proposed increase would have "the gravest economic impact" on the public, attorneys for the medical schemes said in papers tabled before the Medical Council meeting.

The tariff committee of the Medical Council recommended in February that the present tariff of 80c per unit payable by the medical schemes be increased to R1, an effective increase of 25 per cent, and gave the medical schemes two months to comment.

Rams claimed they were not given enough time to consider the proposed increases, and objected to the procedure adopted which "is not one sanctioned by the legislation".

"We call upon the committee forthwith to indicate that it proposes to desist from any further action concerning a tariff of fees and that it will not purport to recommend any interim tariff to the council.

"If we do not have these assurances forthwith our clients propose to take legal action to set aside the proceedings thus far," attorneys for the medical schemes said.

The medical schemes also strongly objected that the tariff committee composition was "loaded in favour of the profession".

"The medical tariff committee is apparently comprised of eight persons of whom only one is not a medical practitioner".

Rams said they were asked only to respond to an increase proposal after it was decided on, not whether there should be an increase at all. — SAPA.

SA medics hit at British hate campaign

Sun Times 22/4/79 (93)

By DOREEN LEVIN

AN appeal to a British medical journal to halt a hate campaign aimed at the University of Natal's Medical School in Durban was made this week by the Dean, Professor Theodore Sarkin.

This follows an angry editorial in last week's South African Medical Journal, hitting at World Medicine — a journal for British doctors — for publishing Goebbels-style propaganda and fostering "international hatred".

The reason for the distress is an article, "Why does the GMC (British General Medical Council) still recognise South African degrees?".

Co-authors were Kennedy Cruickshank, a Birmingham medical registrar, and Nkosazana Dlamini, said to have recently qualified at Bristol.

It is claimed Dlamini "had to leave" medical school in Natal in 1976 (denied by Prof Sarkin).

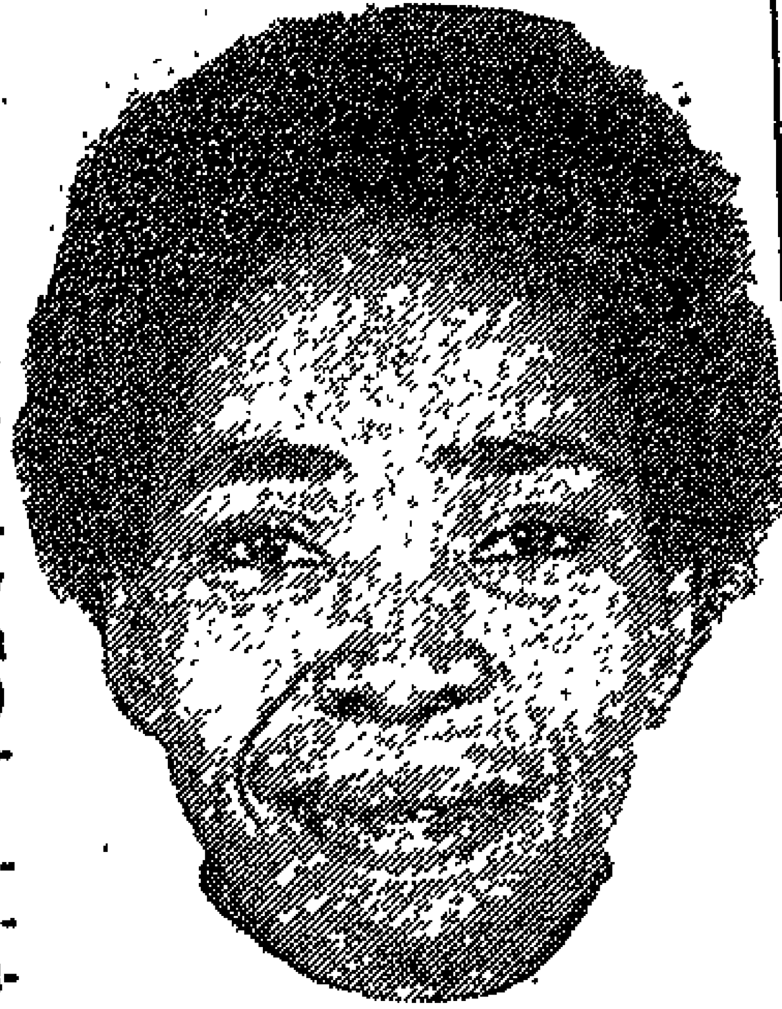
The co-authors' allegations included:

- South African doctors could not be good doctors in their present environment.
- South African medical authorities have been conspicuously absent from taking initatives to improve the health of the people.
- Blacks may not treat, look after or see white patients.
- Black infant mortality is 40 per cent.

Durban's black medical school was described as a "palliative" and the Medical University of Southern Africa (Medunsa) as being situated "in the infertile backwater of the BophuthaTswana homeland" where "there is little doubt that the eventual result will be the production of graduates of lower quality whom the apartheid regime will then deem fit to practise only in the homelands".

In a letter to the editor of World Medicine, Prof Sarkin pointed out:

- The present staff at the University of Natal's Medical School in Durban was completely colour-integrated at all levels, including professors.



Nkosazana Dlamini ... co-author of the "hate" article

- White post-graduates were admitted and studied alongside their black colleagues, and seniority and appointments were independent of race, religion, sex or colour.
- Black doctors were in charge of and looked after white patients and did post-mortems on all races.
- Salaries had been equalised.

continued to expand, to explain, and to justify. But it was long before the reputation he had earned for unorthodoxy in the matter of Biblical inspiration was allowed to die a natural death.

The consequences for Pusey were grave. He came to regret the publication of the two books as a mistake. In his will, dated 19 November 1875, he expressed a wish that these books should not be republished. He retreated into a rigid conservatism, which refused even to see that certain questions might need to be reopened, certain old doctrines re-expressed. Fifty years after the period of his in Germany, he was still writing on the Old Testament in a which implied that nothing had happened in theology since of those ancient fathers of the Church, of whom he had mental a knowledge, and whom he was able to cite with si appositeness in illustration of the doctrine of the Minor P

III

If Englishmen, having dealt with the mild unortho Pusey, imagined that they could settle down untrouble ment of their traditional beliefs, they were destined to long a rude awakening. In 1835 David Friedrich St published the two volumes of his *Life of Jesus*. This y marked, as few others have done, a turning-point in Christian faith.

In order to understand Strauss one must love him. He was not and not the deepest of theologians, but he was the most absolutely sincere. His insight and his errors were alike the insight and the errors of a prophet. And he had a prophet's fate. Disappointment and suffering gave his life its consecration. It unrolls itself before us like a tragedy, in which, in the end, the gloom is lightened by the mild radiance which shines forth from the nobility of the sufferer.

So Albert Schweitzer in his famous *Quest*.[2] The terms are rather rhetorical; they do justice, however, to the fact that the godly of

[1] 'Pusey on the Minor Prophets' is a spiritual classic. But no one, reading it, would guess what had been happening in the world of Old Testament studies in the nineteenth century.

[2] *The Quest of the Historical Jesus* (Macmillan Paperback Ed., 1961), p. 68. It is to be noted that Karl Barth, in his far from unsympathetic study of Strauss, takes the view that he was a very *untragic* figure. See *Die Protestantische Theologie im 19. Jahrhundert* (1947: English trans., *From Rousseau to Ritschl*, 1961), pp. 490–516. Here and for the rest of this chapter I am much indebted to what, in my opinion, is the best book that Karl Barth has ever written, and the one that is likely to have a longer life than any other.

Strauss's day recognized, however muddily and unfairly, that, if Strauss's interpretation of the Gospels came to be accepted, Christianity as it has been understood through the centuries would come to an end in a generation.

Emanuel Hirsch, in his account of Strauss, remarks, rightly in my judgement, that 'out of the power of truth a question-mark has been set up over against our religion, with which up to the present day theology and the Church have not dealt adequately and in the manner appropriate to the question'.

...hen, was this revolutionary doctrine? Strauss had realized ...ation of the Gospels, the supernaturalists who ... it was written, and the rationalists ...nost everything if not to explain it ...andstill, and that there was an urgent ... interpretation should be found. This ...elf to have discovered in 'the mythical'. ...ate the presence of the supernatural or ...culty has been at work; only by recognizing the sources that we have.

... clearly what he meant by the mythical, and ... on theology through this lack of precision. ...monly used in one of three connexions. A ...oings of gods and other more-than-human ... can see that the myth is a rude and poetic ...e world, in fact, a kind of 'philosophy before ... the word is used of those majestic tales, such as ...nesis, in which a profoundly religious understanding of the ... situation, such as can hardly be better conveyed than through such a tale, is made known to us. In the third place, as in the case of the Oedipus sequence, the myth may be a projection outwards of the human sense of man's inner problems as he wrestles with a dark and perplexing destiny. In none of these cases has the myth any direct connexion with history; and it makes no difference to the significance of the myth whether there is any basis in history for the tale or not. For a different kind of exercise of the creative imagination, other words—for instance, saga and legend—are used. Here the action takes place definitely within the field of history; imagination has been at work on the historical material to interpret it in accordance with certain categories of understanding which do not necessarily arise out of the material itself. Most readers of the great saga of Gideon

(93)

Attacked doctors say: give us facts to investigate

93

27/4/79

INDABA ??

UMTATA — Doctors came under fire in the National Assembly here. The attack was related by a Medical Association spokesman who asked for specific facts for investigation rather than generalities.

The deputy leader of the opposition Democrative Progressive Party, Mr Sizakele Caledon Mda, said doctors were not prepared to attend to patients after working hours and at night.

He asked whether doctors were putting their shoulders to the wheel in alleviating pain and suffering.

He said Transkeians felt doctors were not prepared to assist them at awkward hours.

"Doctors were friends of the sick," Mr Mda said. "White doctors were diligent workers and now the general opinion is that when our people take over they leave us in the lurch."

Opposition front bencher Mr T. Dweba said there was a hue and cry from patients that they did not receive medical treatment at hospitals and they resorted to witchdoctors. No medicine was given to patients in certain hospitals and clinics and some patients were rationed with pills, he said.

He commended the Department of Health for acquiring doctors at a hospital where there were no doctors for six months and he appealed to the department to provide suitable living quarters for doctors and matrons at hospitals. The secretary of Transkei Medical Association, Dr A. T. Mtimkulu, said in an interview that the matter might be discussed at a meeting on May 19.

Dr Mtimkulu said if the attack were to carry weight the people concerned should investigate each case on merits and they could then answer the allegations.

"If people howl in Parliament with no facts we find it difficult to answer," he said. "We accept complaints substantiated with facts. Parliamentarians can say anything in the house knowing well they are covered by immunity."

They had an ethics committee that handled complaints. The committee upheld the ethical standards of the Medical Association, he said.

93

SUNDAY TRIBUNE, MAY 6, 1979

Doctors make 1 000% profits on pills

Mr Kosie van Zyl

... and I can prove it, says leading pharmacist

Tribune Reporter

A TOP pharmacist said this week he could prove that some doctors are making more than 1 000 percent profit on certain medicines they prescribe and dispense to their patients.

Mr Kosie van Zyl, vice president of the South African Pharmacy Board, was reacting to medical spokesmen who have dismissed his claim as highly unlikely.

Mr van Zyl said he could not disclose his source of information but he had the names of doctors concerned and of drugs they made the huge profits on.

Action if ...

A spokesman for the Medical Association said this week he would very much like to receive the information which Mr van Zyl had. The association would certainly take action if it could be substantiated.

Mr van Zyl was highly critical of certain drug manufacturers who supplied "trading" doctors with drugs at greatly reduced prices but refused to supply pharmacists at the same prices.

"It is blatant discrimination and it is detrimental to the general public," he said. "Surely if these companies can charge the doctors so little, they should be able to do the same for retail chemists who would pass on the very substantial savings to their customers."

Mr van Zyl, a member of the Medical and Dental Council, raised the issue at a meeting of the council in Durban. He submitted figures showing that doctors could sell one particular drug at a profit of 1 300 percent.

He found the doctors could obtain chloramphenicol tablets at R21 for 1 000 — if they bought 5 000. They could then sell them at the recommended price of R6,45 for 24.

Isolated

"I personally checked and was told a retail chemist would have to pay R114 a thousand even if he bought 10 000. I asked the manufacturer what the price was for doctors but he was not prepared to tell me."

He obtained the information from another source. Mr van Zyl, who was a retail pharmacist for many years, is now in Government service.

He realised some doctors enabled low-income patients to benefit from the low prices paid for the drugs. The doctors made little or no profit in prescribing and supplying them to the patients. This was an admirable service.

Dr Fred Clarke, MPC for Durban North, has said that Mr van Zyl must have made his claim from an isolated incident.

"He is pulling a very rare case out and blowing it into a big story."

However, he said if some doctors were making such big profits as claimed then they were acting in a disgraceful and unethical manner.

old camp while the real track started half a mile on the west side. I found this out after spending a night on the veldt. The Brigadier also sent to tell me that he would wait one day

Hansard 13 (827) 9/5/79

Medical students

806. Mr. G. N. OLDFIELD asked the Minister of National Education: (93)

(1) How many (a) White, (b) Coloured, (c) Indian and (d) Black medical students are at present registered as students in each year of study at each university with a faculty of medicine;

(2)(a) how many applications for first-year study of medicine in 1978 were received from each race group at each university and (b) how many such applications for each race group at each university and (b) how many such applications for each race group at each university were successful.

The MINISTER OF NATIONAL EDUCATION:

(1) Since figures for 1979 are not available, the figures for 1978 are furnished:

		Years					
		1st	2nd	3rd	4th	5th	6th
U.O.F.S.	(a)	109	114	69	64	52	45
U.P.	(a)	237	194	202	176	195	171
U.S.	(a)	196	178	118	115	118	107
	(b)	5	—	—	—	—	—
U.C.T.	(a)	151	168	146	138	155	146
	(b)	10	7	19	13	8	6
	(c)	5	4	5	9	7	6
	(d)	1	—	—	—	—	[illegible]
U.W.	(a)	197	192	172	180	164	177
	(b)	3	2	1	5	1	—
	(c)	12	15	29	9	15	31
	(d)	—	—	1	5	—	—
U.N.	(b)	8	3	6	—	6	[illegible]
	(c)	51	73	63	50	54	[illegible]
	(d)	27	56	28	55	35	[illegible]

(2) (a) this information cannot be furnished since statistics are unreliable as some students apply simultaneously at different universities; and

(b) this information is not avail[illegible]

17/5/79 RDM (93)

First Coloured hospital chief

CAPE TOWN — Dr Ahmed Fouad Gamieldien has become the first Coloured doctor in the Western Cape to be appointed medical superintendent of a state hospital.

He has been appointed head of the Dr A. J. Stals Care and Rehabilitation Centre, formerly known as Westlake Hospital.

Dr Gamieldien said there was no discrimination at the hospital and all doctors, nurses and staff used the same facilities.

The hospital caters for just under 1 000 Coloured and Indian mental and tuberculosis patients.

Dr Gamieldien, who was born and educated in Cairo, said all the main administrative staff at the hospital were white but they had accepted him and he had had no problems since assuming his post this month.

There was no discrimination whatsoever and the toilets, eating places and waiting rooms were completely integrated.

"The atmosphere is wonderful," he said.

Dr Gamieldien said his parents moved from District Six to Cairo in 1930 after deciding to give his two elder brothers an education in Islam.

He took his medical degree at Cairo University in 1958, and also did his internship there before going to London to specialise in anaesthetics.

He is a member of both the Royal College of Physicians and the Royal College of Surgeons.

Because of strong family ties — his wife is from Cape Town and his two brothers are prominent religious leaders here — he decided to return to South Africa in 1970.

He started as a medical school inspector here and in 1972 joined Valkenberg Hospital as a medical officer, becoming the assistant medical superintendent in 1977. — SAPA

RAND DAILY MAIL, Thursday, May 17, 1979.

A first for Cape's Dr Gamieldien

CAPE TOWN. — Dr Ahmed Fouad Gamieldien has become the first coloured doctor in the Western Cape to be appointed medical superintendent of a State hospital.

He has been appointed head of the Dr A J Stals Care and Rehabilitation Centre — once known as Westlake Hospital.

In an interview yesterday, Dr Gamieldien said there was no discrimination at the hospital and all staff used the same facilities. "The atmosphere is wonderful," he said.

The hospital caters for nearly 1 000 coloured and Indian mental and tuberculosis patients.

The white hospital administrative staff had accepted him completely. He had had no problems, he said.

Dr Gamieldien said his parents moved from District Six to Cairo in 1930 after deciding to give his two elder brothers an Islamic religious eduction.

He enroled for his medical degree at Cairo University in 1958 and also did his internship there before going to London to specialise in anaesthetics.

He is a member of the Royal College of Physicians and the Royal College of Surgeons.

Because of strong family ties he decided to return to South Africa in 1970.

He started as a medical school inspector in Cape Town and in 1972 joined Valkenberg Hospital as a medical officer. He became the assistant medical superintendent in 1977.

He started as medical superintendent at the Dr Stals Centre at the beginning of the month. — Sapa.

Medical profession shocked by complaint

20/7/79 Sund Express (93)

Sunday Express Reporter

MEMBERS of the medical profession are shocked that a doctor at the Park Lane Clinic should have complained about Coloured nursing sisters working at the clinic.

The doctor, believed to be a prominent gynaecologist, is keeping quiet, and those in the know will not identify him.

An Indian doctor phoned the Sunday Express to ask the name of the doctor, saying he did not want to recommend any patients to a man with racial prejudice.

Other Johannesburg gynaecologists are just as anxious to know his identity.

The Indian doctor said:

"I certainly would hate to think that I have been letting a man with a biased attitude get fat on my patients' money."

Last week the Sunday Express revealed that the Transvaal Provincial Administration had ordered the Park Lane Clinic to dismiss 12 highly-qualified Coloured nurses — threatening to revoke the clinic's licence if this was not done.

A 21-year-old Provincial Council regulation bars Black, Indian or Coloured nurses from nursing Whites. After the complaints from the doctor and some patients, the Park Lane was told to observe the rule.

The Registar of the South African Medical Council, Mr W H Barnard, told the Sunday Express the matter had not been brought to the council's attention.

"I glanced at some headlines about nurses but I don't know anything about the situation," Mr Barnard said

The manager of the Park Lane, Mr Hilton Fisher, who considered sacking the Coloured sisters after the Express report appeared, has now decided to keep them.

They are now doing work similar to that done by Black staff at other private clinics — preparing feeds in sterile conditions and packing sterile surgical packs.

Despite the provincial regulation the clinic's management intends to fight for the sisters' right to nurse.

17

PART U P.P 81 - 92

9) PIRASTEH, R. "PREVENT BLUNDERS IN SUPPLY AND DISTRIBUTION" HARVARD BUSINESS REVIEW ~~VOL~~ PART U. PP. 61 - 75.

10) DONNELLY, J, H. Jr. "MARKETING INTERMEDIARIES IN CHANNELS OF DISTRIBUTION FOR SERVICES" THE JOURNAL OF MARKETING VOL 40, 1976 P.P 55

11) ETGAR, M. "CH[...] CHANNEL LEADE[...] T. AND MARKETING RES[...] OF [...] 1977 (FEB.) P.P. 69 - 76.

Medical University of Southern Africa

Hansard's (923)

807. Mr. G. N. OLDFIELD asked the Minister of Plural Relations and Development:

93 26/5/79

(1) How many medical students are at present registered in each year of study at the Medical University of Southern Africa;

(2)(a) how many applications for first-year study in 1978 were received at the university and (b) how many applications were accepted.

The MINISTER OF PLURAL RELATIONS AND DEVELOPMENT:

(1) Second-year 59
Third-year 54

(2) (a) None.

(b) Medunsa does not offer first-year study courses in medicine.

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NOTICE 388 OF 1979

DEPARTMENT OF HEALTH

I, Schalk Willem van der Merwe, Minister of Health, hereby make known for general information that the following rules have been submitted to me by the Chiropractic Association of South Africa for consideration in terms of section 2A (3) of the Chiropractors Act, 1971 (Act 76 of 1971).

Interested persons are invited to submit to the Secretary for Health, Private Bag X88, Pretoria, 0001 (for atention Mr J. A. N. Groenenberg), any comments on or representations they wish to make in regard to the said rules within three months of the date of this notice.

RULES PRESCRIBING THE CONDITIONS SUBJECT TO WHICH ANY PERSON WHOSE NAME APPEARS ON THE LIST REFERRED TO IN SECTION 2 OF THE ABOVE ACT MAY PRACTISE FOR GAIN AS A CHIROPRACTOR

Definitions

1. In these rules, unless the context otherwise indicates—

"Act" means the Chiropractors Act, 1971 (Act 76 of 1971), as amended;

"an emergency" shall be a case which the chiropractor genuinely believes at the time to be an emergency, whether or not this proves to be so later on;

"Association" means the Chiropractic Association of South Africa;

"Department" means the Department of Health;

"Designated Officer" means the officer in the Department of Health designated by the Minister of Health in terms of section 2 of the Act;

"list" means the list referred to in the Act;

"medical practitioner" means a medical practitioner as defined in the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974);

"chiropractor" means a person whose name appears on the list.

Penalties

2. A chiropractor who contravenes or fails to comply with the following rules shall be guilty of an offence and liable—

(a) on a first conviction, to a fine not exceeding R50; and

(b) on a second or subsequent conviction, to a fine not exceeding R100.

Conduct towards the public

3. A chiropractor shall not—

(a) during examination or treatment of a patient, perform any act which is immoral;

(b) conduct himself in a manner not befitting his profession or which reflects unfavourably on his profession;

(c) attend indefinitely a patient whose state of health is deteriorating, without recommending to the patient (or a person properly acting for such patient) that he consult a medical practitioner;

(d) except in an emergency, perform professional acts for the performance of which he is inadequately trained and/or insufficiently experienced;

KENNISGEWING 388

DEPARTEMENT VAN G

Ek, Schalk Willem van der
Gesondheid, maak hierby vir alg
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ciation of South Africa aan my
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praktisyns, 1971 (Wet 76 van 1971).

Belanghebbende persone word
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met genoemde reëls wil rig, aan
Gesondheid, Privaatsak X88, P
dag mnr. J. A. N. Groenenberg), v

REËLS WAT DIE VOORWAAR WAAROP ENIGE PERSOON DIE LYS VERSKYN IN AR WET GENOEM, VIR WINS AS TISYN MAG PRAKTISEER

Woordomskr

1. In hierdie reëls, tensy dit uit
blyk, beteken—

"Wet" die Wet op Chiropr
van 1971), soos gewysig;

"'n noodgeval" 'n geval wat
betrokke tydstip opreg glo 'n
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"Vereniging" die Chiropractic
Africa;

"Departement" die Depar

"Aangewese Beampte" die
ment van Gesondheid wat
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"lys" die lys in die Wet geno

"chiropraktisyn" 'n persoon
verskyn.

Strafbepali

2. 'n Chiropraktisyn wat die
of nie daaraan voldoen nie, is
en stel hom bloot aan—

(a) by 'n eerste skuldig
hoogstens R50; en

(b) by 'n tweede of daar
ding, 'n boete van hoogstens R

Gedrag teenoor die

3. 'n Chiropraktisyn mag—

(a) nie gedurende die on
van 'n pasiënt enige handeling
rig nie;

(b) hom nie op 'n manier
beroep pas of sy beroep in
nie;

(c) nie 'n pasiënt wie se
vir 'n onbepaalde tyd beh
pasiënt (of iemand wat b
optree) aan te beveel dat hy
nie;

(d) geen professionele
onvoldoende opleiding en/of
vinding besit, uitvoer nie,
geval is;

(e) distort, misrepresent or misuse knowledge of a patient's case for monetary gain, either for himself or someone else;

(f) prevent or attempt to prevent a patient (or a person properly acting for such patient) who wishes to seek the opinion of or treatment by a practitioner registered with the South African Medical and Dental Council or the Department, from so doing;

(g) perform professional acts on patients under improper conditions, except in an emergency;

(h) perform on a patient a professional act in a negligent manner;

(i) attend a patient while under the influence of or while affected by alcohol or drugs of any nature, or while knowingly suffering from an infectious or contagious disease.

Advertising

4. (1) Subject to the provisions of subrule (2), a chiropractor shall not advertise his practice. The following shall be regarded as advertising:

(a) Advertising in any form whatsoever, whether in the press, by means of any paid advertisement or interview, through the medium of the radio or television, by hand bill or poster or by any other means, including the use of bold type in directories, or having a financial interest, whether by way of fixed salary or otherwise, in sick benefit clubs or associations which advertise for members or patients in the lay press, or by circular, or card, or in any other manner;

(b) delivering an address or lecture on a professional subject normally taught at a chiropractic college with the object of tutoring a student or lay assembly in the aforementioned subject: Provided that this rule shall not apply to any lecture or address on a professional subject given with the sanction in writing of the Executive Council of the Association;

(c) printing on envelopes used in his practice any information other than his name, the words "Listed Chiropractor" and a return address in case of non-delivery;

(d) using any means of indicating his place of residence or consulting rooms other than one nameplate, which shall not exceed 350 x 250 mm in size, without the prior sanction in writing of the Executive Council of the Association. The nameplate shall incorporate the chiropractor's name and the words "Listed Chiropractor". Where the chiropractor moves to new premises, his name and new address may remain in reasonable evidence for a period not exceeding 12 months. Professional nameplates are not allowed at any place unless a chiropractor actually resides or practices at such place;

(e) using the nameplate of a retired partner or predecessor for a period exceeding 12 months. (After 12 months, the term "successor to" may be used for a period not exceeding 24 months.)

(e) nie kennis van 'n pasiënt se geval, hetsy vir sy eie of iemand anders se geldelike gewin, verdraai, wanvoorstel of misbruik nie;

(f) nie 'n pasiënt (of iemand wat behoorlik vir so 'n pasiënt optree) wat begerig is om die opinie van of behandeling deur 'n praktisyn geregistreer by die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad of die Departement te verkry, verhinder of probeer verhinder om dit te doen nie;

(g) nie professionele handelinge ten opsigte van pasiënte onder onbehoorlike toestande verrig nie, uitgesonderd in 'n noodgeval;

(h) nie 'n professionele handeling op nalatige wyse ten opsigte van 'n pasient verrig nie;

(i) nie terwyl hy onder die invloed van of aangetas is deur sterk drank of dwelmmiddels van watter aard ook al of terwyl hy daarvan bewus is dat hy aan 'n aansteeklike of besmetlike siekte ly, 'n pasiënt behandel nie.

Advertering

4. (1) Behoudens die bepalings van subreël (2) mag 'n chiropraktisyn nie sy praktyk adverteer nie. Die volgende word as advertering beskou:

(a) Advertering in enige vorm hoegenaamd, hetsy in die pers, by wyse van betaalde advertensie of onderhoud, deur middel van die radio of televisie, biljette of plakkate of enige ander middel, insluitende die gebruik van vet letters in gidse, of deur 'n geldelike belang te hê, hetsy in die vorm van 'n vaste salaris of andersins, in siektebystandsklubs of -verenigings wat in die lekepers of by wyse van omsendbriewe of kaartjies of op enige ander wyse adverteer om lede of pasiënte te verkry;

(b) die lewering van 'n toespraak of lesing oor 'n professionele onderwerp wat gewoonweg by 'n kollege vir chiropraktyk gedoseer word, met die doel om 'n studente- of lekebyeenkoms in die voormelde onderwerp te onderrig: Met dien verstande dat hierdie reël nie van toepassing is nie op enige lesing of toespraak oor 'n professionele onderwerp wat met die skriftelike goedkeuring van die Uitvoerende Raad van die Vereniging gelewer is;

(c) druk op koeverte wat in sy praktyk gebruik word van enige ander inligting as sy naam en die woorde "Ingeskrewe Chiropraktisyn" en 'n adres vir terugsending ingeval dit nie afgelewer is nie;

(d) die gebruik van enige metode om sy woonplek of spreekkamers aan te dui, uitgesonderd een naamplaat nie groter as 350 x 250 mm nie, sonder die voorafverkreë skriftelike goedkeuring van die Uitvoerende Raad van die Vereniging. Die naamplaat moet die naam van die chiropraktisyn en die woorde "Ingeskrewe Chiropraktisyn" ophê. In die geval waar daar na 'n nuwe perseel getrek word, mag die naam en die nuwe adres van die chiropraktisyn vir 'n tydperk van hoogstens 12 maande op redelike sigbare wyse vertoon bly. Professionele naamplate word nie op 'n plek toegelaat nie, tensy 'n chiropraktisyn werklik daar woon of praktiseer;

(e) die gebruik van die naamplaat van 'n afgetrede vennoot of voorganger vir 'n tydperk langer as 12 maande. (Na 12 maande kan die woorde "opvolger van" vir 'n tydperk van hoogstens 24 maande gebruik word.)

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(2) The following shall not be regarded as advertising:

(a) Sending a notification of having commenced practice to persons registered with the Department or the South African Medical and Dental Council, provided that each communication shall bear the name of the practitioner to whom it is addressed and shall be enclosed in an envelope;

(b) communicating with bona fide patients to advise them of any change of address, dissolution of partnership and the like, provided that each communication shall bear the name of the patient to whom it is directed and shall be enclosed in an envelope;

(c) publishing in the official telephone directory, in ordinary type, the chiropractor's name and profession and that of his partner, the address of his home and consulting rooms and one or more telephone numbers and special telephone numbers in case of no reply from the usual telephone numbers;

(d) permitting the publication under his name and professional qualifications of articles in professional journals, scientific papers and books for use by the professions and by students;

(e) permitting the publication, under his name but without an indication of professional qualifications, of non-professional books and non-professional articles in the lay press.

Business advertisement

5. A chiropractor shall not—

(a) permit his name or the name of his professional practice to be used in connection with advertisements for equipment, instruments, appliances, dressings, beverages, toilet or dietary preparations or any other similar products, in the press or anywhere else;

(b) permit his name to be used as part of the title of a professional practice carried on or managed by any company or by a person who is not a chiropractor;

(c) permit the publication of his name in connection with advertisements or appeals to the public on behalf of sick benefit societies or similar commercial organisations.

Canvassing and touting

6. A chiropractor shall not canvass or tout for patients, either personally or through agents or in any other manner.

Fees, commissions and partnerships

7. A chiropractor shall not—

(a) accept a commission or reward, monetary or otherwise—

(i) from makers of or dealers in equipment, instruments, appliances and materials; or

(ii) from any person in return for recommending services or wares to patients;

(b) pay a commission or reward, monetary or otherwise, to, or receive any gift from, any person, for recommending patients;

(c) share fees (dichotomy) with any person who has not taken a commensurate part in the service for which the fees are charged.

(2) Die volgende word nie as adv...

(a) Die versending van 'n kennis... 'n praktyk begin is, aan persone ... ment of die Suid-Afrikaanse Gen... heelkundige Raad geregistreer is, ... die naam van die praktisyn aan ... bevat en in 'n koevert versend word;

(b) mededelings van adresver... van vennootskap en iets dergel... pasiënte, mits elke mededeling die ... aan wie dit gerig word, bevat en in ... word;

(c) die publikasie in die amp... gewone druk, van die chiropr... beroep en dié van sy vennoot, sy ... adres en een of meer telefoonn... foonnommers ingeval geen antw... telefoonnommers gekry kan word ...

(d) toelating van die publikasie... professionele kwalifikasies, van... skrifte, wetenskaplike referate e... deur die beroepe en deur studente;

(e) toelating van die publikasie... sonder vermelding van professio... nie-professionele boeke en nie-p... die lekepers.

Besigheidsadver...

5. 'n Chiropraktisyn mag nie—

(a) toelaat dat sy naam of ... fessionele praktyk gebruik ... advertensies vir uitrusting, ins... bandgoed, dranke, toilet- of ... enige ander dergelike produkte ... nie;

(b) toelaat dat sy naam ge... die naam van 'n professionele ... bestuur deur enige maatskappy ... nie 'n chiropraktisyn is nie;

(c) toelaat dat sy naam ge... band met advertensies of ... ten behoewe van siektebys... like handelsorganisasies nie.

Werwing en lok...

6. 'n Chiropraktisyn mag ... bemiddeling van agente of ... pasiënte werf of lok nie.

Gelde, kommissie en...

7. 'n Chiropraktisyn mag nie—

(a) 'n kommissie of bel... sins, aaneem—

(i) van vervaardigers van ... rusting, instrumente, toeste...

(ii) van enige persoon as ... beveling van dienste of ware ...

(b) 'n kommissie of bel... sins, betaal of enige geskenk ... vang vir die aanbeveling van ...

(c) gelde deel met enige ... redig deelgeneem het aan ... gelde gevorder word nie ...

Covering

8. A chiropractor shall not—

(a) employ as an assistant or *locum tenens* any person whose name does not appear on the list or enter into partnership with any such person;

(b) except in an emergency, consult or act in collusion or in collaboration with any person whose name does not appear on the list, or who is not registered with the South African Medical and Dental Council or the Department or in any way assist or support any such person in illegitimate practice.

Note.—Where a chiropractor is called in an emergency to aid any of the above-mentioned persons professionally, he must immediately report the case to the Council of the Association.

Association with charitable institutions

9. A chiropractor shall not knowingly be associated professionally in any manner with an institution which falsely purports to be a charitable institution.

Financial interest in clubs and other associations

10. A chiropractor shall not have a financial interest, whether by way of fixed salary or otherwise, in sick benefit clubs or associations which advertise for members or patients in the press, or by circular or card, or in any other way.

Tendering

11. A chiropractor shall not tender for full-time, part-time or any other type of appointment.

Supersession

12. A chiropractor shall not supersede another chiropractor who is in charge of a case which he has seen in consultation with, or on behalf of such chiropractor, except with the consent of such chiropractor, unless such consent is unreasonably withheld or no other assistance by a chiropractor is available: Provided that nothing herein contained shall preclude a chiropractor from accepting for examination or treatment a patient who decides of his own accord to consult such chiropractor exclusively, notwithstanding that he had previously been treated by the referring chiropractor.

Professional reputation of people in the field of health

13. A chiropractor shall not cast adverse reflection, by word or implication, upon the probity or professional reputation or skill of a chiropractor, or a person registered with the South African Medical and Dental Council or the South African Nursing Council or the Department.

Professional secrecy

14. (1) A chiropractor may not divulge, verbally or in writing, to any person other than the patient any information which should not be divulged regarding

Verberging

8. 'n Chiropraktisyn mag nie—

(a) enige persoon wie se naam nie op die lys verskyn nie, in diens neem as 'n assistent of *locum tenens* of in vennootskap met enige sodanige persoon tree nie;

(b) enige persoon wie se naam nie op die lys verskyn nie of wat nie by die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad of die Departement geregistreer is nie, raadpleeg of in kollusie of in samewerking met hom optree nie of op enige manier enige sodanige persoon help of ondersteun in onwettige praktyk nie, behalwe as dit 'n noodgeval is.

Let wel.—Waar 'n chiropraktisyn in 'n noodgeval ontbied word om enige van bogenoemde persone professioneel by te staan, moet hy die voorval onmiddellik aan die Raad van die Vereniging rapporteer.

Assosiasie met liefdadigheidsinrigtings

9. 'n Chiropraktisyn mag nie willens en wetens professioneel op enige wyse geassosieer wees met 'n inrigting wat valslik voorgee 'n liefdadigheidsinrigting te wees nie.

Finansiële belang in klubs en ander genootskappe

10. 'n Chiropraktisyn mag nie 'n geldelike belang hê, hetsy in die vorm van 'n vaste salaris of andersins, by siektebystandsklubs of -verenigings wat in die pers of by wyse van omsendbriewe of kaartjies of op enige ander wyse adverteer om lede of pasiënte te verkry nie.

Tender

11. 'n Chiropraktisyn mag nie vir voltydse, deeltydse of enige ander soort aanstelling tender nie.

Supersessie

12. 'n Chiropraktisyn mag nie die plek neem van enige ander chiropraktisyn wat beheer het oor 'n geval oor wie hy saam met of ten behoewe van sodanige chiropraktisyn gegaan het nie, uitgesonderd met die toestemming van sodanige chiropraktisyn, tensy sodanige toestemming onredelik geweier word of geen ander hulp deur 'n chiropraktisyn beskikbaar is nie: Met dien verstande dat niks hierin vervat 'n chiropraktisyn belet om 'n pasiënt wat op sy eie besluit om sodanige chiropraktisyn uitsluitlik te raadpleeg, vir ondersoek of behandeling aan te neem nie, nieteenstaande die feit dat hy vantevore behandel is deur die chiropraktisyn wat hom verwys het.

Professionele reputasie van persone op die gesondheidsgebied

13. 'n Chiropraktisyn mag nie ongunstige toespelings, mondelings of by insinuasie, maak op die eerlikheid, professionele reputasie of bekwaamheid van 'n chiropraktisyn, of 'n persoon geregistreer by die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad of die Suid-Afrikaanse Raad op Verpleging of die Departement nie.

Professionele geheimhouding

14. (1) 'n Chiropraktisyn mag geen inligting aangaande die aandoenings van 'n pasiënt wat nie bekend gemaak behoort te word nie, mondelings of skriftelik

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the ailments of a patient except with the express consent of the patient or, in the case of a minor, with the consent of his parent or guardian, or, in the case of a deceased patient, with the consent of his next-of-kin or the executor of his estate.

(2) In a court of law information referred to in subrule (1) shall only be divulged under protest and after the presiding judicial officer has directed that such information should be so divulged.

Certificates

15. A chiropractor shall not issue a certificate in his professional capacity unless he is satisfied from personal observation that the facts are correctly stated therein.

Use of unacceptable apparatus and techniques

16. A chiropractor shall not make use, in the conduct of his practice, of—

(a) any form of treatment, apparatus or technical process which is secret or is claimed to be secret;

(b) any apparatus which proves upon investigation to be incapable of fulfilling the claims made in regard to it;

(c) any technique, apparatus or procedure not accepted within the chiropractic field.

Consulting rooms

17. (1) Consulting rooms of a chiropractor shall not have an entrance through or a nameplate at the entrance of premises licensed to sell intoxicating liquor, a pharmacy or a health food shop.

(2) A chiropractor shall not share a suite of rooms for consulting, waiting or any other professional purpose with persons whose names are not registered or entered with the Department or the South African Medical and Dental Council, unless such sharing is authorised in writing by the Council of the Association.

(3) A chiropractor shall not use in connection with his consulting rooms the terms "hospital", "clinic" or any other similar term which might lead the public to believe that the consulting rooms are part of a hospital, nursing home or other similar institution or have features differing from those of ordinary consulting rooms, and shall not sell or dispose of from his consulting rooms or any adjoining room or rooms or any room or rooms on the same floor medications, drugs, health foods or appliances normally sold for profit in a pharmacy, general dealer's store, health food shop or any other shop.

Practice of radiology

18. A chiropractor may not take a sciagram for a person other than his patient or fellow chiropractor or registered medical practitioner or person registered with the Department.

Breach of duty towards the Council of the Association

19. A chiropractor shall refrain from any wilful act or omission which prevents or is calculated to prevent the Council of the Association from carrying out its lawful duties.

openbaar aan enigiemand anders behalwe met die uitdruklike [illegible] pasiënt, of, in die geval van 'n [illegible] toestemming van sy ouer of voog, 'n pasiënt wat oorlede is, met [illegible] sy naasbestaande of die eksekuteur [illegible]

(2) In 'n geregshof mag die [illegible] genoem, openbaar gemaak word [illegible] en nadat die voorsittende regte[illegible] dat dit openbaar gemaak word.

Sertifikate

15. 'n Chiropraktisyn mag [illegible] professionele hoedanigheid uitreik waarneming daarvan oortuig is [illegible] vermeld juis is.

Gebruik van onaanneemlike [illegible]

16. 'n Chiropraktisyn mag nie sy praktyk gebruik maak van—

(a) enige soort behandel[illegible] proses wat geheim is of waar[illegible] dit geheim is nie;

(b) enige toestel wat by [illegible] blyk te wees om te voldoen [illegible] ten opsigte daarvan gemaak is [illegible]

(c) enige tegniek, toestel of [illegible] binne die gebied van die [illegible] nie.

Spreekk[illegible]

17. (1) 'n Chiropraktisyn se [illegible] 'n ingang hê deur, of 'n na[illegible] tot, 'n perseel wat gelisensieer [illegible] drank te verkoop, 'n apteek o[illegible] heidsvoedsel nie.

(2) 'n Chiropraktisyn mag [illegible] spreekkamers, wagkamers of [illegible] sionele doel saam gebruik me[illegible] nie by die Departement of die [illegible] kundige en Tandheelkundige R[illegible] skryf is nie, tensy sodanige [illegible] die Raad van die Vereniging g[illegible]

(3) 'n Chiropraktisyn mag [illegible] spreekkamers die uitdrukking [illegible] enige soortgelyke naam gebr[illegible] laat glo dat die spreekkame[illegible] hospitaal, verpleeginrigting of [illegible] ting, of eienskappe besit wa[illegible] gewone spreekkamers nie, of [illegible] of enige aangrensende kamer [illegible] of kamers op dieselfde ver[illegible] syne, gesondheidsvoedsels of [illegible] vir wins in 'n apteek, 'n win[illegible] delaar, 'n winkel vir gesond[illegible] ander winkel verkoop word, [illegible] sit nie.

Radiolog[illegible]

18. 'n Chiropraktisyn mag [illegible] vir 'n ander persoon as sy [illegible] tisyn of 'n geregistreerde ge[illegible] by die Departement geregistreer [illegible]

Pligsversuim teenoor [illegible] Vereniging

19. 'n Chiropraktisyn moet [illegible] opsetlike handeling of ver[illegible] daarop bereken is om te ve[illegible] die Vereniging sy wetlike pligte [illegible]

Exploitation

20. A chiropractor shall not permit himself to be exploited in a manner detrimental to the public or professional interest.

Itinerant practice

21. (1) A chiropractor may not carry on a regular itinerant practice at a place where another practitioner is established, unless he renders in his practice a full and satisfactory service to his patients similar to and at the same cost as the service he would render in the area in which he is resident.

(2) A chiropractor shall notify his intention to visit any place in is professional capacity in the following manner:

(a) By letter, enclosed in a sealed envelope, addressed to a bona fide patient. Itinerary cards shall not be used. (For the purposes of this paragraph, "bona fide patient" means a patient who has been treated by the chiropractor concerned during the 12 months immediately preceding the month in which the notification is despatched); and/or

(b) by affixing a nameplate bearing his name and hours of attendance at his consulting room in that town.

(3) Where a town is visited in which there is a resident chiropractor, such visits shall be made—

(i) at least once a month;

(ii) at rooms maintained for the purpose, to which shall be affixed a nameplate on which are set out the days and hours of attendance.

Limitations as to the scope of practice

22. Professional acts in relation to the following conditions, which shall be outside the ambit of chiropractic practice, shall not be performed by a chiropractor:

(a) Infectious and contagious diseases;

(b) septic foci such as abscesses;

(c) neoplasms of all kinds, whether benign or malignant;

(d) parasitic infestations;

(e) all conditions due to toxic application or ingestion;

(f) trauma, fractures, or soft tissue damage or destruction requiring surgical repair;

(g) mental derangements;

(h) obstetrics and gynaecology;

(i) any condition in respect of which an internal examination is indicated: Provided that it shall be regarded as professional conduct for a chiropractor to carry out the following internal examinations:

(i) Examination of the coccyx through the rectum;

(ii) any visual examination with the naked eye or by means of an ophthalmoscope, or otoscope, including examination of the mouth, ear, nose and throat;

(j) treatment by means of medicines, surgery, or X-rays, radium or isotopes.

(2) A chiropractor shall not withdraw blood or a blood sample or have blood or a blood sample withdrawn from any person.

Post-graduate education

23. Every chiropractor shall complete a minimum of 20 hours of personal attendance at post-graduate lectures and/or symposia and/or seminars organised or approved at intervals determined by the Council of the Association.

Uitbuiting

20. 'n Chiropraktisyn mag nie toelaat dat hy op so 'n manier uitgebuit word dat dit tot die nadeel van die publiek of professionele belang strek nie.

Rondreispraktyk

21. (1) 'n Chiropraktisyn mag nie 'n gereelde rondreispraktyk op 'n plek waar 'n ander praktisyn gevestig is, uitoefen nie, tensy hy in sy praktyk 'n volle en bevredigende diens aan sy pasiënte lewer, soortgelyk aan en teen dieselfde koste as die diens wat hy sou lewer in die gebied waarin hy woonagtig is.

(2) 'n Chiropraktisyn moet op die volgende wyse van sy voorgenome professionele besoek aan enige plek kennis gee:

(a) Per brief, in 'n verseëlde koervert, geadresseer aan 'n bona fide-pasiënt. Kaarte wat die reisplan aandui, mag nie gebruik word nie. (Vir die doel van hierdie paragraaf beteken "bona fide-pasiënt" 'n pasiënt wat deur die betrokke chiropraktisyn behandel is gedurende die 12 maande wat die maand waarin die kennisgewing uitgestuur word, onmiddellik voorafgaan); en/of

(b) deur die aanbring van 'n naamplaat, met sy naam en spreekure daarop, by sy spreekkamer in daardie dorp.

(3) Waar 'n dorp waarin daar 'n inwonende chiropraktisyn is, besoek word, moet sodanige besoeke afgelê word—

(i) minstens een keer per maand;

(ii) in kamers vir dié doel gehou, waaraan 'n naamplaat aangebring is waarop die dae en ure van besoek aangegee word.

Beperkings ten opsigte van die bestek van praktyk

22. Professionele handelinge ten opsigte van die volgende toestande, wat buite die omvang van die chiropraktyk val, mag nie deur 'n chiropraktisyn verrig word nie:

(a) Aansteeklike en oordraagbare siektes;

(b) septiese foci soos absesse;

(c) alle soorte gewasse, hetsy benigne of maligne;

(d) besmetting deur parasiete;

(e) alle toestande te wyte aan toksiese aanwendings of innames;

(f) trauma, frakture, of beskadiging of vernietiging van sagte weefsel wat chirurgiese herstel nodig het;

(g) geestesversteurings;

(h) verloskunde en ginekologie;

(i) enige toestand wat inwendige ondersoek nodig maak: Met dien verstande dat die uitvoering deur 'n chiropraktisyn van die volgende inwendige ondersoeke as professionele gedrag beskou word:

(i) Ondersoek van die stuitjie deur die rektum;

(ii) enige visuele ondersoek met die blote oog of met die gebruik van 'n oftalmoskoop, of otoskoop, met inbegrip van ondersoek van die mond, oor, neus en keel;

(j) behandeling met medisyne, chirurgie, of X-strale, radium of isotope.

(2) 'n Chiropraktisyn mag nie bloed of 'n bloedmonster van iemand neem of laat neem nie.

Nagraadse opleiding

23. Elke chiropraktisyn moet minstens 20 uur bestee aan die persoonlike bywoning van nagraadse lesings en/of simposiums en/of seminare gereël of goedgekeur met tussenpose bepaal deur die Raad van die Vereniging.

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Administration

24. (1) Every chiropractor shall notify the Designated Officer and the Association of any change of professional address within 30 days of such change.

(2) Every chiropractor shall before 31 January of each year pay an amount of R100 to the Association for the purpose of administering the affairs and promoting the interests of Chiropractic in South Africa. The Executive Council of the Association may in its discretion, upon receipt of a fully motivated request therefor, grant exemption from or postponement of payment or a reduction of such fee. Such request shall reach the Executive Council at least 30 days before the due date, whereupon the Executive Council shall inform the applicant in writing of its decision and, if such exemption, postponement or reduction is granted, of the conditions which apply thereto.

(25 May 1979)

Administrasie

24. (1) Elke chiropraktisyn m[illegible]
adresverandering die Aangewese [illegible]
eniging van sodanige adresver[illegible]

(2) Elke chiropraktisyn moet [illegible]
elke jaar 'n bedrag van R100 aan [illegible]
vir die administrasie van die sake [illegible]
van die belange van die Chiropra[illegible]
Die Uitvoerende Raad van die Ve[illegible]
dunke, na ontvangs van 'n volled[illegible]
soek daarom, vrystelling of uitstel [illegible]
sodanige bedrag verleen, of 'n v[illegible]
nige bedrag toestaan. Sodanige v[illegible]
voerende Raad minstens 30 da[illegible]
betaaldatum bereik, waarna die U[illegible]
aansoeker skriftelik verwittig van [illegible]
sodanige vrystelling of uitstel ver[illegible]
mindering toegestaan word, van [illegible]
daarop van toepassing is.

(25 Mei 1979)

Star 4/6/79

(93)

Doctors threaten strike over civil-servant status

Doctors are threatening to go on strike throughout Portugal in protest against the Health Department's decision to give them the status of civil servants.

Dr G dos Santos said at a meeting in Oporto that he condemned and thought it degrading that the Government was trying to socialise medicine in Portugal and infringe on the rights of private doctors.

★ ★ ★

A former Minister in the Salazar Government has criticised the stand taken by the Portuguese delegation regarding South Africa at a United Nations conference.

Professor Adriano Moreira said the Portuguese Government in its present enfeebled condition should avoid speeches that did not favour the Government's interests, or that might affect the Portuguese community living in South Africa.

PORTUGUESE NEWS

★ ★ ★

South Africa has refused to grant Portugal higher quotas for its trawlers fishing in South African teritorial waters.

★ ★ ★

NEWS IN BRIEF

- Refugees from former Portuguese colonies have protested against the celebration of the 16th anniversary of the founding of the Organisation of African Unity held recently in Lisbon.
- Britain is willing to enter new negotiations that will strengthen the 100-year alliance existing between the two countries.
- An American oil company has reported that all the holes drilled in the Viana do Castelo area have been abandoned as dry holes.

Medical fees may rise in August

Star 20/6/79

(93)

A new scale of medical-aid fees for doctors and dentists, which is being prepared by the tariffs committee of the South African Medical and Dental Council, will be considered by the full council at the end of August.

The new fees, if approved, will then come into force as soon as details can be circulated by the Government Printer.

The committee has been hearing represepresentations from interested parties after its original proposals were blocked by the council in April.

The blocked proposals were for an interim 25 percent overall increase.

The extra cost to the medical schemes would have been around R40-million a year.

The Representative Association of Medical Schemes raised strong objections to the proposals, even threatening to take the council to court if the interim tariffs were adopted.

RAMS claimed it was not given enough time to consider the proposed increases.

The council decided at a meeting in Durban to cancel the interim increases and called a special meeting for August to discuss fresh proposals.

S. 2 (Cont.)

1. The revised report eliminates the effect of increased production costs as they are not controllable by the branch manager. Other comments:

2. Increased contribution from increased prices.

3. The increased price of widgets may have caused the decrease in volume of widgets. As these have a much higher marginal income ratio than gadgets it might have been better not to increase the price. Consider reducing the price if it will stimulate demand.

4. It seems as though there has been a successful promotion of gadgets (volume-wise) in spite of the increased price, but these have a relatively low marginal income ratio which, combined with the reduced volume of widgets, has resulted in an adverse mix variance.

5. Increased selling e[...] in travel and enter[...] expense. [...] the 126% increase [...] increase in office

NUMBER :

HYPERMARKETS QUESTIONNAIRE I

Good afternoon. I am helping a final-year university student, who is doing a project on the future of hypermarkets. I wonder if you would spend a few minutes helping me complete this questionnaire ?

1. Do you enjoy shopping at the hypermarket ?

YES	5-1
NO	-2
NO MORE THAN ANYWHERE ELSE	-3
NOT REALLY	-4

2. What do you like about it ? (CHECK EACH ONE RESPONDENT MENTIONS)

	YES	NO
CONVENIENT	6-1	-2
ONE-STOP	7-1	-2
BIG	8-1	-2
GOOD SELECTION	9-1	-2
PRICES	10-1	-2
SPACE / OPEN	11-1	-2
LAYOUT	12-1	-2
PARKING	13-1	-2
TAKE the FAMILY	14-1	-2
OTHER (STATE)	15-1	

....

3. What don't you like about it ? (CHECK EACH ONE RESPONDENT MENTIONS)

NOTHING	16-
SLOW CHECKOUTS	17-
NO SMALL PACKS	18-
NOISE	19-
CROWDED	20-
CONFUSING	21-
FAR AWAY	22-

4. How often do you shop [

ONCE A WEEK
ONCE IN 2 WEEKS
ONCE A MONTH
2 OR 3 TIMES A YE
OTHER (STATE)

20% increase in doctors' fees likely

Pretoria Bureau

DOCTORS' fees are likely to be increased before the end of the year, probably in October.

The chairman of the Federal Council of the Medical Association of South Africa, Professor Guy de Klerk said yesterday the council had completed its recommendations and they were being considered by a remuneration committee of the SA Medical and Dental Council.

He declined to say what the recommended increase was but, it is understood, it was not likely to be less than 20%.

Prof de Klerk pointed out it was four years since doctors' tariffs were adjusted.

Rising living costs, particularly those which had taken place this year, stressed the urgent need for relief.

The recommendation of the remuneration committee will be submitted to a meeting of the four medical councils in Pretoria on August 27.

The committee will approve the tariffs applicable to medical aid schemes and will lay down tariff guidelines for those doctors who have contracted out of the Medical Schemes Act.

Further hikes in doctors' tariffs, medical aid society sources said, would probably mean that contributions to medical aid funds would have to be increased.

This would add another significant cost factor to the budget of wage and salary owners, it was stated.

Doctors' fees certain to rise

21/6/77

PRETORIA — A big increase in doctors' fees is certain before the end of the year, probably in October.

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Further increases in doctors' tariffs, medical aid society sources said, would probably mean that contributions to medical aid funds would have to be raised. — DDC.

Mennonite Central Committee se Konferensie oor: 'Die Rol van Geskiedkundige Vredeskerke', Gaborone, Botswana. Verhandeling voorgelê oor: 'The Role of Churches in Promoting Justice in Southern Africa' (Oktober).

Konferensie van die Afrikaanse Calvinistiese Beweging, Potchefstroom (Oktober).

(c) Deelname aan Welsyns- Professio...

Star 5/7/79 95 93

Doctors, nurses in food protest

More than 200 coloured and Indian nurses and 20 doctors at the Coronation Hospital are on a food-protest strike.

The nurses who live in decided earlier this week to stop eating meals supplied to them by the hospital. Yesterday doctors decided to join the boycott.

The "strike" has not affected their duties. They are continuing to attend to patients.

They said they decided on the food strike after numerous complaints about bad meals and dining facilities had fallen on "deaf ears."

Their grievances are:

- Meals were badly prepared and unpalatable.
- Dining facilities were "primitive." No tablecloths were laid. Water was served in chipped cups instead of glasses, teaspoons were not supplied with tea.
- There was no decent choice of menu or variety in meals.
- Although it was a non-white hospital, racial discrimination was being practised where coloured and Indian nurses were not allowed to share the same dining canteen with white doctors and other white staff. (Indian doctors are now allowed to eat with white staff).

... van Kaapstad het benewens 'n bydrae tot die bedryfskoste van die Sentrum, ook vir die Sentrum sedert sy stigting in kantoorruimte voorsien. Met die uitbreiding van personeel het ons die huisie op die laer

navorsings-Fellows het aansienlik tot die Sentrum se program bygedra: dr Sheila T. van der Horst, afgetrede mede-professor van Ekonomie, U.K., en professor J.L. Boshoff, gewese Rektor van die Universiteit van die Noorde.

LIDMAATSKAP

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Sir Richard Luyt
Professor S.J. Saunders
Professor H.W. van der Merwe
Mede-professor D.J. Welsh
Professor Monica Wilson

(93)

PERSVERKLARING DEUR SY EDELE DR. SCHALK VAN DER MERWE, MINISTER VAN GESONDHEID IN VERBAND MET DIE DISPARITEIT IN DIE SALARISSE VAN SWART GENEESHERE EN ANDER GROEPE

Die Regering het die beginsel van gelyke besoldiging vir gelyke werk aanvaar waar die kwalifikasies en die produktiwi= teit ook gelyk is. Om by die doelwit uit te kom is dit die Regering se beleid om pariteit beginnende by die hoogste poste vir werknemers van die Staat te bewerkstellig en dat die proses geleidelik na laer vlakke deurgevoer moet word.

Met die onlangse salarishersienings is die beleid geleidelik verder gevoer en is die salarisgaping vir sommige kategorieë aansienlik vernou en in sommige gevalle heeltemal uitgewis.

Hierdie verklaring word uitgereik na aanleiding van onlangse persberigte oor ongelyke salarisse van geneeshere. Hierdie berigte berus blykbaar op inligting wat reeds verouderd is.

Verdere besonderhede oor die aangeleentheid sal later uitgereik word.

UITGEREIK DEUR DIE INLIGTINGSDIENS VAN SUID-AFRIKA OP VERSOEK VAN DIE DEPARTEMENT VAN GESONDHEID

PRETORIA
5 Julie 1979

1 000 doctors for Durban congress

93

5/7/79

CLOSE on 1 000 doctors from South Africa and overseas will meet in Durban from July 15 to 22 for the 52nd bi-annual South African Medical Congress.

The theme of the congress is advances in medical practice and will cover a wide range of aspects including:

- Special new techniques developed for the care and treatment of road accident victims.
- Advances in diagnoses — developments such as scanner photography, thermography and ultrasound.
- The motivations for the unusual incidence of pact suicides among Indians.
- Diet and heart disease — the cholesterol controversy.

A total of 40 international authorities on various aspects of medicine — including Dr. Paul Kapapa, one of the few Black psychiatrists in Africa, will address the congress at the University of Natal.

Dr. Kapapa will present a paper on the difficulties of applying modern Western medicine in the treatment of mental disorders among Blacks who, he maintains, have been conditioned by centuries of *Muti* and witchdoctors.

One session of the congress will be devoted to how investigation of mummies from Egyptian tombs has aided modern medicine.

Dr. George Dimopoulos, chairman of the congress organising committee, said: "This, the 52nd congress, will certainly be one of the most comprehensive. We have an excellent line-up of international authorities, so much so that we have had an approach from American medics who want to send a special delegation."

Dr. Dimopoulos pointed out that July is Durban's in season, so accommodation will be at a premium. He urged doctors who have not yet registered to do so without delay.

The Natal Mercury

SATURDAY, JULY 7, 1979

DRAFTING THE DOCTORS

THE major issue facing the health services of southern Africa is the maldistribution of the skills available.

In the cities and towns the service is, by and large, comparable with the best in the world. But many rural districts, particularly the Black homelands and States, are health care problem areas with 30 to 40 percent of district physician posts vacant.

This is why the suggestions made recently by Professor John Downing, head of the Department of Anaesthetics at the University of Natal Medical School, are particularly appropriate.

He pointed out that there were two problem areas — the lack of experience of newly-qualified doctors and the staff shortages mentioned above.

The two-fold plan he outlined would deal with both shortcomings. He said that newly qualified doctors should be required to spend two years in a recognised hospital gaining experience in all departments, after which they would work for six months in a health care problem area.

This period would ensure that for at least part of each year there would be a reasonably skilled medical practitioner available where needed.

While half measures are better than none, surely a case could be made out for a full year's field service, thus giving "round-the-clock" coverage.

Various incentives, perhaps in the form of tax concessions, free housing and reduced military service, along with better salaries and conditions, could be used to compensate doctors for their temporary duties.

In making his proposals, Professor Downing places the onus to act initially on the South African Medical Association and so on the doctors themselves.

So far, the Republic, while in the forefront of scientific and technological medicine, has lagged shamefully behind in the provision of adequate primary health care and family medicine, particularly for those less privileged and more isolated citizens of States, homelands and provinces.

The medical profession must bear some of the responsibility for this state of affairs and as such rise to the challenge now.

It is under a moral and ethical obligation to solve the problems of maldistribution of both medical manpower and health care services in southern Africa.

Black psychiatrist at congress

The teachings of Freud may work for neurotic whites, but have little relevance to mentally disturbed blacks — conditioned by centuries of muti and witchdoctors.

This will be the theme of a paper by Dr Paul Kapapa, one of the few black psychiatrists in Africa, to be delivered at the South African medical congress in Durban later this month.

Dr Kapapa was educated in Germany and born in Malawi where he now practises. His approach is that traditional African society is vastly different to the sophisticated Western culture on which modern psychiatry is based.

He maintains psychological disturbances in blacks stem from fears and anxieties completely different to those besetting Westerners. Thus the remedial teachings of contemporary Western-based psychiatry are often inappropriate to blacks.

Dr Kapapa will be one of 40 international authorities on various aspects of medicine addressing the congress.

Close on 1 000 doctors from South Africa and overseas are expected to attend the congress at the University of Natal from July 15 to 22.

The theme of the congress, which is held every two years, is "Advances in Medical Practice". It will cover a wide range of aspects including.

Traffic accidents — the care and treatment of road accident victims and special new techniques developed in this aspect.

Advances in diagnoses developments such as scanner photography, thermography and ultrasound.

Pact suicides — the motivations for the unusual incidence of pact suicides among Indians.

Diet and heart disease — the cholesterol controversy.

One session of the congress will be devoted to how investigation of mummies from Egyptian tombs has aided modern medicine. Professor Ian Igherwood, an English expert on Egyptology, will describe radiological techniques used in examining mummies.

Dr George Dimopoulos, chairman of the congress organising committee, said: "This will be the 52nd congress to be held and will certainly be one of the most comprehensive. We have an excellent line-up of international authorities — so much so that we have had an approach from American medics who wish to send a special delegation.

"Accommodation in Durban during July will be at premium so we would urge doctors who have not yet registered for the congress to do so without delay."

se Konferensie oor: 'Die
deskerke', Gaborone,
orgelê oor: 'The Role of
ce in Southern Africa'

se Calvinistiese Beweging,

essionele en Openbare

in die Suid-Afrikaanse
as 'n lid van die Weskaap-
Uitvoerende Komitee en van

Service Fund in die Kaap,
enstige Vriendekring
keling op die platteland

n die Raad van die
elike Afrika. Hy is
Sosiologiese Vereniging
giese Vereniging. Hy
se afgevaardigde in die
logiese Vereniging vir

ANK

entheid wat die jaar-
betuig aan lede van die
eheerraad vir hulle

navorsings-Fellows het aansienlik tot die Sentrum se program bygedra: dr Sheila T. van der Horst, afgetrede mede-professor van Ekonomie, U.K., en professor J.L. Boshoff, gewese Rektor van die Universiteit van die Noorde.

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Professor H.W. van der Merwe
Mede-professor D.J. Welsh
Professor Monica Wilson

CT 17/7/79

Equal pay for senior doctors

(93)

Own Correspondent

DURBAN. — All senior doctors in the public service, irrespective of race, will in future receive equal salaries.

This was announced in Durban last night by Dr Johan De Beer, Secretary for Health, when he opened the 52nd Congress of the Medical Association of South Africa (Masa).

"In future, all doctors in the grades of senior medical officer and higher, as well as all grades of specialists, shall receive equal salaries irrespective of race," Dr De Beer said.

The new salary scales will apply to doctors in government, provincial service and inlocal authorities.

Medical officers would receive similar consideration soon, he said.

Star 17/7/79 (93)

Medical 'union' welcomes equal pay

The Medical Association of South Africa has welcomed the announcement by the Secretary for Health, Dr Johan de Beer, that senior doctors in the public service are to receive equal salaries irrespective of race.

Opening the association's congress in Durban yesterday, Dr de Beer said the salary equality would apply to doctors in Government and provincial service as well as those working for local authorities.

Grades in which salary discrimination based on race would still obtain are medical officer, senior houseman, registrar and intern.

But according to Dr de Beer the entry grade of medical officer will receive similar consideration at the next opportunity.

Dr de Beer's statement is an affirmation of an announcement by the Prime Minister, Mr P W Botha, in March that about 400 employees in the so-called management cadres of the public service would be placed on full parity while another 1 300 would move closer to parity.

Among them are such posts as professor, specialist, senior specialist, first specialist and others.

At the time Professor Guy de Klerk, chairman of the Medical Association's federal council, said the association could justifiably be proud of the significant role it had played in bringing about this change.

But it would maintain its efforts until all discrimination on the basis of colour had been abolished, he added.

Dr J J le Roux, deputy secretary of the association, said today: "We are very pleased."

The authorities could not say today how many black doctors are involved.

Mennonite Central Committee se Konferensie oor: 'Die Rol van Geskiedkundige Vredeskerke', Gaborone, Botswana. Verhandeling voorgelê oor: 'The Role of Churches in Promoting Justice in Southern Africa' (Oktober).

Konferensie van die Afrikaanse Calvinistiese Beweging, Potchefstroom (Oktober).

(c) Deelname aan Welsyns- Professionele en Openbare Organisasies

Die Direkteur het aktief gebly in die Suid-Afrikaanse Instituut vir Rasseverhoudinge ...

navorsings-Fellows het aansienlik tot die Sentrum se program bygedra: dr Sheila T. van der Horst, afgetrede mede-professor van Ekonomie, U.K., en professor J.L. Boshoff, gewese Rektor van die Universiteit van die Noorde.

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17/7/79

Own Correspondent

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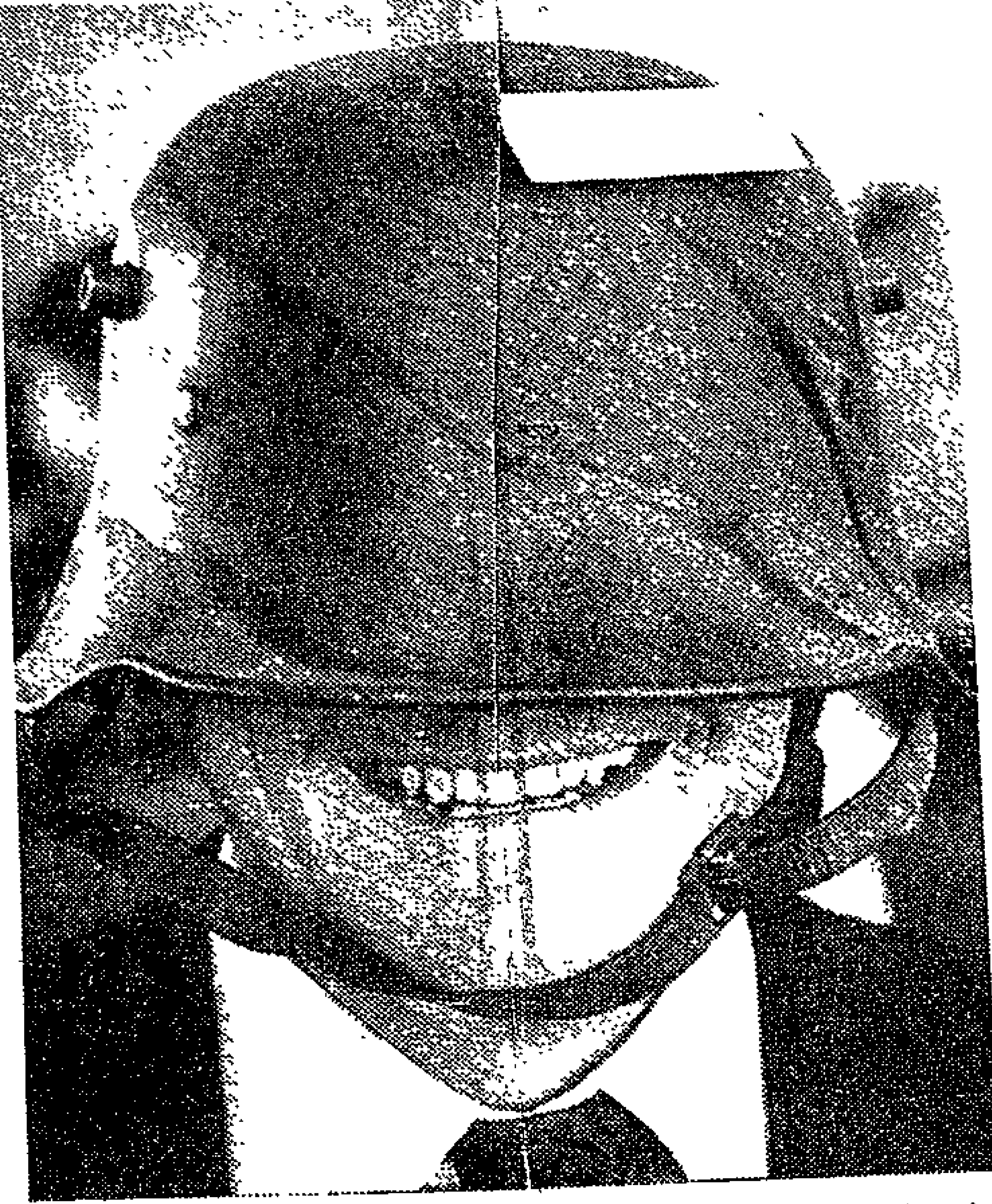
The new salary scales will apply to doctors in government, provincial service and inlocal authorities.

Medical officers would receive similar consideration soon, he said.

Medical men take time off for the lighter side of life . . .



THE lighter side of a medical congress. Dr. Fred Clarke, MPC, shows off part of his collection of hats and uniforms in the doctors' hobbies display. The face-enveloping helmet is a German one of World War I vintage, while the London bobby's needs no introduction.

Equal-pay prom[...] to doct[...]

17/7/79

Science Correspondent

ALL senior doctors in the public service, irrespective of race or colour, will receive equal salaries.

This was announced in Durban last night by Dr. Johan de Beer, Secretary for Health, when he opened the 52nd congress of the Medical Association of South Africa (Masa).

"It is my pleasure to inform you this evening that the Cabinet has recently reconsidered its previous policy regarding salaries and conditions of service for full-time doctors.

"In future all doctors in the grades of senior medical officer and higher as well as all grades [of] specialists shall rece[ive] equal salaries irrespect[ive] of race or colour.

"The entry grade [of] medical officer sh[all] receive similar consid[era]tion at the next op[portu]nity," said Dr. de B[eer].

Doctors had a big ro[le to] play in the changing [and] expanding health servi[ces of] southern Africa, but would have to think afresh about relinquishing traditional tasks to allied health professions, without giving up their leadership role, he said.

Desire

The philosophy of the medical schools "should be a desire for change to improve the health of the people and an ongoing intellectual enquiring mind as to how to achieve it.

"People with these attributes must be of high calibre and are entitled to equal recognition, irrespective of race, colour or religion."

Dr. de Beer's announcement was welcomed by Dr. M. B. Asherson, president of Masa.

"Masa has always been against discrimination on grounds of race, colour or creed. We have fought it tooth and nail for years."

Durban's MOH, Dr. C. R. Mackenzie, also welcomed the move but pointed out that his department has been paying doctors equally for several years.

18/7/79

Equal pay move is welcomed

Mercury Reporter

EQUAL pay for senior Black doctors in the public service was welcomed last night by Professor Y. Seedat, vice-chairman of Fulmed, as "one of the country's greatest achievements".

Reacting to Secretary for Health Dr. Johan de Beer's statement at the Medical Association's 52nd congress that parity in salaries for all senior and higher medical officers and all specialists, irrespective of race, was to come about, Professor Seedat said the move would "go a long way" in improving South Africa's image with the rest of the medical world.

He said there had been a great deal of bitterness among Black doctors who received the same training and qualifications, registered with the same body (the South African Medical and Dental Council), worked the same hours, yet received less pay.

"Many Black doctors were discouraged from specialising and working in hospitals because of the discrimination in salaries," he said. "A private practice proved far more lucrative."

Overdue

Dr. S. B. Pitsoe, senior lecturer in the department of obstetrics and gynaecology at the University of Natal's Medical School, echoed Professor Seedat's sentiments. "Parity for Black doctors is long overdue," he said, "but everyone welcomes it having come at last."

Dr. Pitsoe added that he felt the new salary scales shouldn't affect just senior staff, but also interns, nurses, and other paramedics.

Indian and Coloured doctors' salaries were brought on par with Whites in

Taking care of the dying

Science Correspondent

THE CARE of the dying is now an important part of the work of doctors, yet most of them are not well prepared to deal with the task.

"Their medical school training sadly neglects this vitally important aspect of patient care," said Dr. Stanley Levenstein, of the College of Medicine of South Africa yesterday.

He was speaking to the congress of the Medical Association of South Africa, now being held in Durban.

The reason for the neglect was that most doctors found death and dying a very threatening subject to think about, and so avoided doing so, he said.

But they had to face up to it, and deserved the training to do so, because most general practitioners, owing to their close relationship with patient and family, were very well placed to render help.

GPs can make this period of a patient's life a highly meaningful and worthwhile experience, he said.

Another speaker, Dr. L. J. Arens of the Department of Paediatrics at the University of Cape Town, said that in South Africa, no medical examination of children up for adoption is required by law.

Yet the incidence of cerebral palsy — and probably that of other handicaps — is very high among such children, she said.

Dr. Arens is associated with a cerebral palsy school in the Cape.

Many South African adoptions are arranged through adoption societies. These do insist on a medical examination, she said.

"But they do not specify who should carry it out.

"It is surely unrealistic to expect a general practitioner to be able to identify early abnormalities in children. This requires a great deal of expertise," said Dr. Arens.

Among the measures she recommended was that adoption be delayed until the child was several months old.

Careful examinations during this period were necessary, because the baby could often pass through a period of apparent normality before defects showed up.

She also said, however, that all but the most severely handicapped children should, if possible, finally be placed with adoptive parents, with careful counselling and, if necessary, with the help of State subsidies.

Tell patients truth conference urged

DURBAN — Doctors must never be dishonest with patients who are suffering from a terminal illness — but they should not deprive them of hope either, Dr S. Levenstein, of the Cape Town College of Medicine of South Africa, said here yesterday.

Speaking at the 52nd congress of the Medical Association of South Africa, Dr Levenstein said a dying patient had a desperate need to communicate his feelings.

"But they don't want glib comments like 'Stop worrying' and 'You'll be all right'.

"Doctors must avoid meaningless reassurances," he said.

Speaking on the role of the general practitioner in the care of the dying patient and his family, Dr Levenstein said it was the practitioner's responsibility to alleviate suffering but not to attempt to prolong life unnecessarily.

It was imperative that doctors came to terms with their own anxieties about death before they could treat and help a dying patient, he said.

Earlier, Dr P. Kapapa, a clinical psychologist from Malawi, said that traditionally death was seen as selfish on the part of the dying person.

In his speech entitled "Death and punishment — the traditional view", Dr Kapapa said death remained a paradox.

In many African societies the death of a child was seen to be a greater punishment than the death of a parent who had several children. — SAPA.

Doctors in army liable

CAPE TOWN — Doctors serving with the South African Defence Force are still liable for a malpractice claim, according to an announcement in the latest issue of the SA Medical Journal.

This is the case even if the doctor is simply doing national service, says the journal, adding that the news was received in a directive from the Surgeon-General.

The directive says:

"In the case of a medical officer employed by, or rendering national service in, the SA Defence Force, the SADF will only accept liability where the action taken or service rendered was in the interest and or on behalf of the SADF." — DDC.

Nurses to stand in — prof

DURBAN — Most of the tasks at present performed by doctors could and would be done by trained nurses, the congress of the Medical Association of South Africa was told yesterday.

"Whole areas of this country are without any health care at all and we will never have enough doctors to fill these gaps," Professor T. L. Sarkin, Dean of the University of Natal Medical School, told the congress.

Doctors did not need to deal personally with every patient as they had done traditionally.

"Almost all routine health care can be handled by nurses. Doctors could then concentrate on the bigger aspects of the health scene." — SAPA.

Medical clash with Minister

CAPE TOWN — The Medical Association of South Africa has had "quite sharp" differences with the former Minister of Health, Dr Schalk van der Merwe, but this has never affected his relations with members of the association, says an editorial in the latest issue of the SA Medical Journal.

The chairman of the Association's federal council, Professor J. N. de Klerk, wrote that the change of Ministers with Dr L. Munnik taking over from Dr Van der Merwe had led to speculation about how it would affect the country's health service and medical profession.

The association looked forward to a happy relationship with the Department of Health under the guidance of Dr Munnik, he said. — SAPA.

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Disgraceful conduct: Three doctors guilty

By JANE ARBOUS

TWO Cape Town doctors and a Pretoria doctor were yesterday found guilty of disgraceful conduct by a disciplinary committee of the South African Medical and Dental Council.

Three more doctors will appear today before the committee, which is sitting in Cape Town.

The chairman of the committee, Professor H W Snyman, and his assessors, Professor Bromilow Bromilow-Downing and Professor A J Brink, recommended that the name of a Constantia doctor, Dr Frederick John Schofield, 58, be struck off the roll of medical practioners.

A former South African fighter pilot in World War II and subsequent prisoner-of-war in Germany, Dr Schofield was found guilty of disgraceful conduct after being convicted in 1977 of dealing in a dangerous, habit-forming drug, Mandrax, and procuring three abortions.

Mr R J Filmater, for the council, said Dr Schofield's offences had not been acts of compassion, but had been committed "solely and deliberately for gain".

Appearing for Dr Schofield, Dr W Cooper, SC, said in mitigation that Dr Schofield, who graduated from the University of Cape Town after matriculating at Rondebosch Boys' High School, had suffered enough for his transgressions.

Divorced, with three children, he had spent more than a year in prison after being convicted in 1977, and after he was unconditionally released earlier this year he took up a locum in Fraserberg.

A Ravensmead doctor, Dr S R Lynch, released from prison last month after serving nearly two years for five convictions of driving under the influence of liquor, admitted to the committee that he was an alcoholic. His driving licence has been permanently revoked.

To give him an opportunity to prove himself, the committee recommended that his name be erased from the register of medical practioners but that the penalty be suspended for five years, provided he was not found guilty of any misdemeanour by the council during that period.

The committee found too that it would be contrary to the public interest to allow Dr Lynch to practise without restrictions.

It recommended that he be placed under certain restrictions: that he work full-time in an institution approved by the council; that he be supervised and treated by a psychiatrist, Dr R Karelse, who would submit three-monthly reports to the council; and that he be forbidden to prescribe scheduled drugs Six and Seven.

Dr Lynch said in mitigation that he had turned to alcohol in an attempt to "drown his sorrows" while experiencing marital problems. His drinking had been confined to after-hours. After a lengthy period in jail, where he had been forced to give up alcohol, he now felt he could do without it and was eager to practise again as a doctor.

A young Pretoria doctor, Dr L R Odendaal, convicted in last October of dealing in a dangerous, habit-forming drug, Obex LA, told the committee that he had spent a year at the Pro-Tem Centre where he was treated for his addiction to the drug.

The committee recommended that his name be erased from the register for a year but that the penalty be suspended for three years, provided he was not found guilty of any misdemeanour during that period.

The committee recommended further that he practise full-time in a hospital under the supervision of the medical superintendent, that he be forbidden to prescribe the scheduled drugs Six and Seven, and that he continue treatment and that his psychiatrist send three-monthly reports on him

group could have hived off, and, each group had the potential to act as a nucleus for further expansion, the present model can account for divergen- lines of evolution within a tradition.

In the description of the two models used in the present study, it was pointed out that group fission could have resulted from two different processes: (1) social stress as a result of overcrowding, and (2) increased mortality and lowered reproductive fitness due to the scarcity of a particular resource. Group fission would appear to have been associated with social conflict fairly often (Legassick, 1969; Monnig, 1967; Turner, 1954). This association would suggest that social stress rather than resource scarcity determined when group fission occured. However, oral tradition cannot provide an accurate picture of the initial colonisation and an archaeological test between the

270 posts vacant

CAPE TOWN — More than 270 medical posts are vacant at Groote Schuur Hospital, according to an advertisement in the latest issue of the South African Medical Journal

The list, inserted by the hospitals department of the Provincial Administration of the Cape, includes three for Ciskey Hospital and one for the provincial hospital, Port Elizabeth.

Posts are available for 258 registrars. The remaining posts are for senior housemen. The registrars will be under contract for a year starting next February.

Candidates for posts as registrar must have had two years' experience after graduation and must register as post-graduate students at the University of Cape Town — DDC

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mechanism, by separating groups in space, would have promoted rapid differentiation of Early Iron Age pottery. Fission and movement have been associated with totem changes in Sotho groups (Legassick, 1969; Monnig, 1967). Totems indicate group membership, as do pottery styles, (Huffman, 1972; Schapiro, 1962) and totemic change may be paralleled by changes in pottery. If totemic change is used as a model, fission should be associated with a rapid change in pottery styles and not a gradual divergent evolution. This suggestion should also be tested against the archaeological record.

The analysis of the radiocarbon chronology indicated that the flutted and bevelled complex dispersed rapidly although individual cultures showed a slower rate of spread. A number of problems are associated with the analysis and the results cannot be used as an absolute confirmation of the validity of the discontinuous spread model.

The major problem with the radiocarbon chronology is the small sample size. Only four Silver Leaves sites have been dated and one of these Eiland is a specialized activity area (Evers, 1975). Kwale and Urewe have more dated sites but again samples are very small. In the discontinuous spread model it was suggested that the overall rate of spread would have been faster than the expansion of an individual culture. Therefore, the regression for the overall rate of spread was calculated from the earliest known dates for each culture and this reduced the sample size. It is possible that the sample sizes are so small that they do not reflect the real population of dates. Because of the sample size problem an independent evaluation of the two mechanisms of dispersal is necessary.

The data used in the present study were derived from only one tradition, the flutted and bevelled complex, and therefore the analysis would seem to be tied to the validity of a particular culture-historical reconstruction. While this is true, the rapidity of spread associated with the simulation of the discontinuous spread model would seem to indicate that this is the most likely mechanism of dispersal.

ACKNOWLEDGEMENTS

I would like to thank Professor T.N. Huffman for reading and commenting on the numerous drafts of the paper. Miss C.S. Harcourt helped edit the manuscript and Mrs J. Howard-Tripp typed the final drafts.

I would like to express my special thanks to Dr D.S. Wilson who introduced me to evolutionary ecology and helped to debug the programmes.

93

Are giant hospitals outdated?

A NUMBER of important new trends in medicine emerged during the congress of the Medical Association of South Africa, which ended in Durban last week.

Perhaps the most marked was the emphasis placed by many speakers on the idea that doctors should move out into the community rather than expect the community to come to them.

The Secretary for Health, opening the congress, sounded the first note on this theme, when he said that some doctors could not see any role for themselves in helping to formulate a comprehensive health plan for South Africa on a national basis.

They see themselves as totally committed to the cure of disease and the alleviation of pain.

But doctors are not only there to provide medical care. They have been trained to take responsibility for the total health care of people and communities.

General practice was described as being alive and well in South Africa. But it was pointed out that medical undergraduates in teaching hospitals see only the patients admitted. These represent only one percent of the country's sick, and so the GP-to-be gets little experience in typical illness patterns.

This is now being remedied at the University of Pretoria, with the introduction at undergraduate level of the study of family practice, with strong emphasis on practical work.

But it is disquieting to note that hospitals deal with only one percent of the country's sick. How many hundreds of millions of rands of scarce health resources have been spent on new hospitals such as Tygerberg in the Cape and the Johannesburg General in the past few years?

Several doctors expressed themselves privately as being dismayed with these huge new hospitals and described them as monuments to out-dated thinking. In view of the official emphasis on outgoing community health, it seems we may not see their likes again.

At the congress, several spoke out against the idea of keeping a body technically alive by means of aggressive medical means involving complex machines, after all hope of a meaningful life had departed. This thinking was well received and undoubtedly represented the feeling of the majority.

Last but not least, the sex therapy sessions drew large audiences during which frank questions and answers were exchanged. Clearly there was much interest on the part of GPs in becoming involved in such therapy.

As one doctor put it, it is heartening to know that this country is moving out of a Victorian age of closed curtains often masking deep personal unhappiness.

28/1/79 NM

U.S. men see 75 doctors

(93)

Mercury Correspondent

JOHANNESBURG — Two representatives of the world's largest hospital management company interviewed 75 Johannesburg doctors this week in a recruitment drive to place South African doctors in hospitals in the United States.

Mr. Jack Kennedy and Mr. Thomas Hayes of Hospital Affiliates International, based in Nashville, Tennessee, are on a special three-week visit to South Africa to recruit doctors for the company's 150 hospitals throughout the U.S.

The recruitment drive was prompted by the company's high regard for services provided by South African doctors presently working in its hospitals.

Yesterday Mr. Kennedy, director of public relations, said that he and Mr. Hayes had interviewed about 75 Johannesburg doctors.

They had received twice as many phone calls and would probably accept about a dozen applicants.

Today they will attempt to recruit Zimbabwe-Rhodesian doctors from their hotel room in Salisbury and will then spend next week in Cape Town and the following week in Durban.

Mr. Hayes said his company hoped to recruit about 20 top South African doctors to fill vacancies in hospital in the U.S. So far results had been encouraging.

SUNDAY EXPRESS July 29, 1979

AMERICAN RECRUITING TEAM ON 'POACHING' TRIP TO SOUTH AFRICA

ATTENTION PHYSICIANS
ARE YOU INTERESTED IN PRACTICING IN THE UNITED STATES?

● The tempting advertisement.

Sixty doctors answer US ad

By MARIAN SHINN

MORE than 60 Johannesburg doctors inquired this week about work in the United States — at a time when South Africa is short of doctors.

By the end of this coming week another 40 are expected to have consulted representatives of an American private hospital organisation who are recruiting doctors in Johannesburg, Cape Town and Durban.

Although there are indications that the medical brain drain from South Africa has slowed, statistics show that, proportionately, there are twice as many doctors in the United States as in South Africa.

The secretary-general of the Medical Association of South Africa, Dr Marais Viljoen, said the country's 15 000 registered doctors were spread thinly and statistics showed there was one doctor per 1 900 to 2 000 people. In the United States there was a doctor for every 700 to 800 people.

He said the association could do nothing to stop the overseas recruitment of doctors but he hoped doctors who graduated in South Africa would feel obliged to work in this country as the taxpayer had subsidised h[is] education.

He added that many South African doctors had gone overseas to gain experience. "Let's face it, the United States is the medical leader. I just hope they come back to share their experience."

The president of the South African Medical and Dental Council, Professor H W Snyman, was surprised to learn that local doctors were being recruited for the United States.

"My information is that there is an oversupply of doctors in the United States. Naturally one doesn't like this type of recruiting — I don't want to call it poaching — in our preserves. But there is nothing we can do about it.

"We must leave the doctors with the freedom to decide. We hope there is a sense of loyalty because the people of this country have contributed to the cost of their training."

Mr Jack Kennedy, Director of Public Relations for the US hospital group, said he doubted if more than 20 applications at the most would be successful

"If we get 10 South African doctors to the US, we will be ecstatic. Taking 10 doctors away from your 15 000 will hardly have an adverse affect on the health services of your country."

A director of the group, Mr Thomas Hayes, said South Africans already employed by the group had proved excellent doctors "and if there are others here like them, we would like to employ them".

He added that applicants would have to pass the Visa Qualifying Examination and the Federal Licensing Examination before application could be made through the group's immigration lawyers for them to enter the United States.

Mr Kennedy said they had not asked doctors their reasons for wanting to leave South Africa. "It's not really our business."

He added there had not been time to probe the doctors' backgrounds as "they were all wanting to ask us questions".

Mr Kennedy said most of the applicants were "family men" in the 23 to 58 age bracket.

He added that about 25% of the doctors who had seen either himself or Mr Hayes had already sat the Visa Qualifying Examination at the United States consular offices in Johannesburg.

"The clinical part of it presents no problems, because it just tests their ability as doctors. But the written scientific side of it is where many doctors, who have been practising for some time, fall down. That is no reflection on their abilities as doctors, but without it they could not pass the exam.

"We would like to get that part of the exam scrapped, as it does not really serve any purpose and many good doctors are stopped from coming to the United States because they cannot remember medical school chemistry — which most of them don't need to practise medicine."

● Mr Thomas Hayes ... we have some excellent South African doctors working for us.

Star 3/8/79 (93)

Doctors in south on strike against 'officialdom'

All doctors in the south of Portugal are on strike at hospitals, private clinics and nursing homes in protest against "obsolete officialdom" dogging their profession.

During the three-day strike, the doctors will only answer strict emergency calls.

★ ★ ★

Two Portuguese tourists have been injured in recent terrorist attacks in the Spanish capital of Madrid.

One of them is a 25-year-old woman who was hurt in a bomb blast at Atocha railway station and is in a serious condition in the local hospital. The other victim, a man, suffered minor injuries and has been released from hospital after treatment.

★ ★ ★

The value of the Portuguese escudo has dropped

PORTUGUESE NEWS

by nearly 48 percent since 1975.

It devalued at a global rate of 109,2 percent and its highest devaluation rate is 201,3 percent in relation to the Swiss franc.

★ ★ ★

A daring factory robbery at Setubal, south of Lisbon, has netted three robbers more than R300 000 in cash.

The men were masked and were armed with sawn-off shotguns, while they held up staff of the industrial complex of Portucel.

c) Ander lede:

Mnr K. Bosman	Mnr H.W. Middelmann
Professor A. Cupido	Eerw. M.T.L. Moletsane
Mnr N. Daniels	Professor A.D. Muller
Mnr Achmat Davids	Sheik A. Najaar
Professor R.J. Davies	Mnr Victor Norton
Professor J.J. Degenaar	Professor N.J.J. Olivier
Mnr René de Villiers	Mnr L. Phillips
	... Pollak

A. Mobiliteit en Politieke Verandering in Suid-Afrika

Hierdie projek is 'n paar jaar gelede aangepak. 'n Ondersoek onder die kleurling bevolking van die Kaapse Skiereiland is onderneem. 'n Aantal tydelike navorsings-

Friends (Quakers) en van die American Friends Service Committee deurgebring. Hy het 'n aantal konferensies in verskillende dele van die land bygewoon, baie vergaderings toegespreek en senior beamptes van die Carnegie Corporation, van Community Relations Services van die Departement van Justisie van die Amerikaanse regering, van die American Friends Service Committee en kollegas verbonde aan verskeie universiteite besoek.

Gedurende Augustus en September het die Direkteur Engeland, Nederland, Switzerland, Swede, Israel en Zambië besoek. Hy het vooraanstaande joernaliste, Suid-Afrikaanse diplomate, senior amptenare van die Suid-Afrika-Stigting en verskeie regerings betrokke by Suid-Afrikaanse belange ontmoet. Hy het besprekings gevoer met stigtings, trusts en opvoedkundige verenigings. As gevolg van sy besoek aan Nederland het hy 'n toelae vir die Konstruktiewe Program ontvang van die Algemeen Diakonaal Bureau van die Gereformeerde Kerken in Holland.

Professor J.L. Boshoff, ere-Fellow van die Konstruktiewe Program, het met 'n aantal instansies, wat universiteite in Natal en Transvaal insluit, en met verskeie handels- en industriële firmas in Natal, kontak opgebou.

(b) Konferensies

Gedurende 1978 het die Direkteur die volgende konferensies bygewoon:

Jaarlikse Konferensie, Nasionale Uitvoerende Komitee- en Raadsvergadering van die Suid-Afrikaanse Instituut vir Rasseverhoudinge, Kaapstad (Januarie).

Suid-Afrikaanse Jaarlikse Vergadering van die Religious Society of Friends, Stutterheim (April).

Negende Wêreldkongres van Sosiologie, Uppsala, Swede. Verhandeling voorgelê in Werkgroep 6 en vergaderings bygewoon van die Raad van die Internasionale Sosiologiese Vereniging as die amptelike afgevaardigde van Suid-Afrika (Augustus).

SP 5/8/79

Equal pay for doctors — 'a hoax'

By MANDLA NDLAZI

THE Transvaal Medical Society has dismissed pay equalisation for both black and white doctors as a "hoax".

Senior black doctors in hospitals received low wages as compared to whites again last month.

Secretary for Health Dr Johan de Beer announced in July when he opened the 52nd congress of the Medical Association of South Africa in Durban that all senior doctors in the public service would receive equal pay.

But this announcement was "yet another hoax", the Transvaal Medical Society said. "The so-called African doctors in senior categories have received the same discriminatory salaries again." The salaries are in keeping with the old scales published by the society.

Mr L Pienaar, private secretary to the Minister of Health, Mr Schalk van der Merwe, told SUNDAY POST yesterday there could have been an administrative error and this would be investigated.

In his announcement at the 52nd congress of Masa, Dr de Beer had said: "The Cabinet had recently reconsidered its previous policy regarding salaries and conditions of service for full time doctors.

"In future," he added, "all doctors in the grades of senior medical officer and higher, as well as all grades of specialists, will receive equal salaries irrespective of race or colour."

Biko: call for inquiry

JOHANNESBURG — The ombudsman's office of the South African Council of Churches has instructed its lawyers to call on the SA Medical and Dental Council to institute an inquiry into the conduct of three doctors who gave evidence at the Biko inquest.

Mr Eugene Roelofse said yesterday the recent out-of-court settlement between the state and dependants of Mr Steve Biko, the black consciousness leader who died in detention in September 1977, had cleared the last obstacle for the council to institute the inquiry.

"Our view is that there was no reason for the unprecedented delay in getting to grips with something which is so serious that it aroused unusual international interest," Mr Roelofse said.

The chairman of the council, Prof Hennie Snyman, said: "It's a matter for the council to decide on the procedure. I cannot say when they are going to do so."

Last week, Prof Snyman said the council was awaiting a reply by the doctors — Dr L. H. Lang, Dr B. J. Tucker and Dr C. Hersch — on the complaint made against them before it considered possible disciplinary action. — DDC.

Mennonite Central Committee se Konferensie oor: 'Die Rol van Geskiedkundige Vredeskerke', Gaborone, Botswana. Verhandeling voorgelê oor: 'The Role of Churches in Promoting Justice in Southern Africa' (Oktober).

Konferensie van die Afrikaanse Calvinistiese Beweging, Potchefstroom (Oktober)

(c) Deelname aan Welsyns- Professionele en Openbare Organisasies

Die Direkteur het aktief gebly in die Suid-Afrikaanse Instituut vir Rasse-Verhoudinge as 'n lid van die Wesk[illegible] Distrikskomitee, die Nasionale Uitvoerende Komitee en die Raad.

Hy is Voorsitter van die Quaker Service Fund in die K[illegible] die diensafdeling van die Godsdienstige Vriendekring (Quakers), wat gemeenskapsontwikkeling op die plattel[illegible] en in die stadsgebiede bevorder.

Die Direkteur is gekies as lid van die Raad van die Vereniging vir Sosiologie in Suidelike Afrika. Hy is ook 'n lid van die Suid-Afrikaanse Sosiologiese Vereniging en van die Internasionale Sosiologiese Vereniging. Hy is aangestel as die Suid-Afrikaanse afgevaardigde in die Raad van die Internasionale Sosiologiese Vereniging vir die tydperk 1978-1982.

WAARDERING EN DANK

Ek is altyd dankbaar vir die geleentheid wat die jaarverslag bied om my waardering te betuig aan lede van die Akademiese Advieskomitee en die Beheerraad vir hulle leiding, aanmoediging en belang in die aangeleenthede van die Sentrum.

Die Universiteit van Kaapstad het benewens 'n bydrae tot die bedryfskoste van die Sentrum, ook vir die Sentrum sedert sy stigting in kantoorruimte voorsien. Met die uitbreiding van personeel het ons die huisie op die laer

navorsings-Fellows het aansienlik tot die Sentrum se program bygedra: dr Sheila T. van der Horst, afgetrede mede-professor van Ekonomie, U.K., en professor J.L. Boshoff, gewese Rektor van die Universiteit van die Noorde.

LIDMAATSKAP

Professor E.V. Axelson
Professor J.F. Beekman
Professor J.F. Brock
Mnr C.S. Corder*
Professor W.H.B. Dean
Dr J.P. Duminy*
Professor G.F.R. Ellis
Biskop A.W. Habelgaarn
Mnr E.V.E. Howes*
Professor M.F.Kaplan
Ds. W.A. Landman
Mnr G.K. Lindsay
Sir Richard Luyt
Professor S.J. Saunders
Professor H.W. van der Merwe
Mede-professor D.J. Welsh
Professor Monica Wilson

c) Ander lede:

Mnr K. Bosman	Mnr H.W. Middelmann
Professor A. Cupido	Eerw. M.T.L. Moletsane
Mnr N. Daniels	Professor A.D. Muller
Mnr Achmat Davids	Sheik A. Najaar
Professor R.J. Davies	Mnr Victor Norton
Professor J.J. Degenaar	Professor N.J.J. Olivier
Mnr René de Villiers	Mnr L. Phillips
Dr I.D. du Plessis	Professor H.P. Pollak
Professor J.J.F. Durand	Mnr W.J. September
Professor J.B. du Toit	Mnr Franklin Sonn
Mnr A. Flederman	Mnr P.M. Sonn
Professor R.F. Fuggle	Regter J.H. Steyn
Mnr G.J. Gerwel	Mnr R. Tobias
Eerw. D. Guma	Professor R.E. van der Ross
Professor A. Paul Hare	Professor J.H. van Rooyen
Dr Gertrud Heydorn	Mev. S. Walters
Mnr F.A. Jacobs	Professor F.A.H. Wilson
Mnr H.M. Jimba	

d) Twee Ere-Fellows:

Professor J.L. Boshoff
Dr Sheila T. van der Horst

Lede word na die Algemene Jaarvergadering van die Maatskappy uitgenooi en kies elke drie jaar 'n verteenwoordiger op die Beheerraad. 'n Verkiesing is in 1978 gehou en die huidige ampsdraer is Biskop A.W. Habelgaarn. Terwyl geen verpligtinge aan lede opgelê word nie, word hulle geraadpleeg in verband met sake wat die Sentrum se program raak.

NAVORSING

Gedurende die verslagjaar het die navorsing van die Sentrum die volgende behels:

A. Mobiliteit en Politieke Verandering in Suid-Afrika

Hierdie projek is 'n paar jaar gelede aangepak. 'n Ondersoek onder die kleurling bevolking van die Kaapse Skiereiland is onderneem. 'n Aantal tydelike navorsings-

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DAILY DISPATCH, TUESDAY, AUGUST 21, 1979 — 11

Doctor, dentist fees to go up

JOHANNESBURG — Medical and dental costs in South Africa could rocket if the South African Medical and Dental Council allows tariff increases at a meeting next week.

Last night the vice-president of the Dental Association of South Africa said he would not be surprised if tariffs increased by as much as 33 per cent. For many years statutory fees laid down for dentists had not kept pace with the increase in the cost of living, he said.

A spokesman for the Medical Association said doctors' tariffs would also probably go up as present tariffs had been static for five years.

A substantial increase could result in a massive comeback of doctors who have contracted out of the Medical Schemes Act.

The probable increases will come hard on the heels of the shock regulations in last week's Government Gazette authorising an 80 per cent increase in dispensing fees for pharmacists. — DDC.

Khama in hospital

GABORONE — The President of Botswana, Sir Seretse Khama, has been admitted to hospital in Molepolole for a routine checkup, it was announced here yesterday. — SAPA.

[illegible] afgevaardigde van Suid-Afrika (Augustus).

Indian doctors to vacate surgeries

22/8/77 Post

EVATON Indian doctors have ben issued with notices to vacate their present surgeries as they do not conform to the building regulations of the Evaton Community Council.

A deputation has been sent to the chairman of the Community Council, Mr Samuel Rabotapi, on the issue. Yesterday Mr Rabotapi confirmed that a delegation of doctors has seen him.

Dr A R Tayob, who is practising in the township, confirmed that the notices have been received by some doctors. They were to move out of their surgeries on August 20.

He said they were still waiting for the word from the council.

Dr Tayob said they expected a reprieve and hoped they would be allowed to build better surgeries.

Mr John Knoetze, the chief director of the Orange-Vaal Administration Board, said yesterday the notices were issued on the authority of the Evaton Community Council early this month.

JAARVERSLAG

1978

SENTRUM VIR INTERGROEPSTUDIES

(Geregistreer as The Abe Bailey Institute of Inter-Racial Studies Limited (Beperk deur Garansie))

Posadres:
p/a Die Universiteit van Kaapstad
Rondebosch
Republiek van Suid-Afrika
7700

Kantooradres:
Leslie Social Sciences Building
University Avenue
Groote Schuur Campus

Telefoon: 65-4145; 69-8531 Uitb. 766

INLEIDING

Gedurende die eerste nege jaar van sy bestaan het die Sentrum vir Intergroepstudies gereeld 'n jaarverslag oor sy werksaamhede gepubliseer. Om die Sentrum se 10de verjaarsdag op 1 April 1978 te vier is die jaarverslag in 1977 vervang deur 'n Oorsig oor die Eerste Tien Jaar.

DIE OORSPRONG EN DOELSTELLINGS VAN DIE SENTRUM

Die Sentrum word grootliks gefinansier deur die Abe Bailey-Trust wat ingevolge die testament van Sir Abe Bailey gestig is. Dit is geregistreer as The Abe Bailey Institute of Inter-Racial Studies Limited (Beperk deur Garansie) - 'n maatskappy beperk deur garansie en sonder 'n aandele-kapitaal kragtens die Maatskappywet 1973 (Wet Nr. 61 van 1973).

POST
TRANSVAAL

Telephone 27-6081

Scandal of little faith

THE explanation by Dr A F Chemaly, superintendent of Natalspruit hospital, that all staff members of the hospital are subjected to body searches because this is in the hospital regulations, is just not good enough.

To subject nurses to this kind of searching is nothing short of scandalous, and the good doctor should know that.

With the greatest respect to Dr Chemaly's veracity, we doubt that any white employee, at any firm, let alone hospital white staff, would take kindly to have themselves searched in this fashion.

It is a shame that any employer should have such little faith in the honesty of his employees to have them subjected to such intimate searches.

The point is that nobody likes to be searched bodily unless this is done by policemen or law-enforcing agents, who might suspect that a crime has been committed.

As soon as people are made to strip, not only their bags, but their persons, then there must be something wrong in the whole administration.

We are equally surprised to learn, the practice of searching nurses and other hospital staff is in the regulations. The surprise is even greater because we were alerted by the very people who should know the regulations, about the indignities they say are inflicted on them. Why, if they knew the regulations, did they have to make such a hue and cry about them.

In any event, regulations or no regulations, we feel highly insulted that nurses have to be jumped upon and searched at the drop of a hat. This thing, we feel very strongly, must be brought to an immediate halt.

Searches are routine, says hospital head

THE superintendent of Natalspruit Hospital, Dr A F Chemaly, said yesterday that the searching of nurses at the hospital was routine and was gazetted in the Hospitals Service Regulations.

Dr Chemaly was reacting to a story which appeared in POST on August 8.

Nursing sisters at the hospital claimed they were ushered into a new block where they were searched by a security officer. They were bodily searched by a woman guard and contents of their bags emptied.

By PAULINE BUTHELEZI

The nurses also claimed that they were made to sign a register when they drove into the hospital grounds whereas whites were not.

"It is true that we search the nurses. But, I would like to make this clear that this we do because it is routine and that this has been gazetted with the Hospitals Services Regulations," Dr Chemaly said.

"This is not done everyday but is done on certain days. The spot checks are conducted at the two main gates of the hospital — the Eastern and Western gates.

"The nurses are searched by a woman security guard and the male staff by a male security officer." Dr Chemaly said.

EVERYBODY

Dr Chemaly said this was not done only to the black staff but even whites are searched.

"A week or two before the black staff was searched, the whites were searched at the western gate. I was also searched. This does not mean that only nurses are searched, but everybody working in the hospital is," Dr Chemaly said.

Dr Chemaly said the searches were only con-

Dr Chemaly said the searches were only con-ducted when it was found there is a great loss of the hospital's equipment when the inventory is checked.

"I met the delegation of the nurses and it was resolved that when the nurses were searched, a matron or a senior sister should be present to attend to their complaints," he said.

Dr Chemaly said it was true that the nurses are made to sign a register when they drive into the hospital grounds.

"Only matrons and senior sisters are allowed in without signing the register. We cannot allow everybody to enter the hospital grounds. With the white staff, they are small in number, mostly doctors and they too, sign the register at night only," he said.

SEPARATE

On the issue of black and white doctors having to use separate dining rooms while working together on the wards, Dr Chemaly said this was due to lack of space.

gether on the wards, Dr Chemaly said this was due to lack of space.

"They are allowed to eat wherever they want to. The dining rooms were planned at that time for different racial groups, but that time has long passed and we no longer practice apartheid," he said.

He said he had met a delegation from the nurses over the food issue. Scores of black nurses were boycotting the hospital food claiming it was badly cooked.

He said everything was solved and back to normal. He further said there was a specially employed dietician who looked after food.

"If the nurses have any complaints, my doors are open for dialogue," he said.

On the issue of overcrowding, Dr Chemaly said the hospital is overcrowded.

"The reason is that at the moment, the hospital is being renovated. This means that we have to vacate a ward at a time. Ward one to 12 will be renovated by the end of this year and the rest will be done next year.

"We have lots of demands from outside hospitals wanting to send their patients to our hospitals, but now we have reached a stage where we cannot cope," Dr Chemaly said.

Dr Chemaly . . . "Searching for nurses is a routine work."

Star 27/8/79 (93)

Doctors' charges may rise by third

Doctors' fees are expected to rise by more than a third if recommendations by the Tarriff Committee of the South African Medical and Dental Council are adopted.

This means medical aid schemes could pay out R68,18-million to doctors.

The Tariff Committee, at its meeting in the new Johannesburg Hospital today, said that if the patients' share is added, the amount will be R76-million.

MEDICAL AID

Each of South Africa's 1 578 897 medical aid society members will have to pay R43 a year more.

The chairman's report at today's meeting said this amount would "probably be contributed on a 50-50 basis by employer and employee, with a member's contribution being about R21."

In a 60-page report, the Tariff Committee said: "The total pay-out of all medical schemes to doctors in 1977 was R121,5-million."

General practitioners' consultation fees will rise from R4,40 to R6,60, anaesthetic fees will rise to R15,40, gynaecologists' fees to R15,40, and physicians' fees to R23,10.

The report says "the reason why such large increases were necessary was because of the "accumulative shortfall which doctors have experienced over the last 10 years."

"While the consumer price index has increased by 168 percent, statutory tariffs have increased by only 58 percent.

"It is not an 'agterskot' pay-out for what has been lost over the years.

"An adjustment of the same magnitude should not be necessary in the foreseeable future, but in view of rapidly changing economic circumstances, the committee feels the tariffs should be revised at least annually," the report said.

The committee is expected to announce the new tariff rates later today or tomorrow.

ɹr H.W. Middelmann
ɪrw. M.T.L. Moletsane
ofessor A.D. Muller
ɪeik A. Najaar
ɪr Victor Norton
rofessor N.J.J. Olivier
nr L. Phillips
rofessor H.P. Pollak
Mnr W.J. September
Mnr Franklin Sonn
Mnr P.M. Sonn
Regter J.H. Steyn
Mnr R. Tobias
Professor R.E. van der Ross
Professor J.H. van Rooyen
Mev. S. Walters
Professor F.A.H. Wilson

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e jaar 'n verteenwoordiger
is in 1978 gehou en die

Friends (Quakers) en van die American Friends Service Committee deurgebring. Hy het 'n aantal konferensies in verskillende dele van die land bygewoon, baie vergaderings toegespreek en senior beamptes van die Carnegie Corporation, van Community Relations Services van die Departement van Justisie van die Amerikaanse regering, van die American Friends Service Committee en kollegas verbonde aan verskeie universiteite besoek.

Gedurende Augustus en September het die Direkteur Engeland, Nederland, Switzerland, Swede, Israel en Zambië besoek. Hy het vooraanstaande joernaliste, Suid-Afrikaanse diplomate, senior amptenare van die Suid-Afrika-Stigting en verskeie regerings betrokke by Suid-Afrikaanse belange ontmoet. Hy het besprekings gevoer met stigtings, trusts en opvoedkundige verenigings. As gevolg van sy besoek aan Nederland het hy 'n toelae vir die Konstruktiewe Program ontvang van die Algemeen Diakonaal Bureau van die Gereformeerde Kerken in Holland.

Professor J.L. Boshoff, ere-Fellow van die Konstruktiewe Program, het met 'n aantal instansies, wat universiteite in Natal en Transvaal insluit, en met verskeie handels- en industriële firmas in Natal, kontak opgebou.

(b) Konferensies

Gedurende 1978 het die Direkteur die volgende konferensies bygewoon:

Jaarlikse Konferensie, Nasionale Uitvoerende Komitee- en Raadsvergadering van die Suid-Afrikaanse Instituut vir Rasseverhoudinge, Kaapstad (Januarie).

Suid-Afrikaanse Jaarlikse Vergadering van die Religious Society of Friends, Stutterheim (April).

Negende Wêreldkongres van Sosiologie, Uppsala, Swede. Verhandeling voorgelê in Werkgroep 6 en vergaderings bygewoon van die Raad van die Internasionale Sosiologiese Vereniging as die amptelike afgevaardigde van Suid-Afrika (Augustus).

Doctors' fees to rocket by 50pc

NM 21/8/79 (93)

Mercury Correspondent

JOHANNESBURG — Massive increases in doctors' and dentists' fees were announced yesterday.

Hard-hit South Africans will have to pay a shock overall increase of 52,4 percent in doctors' fees and 33,3 percent in dentists' fees from November 1.

They were granted by the Medical and Dental Council at a meeting in Johannesburg yesterday, after two days of gruelling discussions.

The Secretary of Health, Dr. J. de Heer, said they were the largest ever granted by the council.

Medical aid

The increases mean:

- Doctors will be paid R68 million more by medical aid schemes. If the patients' share of the account is added, the doctors will receive about R76 million more a year.
- South Africa's 1 578 897 members of medical aid schemes will have to pay an average of nearly R7 more a month on subscription fees;
- Each doctor will collect an estimated R12 436 more a year from medical aid societies.

The new minimum statutory fees mean that:

- The family doctors consultation fee will rise from R4 to R6,60 and a specialist's consultation fee from R16 to R23,10;
- A doctor's visit to a private home, hospital or nursing home will increase from R6,88 to R13,20;
- An adult tonsillectomy performed by surgeon will increase from R38,50 to R52,80;
- Removal of the appendix by a surgeon will increase from R72 to R99.

That is expected today.

The national president of the Housewives' League, Mrs. Joy Hurwitz, said last night: "This is an extremely hard blow for the consumer, who cannot dictate whether he falls ill or not."

Dr. Fred Clarke, MPC for Umhlanga, said last night he was "delighted" with the news.

"For some time it has been hardly economic to run a private practice," he said.

The council defended its decision to grant the increases by accepting a submission from the Medical Association that the costs of running a medical practice had escalated while statutory tariffs did not compensate doctors for the general increase in the cost of living.

The 60-page report submitted to the council stated: "It is clear that the financial position of doctors has, over the past few years, lagged behind the consumer price index and inflation rate."

The 64,6 percent increase in statutory tariffs granted to general practitioners is seen as a move to narrow the gap between statutory and private tariffs.

Shortfall

Contracted-out doctors charge an average 19 percent more than the fees laid down in the statutory tariff.

The tariff committee conceded that while the increase was large it had become necessary because of a cumulative shortfall which doctors had experienced over the past 10 years.

The Representative Association of Medical Schemes said in objection that such huge increases could never be justified to the man-in-the-street.

A Mercury reporter writes that Dr. M. B. Asherson, president of the Medical Association, last night refused to comment.

"It was decided at an executive meeting of the Federal Council on Friday that no comment was to be made on the matter until the Secretary-General, Dr. Marais Viljoen, had made an official statement."

The Natal Mercury

THURSDAY, AUGUST 30, 1979

PAIN IN THE POCKET

IN THESE inflationary times doctors and dentists are as much entitled as anyone else to regular increments to enable them to meet the rising costs of running a practice and maintain a standard of living befitting their profession.

Most reasonable people do not resent the fact that doctors are among the more visibly affluent members of society, and would agree that their skilled services, the responsibility they bear, their arduous training, relatively short peak earning period, and the need to provide for retirement all entitle them to substantial rewards.

But having dismissed the sort of carping knee-jerk criticism that is usually evoked by increases in medical fees, one must go on to question whether the latest round of massive increases, the largest ever granted, are really justified or are in keeping with the anti-inflationary restraint urged by the Government and the sense of responsibility one expects from professional people in this regard.

With the inflation rate now running near 13 percent (after a sharp and recent increase), the figures granted by the Medical and Dental Council on Tuesday would look more at home on a list of militant trade union demands. General practitioners will get 64,45 percent more and dentists 33,2 percent, while with adjustments in tariffs for various other branches of medicine the overall increase is calculated at 52,45 percent. The last increase in doctors' fees was four years ago. Dentists had an average increase of 23 percent in February 1978, and before that in November 1974.

The steepness of the increases will seem excessive to many. They are expected to add up to R100-million a year to medical aid fund bills, which would mean some R7 a month more on the average subscription paid by South Africa's 1 578 000 fund members.

Certainly some further explanation is required of what went on at the two-day session of the Medical and Dental Council.

When the Council met last April a proposal for an interim 25-percent increase in fees (based on inflation since the previous tariff increase) was withdrawn on threat of legal action by the Representative Association of Medical Aid Schemes, which said that the proposed increase would have "the gravest economic impact" on the public.

It would be enlightening to know how a 25-percent increase apparently considered adequate in April comes to be more than doubled only four months later.

The Medical Council should heed the advice of the Minister of Health, Dr. Munnik, to reconsider its position.

The Star
Thursday August 30 1979

(93)

Take a deep breath —and say 'ouch'

THE new medical aid tariff, representing an overall increase of more than 50 percent in doctors' fees, has come as a profound shock. Even taking into account the effects of inflation and the long period that has elapsed since an increase was last sanctioned, an extra R1 000 a month to the individual doctor's income seems breathtaking. Coupled with the recent increase in the dispensing fee charged by pharmacists, the public may have to dig deeply into its already frayed pocket to meet the increased medical aid subscriptions which are bound to follow.

The doctors had a good case for an increase, but to justify an increase of this magnitude is another matter. The Secretary for Health, Dr Johan de Beer, the medical movement and consumer bodies certainly do not think doctors are justified.

The old system of remuneration commissions presided over by a judge was a failure. The new —that of leaving it to the doctors themselves to decide on their fee structure through the Medical and Dental Council— may be heading the same way. The Minister of Health, Dr Munnik, agrees and intends taking a close look at the issue. The sooner he does so the better for the health of the country.

Where does it leave the patient? At this stage he should not be too pessimistic about the future.

People who are not covered by medical aid are no worse off than before—unless doctors regard the new tariff as an excuse to put up their private fees which are already well above those laid down in the tariff. They should heed the advice of their professional association and act responsibly and in accordance with their patients' means.

The new tariff could actually have an unexpected benefit for the medical aid patient unlucky enough to have to consult a contracted-out doctor who is not obliged to charge the tariff. The gap between fees charged under the tariff and those currently charged by these doctors has now been narrowed significantly. The individual patient would thus have to pay less out of his own pocket.

'n aandele-kapitaal kragtens die Maatskappywet 1973 (Wet Nr. 61 van 1973).

c) Ander lede:

Mnr K. Bosman	Mnr H.W. Middelmann
Professor A. Cupido	Eerw. M.T.L. Moletsane
Mnr N. Daniels	Professor A.D. Muller
Mnr Achmat Davids	Sheik A. Najaar
Professor R.J. Davies	Mnr Victor Norton
Professor J.J. Degenaar	Professor N.J.J. Olivier
Mnr René de Villiers	Mnr L. Phillips
Dr I.D. du Plessis	Professor H.P. Pollak
Professor J.J.F. Durand	Mnr W.J. September
Professor J.B. du Toit	Mnr Franklin Sonn
Mnr A. Flederman	Mnr P.M. Sonn
Professor R.F. Fuggle	Regter J.H. Steyn
Mnr G.J. Gerwel	Mnr R. Tobias
Eerw. D. Guma	Professor R.E. van der Ross
Professor A. Paul Hare	Professor J.H. van Rooyen
Dr Gertrud Heydorn	Mev. S. Walters
Mnr F.A. Jacobs	Professor F.A.H. Wilson
Mnr H.M. Jimba	

d) Twee Ere-Fellows:

Professor J.L. Boshoff
Dr Sheila T. van der Horst

Lede word na die Algemene Jaarvergadering van die Maatskappy uitgenooi en kies elke drie jaar 'n verteenwoordiger op die Beheerraad. 'n Verkiesing is in 1978 gehou en die huidige ampsdraer is Biskop A.W. Habelgaarn. Terwyl geen verpligtinge aan lede opgelê word nie, word hulle geraadpleeg in verband met sake wat die Sentrum se program raak.

NAVORSING

Gedurende die verslagjaar het die navorsing van die Sentrum die volgende behels:

A. Mobiliteit en Politieke Verandering in Suid-Afrika

Hierdie projek is 'n paar jaar gelede aangepak. 'n Ondersoek onder die kleurling bevolking van die Kaapse Skiereiland is onderneem. 'n Aantal tydelike navorsings-

Friends (Quakers) en van die American Friends Service Committee deurgebring. Hy het 'n aantal konferensies in verskillende dele van die land bygewoon, baie vergader- ... toegespreek en ... beamptes van die Carnegie

30/8/79

(93) bot

Equal pay for doctors

SALARIES of white and black doctors in full-time Government or provincial employ should soon be equal.

The Secretary of Health, Dr Johan de Beer, said today that the Treasury and the Public Service Commission had officially approved the new deal for black doctors which he announced at the congress of the Medical Association last month.

All categories of medical staff are included in the scheme except for the grade of medical officer which will be considered at a later stage.

The problem was that computers had to be reprogrammed and other machinery set in motion before the changes could be implemented, Dr de Beer said.

It was inevitable that the administrative process would take some time, but no one would lose out as the increases would be dated to April 1.

... Society of Friends, Stutterheim (April).

Negende Wêreldkongres van Sosiologie, Uppsala, Swede. Verhandeling voorgelê in Werkgroep 6 en vergaderings bygewoon van die Raad van die Internasionale Sosiologiese Vereniging as die amptelike afgevaardigde van Suid-Afrika (Augustus).

Think again, Munnik tells doctors

NM 30/5/79

(93)

PRETORIA — The Minister of Health, Dr. L. A. P. A. Munnik, announced yesterday he intended asking the South African Medical and Dental Council to reconsider the tariff increases it announced on Tuesday.

He said he would do so before November 1 — the date on which the higher tariffs are due to go into effect.

Dr. Munnik said he had already made arrangements for a meeting with the Medical and Dental Council, the South African Medical Association, the Representative Association of Medical Schemes and representatives of all bodies concerned with the setting of fees for medical and health services.

A statement from Dr. Munnik said:

"With reference to the announcement by the Medical and Dental Council on the increase of medical and dental tariffs which will be applicable to members of medical schemes, I would like to state clearly that the council's decisions should be in the interests of the two professions concerned, but particularly in the general interest of the country.

"The authority vested in the council however, does not absolve me or the Government from the responsibility of ensuring that the best interests of the public and the country are served.

"In terms of legislation I, as Minister of Health, have no authority or power to change or amend any decision taken by the council.

"Mindful, however, of the government's responsibility to the public, the present legislation shall be considered carefully.

"I intend to meet the Medical and Dental Council, the Medical Association, the Association of Medical Aid Schemes and the Pharmaceutical Council for thorough discussion on the whole question of health costs and subsequent implications to the public.

"My future response will be determined by these discussions." — (Sapa.)

Die hoofdoel van die Sentrum is om navorsing na die onderlinge groepsverhoudinge in Suid-Afrika te bevorder en te lei, in die besonder oor verhoudinge tussen rasse- en taalgroepe.

AKADEMIESE ADVIESKOMITEE EN RAAD VAN BEHEER

Die program van die Sentrum staan onder die toesig van 'n Akademiese Advieskomitee wat in 1978 bestaan het uit die Direkteur (Voorsitter), die Prinsipaal van die Universiteit van Kaapstad, Sir Richard Luyt, die Adjunk-Prinsipaal, professor M.F. Kaplan, professor W.H.B. Dean, professor G.F.R. Ellis en mede-prof...

New deal for black doctors in works

Science Editor

Parity between the salaries of white and black doctors in full-time government or provincial employ should soon be a reality.

The Secretary for Health, Dr Johan de Beer, said today that both the Treasury and the Public Service Commission had now officially approved of the new deal for black doctors which he announced at the congress of the Medical Association last month.

All categories of medical staff are included in the scheme except for the grade of medical officer which will be considered at a later stage.

The problem was that computers had to be reprogrammed and other machinery set in motion before the changes could be made, Dr De Beer said.

It was inevitable that the administrative process would take some time, but no one would lose out as the increases would be backdated to April 1.

...raad van beheer.

PERSONEEL

Die vaste personeel bestaan uit die Direkteur, professor Hendrik W. van der Merwe, M.A. (Stellenbosch), Ph.D. (Kalifornië), die Administratiewe Assistente, mev. H. Albertyn en 'n deeltydse sekretaresse, mev. B.J. Chapman.

Gedurende die jaar is mejj. Morna Cornell en Ruth Rutherford as tydelike klerklike assistente en mej. Judith Cornell, B.A. (Universiteit van Kaapstad) as deeltydse navorsingsassistente in diens geneem. Twee ere-

kampus, waar ons gedurende die laaste vyf jaar gehuisves was, ontgroei. Daarom is ek besonder dankbaar vir die ekstra ruimte wat ons nuwe kantoor in die Leslie Social Sciences Building op die Groote Schuur Campus aanbied.

Ek wil weereens die Carnegie Corporation en die Algemeen Diakonaal Bureau van die Gereformeerde Kerken van Nederland bedank vir hulle gulle ondersteuning van die Konstruktiewe Program wat ons in staat gestel het om meer personeel aan te stel en om publikasies en werkgroepe te finansier. Ek wil ook graag weereens die ondersteuning deur plaaslike skenkers, firmas en trusts noem, kort nadat die Program gestig is. Hulle hulp het dit moontlik gemaak om etlike publikasies gratis te versprei onder almal wat in die bevordering van 'n oop samelewing belangstel.

Ten slotte is dit met innige genoeë dat ek my verpligtings teenoor die ere-navorsingsbeamptes van die Sentrum vir hulle bydraes tot die navorsingsprogram, boekstaaf en teenoor die personeel vir die wyse waarop hulle hulle pligte gedurende die jaar uitgevoer het.

Hendrik W. van der Merwe
Direkteur

Desember 1978

MEDICAL FEES

Contagious increases

Medical Aid societies will not be able to absorb the hikes in doctors' and dentists' fees announced on Tuesday. But they may not have to. Minister of Health Lapa Munnik intends asking the SA Medical and Dental Council to reconsider the tariff increases. Indeed, the government is furious that the doctors and dentists did not tell it about their intentions in advance. Most societies are operating close to the bone. Medschemes Administrators researched fourteen major medical aid schemes last year and found that only six of them were profitable. Their surpluses totalled R950 000, an average of a meagre 1,7% of contributions. The remaining eight lost R1,37m, which was over 5% of income.

Says Medschemes MD, Keith Hollis, "Many schemes have been holding back on necessary contribution increases in anticipation of this one."

Rough calculations indicate that the fees hike will mean a cost increase of 25% to medical aid societies. Typically, around 16% of their payments go to GP's, and 22% to specialists. Hence a sizeable chunk of societies' outlays will jump by the 52,4% increase in doctors' fees. Dental bills account for roughly 14,5% of societies' costs and dentists will charge 33,3% more from November 1.

The average white family breadwinner pays R38-R40 per month in medical aid subscriptions. Half of this is generally borne by the employer. Thus each family will face an increase of around R4,75 per month. Employers will have to cough up a similar amount.

While whites will feel the pinch, blacks are dealt an even harder blow. Between 70% and 80% of black medical aid societies' payments are accounted for by GP and specialist bills. Hence they face an increase in costs of roughly 40%. Says Hollis: "We have been trying to encourage more broadly-based medical aid schemes. The latest hikes will certainly have a greater impact on blacks, and set back expansion prospects."

At the time of going to press, the Representative Association of Medical Schemes was considering fundamental changes to SA's medical aid system. A number of societies are believed to be proposing radical reforms.

Needless to say, doctors feel that the increases in their fees are fully justified. They point out that fees have not kept pace with the rise in the cost of living and the costs of running a medical practice. Says one Johannesburg doctor: "The increases are definitely needed. Those of us who have contracted-out of medical aid schemes may now consider returning."

But there are other aspects to the latest increases. Consumers have little choice but to accept doctors' and dentists' treatment at prescribed rates. And research in the US has shown that medical practitioners, like sellers of any other price-controlled product charge the maximum fees allowed.

DAVID BOURNE

Paying more for the pain

93 ~~128~~

The Cape Times, Tuesday, September 4, 1979

Doctors want 'reasonable and just' rise

By BOB MOLLOY

SOUTH AFRICANS spend three times as much on alcohol and twice as much on tobacco as they do on medical bills, according to a supplement to the latest issue of the SA Medical Journal, which criticizes the press for "speculation, ignorance and slanted truths" regarding medical tariffs.

The Medical Association news supplement, after outlining the history of medical tariffs since the first preferential tariff was introduced during the depression years, said medical practitioners rendered a necessary service to the community and so were entitled to "a reasonable and just level of remuneration".

It pointed out that in 1974 and 1977 the statutory tariff was increased by an average of 20 percent and nine percent respectively. The association calculated that practice costs had increased by an average of 51 percent during the same period.

The newsletter also claimed that the consumer price index rose by 75 percent from 1974 to 1979.

"From these statistics it is clear that the adjustment in gross income was totally inadequate to cover increases in practice costs and the cost of living for the doctor."

According to a survey of highly-qualified whites, a relative deterioration in the income structure of medical practitioners as compared with other professions had become evident in recent years, the newsletter said.

It warned that the "slow and dawdling adjustment of the income situation of the doctor may result in long-term movements within professional groups and/or manpower groups across national borders".

The effect of the ability of the community to pay for medical services was demonstrated by the fact that, according to the Reserve Bank, the remuneration of employees and available personal income had increased by 66 percent and 60 percent respectively from 1974 to 1978.

Total expenditure on medical services in the Republic was 1,5 percent of the gross national product, compared with more than five percent for alcohol and more than 2,5 percent for tobacco.

"The effect of the increase (52 percent) in the tariff of fees on the inflation rate would be minimal if it were borne in mind that in the official consumer price index a weight of 0,57 is allocated to doctors' fees, while the inflation impact of alcoholic beverages (2,08), tobacco (1,69), recreation and amusement (3,08) is much stronger," the article said.

It ended with an appeal to the community to "realize that the rendering of extensive and efficient medical services should be a prime priority, and it necessitates that the medical profession should not be hampered by economic factors in any way."

Threat to control medical fees

Argus 6/9/79 (93)

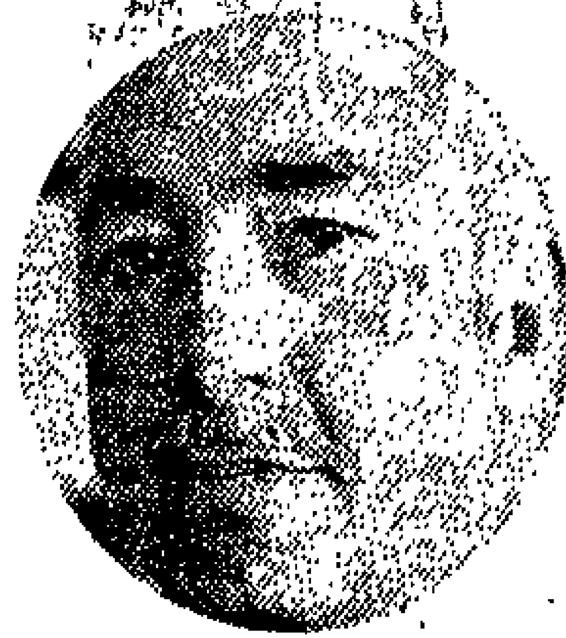
Political Staff

BLOEMFONTEIN. — Legislation to bring medical fees under Government control and steps to solve the problem of wholesale contracting out of medical schemes by doctors were threatened by the Minister of Health, Dr L A P A Munnik, last night.

Dr Munnik said there was a shortcoming in the Medical Schemes Act which prevented the Minister of Health from having a say in the determination of fees.

He told the Free State congress of the National Party that the final say in fees should be brought back to the Minister who was responsible to the Cabinet.

He was seeing representatives of the Medical Council, the Dental Council, the Association of Medical Schemes and the Pharmacy Board on September 10, 11 and 12, about the latest 52 percent increase in fees and if there was no agreement he would have to introduce legislation next year.



Dr L A P A Munnik

He hoped the bodies would be reasonable and that there would be no cause to introduce legislation. He believed that he would be dealing with reasonable people.

He would also discuss in due course the question of doctors contracting in and out of medical schemes. He hoped that it would be possible to get back to the system of a maximum fee which doctors could charge medical aid patients.

At their discretion doctors could charge affluent patients more than the less affluent. The proportion of the fee paid by medical aid would be less for the affluent than for others.

Fair fee

The doctor could not be seen as separate to the structure of medical costs. It was the Governments' responsibility to see that inflation did not get out of hand and also that doctors should get a fair fee.

Although the Medical Association and the doctor ... able fees, he did not regard the 52 percent increase as justified. The Government could not dodge its responsibilities when costs got out of hand.

It was perhaps time that a thorough study was made by experts in economics to establish how unco-ordinated medical fee increases affected the medical costs structure.

Police College 'half full'

Political Staff

BLOEMFONTEIN. — The Police College in Pretoria is half full, the Minister of Police, Mr Louis le Grange said yesterday.

Answering a question from the floor at the Free State National Party Congress here, the Minister said: 'No, it is not and it gives us cause for concern. It ought to be full.

'We have had shortages of students before and also in years past, too many applications. We are carrying out a recruiting campaign and next year we should have full enrolment.'

The Minister claimed the shortage of students had nothing to do with police pay although this was a factor.

He said the Government was working on the elimination of imbalances in salary scales and the low pay ceilings of certain ranks.

kampus, waar ons gedurende die laaste vyf jaar gehuisves was, ontgroei. Daarom is ek besonder dankbaar vir die ekstra ruimte wat ons nuwe kantoor in die Leslie Social Sciences Building op die Groote Schuur Campus aanbied.

Ek wil weereens die Carnegie Corporation en die Algemeen Diakonaal Bureau van die Gereformeerde Kerken van Nederland bedank vir hulle gulle ondersteuning van die Konstruktiewe Program wat ons in staat gestel het om meer

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Die hoofdoel van die Sentrum is om navorsing na die onderlinge groepsverhoudinge in Suid-Afrika te bevorder en te lei, in die besonder oor verhoudinge tussen rasse- en taalgroepe.

AKADEMIESE ADVIESKOMITEE EN RAAD VAN BEHEER

Die program van die Sentrum staan onder die toesig van 'n

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gedurende die jaar is mej. Norma Cornell en Ruth Kutner-ford as tydelike klerklike assistente en mej. Judith Cornell, B.A. (Universiteit van Kaapstad) as deeltydse navorsingsassistente in diens geneem. Twee ere-

Tucsa hits at doctors' tariffs

Argus 11/9/79

(93)

THE proposed increase in medical tariffs was unanimously condemned by the Trade Union Council o fSouth Africa (Tucsa) at its annual conference in Cape Town yesterday.

It was not understandable how doctors' costs could have risen by 52,4 percent, said Mr Norman Daniels, chairman of the Western Province area division of Tucsa.

'Our members will in actual fact die. They just haven't got the money to pay this extra cost . . . it's iniquitous,' he stated.

He objected to the medical profession itself having the final say in doctors' tariffs.

NEGOTIATION

Mr E 'Lief' van Tonder, a past Tucsa president, said doctors should have to negotiate increases like the trade unions negotiated pay increases — with those most affected by the increases.

Only a drastic amendment in the legislation could prevent doctors from getting their demanded increase, he said.

Tucsa's new president, Mr Andre Malherbe, said the legislation which deprived the medical aid schemes from a say in the fixing of doctors' tariffs had been passed only recently.

Tucsa had written a letter of protest to the Minister of Health Dr L A P A Munnik about the increase being demanded by doctors as well as the increase in the cost of medicines.

The proposed increase in medical tariffs was 54 percent on average but it amounted to as much as 58 percent in some cases, Mr Malhebe said.

Tucsa was told that the income limit for unemployment insurance benefits and contributions would be increased from R8 400 to R9 600 a year, if the Unemployment Insurance Board had its way.

But blacks from independent homelands were losing out, irrespective of their incomes.

Miss Christine du Preez, a member of the Unemployment Insurance Board, said the board had proposed that the income ceiling be raised to R9 600.

And the Minister of Manpower now had the power to do this by proclamation, instead of the legislation previously required, she said.

But citizens of independent homelands had no recourse to the Unemployment Insurance Fund, she added.

Tucsa condemns doctors' pay demands

By Sieg Hannig, Labour Reporter

CAPE TOWN — The increases in tariffs demanded by the medical profession have been condemned unanimously by the annual conference of the Trade Union Council of South Africa (Tucsa).

It was incomprehensible that doctors' costs could have risen by 52,4 percent, Mr Norman Daniels, chairman of the Western Province area division of Tucsa, told the conference yesterday.

"Our members will, in actual fact, die," he stated. "They just haven't got the money to pay this extra cost. It's iniquitous."

Mr Daniels objected to the medical profession having the final say in the determination of its own tariffs.

MR MALHERBE

Mr E "Lief" van Tonder, a past Tucsa president, said doctors should have to negotiate increases in tariffs as the trade unions had to negotiate pay increases with the people most affected by the increases.

Only a drastic amendment in legislation could prevent doctors getting the increases they demanded, he said.

Tucsa's new president, Mr Andre Malherbe, said the legislation which deprived medical aid schemes of a say in the fixing of doctor's tariffs had been passed only recently.

RPM TOO

Tucsa had protested to the Minister of Health about the increase which doctors demanded, as well as the increase in the cost of medicines.

Mr Ray Altman, of the white and coloured shop workers' unions, said his unions had protested to the relevant Ministers about resale price maintenance in medicines.

Recently published regulations compelled pharmacists to charge no less than 50 percent more than the manufacturers' cost of medicines, he said.

He considered this a direct contravention of the law against resale price maintenance.

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(93) FM 14/9/74

MEDICAL FEES

A sniffle in the health market

Somewhere between the bureaucratic nightmare of Britain's National Health and the excesses of the US system there must be a compromise that will best serve the public interest.

In SA, the emotive issue of doctors' fees is under scrutiny in the wake of the huge tariff increases announced recently.

Minister of Health Lapa Munnik has been talking to SA Medical and Dental Council members this week in an effort to get them to moderate the tariff hikes, which average 52%. And, he has warned, new legislation on the fee-setting mechanism will be considered if his talks are unsuccessful.

In keeping with the government's welcome new approach to free market economics, it is to be hoped that the medical profession does not end up in a straitjacket that will discourage entry to the profession and lead to lower standards.

Doctors feel they should not be subject to market forces. The Medical Association of SA (Masa) reckons: "The community should realize that the rendering of extensive and efficient medical services should be a prime priority, and it necessitates that the medical profession should not be hampered by economic factors in any way."

This is a strange statement. Increased exposure to market forces could well result in higher incomes, the entry of more people into the profession and a general raising of standards.

Medical fees are currently set by the SA Medical and Dental Council on the recommendations of its tariff committee. It seems that neither doctors nor the Representative Association of Medical Schemes (Rams) is happy with this set-up.

While Masa feels the transfer of the task of setting tariffs to the parties concerned "with the medical market situation" (fees were previously set by remuneration commissions, headed by a judge) is a step in the right direction, Rams roundly condemns the present sys-

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tem.

Rams objects to the fact that the professions should be so strongly represented on both the tariff committee and the council while medical schemes are denied representation. Further, says Rams, doctors and dentists not only enjoy the privilege of setting their own tariffs but also the protection of legislation, in that medical schemes are forced to comply with those tariffs and guarantee payment to contracted-in practitioners. But, if doctors are not happy, they have the option of contracting out.

Both the present and previous methods of setting tariffs are unsatisfactory. The latest increases illustrate the point.

Doctors were granted increases of 21% in 1969, 20% (1974) and 10% (1977) by successive remuneration commissions arbitrating between doctors and Rams. Thus, taking 1969 as a base year, doctors claim that their 'fee index' is now 158, compared to a CPI of 268. But, in fact, evidence accepted by the third remuneration commission (1972, which granted no increase) showed that the increase of 21% granted in 1969 actually resulted in a 58% hike in costs to members of medical schemes — most of which must have been paid out to doctors.

The fifth remuneration commission (1977) intended to award an average tariff increase of 9,9% but, evidence has shown, the actual increase amounted to almost 16%. According to Rams' figures, based on actual rather than intended increases, the doctors' fee index is now nearly 220 (and not 158), which, admittedly, is 18% behind the CPI.

Meanwhile, Masa submitted figures to the Council showing that practice costs had increased by an average of 51% between 1974 and 1978, and that the CPI rose by 75% from 1974 to June this year. This haggling indicates that no one really has any idea of the intrinsic worth of a doctor's services — something that is more likely to become apparent in a free market situation.

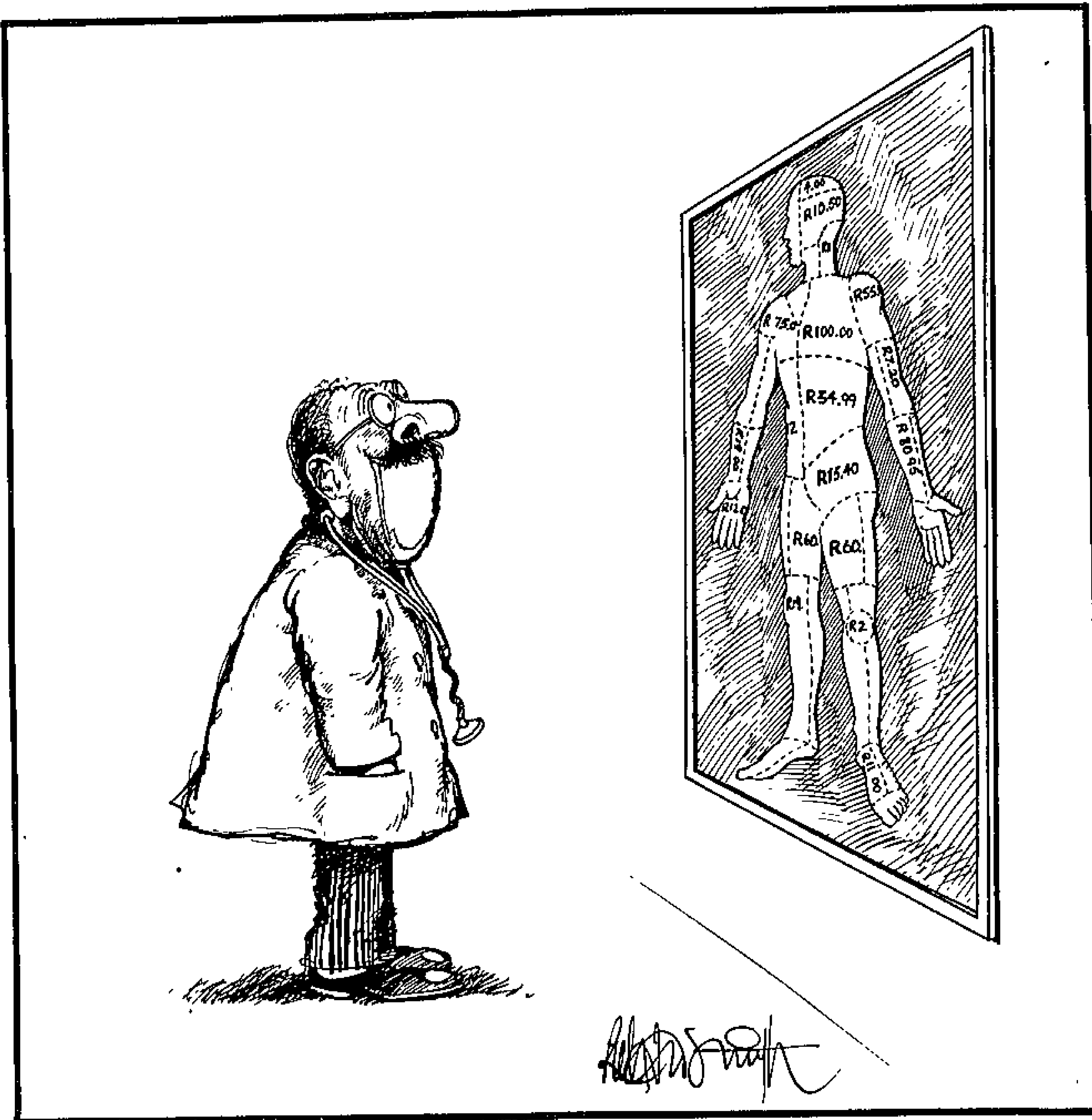
American fees

Doctors' charges are largely determined by market forces in the US, and fees are at high levels. But, at the same time, the quality of medical services is good and there is no shortage of doctors.

And, a point often overlooked in discussing the man-in-the-street's ability to pay his medical bills is that many of the major advances in medical treatment cost him virtually nothing. For instance, the development of a new drug or vaccine, which all but eliminates a disease such as polio, brings an immeasurable increase in human welfare out of all proportion to the actual medical expenditure incurred.

The real bone of contention among doctors is that tariffs were originally set membership of medical schemes to a much larger section of the community —

in the depression of the Thirties at preferential rates. They were designed to assist lower-paid members of the community, who constituted roughly 30% of all white patients. In 1967, the Medical Schemes Act was promulgated, opening up



who were then treated at historically preferential rates.

Hence doctors' claim that all subsequent tariff adjustments start from this low base — a third lower than private tariff rates operating at the time.

Medical schemes are concerned that much higher medical costs will make their services unattractive to the public. This seems unlikely. In the US, there has been no fall-off in medical insurance scheme membership. Indeed, membership has become more important — so that the possibility of falling seriously ill, with the resulting medical bills, is covered.

Getting the best possible medical care for the greatest number of people should be an objective of any community. This entails training adequate numbers of doctors and remunerating them at levels they find acceptable. At the same time, some control over ethical practices must be maintained — and this is best achieved through a body of peers. And, as some members of the community can ill afford high doctors' bills, provision must be made for their needs.

There is an urgent need for public debate on the whole structure of the SA medical system, particularly on future direction. As a starting point, the *FM* offers the following suggestions.

- A recent survey of some 300 000 consultations by Rams revealed that contracted-in GPs treated each patient just over four times in the period reviewed, while contracted-out GPs serviced each patient just under three times. This suggests a degree of over-servicing by GPs charging the lower statutory tariff or, alternatively, unnecessary visits to doctors by patients receiving full payment of bills through medical schemes.
- Special tax concessions, similar to those granted to exporters, should be granted to doctors operating in areas where there is a shortage of medical services.
- Newly qualified doctors are required to serve two years in the Defence Force. A percentage of these should be re-routed and posted to civilian hospitals where there is a shortage of doctors.
- Doctors should be allowed faster tax write-offs on medical equipment so they can effectively reduce practice running costs, and hence fees. This would also encourage the purchase of the latest technology and the maintenance of the highest standards.

Therefore, the *FM* believes, movement to a freer market, though it will cost the public more (and benefit the Treasury through the high marginal tax rates paid by doctors), will bring a considerable increase in the community's welfare.

16/9/79

THINK AGAIN ON DOCTORS RISING FEES

By MAUREEN GRIFFIN

DOCTORS have admitted for the first time that the 52 percent medical fee increase they are seeking could be too high.

Professor H. W. Snyman, president of the South African Medical and Dental Council — the body which recently gave doctors their increase and dentists a 33 percent increase in fees — said yesterday that if the council had based these increases "on facts that were not then available or possibly insufficiently gleaned", it would be forced to reconsider.

"Of course, if new and compelling facts are brought forward the council as an open scientific body will certainly consider them," he said.

"We are accustomed to work on facts. We try to establish tariffs on the basis of the facts in front of us. The facts presented were the facts apparently available."

He was commenting on a report published as a supplement to the latest issue of the South African Medical Journal. The report says that the tariff committee of the Council based its final recommendations for the increase in medical fees on "inadequate data".

Suffered

The report says the committee had suffered a lack of accurate and complete information on some points.

"If in future it is proved that the committee's judgement on these matters was wrong, the necessary adjustments will have to be made," said the report.

The committee agreed on an increase from 80 cents a unit to R1,10 a unit for general practitioners contracted to a medical scheme.

This means that a consulation in a GP's rooms now costs R6,60 instead of the previous R4,80. For a visit to a home or hospital a contracted GP now charges R13,20 compared with R6,80 previously.

Fees for consultations in other medical disciplines were also increased.

Shortfall

The report said that the reason for such a large increase was the cumulative shortfall which doctors had experienced during the past 10 years.

"While the Consumer Primc Index has increased by 168 percent, the statutory tariff has increased by only 58 pr- cent."

The report said the increase was in no sense a pay-out for what had been lost over the years. An increase of the same magnitude should not be necessary again in the future because the council would make annual adjustments, necessitated by the rate of inflation.

SUNDAY POST, September 16, 1979 (93) (58)

BLACK DOCTORS 'A BAD RISK'

Black and white doctors . . . equal in hospital, but not in insurance.

By ZWELAKHE SISULU

A LEADING firm of insurance brokers, which has a special scheme for hospital employees, has excluded black people from the scheme — because no insurance company will insure them.

Although the firm, Plus Insurance Brokers' claim that no local insurance company is prepared to back the scheme because of the high risk factor in black areas, the Transvaal Medical Society has accused the firm of discrimination.

"No insurance company in this country is prepared to back the scheme — we have been to all of them," Plus Brokers' Mr L P Kriek sasy.

"We even went to American companies operating in the country — since they have a lot to say about discrimination — and we wanted them to put their money where their mouths were. They were not prepared to start such a policy," he said.

The policy, which exists for white hospital employees gives insurance coverage for cars, houses and personal policies at favourable rates.

A spokesman for the Transvaal Medical Society this week said various black hospital employees had approached the firm to enquire about the policy and were told that one was being prepared for black people.

A statement by the Medical Society said: "We reject totally the concept that we are not eligible for the insurance scheme because we are a high risk group.

"We detect an underlying conflict of outlook, as insurance companies freely underwrite policies of black people outside the hospital, but regard black people as a high insurance risk group when it is convenient for them," the statement said.

"We cannot see black people having any further involvement with companies which are not clear in their attitudes, and who regard black people as third rate citizens for reasons beyond their control," the statement said.

However, Mr Kriek was adamant that it was the risk factor and not colour which was stalling the underwriting of such policies to black people.

"There are more thefts and robberies in black areas and therefore the risk factor has to be higher," he said.

His firm was presently negotiating for a group scheme for the South African Teachers' Association, a coloured group.

18/9/79

Munnik plea on fees rejected

JOHANNESBURG — Doctor and dentist associations are standing firm on the massive fee hikes announced last month and have rejected a plea by the Minister of Health, Dr L. Munnik, to review them.

Both the South African Medical Association and the South African Dental Association have refused requests by the Minister to ask the South African Medical and Dental Council to reconsider the increases.

Statutory medical tariffs are to be raised by 52,4 per cent.

Dr Munnik said in Pretoria yesterday that the Medical Association stood by its point of view that the new tariffs were reasonable and fair. It was not prepared to request the council to review the matter.

"Representations were also made to the Dental Association during our discussions, to request the SA Medical and Dental Council to review the new tariffs in the light of the country's economic position. This association also has not seen its way clear to accede to my request," he said.

The Minister said the full structure of medical costs would be thoroughly investigated in order to allow increases to take place in an orderly and controlled manner.

If amendments to existing legislation were necessary to provide for this, it would be submitted to the Cabinet for consideration, he said.

Dr Munnik said the executive committee of the SA Medical and Dental Council had, however, agreed to his request to withhold the publication of the proposed tariff of fees until the next meeting of the council on October 15-17.

"For this I am grateful. On that occasion I will address the council at their invitation," Dr Munnik said.

He also disclosed he would submit a written request to the SA Medical and Dental Council for the proposed tariffs to be reviewed.

"I also intend to institute an investigation into the cost structure of medical schemes, especially as regards administrative costs and member benefits.

The Association of Medical Schemes had no objection to such an investigation and had offered their co-operation.

"It is obvious that at this stage I cannot apply a time limit to these investigations. I am, however, very much aware of their seriousness, and will institute the necessary steps as soon as possible," Dr Munnik said. — DDC-SAPA.

19/9/79 NM (93)

Unions tear into 'self-seeking' doctors

Mercury Correspondent

PRETORIA — Labour leaders demanded yesterday that the Government should act swiftly to strip the Medical and Dental Council of its power to fix doctors' and dentists' fees.

They accused the council of acting with reckless, self-seeking disregard for public welfare by refusing to cut the huge 52 percent tariff increase, which comes into operation from November 1.

This week the Minister of Health, Dr. L. A. P. A. Munnik, said the council had rejected a plea to reconsider the increases.

The council has agreed to with-hold publication of the proposed tariff rises until its next meeting on October 15 when Dr. Munnik will address the council.

Yesterday the president of the Confederation of Labour, Mr. Attie Nieuwoudt, said the confederation had warned the previous Minister of Health he was moving in a dangerous direction by giving the medical council power to fix its own tariffs.

"We told him you cannot trust these people, and some measure of Government control should be retained. What has happened since merely reinforces our earlier attitude that the doctors should never have been given the authority to decide on the level of their own fees," Mr. Nieuwoudt said.

The general secretary of the Trade Union Council of South Africa, Mr. Arthur Grobbelaar, said the council had shown itself unable to use responsibly the powers given it last year, and they should be summarily cancelled.

The president of the Garment Workers Union, Senator Anna Scheepers, agreed the council should be deprived of its fee-fixing power.

If the massive increase in fees came into operation the contributions to medical aid funds would rise to a level where they would aggravate the hardships already being suffered in the families of the less well paid workers, she said.

The general secretary of the National Union of Distributive Workers, Mr. Ray Altman, said his union had for years opposed any suggestion that doctors should be given a unilateral authority to fix fees.

Sapa reports that the Dental Association said in Johannesburg yesterday that the increase of 33,3 percent in fees recommended by the Medical and Dental Council was applicable only to the medical aid (statutory) tariff. It would not apply to contracted-out dentists.

Dentists

These dentists comprised about 1 000 of South Africa's 1 500 dentists in private practice.

The Mercury's political correspondent reports from Pretoria that Dr. Munnik is to ask for a commission of inquiry into the cost of medicine and health services.

Botha may ask Blacks to his big indaba

ORMANDE POLLOK
Political Correspondent

PRETORIA — Black industrialists and businessmen could be invited to the Prime Minister's conference on a constellation of States in November.

Mr. Botha revealed this in a brief interview at the National Party's congress in Pretoria yesterday, following his announcement that he was calling in private enterprise to help him get his scheme going.

He also disclosed that he already had had "good" discussions with Black governments in southern Africa apart from newly independent homelands and non-independent Black governments.

However he emphasised that the conference, which would be attended by the Cabinet, was purely for local industrialists and businessmen and other countries would not be represented at this stage.

Asked if they might include Black businessmen as well, Mr. Botha said: "Yes, if there were some who could help." He could not name any of the people who were being invited at this stage.

It is understood that the conference will be behind closed doors and that a large number of invitations will be sent out.

19/9/79

Govt, doctors head for clash over fees

Pretoria Bureau

A HEAD-ON clash between the Government and the country's doctors and dentists seems inevitable unless they are prepared to compromise on the huge fee increase of 52.4% proposed by the South African Medical and Dental Council.

And there are no indications at this stage that the South African Medical Association — the doctors trade union — or the Medical Council are prepared to relent and reduce the adjustment in their fees

However, the president of the Medical Association of South Africa, Professor Guy de Klerk, said the association would abide by any decision taken by the Medical Council after its meeting on October 15

Even if the Med cal Council should review the decision in the light of further evidence, the association will abide by this, Prof De Klerk said.

The attitude of the doctors is seen as a challenge to Government authority In the face of pleas from the Minister of Health, Dr L A P A Munnik, to reconsider the increases, they have been defiant.

The doctors made it clear to Dr Munnik at a meeting in Pretoria last week that they would not budge on the Medical Council's proposals

At the Transvaal National Party congress in Pretoria earlier this week, the Minister of Finance, Senator Owen Horwood, called on the doctors to think again and to see the issue of fees "in perspective".

The clear implication is that the Medical Association and the Medical Council are being irresponsible — and this is the view coming from all sectors of the economy, particularly from labour leaders

The Medical Council will withold the publication of the new fees until after its meeting in Johannesburg from October 15 to 17. The Minister has been asked to address the meeting

If the doctors still refuse to review their tariffs after next month's meeting, then legislation to strip the Medical Council of its authority to fix fees is likely to be introduced during the next Parliamentary session.

Labour leaders have condemned the "irresponsible, grasping" attitude of the doctors and have demanded that the Medical Council be stripped of its power to set fees.

The president of the Confederation of Labour, Mr Attie Nieuwoudt, said: "We warned the Government two years ago that these people (the doctors) could not be trusted with full authority to fix fees. Government must legislate to regain control "

The general secretary of the Trade Union Council of South Africa, Mr Arthur Grobbelaar, said: "The council has been given a blank cheque by the Government to fix its own fees — an impossible situation."

Doctors' fees: concern over Govt threat

CAPE TOWN. — If medical fees were brought under Government control, South Africa would end up with "socialised medicine" — a disaster for the medical profession, Professor J N de Klerk, chairman of the federal council of the South African Medical Association, said yesterday.

In a newspaper interview published yesterday, Prof De Klerk said he was gravely concerned at threats made by the Minister of Health, Dr L A P A Munnik, following the recent 52,4% rise in the statutory tariff for doctors contracted in to medical schemes. There were dangers inherent in the idea of a Minister wishing to have a right to veto.

"I can understand Dr Munnik's concern. He was presented with a fait accompli which has put him in a politically difficult situation."

However, it was one of the "cornerstones" of the Medical and Dental Council's activities that it had always stood above politics and matters which could become political issues.

He emphasised that the recent increase in fees was not a rise in salaries.

"We are dealing with the income of self-employed professional people. A salaried individual has a pension scheme, housing loans and other fringe benefits which the self-employed professional lacks."

It was also hoped that the increases would encourage doctors who had contracted out of medical schemes to contract back in.

If a doctor charged exorbitant fees a patient had recourse. He could report it to the Medical Association, who would then inform the Medical Council.

The chairman of the Representative Association of Medical Schemes, Mr N J J van Rensburg, said he wished to challenge certain of the statements made by Prof De Klerk.

In a statement issued to Sapa on behalf of the Representative Association of Medical Schemes, Mr Van Rensburg said:

"This association remains more than ever convinced that increases in the tariffs of the magnitude announced by the SA Medical and Dental Council are indefensible and unacceptable.

"As far as this association is aware — and this is our main objection — neither the tariff committees nor the Medical Council conducted any proper investigation into the actual earning and practice costs of the professions.

"The calculations upon which the recommendations were based are purely hypothetical and are questionable at every stage.

"Although the statistical evidence presented by this association could not be faulted, it was nevertheless completely ignored in the final recommendation and the decision.

"As far as the medical schemes are concerned, the increased tariffs will result in increases in claims of about R100-million per annum and these additional costs will have to be recovered from members and their employers.

"Over a period of time, much ado has been made about the schemes' so-called extravagant administration costs, high profit ratios and excessive reserves. The true facts are:

"Out of a total income of R228,3-million of 210 registered medical aid schemes in 1977, an average of 90% was paid in direct benefits to members.

"Total administration costs amounted to less than R2 per member per month or 8% of income.

"Reserves amounted to an average amount of R207 000 per scheme or R50 per member as at December 31, 1977. This is far less than the minimum reserve required by the Registrar of Medical Schemes.

"In the absence of any evidence offered to prove such a statement, this association strongly refutes the inference made by Prof De Klerk that the schemes run by entrepreneurs cost more to run or that entrepreneurs make excessive profits out of their administration.

"In so far as the whole controversy about the recent fee determinations by the SA Medical and Dental Council is concerned, this association reconfirms the comprehensive statement of facts set out in its Press release of August 31," Mr Van Rensburg said. — Sapa.

6

Increase in doctors' fees 'deplorable'

Argus 23/10/79

(93)

Argus Correspondent

DURBAN.—The South African Medical and Dental Council's decision to go ahead with the increase in medical tariffs was deplorable and indicative of a total disregard for the current plight of consumers as well as being to the detriment of recent attempts to stimulate the economy, the director of the Consumer Council, Mr. Johann Verheem, said.

Mr. Verheem pointed out that the elderly would be particularly hard hit with their low incomes and increasing need for the services of medical practitioners.

'White households spent an average of R311 each in 1975 on medical services and requirements,' he said.

Mr Verheem said this was almost three times their expenditure on education and double the amount spent on fuel and power.

'Other races are likely to be even more severely affected,' he said.

'IRONICAL'

'It is more than ironical that the representative body of a particularly well-off sector, such as the medical profession, who are devoted to the care of others, is determined to improve their standard of living to such an extent at the expense of the rest of the community — the self-same community that contributed as taxpayers to their education to the tune of about R30 000 a practitioner,' Mr. Verheem said.

Mr Verheem appealed to the Medical and Dental Council to take note of the current economic situation, 'which cannot absorb an increase of this magnitude,' and he appealed to the authorities to use every means at their disposal to resolve the matter, 'even if they have to make use of their ultimate powers.'

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Instruction Course

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2.8 Academic Advice

In indicating whose advice they had primarily sought in planning their university curriculum, the sampe indicated as follows:

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Munnik and doctors discuss fees

CT 25/9/79

(93)

Political Correspondent

THE Minister of Health, Dr L A P A Munnik, told a meeting of doctors last night why he believed medical fees should go up in stages rather than the large increases due to come into effect next week.

About 150 doctors attended the meeting, held at their request following the dispute between Dr Munnik and the Medical and Dental Council over the proposed increases.

The council has turned down an appeal from Dr Munnik to reconsider the planned rise of 52 percent in medical fees and 33 percent in dental charges.

He has said he sees no justification for the increases and that he is considering legislation to give him a final say in future tariff rises.

Most of those present last night live in the Durbanville constituency, where Dr Munnik is standing in the coming by-election. The area is near the Tygerberg and Karl Bremer hospitals.

The two-hour meeting at a local school was closed to the press, and neither Dr Munnik nor any of the doctors would comment in detail on the discussions.

Dr Munnik said afterwards the doctors had put a number of searching questions and that a frank and interesting discussion had resulted. Most of the questions concerned the tariff increases.

He had explained that he as Minister of Health had to take into consideration the practitioners, the patients and the economic effect on the government.

"I feel doctors certainly have a right to increased fees.

"The suggestion that I made to the Medical and Dental Council was that the increase should rather be made in a number of stages, rather than all at once. This was turned down by the council."

Dr Munnik said he had explained the situation in detail to the doctors, as they were not in a position to have full knowledge of his discussions with the council.

Some of the doctors spoken to afterwards criticized newspapers for failing to put their side of the case properly or objectively. Others, upset that Dr Munnik had made a statement while they were prohibited professionally from doing so, felt the meeting should have been open so their views could have been reported.

(News by M P Acott, 77 Burg St Cape Town)

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STAR 28/9/79

Prisoner lays complaint against operation doctor

Mr Raymond Suttner, a political prisoner, who claims he was sent back to prison only hours after an operation, has complained to the Medical and Dental Council about the alleged misconduct of a surgeon.

His mother, Mrs Sheila Suttner, confirms that a complaint has been made.

Mr Suttner, who is serving 7½ years, had an operation for haemorrhoids.

He claims he was sent back to prison in Pretoria four hours after the operation in May at the Eugene Marais Hospital.

His mother said he protested, but was told a doctor had signed his discharge from hospital.

Mr Suttner claims the surgeon did not make follow-up visits until five days after the operation.

A medical council spokesman said particulars of the complaint could be revealed only when and if the council's disciplinary committee charged a doctor.

A Prisons Department spokesman said: "A complaint was referred to the medical council and is being investigated by them."

Mrs Suttner added: "A week after the operation, I saw Raymond in prison. He looked ill. He was white-lipped and transparent. He told me what had happened."

B E V E R A G E S

"Ah my Beloved, fill the cup that clears
Today of Past Regrets and Future Fears"
Omar Khayyam

GINGER BEER

Judy Morris, Port Elizabeth

10 bottles (750 ml) water
4 cups sugar
1 1/4 (20 ml) bottles Jamaica Ginger
1 t cream of tartar
1 1/2 heaped t dry yeast

Mix all together and leave for 6 hours. Then bottle in screw top bottles. Leave for a couple of days to mature. Keep it in fridge when mature.

Feelings ran high on doctors' fees

93 Argus 2/11/79

By John Richards

THE medical profession was allowed to put its case for greatly increased fees on Forum last night, and feelings ran high, even among the doctors.

There can be no doubt that doctors are entitled to an increase in fees. The question is only whether a 52 percent increase can be justified by the medical profession and paid by the lay public without undue hardship.

The consumer price index has risen by 106 percent since 1969 and medical fees have risen by 58 percent in the same period, leaving a gap of 48 percent.

Nobody can dispute these figures. They are available to all. What can be disputed is that the average man is now in a position to pay his physician much, much more than he has been doing.

Can he? Can he really afford an increase of 52 percent in medical fees? In how many salaries has there been an increase commensurate with the rise in the cost of basic necessities, let alone an increase of 106 percent?

A doctor suggested that if people paid a good deal more for their tobacco and alcohol, they should be prepared to pay a great deal more for medical services.

He asked, 'How much is he prepared to pay for his health?' This sounded rather like applying a charge in tune with what the traffic would bear.

Much use was made of medical "mystique," but medical mystique on an economic level.

The final question which should have been asked when the dust kicked up by fanciful dispute had settled was this: If the salaries of virtually all breadwinners have not risen by 106 percent since 1969, then why should the income of doctors do so?

The question was not asked.

Maccono instant coffee to about 3/4 of the glass ... whipped fresh cream, poured slowly over the back of a silver teaspoon.

---oOo---

TIA MARIA

Jane Aullock, Durbanville

2 cups dark brown sugar
7 t Nescafé
1 cup sugar
1 pt cold water
1 t vanilla essence
2 t cocoa
1/2 t rum essence
1 bottle Mainstay

Bring white and brown sugar and water to the boil, and simmer for 1/2 hour stirring frequently. Add Nescafé and cocoa which has been mixed with a little water. Boil up again. Remove from stove and add rum and vanilla essence. Leave to cool and then add Mainstay. Bottle (preferably strained through a muslin cloth).

---oOo---

COFFEE SPECIAL

May Bennett, Ridgeworth

Pour together into coffee glasses, hot milk and strong coffee. Top with following: fresh cream mixed with a good instant coffee, a few drops of vanilla essence and fine sugar.

---oOo---

GRANADILLA DRINK

Mrs Futter, East London

3 cups sugar
3 cups water
12 granadillas
3 t tartaric acid

Boil water and sugar to a thin syrup. Turn out the pulp of the granadillas. Then to this, add 3 t tartaric acid. Pour hot syrup over and allow to cool. Strain and bottle. (Squeeze the pulp to get all the juice out.)

---oOo---

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---oOo---

ORANGE HEALTH DRINK
(Delicious in Hot Weather)

May Bennètt, Ridgeworth

10 oranges
2 lemons
3 pts boiling water
5 lbs sugar
2 pkts citricacid (small pkts)
1 pkt epsom salt
1 pkt tartaric acid
rind of 8 of the oranges

Mix dry ingredients, orange rind, fruit juice and boiling water. Allow to stand for 6 hours. Strain and bottle (6 large bottles). To use, dilute small quantity of orange with cold water or soda water.

---oOo---

Doctor operated with bookkeeper as assistant

Star 3/10/79. (93)

Vereeniging Bureau

A Vereeniging doctor, the author of a textbook on cinical anatomy, was found guilty yesterday on five charges of disgraceful conduct and it was recommended that he be struck from the roll of medical practitioners.

Dr N J Grobler (43) appeared before the disciplinary committee of the SA Medical and Dental Council on seven charges, and was found not guilty on two of them after the hearing at the Vereeniging Hospital.

ALARMED

Three of the charges related to two operations carried out on a woman, during one of which Dr Grobler's bookkeeper, who has no medical qualifications, acted as a theatre assistant.

In the first operation, in the Vereeniging Hospital on June 1, Dr Grobler, conducting a hysterectomy, made an incorrect and inadequate incision, close to the bladder in a dangerous or negligent manner, the committee found.

The operation was stopped by the anaesthetist, Dr J L du Preez, who became alarmed at the length of time Dr Grobler took to complete part of the operation, taking nearly an hour to do what normally takes only five to 10 minutes.

On August 3 in the Union Nursing Home in Alberton Dr Grobler repeated the operation on the patient, using his bookkeeper, Mr Willem Coetzee, as an assistant.

After the operation had dragged on for too long and the patient had lost "an unreasonable amount" of blood, it was completed by Dr P A de Villiers, a specialist gynaecologist.

HIGH DOSE

The other charges related to an incident in Dr Grobler's consulting rooms, when he gave a 13-month-old girl a high dose of pethedine and phenergan, and to Dr Grobler's use of disparaging remarks about fellow doctors.

The recommendation of the disciplinary committee will be forwarded to the SA Medical and Dental Council and Dr Grobler has time to supply the council with any documents related to the finding.

STUFFED CABBAGE SALAD — May Bennett, Ridgeworth

1 fresh green medium size cabbage
onions
carrots
tomatoes
fresh pineapple
radishes

Cut the centre from the cabbage, leaving the outer leaves to form a bowl. Wash well. Chop onion. Peel and cube the carrots and pineapple. Cube tomatoes. Thinly slice some of the inner leaves of the cabbage leaving the stalks. Place the carrots, pineapple, tomatoes, sliced cabbage and the finely chopped onion in a bowl adding any juice from the tomatoes, pineapple and add salt and black pepper to taste. Toss well, then pile the salad

pepper. Use hot or cold.

---oOo---

Transkei's need of doctors

(93) 12/10/79 DD

UMTATA — Transkei needs between 400 and 500 doctors to cope with four million people in Transkei, the president of the Transkei Medical Association, Dr A.B.L. Pupuma told a gathering here, writes Stan Mzimba.

Giving a vote of thanks at the Medical Scholarship dinner, Dr Pupuma said the feasibility of a medical school in Transkei was being looked at by both the association and the Medical Council. At least two medical schools would be required in Transkei.

Dr Pupuma said the Department of Health intended increasing the number of medical scholarship funds for Transkeians.

The Minister of Health, Rev Gladstone T. Vika, said "The dire shortage of black doctors and the history of the situation is known."

There were 160 medical practitioners registered by the Medical Council and 37 private doctors helped his department. There were 102 doctors in government service, of whom 10 were Transkeians.

The Medical Scholarship group, which consists mainly of medical practitioners throughout Transkei, met to launch a fund-raising campaign to give financial assistance to help students wanting to study medicine.

Dr Pupuma said the group seemed to be getting more students than funds.

Dr T. Mtimkulu said they had been inundated with applications from students but could not find the money needed.

EGG SALAD — May Bennett, Ridgeworth

hard boiled eggs
salanaise
salt and pepper
paprika and parsley

Cut eggs in half and lay on a flat salad platter; cut side down. Pour over salanaise.

---oOo---

CHICKEN AND CUCUMBER SALAD — S. Drury, East London

1 cup cooked chicken, diced
4 T finely chopped walnuts
French dressing/mayonnaise
lettuce
1 cup cucumber, peeled and diced
1 cup cooked green peas

Marinade chicken, cucumber, nuts and peas with French dressing. Serve on lettuce with mayonnaise. Cover with greaseproof paper and refridgerate until ready for use.

French dressing:
Blend together 6 T salad oil and 2 T lemon juice.

---oOo---

SPRING GREEN SALAD — May Bennett, Ridgeworth

1 medium size lettuce
2 onions
parsley
1 cucumber
mint (fresh)
scallions

Wash and shred the lettuce, chop onions finely and parsley; keep a few pieces for garnishing. Wash cucumber peel and cube. Wash scallions, and cut tops off leaving a short piece of the green left on. Toss the lettuce, parsley, cucumber, onion and scallions together, salt and pepper. Pour over a little French dressing and serve in a glass bowl. Garnish with a few sprigs of mint and parsley.

---oOo---

EEN BEAN SALAD — Mrs Futter, East London

ed green beans
onions
1 d salt, level
2 cups water

eans (sliced) with salt and onions till cooked, then ne water.

sugar
owder
1 heaped T flour
1/2 bottle vinegar

rry powder, flour with a little water. Mix well, so that no lumps form, and then add the sugar and vinegar, boil up and stir all the time, then add the cooked beans and onions, bring to boil again. Bottle.

---oOo---

APPLE TUNA TOSS SALAD

1 medium head lettuce, torn in bite-size pieces (4 cups)
2 cups diced apple
1 11 oz can (1 1/3 cups) mandarin orange sections, drained
1 6 1/2 or 7 oz can tuna, drained and broken in large chunks
1/3 cup coarsely chopped walnuts
1/2 cup mayonnaise or salad dressing
2 t soya sauce
1 t lemon juice

In a large salad bowl, combine lettuce, apple, orange sections, tuna and nuts; toss together. Combine mayonnaise, soya sauce and lemon juice; mix well. To serve, add dressing to salad; toss gently. Makes 4 - 6 servings.

---oOo---

processes is essential; and the division will have to be more fine the more discriminating public decisions can be.[10]

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RAND DAILY MAIL, Saturday, October 13, 1979

Govt seeks compromise on medical fees rise

BY GERALD REILLY
Pretoria Bureau

THE MINISTER of Health, Dr L A P A Munnik will press for a compromise on the proposed huge increase of 52.4 % in doctors' fees at a meeting with the SA Medical and Dental Council in Johannesburg on Monday.

If he fails, the new scale of fees will come into force from November 1.

The council's attitude is expected to remain uncompromisingly firm.

It claims the increase is justified by the steep rise in doctors' costs and their own living costs.

At a meeting with the Medical Council in Pretoria last month the Minister failed to persuade the doctors to amend the proposed massive increase.

When the increases were first announced the Minister expressed shock and indicated that the Government would again have to have some say in the fee-fixing process.

Legislation went through Parliament last year to give doctors full authority in determining their own fees.

The doctors also failed to respond to an appeal from the Minister of Finance to think again, and to see the proposed increases in perspective.

Pretoria sources believe that if the council refuses to compromise, legislation to strip it of its fee-fixing powers is likely during the 1980 Parliamentary session.

Labour leaders have condemned the "irresponsible, grasping" attitude of the doctors.

The general secretary of the Trade Union Council of South Africa, Mr Arthur Grobbelaar, said the council had been given a virtual blank cheque to fix its own fees — "an impossible situation".

The president of the Garment Workers Union of South Africa, Senator Anna Scheepers, said doctors were among those in least need of financial relief.

It would be a public scandal if the Government allowed the increases.

The Representative Association of Medical Schemes claims medical aid funds would have to pay another R100-million annually to the country's 6 300 doctors and 1 400 dentists.

Doctors' incomes, Rams estimates would rise by about R12 000 a year and medical aid subscriptions by R8.50 a month.

programme it is spent. If the net social benefit from the marginal expenditure on one programme much exceeds that on another, one can do better by withdrawing funds from the second programme and increasing expenditure on the first. By simply looking at a breakdown of the budget between programmes, the amounts spent on each may be compared with our intuitive notions of how much 'ought' to be spent on these things. Our judgement will depend on what we consider the benefits of expenditure under each programme to be, a process which cost-benefit analysis seeks to formalise (see below). For example, if it can be shown that expenditure on preventive medicine constitutes approximately 2% of all expenditure on health,[11] it may be felt that the benefits from this kind of provision warrant an increase in the share of the budget allocated to it.

Unfortunately, such intuitive processes can pick out only the grossest incongruities which are recognised by all, whatever criteria of 'value' are used. The optimum level of expenditure on a particular objective is, from the point of view of intuitive judgement, highly uncertain, because of the wide variation in benefits attributable to a particular type of spend-

ing. This is partly due to a deficiency in information on the results of the programmes which can be resolved by recourse to appropriate data.
also be differences of judgement which cannot
agreement on the relative valuation of different
fed into the analysis; and in the intuitive
may not be differentiated.

f decisions are now taken with no further analysis
steps involve a way of systematically valuing the
grammes to render them comparable to one another.

d for Setting Objectives

guiding the choice of priorities has been
[12] It has been used by medical and nursing
one of its advantages is that it can be used
is available. It, therefore, lends itself to
he experience of a group of people.

s are first listed, and then given a score (from
each of four headings:

Diagram 1: A method of ranking health problems

Problem	Prevalence	Severity	Community concern	Vulnerability to management	Total
Large & poorly spaced families	++++	++++	+++	++	96
Inadequate ante-natal & obstetric care	++++	++	++	+++	48
Malnutrition	+++	+++	++	++	36
Need for medical care	++	++	++++	++	32
Specific diseases:					
V.D.	++	++	++	++	16
Dental problems	++++	+	++	++	16
TB	+++	+++	+++	++	54
Common cold*	++++	+	+	-	0
Yaws*	-	++	+++	++++	0

* Added to test scoring method

STUFFED CABBAGE SALAD — May Bennett, Ridgeworth

1 fresh green medium size cabbage
onions
carrots
tomatoes
fresh pineapple
radishes

Cut the centre from the cabbage, leaving the outer leaves to form a bowl. Wash well. Chop onion. Peel and cube the carrots and pineapple. Cube tomatoes. Thinly slice some of the inner leaves of the cabbage leaving the stalks. Place the carrots, pineapple, tomatoes, sliced cabbage and the finely chopped onion in a bowl adding any juice from the tomatoes, pineapple and add salt and black pepper to taste. Toss well, then pile the salad into the cabbage "bowl". Garnish with radish roses and a small bowl of mayonnaise for those who like it. To make the radish roses, cut across the tops in a double cross, then put them in iced water until the radishes open up.

---oOo---

GERMAN POTATO SALAD — Ethne Board, Port Elizabeth

boiled potatoes
cooked bacon
mayonnaise
chopped onion
salt and pepper

Cube the potatoes while still hot. Chop up the bacon, mix with the potatoes, onion and mayonnaise. Season with a little salt and pepper. Use hot or cold.

SPRING GREEN SALAD — May Bennett, Ridgeworth

1 medium size lettuce
2 onions
parsley
1 cucumber
mint (fresh)
scallions

Wash and shred the lettuce, chop onions finely and parsley; keep a few pieces for garnishing. Wash cucumber peel and cube. Wash scallions, and cut tops off leaving a short piece of the green left on. Toss the lettuce, parsley, cucumber, onion and scallions together, salt and pepper. Pour over a little French dressing and serve in a glass bowl. Garnish with a few sprigs of mint and parsley.

---oOo---

CURRIED GREEN BEAN SALAD — Mrs Futter, East London

2 lbs sliced green beans
2 chopped onions
1 d salt, level
2 cups water

Boil the beans (sliced) with salt and onions till cooked, then pour off the water.

Sauce:
1 1/2 cups sugar
1 d curry powder
1 heaped T flour
1/2 bottle vinegar

Mix the curry powder, flour with a little water. Mix well, so that no lumps form, and then add the sugar and vinegar, boil up and stir all the time, then add the cooked beans and onions, bring to boil again. Bottle.

/3 cup coarsely chopped walnuts
/2 cup mayonnaise or salad dressing
t soya sauce
t lemon juice

ce, apple, orange sections,
ne mayonnaise, soya sauce
and lemon juice; mix well. To serve, add dressing to salad; toss gently. Makes 4 - 6 servings.

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79

Munnik ignored: Fees will rise

Argus 16/10/79. (93)

THE South African Medical and Dental Council yesterday decided to implement the 52 percent rise in medical tariffs by November 1 'or as soon as possible afterwards.'

This decision is a rejection of appeals by the Minister of Health, Dr L A P A Munnik, that the council's tariff committee reconsider the increases it approved after a two-day debate at the end of August.

Dr Munnik has instigated an investigation into medical fees and has threatened to introduce legislation to bring medical fees under Government control.

SCHEMES

He has also hinted that the right of doctors to contract out of medical aid schemes, might be removed.

'He must not show any fright or fear about our decision,' council member Professor H A Shapiro told the council meeting yesterday.

VOTING

'By reaffirming the recommendations of the tariff committee we have done what Parliament asked us to do,' he said.

The council voted 23 to nine in favour of implementing the increases, which will be published in the Government Gazette on November 1 or as soon as possible afterwards.

'Doctors too busy so patients die at Bara'

93

St 16/10/79

A senior physician at Baragwanath Hospital says some patients die because medical staff are too busy.

Dr Roger Blackwood, cardiologist, says he is willing to risk dismissal to expose the "critical shortage" of medical personnel at the hospital.

Dr Blackwood's allegations began in a letter to The Star in which he comments on the controversial documentary on Baragwanath screened on SABC-TV last Tuesday.

Dr P J Beukes, superintendent of the hospital, today refused to comment.

Dr Blackwood told The Star today Baragwanath's intake of medical patients was 80 to 90 patients daily, as against white hospitals' 15 to 20.

Double the number of medical doctors were needed to provide a full service.

Doctors were on duty 24 hours continuously in the intake ward and also had to look after their own wards. After the 24-hour duty they carried out their normal duties.

Dr Roger Blackwood

Often doctors were so tired that vital signs could be missed so that occasionally the death of a patient could occur.

"It should never happen that a man who comes in seriously ill should not have the benefit of continuous observation."

Dr Blackwood said such observation was not possible if doctors were so busy. He said two registrars and five housemen could not monitor 80 to 90 patients properly.

Dr Blackwood expressed concern that many ill patients were seen only once or twice before being discharged prematurely to make room. The only solution was to provide more medical personnel and medical wards.

Dr Blackwood said the outpatients department was far too small.

He said the reply of the Transvaal provincial authorities was that a new hospital was being built on the site of Baragwanath.

FOR 1996

"But we understand it is due for completion in 1996. We also understand it will have no more beds than the present hospital," Dr Blackwood said.

He said the authorities' reply to this was that a new hospital was to be built in the area of Canada Junction.

Comparing the size of the Baragwanath casualty department with that of white hospitals showed the area to be "wholly inadequate," said Dr Blackwood. At Baragwanath stretchers were "lined up against each other," completely blocking the th[illegible]

On a recent Sunday morning when surgeons got out of the operating theatre at 2 am, 50 stretcher cases were waiting for them. This was "not unusual," he said.

The TV documentary, Dr Blackwood said, "highlighted all the super specialities such as cardiac surgery and neurosurgery," which "any large hospital in any large city in any civilised country ought to have as a matter of routine.

"It is therefore no special credit to have these available for the black community."

Mr Kevin Harris, the producer of the TV programme on Baragwanath, described Dr Blackwood's criticism as healthy and encouraging.

"In all the two-and-a-half months I spent doing research at the hospital I saw many shortcomings but I was overwhelmed by the courage of the staff.

"One has to take a line on a subject as vast as Baragwanath and that was the line I took.

"I personally did not see any patients lying between the beds but on the other hand I was not looking for them.

"Dr Blackwood's criticism is healthy and encouraging. The documentary was intended to provoke criticism," Mr Harris said.

<u>HONEY CAKE</u> Jan

1 cup flour
4 t baking powder
2 T butter
1 egg
½ cup sugar
¼ t salt
½ cup milk

3 T honey
1½ T butter

Sift dry ingredients ... spoons ... lk and ... n ... 20 ... r ... ipped ... ret

AY OCTOBER 18 1979

Rise in medical fees approved

Argus 18/10/79 (93)

THE SA Medical and Dental Council yesterday rejected a last-minute motion proposing a six-month postponement of the rise in medical tariffs after members had warned that a delay would cause a major crisis in the medical profession.

The motion, put forward by Professor D McKenzie, followed the council's confirmation of its decision to increase medical tariffs during a special meeting yesterday.

The proposal asked for a delay of the increases until May next year so that representations could be made to the council's tariff committees for further study of the controversial rise in fees.

'This will provide a few months to allow the air to cool and some other decisions to be taken,' said Professor McKenzie.

Dr Louis Babrow warned that the medical profession was 'very angry' and that further delay would be a 'disaster.'

He was supported by Professor 'Ockie' Gordon, who said a delay of four or five months would cause 'a major crisis in the medical profession.'

The rejection of the motion closed what the president, Professor H W Snyman, described as the most troubled and hard-worked meeting of the council he had known, a session during which even its legal competence to give effect to committee decisions had been queried.

if it is too thick. Chill in a large bowl. Before serving pour on sour cream and sprinkle with chopped chives.

<u>BEAN SOUP</u> (Serves 8) Cat

1 pkt sugar beans
1 slice beef shin or soupmeat
1 Kassler rib or bacon bones
handful soup celery chopped
2 bay leaves
1 onion studded with 8 cloves
2 carrots, chopped
2½ litres water
salt & pepper to taste

Wash beans, cover with water, bring to boil. Boil for 2 minutes. Remove from heat and soak for 1 hour. Bring to boil again, add rest of ingredients. Simmer till beans are tender. Cool. Remove meat and 1 cup beans. Purée remaining soup in blender. Heat slowly. Put a few reserved beans in each serving bowl. Sprinkle with Worcester sauce. Cover with soup. Garnish with cream and crumbled bacon or croûtons.

<u>PRESERVED BRINJALS</u> Sue J

brinjals
white vinegar
olive oil
garlic
fresh marjoram

Peel brinjals and cut into Julienne strips. Put into enamelled pot and cover with white vinegar and bring to the boil. Cook for as short a time as

rsday October 18 1979

93

Doctors reject fees freeze and risk court

The Medical and Dental Council has rejected a last-minute motion proposing a six-month postponement of medical tariff increases.

The Council has also rejected appeals by the Minister of Health, Dr L A P A Munnik, and has withstood the threat of a possible court interdict.

Members of the Council have warned of "disaster and a major crisis in the medical profession" if the new scale of fees is not implemented on November 1.

Increases of up to 52 percent will now go ahead as planned.

During a special meeting earlier, council narrowly adopted a motion — by 16 votes to 15 — that it would not consider any representations on the new increases until these were published in the Government Gazette.

The Secretary for Health, Dr J de Beer, opposed the motion and warned that the Government's legal advisors were convinced that the Council did not have to wait until publication before hearing objections. He said they were "prepared to test the matter in court."

The Representative Association of Medical Schemes (RAMS), which has so far fought a losing battle in an attempt to oppose the increases, is to hold a meeting soon to discuss what further steps can be taken.

The last-minute proposal asked for a delay in the increases until May 1980.

It was opposed by doctors who warned that further delay would be a "disaster" as the medical profession was "very angry."

Doctors also said that a delay of four or five months would "cause a major crisis in the profession," and that there was much "heart-searching" for a solution.

ıow the effectiveness of a given amount of money when spent
.fferent objectives, so that choices can be formulated in
s of the alternatives we might afford - so many geriatric
care centres, so many child welfare clinics, etc.

tistics are not traditionally arranged on this basis but in
ch as 'salaries', 'transport', 'medicines', etc. A separa-
tween expenditure on different disease groups or age groups
e.

of expenditure into programmes is an art. Pole, an econo-
.K. Department of Health, writes:

structure should, in my view, be mainly determined
cisions to the taking of which one wishes it to con-
. One might suggest that where decisions are primarily
of political or moral judgement - of determining basic
s - one would want the activities to be compared to
different programmes - the mentally handicapped against
olics; but where it is a more technical question of
cular objectives can best be achieved - drug therapy
ehavioural therapy - one would want the activities to
ed to be within a particular programme. This distinc-
up with an economic jargon of slightly older vintage -
ost-benefit and cost-effectiveness; and through that
in stream of neoclassical welfare economics, which attempts
distinction between the choice of the composition of the
outputs and the choice of the set of resources from
output is to be produced. The former is, in a broad
uestion of tastes, values, or utilities; the latter is
of techniques".

Overall criteria are needed, and they have to be expressed in such a way that they can guide these detailed questions. Essentially, the problem is not only to relate resources used to objectives achieved, but to relate the various objectives to each other.

There are various means of doing this; but all of them require that expenditure be accounted for by the ends it is expected to achieve.

e, it is not an easy matter to make a hard and fast
n between technical matters and matters of values or
in the health services. From one point of view, the
hether to treat schizophrenics in hospital or in the
is a technical one. Which is the cheaper way to fulfil
Whate... re the society's requirements for the treatment of this
group? ut community care originally became fashionable as a
good thing in itself. The practitioners are very apt to muddle
the medical and economic arguments when it suits them, and the
politicians and administrators equally so when it suits them,
but the economist's concern is to keep them separate".[9]

2.1 Programme Budgeting

Programme budgeting, also known as budgeting by objectives, involves the presentation of expenditure data according to the objectives to which it is directed. Thus, projects to combat TB would be grouped together, geriatric problems, sanitation programmes, etc.

This is necessary:

(a) to know the cost of pursuing each objective;

(b) to group together activities with the same objectives which can be compared by cost-effectiveness analysis;

Programme budgeting, then, entails the attempt at this separation, sorting out from the multiplicity of decisions those which can be made on the basis of administrative or economic, together with medical-technical criteria, and those in which the role of the public through political

Doctors' fees rise approved

C.T. 18/10/79 (93)

By BOB MOLLOY

THE MEDICAL and Dental Council yesterday rejected a last-minute motion proposing a six-month postponement of the rise in medical tariffs after members warned of disaster and a major crisis in the medical profession should there be any delay.

The decision closed what the president, Professor H W Snyman, described as the most troubled and hard-worked meeting of the council he had ever known; a session during which even its legal competence to give effect to committee decisions had been queried.

Increases of up to 52 percent will go ahead as planned from November 1, in spite of Tuesday's appeal by the Minister of Health, Dr L A P A Munnik, and the threat of a possible court interdict.

The proposal, by Professor D McKenzie, asked for delay of the increases till May 1980, during which representations could be made to the council's tariff committees for further study of the controversial rise in fees. His reason was that this would give "a few months to allow the air to cool and some other decisions to be taken".

Dr Louis Babrow warned that further delay would be "disaster" as the profession was "very angry". This was supported by Professor "Ockie" Gordon who said a delay of four or five months would cause "a major crisis in the profession".

Professor Guy van Niekerk said he did not want to give the impression that doctors were unyielding — there was much "heart-searching" for a solution, but there was such "a spirit in the profession" that if a further delay was enforced "then I don't know what will happen".

Earlier in the day, during a special meeting to consider the minister's appeal, the council narrowly adopted a motion by 16 votes to 15 that it could not consider any representations on the tariff increases till these were promulgated in the Government Gazette.

The motion also required the tariff committees to be reconvened as soon as possible after publication and report to the council's next meeting in April.

The Secretary for Health, Dr J De Beer, opposed the motion on the grounds that the council would be subject to unnecessary criticism by delaying consideration of representations till after publication.

He warned that the government's legal advisers were convinced that the council did not have to wait till publication of the increase before hearing objectors and they were "prepared to test the matter in court".

STUFFED CABBAGE SALAD

1 fresh green medium size

tomatoes

May Bennett, Ridgeworth

43

SPRING GREEN SALAD

1 medium size lettuce

1 cucumber

1/3 cup coarsely chopped walnuts

1/2 cup mayonnaise or salad dressing

2 t soya sauce

1 t lemon juice

ettuce, apple, orange sections,
ombine mayonnaise, soya sauce
erve, add dressing to salad;
gs.

Mix well,
vinegar,
beans

cooked, then

st London

parsley;
eel and cube.
iece of the
r, onion and
little French
a few sprigs

May Bennett, Ridgeworth

44

7C THURSDAY, OCTOBER 18, 1979

93 18/10/79

Boss warning to Bara doc

THE Chief Superintendent of Baragwanath hospital, Dr P J Beukes, yesterday warned one of the hospital's doctors that if he spoke to the Press about conditions at the hospital he would "get into even deeper water".

Dr Roger Blackwood, a top physician at the hospital, said in a statement that patients were suffering at the hospital as a result of overcrowding and a shortage of medical personnel.

Yesterday he was called in to see the superintendent of the hospital.

Dr Beukes said the hospital was taking the matter "very seriously" and there would be "an investigation."

He said: "We have interviewed Dr Blackwood and want him to prove what he is saying He says patients have died — we want him to prove this."

Dr Beukes said he was aware of some of the conditions mentioned in allegations by Dr Blackwood.

He said no immediate decision had yet been made on what action would be taken. An investigation could take "some time", he said.

He said Dr Blackwood would have to bring the names of patients involved and this might involve speaking to other doctors.

Dr Beukes . . . Baragwanath superintendent.

In a large sal... orange sections, tuna and nuts; toss together. Combine mayonnaise, soya sauce and lemon juice; mix well. To serve, add dressing to salad; toss gently. Makes 4 - 6 servings.

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... Drury, East London

CHICKEN AND CUCUMBER SA...

1 cup cooked chicken, diced
4 T finely chopped walnuts
French dressing/mayonnaise
lettuce
1 cup cucumber, peeled and diced
1 cup cooked green peas

Marinade chicken, cucumber, nuts and peas with French dressing. Serve on lettuce with mayonnaise. Cover with greaseproof paper and refridgerate until ready for use.

French dressing:
Blend together 6 T salad oil and 2 T lemon juice.

---o0o---

EGG SALAD

hard boiled eggs
salanaise

Cut eggs in half and l... down. Pour over salan...

GERMAN POTATO SALAD

boiled potatoes
cooked bacon
mayonnaise

Cube the potatoes whi... with the potatoes, on... salt and pepper. Use...

STUFFED CABBAGE SALA...

1 fresh green medium cabbage
onions
carrots

Cut the centre from ... form a bowl. Wash ... and pineapple. Cube ... leaves of the cabbag... pineapple, tomatoes, ... in a bowl adding any ... salt and black peppe... into the cabbage "bo... bowl of mayonnaise f... roses, cut across th... iced water until the...

Munnik may have bitter pill for medics

By GERALD REILLY
Pretoria Bureau

THE MINISTER of Health, Dr L A P A Munnik, appears set for a showdown with the SA Medical and Dental Council following the council's persistent refusal to compromise over the huge hike in doctors' fees due to take effect on November 1.

Again yesterday the council pushed aside a last minute plea by the Minister.

At a special meeting in Cape Town the council voted by a majority of one to go ahead and implement the 52% rise in doctors' fees.

The motion, passed by 16 votes to 15, said the council was unable to consider the representations until the new tariffs had been published in a Government Gazette.

The motion was tabled by Professor H A Shapiro, who proposed that the various tariff committees be reconvened to review the situation as soon as possible after publication.

They would report back to the council's next meeting in April.

"We accept there are other views but they must be considered in the proper place at the proper time," Prof Shapiro said.

The Secretary for Health, Dr J de Beer, who opposed the motion, said the council would be subjected to unnecessary criticism by only reconsidering the tariffs after publication.

Dr De Beer was also reported to have told the council that the refusal to review the proposed tariffs could have "grave repercussions."

The council, he said, was facing the gravest decision in its history.

Dr De Beer conceded that financial relief was necessary, particularly for general practitioners, anaesthetists and gynaecologists.

Commenting yesterday, the NRP's Parliamentary whip, Mr Bryan Page, MP, said that if the council's uncompromising stance continued the minister might be compelled to curb the council's fee fixing powers by legislation.

In this he would have the full backing of the public.

No-one disputed that doctors were entitled to financial relief. "But to hit the public already burdened with a 14% inflation rate with an increase of this magnitude is unreasonable."

"If what is happening is in defiance of the Minister — and it appears to be — then the council is obviously running the risk of having its powers trimmed."

Dr De Beer said in an interview from Cape Town last night that the fact that the council's tariff committees would only report back to the council in April next year meant in effect that the new fees would come into operation from November 1 until at least April next year.

However, Pretoria sources pointed out that the Government had been angered by the intransigent attitude of the doctors, and it is more than possible that legislation will be introduced early in the next parliamentary session to curb the council's substantial powers.

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...es

...priorities has been
...ed by medical and nursing
... is that it can be used
...refore, lends itself to
...p of people.

2.

Basically, one is looking for inconsistencies. It was noted that a logical axiom, basic to economics, is that a rand should yield approximately the same value in whichever programme it is spent. If the net social benefit from the marginal expenditure on one programme much exceeds that on another, one can do better by withdrawing funds from the second programme and increasing expenditure on the first. By simply looking at a breakdown of the budget between programmes, the amounts spent on each may be compared with our intuitive notions of how much 'ought' to be spent on these things. Our judgement will depend on what we consider the benefits of expenditure under each programme to be, a process which cost-benefit analysis seeks to formalise (see below). For example, if it can be shown that expenditure on preventive medicine constitutes approximately 2% of all expenditure on health,[11] it may be felt that the benefits from this kind of provision warrant an increase in the share of the budget allocated to it.

Unfortunately, such intuitive processes can pick out only the grossest incongruities which are recognised by all, whatever criteria of 'value' are used. The optimum level of expenditure on a particular objective is, from the point of view of intuitive judgement, highly uncertain, because of the wide variation in benefits attributable to a particular type of spend-

...otential health problems are first listed, and then given a score (from one to four pluses) under each of four headings:

Diagram 1: A method of ranking health problems

Problem	Prevalence	Severity	Community concern	Vulnerability to management	Total
Large & poorly spaced families	++++	++++	+++	++	96
Inadequate ante-natal & obstetric care	++++	++	++	+++	48
Malnutrition	+++	+++	++	++	36
Need for medical care	++	++	++++	++	32
Specific diseases:					
V.D.	++	++	++	++	16
Dental problems	++++	+	++	++	16
TB	+++	+++	+++	++	54
Common cold*	++++	+	+	-	0
Yaws*	-	++	+++	++++	0

* Added to test scoring method

processes is essential; and the division will have to be more fine the more discriminating public decisions can be.[10]

The results of programme budgeting may be valuable in themselves, although the mere procedure does not necessarily ensure that better decisions will be made. Their potential is realised only if there follows an assessment of the value of expenditure in each programme.

2.2 Programme Evaluation

[illegible] inconsistencies. It was noted that a logical axiom, basic to economics, is that a rand should yield approximately the same value in whichever programme it is spent. If the net social benefit from the marginal expenditure on one programme much exceeds that on another, one can do better by withdrawing funds from the second programme and increasing expenditure on the first. By simply looking at a breakdown of the budget between programmes, the amounts spent on each may be compared with our intuitive notions of how much 'ought' to be spent on these things. Our judgement will depend on what we consider the benefits of expenditure under each programme to be, a process which cost-benefit analysis seeks to formalise (see below). For example, if it can be shown that expenditure on preventive medicine constitutes approximately 2% of all expenditure on health,[11] it may be felt that the benefits from this kind of provision warrant an increase in the share of the budget allocated to it.

Unfortunately, such intuitive processes can pick out only the grossest incongruities which are recognised by all, whatever criteria of 'value' are used. The optimum level of expenditure on a particular objective is, from the point of view of intuitive judgement, highly uncertain, because of the wide variation in benefits attributable to a particular type of spend-

ing. This is partly due to a deficiency in information o[illegible] the programmes which can be resolved by recourse to appropr[illegible] Nevertheless, there will also be differences of judgement [illegible] be resolved without prior agreement on the relative valuat[illegible] benefits which have to be fed into the analysis; and in th[illegible] process, these two factors may not be differentiated.

A very large proportion of [illegible]

Potentia[illegible] one to f[illegible]

Diagram [illegible]

Problem				
Large & poorly spaced fa[illegible]				
Inadequate antenatal & ch[illegible] care				
Malnutrition				
Need for [illegible] care				
Specific [illegible]				
V.D.			++	+
Dental probl[illegible]		+	++	+
TB	+++	+++	+++	+
Common cold*	++++	+	+	
Yaws*	–	++	+++	+++

* Added to test scoring method

Star — 20/10/77

Doctors back protest over Baragwanath

By Elizabeth Wilson

Black doctors are supporting Dr Roger Blackwood in his protest against conditions at Baragwanath Hospital.

They say a new hospital is essential to relieve congestion at Baragwanath and warn that, if authorities do not give the matter priority, patients will suffer.

Said a Baragwanath doctor: "There is an urgent need for another hospital — or maybe two — to meet the demand."

The doctors were commenting on allegations by Dr Blackwood, that Baragwanath Hospital was seriously short of doctors and was overcrowded.

A senior doctor said: "He is quite right. Although standards at the hospital are good, the patient load is so heavy that sometimes doctors are forced to fall short."

Some doctors at Baragwanath were "working themselves to the limit" to try to provide the best care, he said.

The shortage of medical personnel had reached a critical stage. With many doctors leaving the country it was essential to train more black doctors.

Another doctor said the strain of the heavy patient load was also creating nursing difficulties at Baragwanath.

He claimed that the quota of nurses at the hospital was "far below" that in white hospitals.

In some wards, where there was a shortage of beds, patients sometimes lay "on the floor, under beds or even on the grass outside."

Under these conditions it was possible for a nurse to "miss out a patient" when giving medication.

Dr Nthato Motlana, Committee of Ten chairman, congratulated Dr Blackwood on the "courageous stand" he had had anything to do with Baragwanath because they know at first hand the probems that beset the people of Soweto."

Dr Motlana said the need for another hospital was "an absolute emergency."

"But," he added, "because blacks don't have the vote it is no emergency for anybody — except for blacks."

Biko doctors seek a blocking order

RDM 25/10/7? (93)

By TONY STIRLING
Chief Reporter

THE first steps towards a possible SA Medical and Dental Council disciplinary hearing of the doctors involved in the treatment of black consciousness leader Mr Steve Biko before his death have been taken.

The SAMDC, acting under the instructions of its president, Professor J H Snyman, has sent the two State doctors named at the inquest, Dr Benjamin Tucker and Dr Ivor Lang, complaints levelled against them by Mr Eugene Roelofse, ombudsman of the SA Council of Churches.

Mr Roelofse's complaints were outlined in three letters to the SAMDC. His complaints were based on deductions he made from reading reports on the inquest of Mr Biko late in 1978.

The steps taken by the SAMDC were outlined at a court hearing at Pretoria's Palace of Justice yesterday.

The two doctors involved are seeking a declaratory order to block the SAMDC from proceeding further in its preliminary inquiries unless certain requirements are met.

Prof Snyman, the SAMDC and its registrar, Mr Willie Barnard, named as the respondents, opposed the application. Mr Justice Coetzee reserved judgment.

Dr Tucker is chief district surgeon of Port Elizabeth and Dr Lang principal district surgeon of Port Elizabeth.

On behalf of the doctors it was contended they wanted to reply to complaints against them to "quash" the matter before it could reach a hearing stage before the council or its disciplinary committee.

The court was told the doctors could choose to reply or not to the complaints of Mr Roelofse, but that replies could be used in evidence against them.

Mr F C Kirk-Cohen, SC, for the doctors, instructed by the State Attorney, argued that the complaints of Mr Roelofse did not comply with the requirements of regulations governing the council because they were not concise or specific. Mr Justice Coetzee disagreed.

A third doctor named at the Biko inquest, Dr Colin Hirsch, was not mentioned or represented at the hearing.

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processes is essential; and the division will have to be more fine the more discriminating public decisions can be.[10]

The results of programme budgeting may be valuable in themselves, although the mere procedure does not necessarily ensure that better decisions will be made. Their potential is realised only if there follows an assessment of the value of expenditure in each programme.

2.2 Programme Evaluation

Methods of evaluation range from simple procedures for looking at costs, where the conclusions are left largely to intuition, to highly complicated processes which present more or less clear-cut solutions. For these more precise methods, most of the value judgements have to be made explicitly in advance. Some points on the spectrum between these two extremes are analysed below.

2.3 Looking at Expenditure

Basically, one is looking for inconsistencies. It was noted that a logical axiom, basic to economics, is that a rand should yield approximately the same value in whichever programme it is spent. If the net social benefit from the marginal expenditure on one programme much exceeds that on another, one can do better by withdrawing funds from the second programme and increasing expenditure on the first. By simply looking at a breakdown of the budget between programmes, the amounts spent on each may be compared with our intuitive notions of how much 'ought' to be spent on these things. Our judgement will depend on what we consider the benefits of expenditure under each programme to be, a process which cost-benefit analysis seeks to formalise (see below). For example, if it can be shown that expenditure on preventive medicine constitutes approximately 2% of al[...] expenditure on health,[11] it may be felt that the h[...] of provision warrant an increase in the share of th[...]

Unfortunately, such intuitive processes can pick ou[...] congruities which are recognised by all, whatever c[...] used. The optimum level of expenditure on a parti[...] from the point of view of intuitive judgement, high[...] the wide variation in benefits attributable to a pa[...]

ing. This is partly due to a deficiency in information on the results of the programmes which can be resolved by recourse to appropriate data. Nevertheless, there will also be differences of judgement which cannot be resolved without prior agreement on the relative valuation of different benefits which have to be fed into the analysis; and in the intuitive process, these two factors may not be differentiated.

A very large proportion of decisions are now taken with no further analysis than this. Any further steps involve a way of systematically valuing the benefits of different programmes to render them comparable to one another.

2.4 An Informal[...]

The following me[...] described by Joh[...] students in Thai[...] where no numeric[...] discussion, to d[...]

Potential health [...] one to four pluse[...]

Diagram 1: A me[...]

Problem
Large & poorly spaced families
Inadequate ante-natal & obstetric

* Added to test scoring method

NOTICE 845 OF 1979

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

ELECTION OF MEMBERS OF THE PROFESSIONAL BOARD FOR RADIOGRAPHY

It is hereby notified in terms of section 15 (5) of Act 56 of 1974 and regulation 8 (2) of the regulations for the election of members of the Council published under Government Notice R. 2279 of 3 December 1976, that the following persons have been validly nominated as candidates for election as members of the Professional Board for Radiography for the five year period 1 December 1979 to 30 November 1984:

Mbhele, Thami Frederick.

Ziegler, Francis Xavier Joseph.

As the number of supplementary diagnostic radiographers validly nominated exceeds the number of supplementary diagnostic radiographers to be elected, I have appointed 26 November 1979 at 12h00, before which every person entitled to vote in the election may sign and transmit or deliver to me a voting paper described in the Third Annexure to the said regulations. A voting paper will be posted to the last registered address of every person entitled to vote in the election.

W. H. BARNARD, Returning Officer.

P.O. Box 205, 6115 Oranje-Nassau Buildings, 188 Schoeman Street, Pretoria.

26 October 1979.

(26 October 1979)

KENNISGEWING 845

DIE SUID-AFRIKAANSE GEN... EN TANDHEELKUNDIG...

VERKIESING VAN LEDE VAN ... RAAD VIR RADIOG...

Ingevolge artikel 15 (5) van W... regulasie 8 (2) van die regulasies vir ... lede van die Raad afgekondig by G... gewing R. 2279 van 3 Desember ... bekendgemaak dat ondergenoemde p... mineer is as kandidate vir verkiesin... Beroepsraad vir Radiografie vir d... Desember 1979 tot 30 November 198...

Mbhele, Thami Frederick.

Ziegler, Francis Xavier Joseph.

Aangesien die getal aanvullende ... grafiste wat geldiglik genomineer is ... lende diagnostiese radiografiste ... moet word, het ek 26 November 1... gestel as die dag en tyd waarvoor ... is om by die verkiesing te stem ... Derde Aanhangsel van die gemeld... kan teken en aan my stuur of ... briefie sal gepos word na die laaste ... van elkeen wat geregtig is om ... stem.

W. H. BARNARD, Kiesbeampte.

Posbus 205, Oranje-Nassaugebou, ... straat 188, Pretoria.

26 Oktober 1979.

(26 Oktober 1979)

Baragwanath doctors act on staff shortage, overwork

Sun Express 28/10/79 (93)

By MARIAN SHINN

EVERY doctor who works in the Baragwanath Hospital casualty department is liable for malpractice, according to a doctor who has done shift work there for several years.

"We can get 200 people through here on a busy night, which means we have only a few minutes to examine each patient," the doctor said. "Obviously we can't do it properly.

"We would like to take them into the cubicles and give them a thorough examination. But there isn't the time.

"In the years I've been here I've seen the quality of medicine deteriorate. You have to make instant diagnoses, and after about six hours of the intensive work your awareness is blunted and you are likely to make mistakes.

"In winter, if there is flu around and someone comes in with a headache or cough, he is likely to be given some medication and sent home. The chances of a thorough examination are slight."

Doctors can work a 12-hour casualty duty after a full day's work and go straight from casualty to their usual duties, making it a 36-hour stint.

"Conditions weren't always like this. We could cope once before the pressures on the hospital built up. But as the population of Soweto has increased the hospital has stood still and the number of doctors available has diminished," the doctor said.

"We have complained about the facilities and the shortage of staff but the heads of departments are tied up in red tape.

"Baragwanath has an international reputation for the care it gives its patients and the teaching it offers, but it is losing its good name because the doctors can't cope with the load.

"We've complained, but nothing happens. Many of the seniors have given up complaining and just accepted that this is the way things operate here and try to cope as best they can.

"At the clinics in the townships five doctors — if there are that many available — have to see about 500 patients a day. That means they see 12,5 patients an hour or one patient every 4,5 minutes."

Some clinics are down to two doctors and 11 sisters for each 300 patients. Those who cannot be examined at the clinics because time runs out arrive at the casualty department at night and increase the workload there.

On Thursday Professor Leo Schamroth, head of the department of medicine at Baragwanath, confronted

SOME PUT IN A 36-HOUR STINT, THEY SAY

the superintendent, Dr P J Beukes, with a delegation of doctors.

They gave him a memorandum of what was wrong with the hospital and some suggestions on how to improve the critical bed and staff shortage.

They told him that if the Transvaal Provincial Administration did not do something about these major problems they could no longer teach at the hospital.

The shortage of doctors resulted in more time being spent treating patients, leaving little time to train new doctors.

Baragwanath has an international reputation as a teaching hospital and at the recent Fellowship of the College of Physicians of South Africa examinations Baragwanath had a 100% pass. Other South African hospitals average about a 50% pass.

This is apparently the second time Professor Schamroth has confronted the hospital administration in this way.

Dr Beukes would not reveal what was said at the meeting — it was "a private discussion" — but he said the doctors had given him a report and he was expecting another one from them.

Both these reports would then be submitted to the Director of Hospital Services, Dr Hennie Grove.

The second report is probably the letter supporting the claims of Dr Roger Blackwood, cardiologist at the hospital, who wrote a letter to The Star outlining the problems of Baragwanath. All 500 doctors at the hospital are being asked to sign it.

The meeting with Dr Beukes was arranged after Professor Schamroth met the dean of the medical school at Baragwanath, Dr P J P van Blerk, and Professor T H Bothwell, head of the department of medicine, on Wednesday.

I... T... t... b... o... 2... Me... wh... pr... pr... in... an... 2... Bas... log... mat... soc... tha... pro...

...increasing expenditure on the first. By simply looking at a breakdown of the budget between programmes, the amounts spent on each may be compared with our intuitive notions of how much 'ought' to be spent on these things. Our judgement will depend on what we consider the benefits of expenditure under each programme to be, a process which cost-benefit analysis seeks to formalise (see below). For example, if it can be shown that expenditure on preventive medicine constitutes approximately ... expenditure on health,[11] it may be felt that the benefit... of provision warrant an increase in the share of the budg...

Unfortunately, such intuitive processes can pick out only... congruities which are recognised by all, whatever criteri... used. The optimum level of expenditure on a particular... from the point of view of intuitive judgement, highly unc... the wide variation in benefits attributable to a particul...

La... sp... In... na... ca... Ma... Ne... ca... V... De... TB...

					10
		+	++	++	16
		+++	+++	++	54
...ommon cold*	++++	+	+	-	0
...aws*	-	++	+++	++++	0

* Added to test scoring method

Doctors MUST keep up to date

NM 8/11/79 (93)

DOCTORS who fail to keep up with developments in their profession become out of date in about five years and possibly not fit to practise a couple of years after this.

This isn't some fancy idea from overseas — it is the view of a professor at the University of Natal medical school. Because of the rows he gets into, he says he'd rather not have his name mentioned.

"Keen doctors here do make a point of seeking out courses in continuing medical education. But not enough such courses are available in South Africa and too many private doctors, because of lack of time, fail to attend those that are," he says.

In America, intending patients are quite likely to ask the prospective doctor if he has been keeping up to date. In damages cases against doctors to have kept up to date is often a successful defence.

The professor pointed out that courses in continuing medical education were available at Wits and in Cape Town.

"One is due to be started here but who knows when it will get off the ground."

In the meantime, the Medical Association of South Africa does what it can and the next session in which the experts will educate the "laymen" of their profession will be on November 17 at the Royal Hotel.

"The subject will be immunology, where it is emerging that in a whole range of diseases, the body has turned against itself. There's a lot of very exciting research going on — in one year there are 10 000 new publications on the subject — and new treatments are emerging all the time," he says.

Doctors wishing to attend should contact the Natal Coastal Branch of the Medical Association, not forgetting that expenses for continuing medical education are tax

For full text see GG 6726

(93)

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GOVERNMENT GAZETTE

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GENERAL NOTICES

DEPARTMENT OF HEALTH

NOTICE 877 OF 1979

THE SOUTH AFRICAN MEDICAL AND DENTAL COUNCIL

NOTICE CONCERNING THE TARIFF OF FEES FOR SERVICES RENDERED BY DENTISTS TO MEMBERS OF REGISTERED MEDICAL SCHEMES

In terms of section 53A (4) of the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act 56 of 1974), as amended, I, Willem Hendrik Barnard, Registrar of the South African Medical and Dental Council, hereby publish the tariff of fees set out in the Schedule hereto for services rendered by dentists to members and dependants of members of registered medical schemes, which the Council has determined in terms of section 53A (1) of the said Act in substitution for the tariff of fees published under Government Notice R. 313 of 24 February 1978. The Council has, in terms of section 53A (6) (b) of the said Act, determined that the said tariff shall be binding with effect from date of publication hereof on dentists who, in terms of section 29 (1) of the Medical Schemes Act, 1967 (Act 72 of 1967), render services to members and dependants of members of medical schemes.

SCHEDULE

I. GENERAL RULES

001. A consultation shall include an examination. No further consultation fee shall be chargeable until the treatment plan resulting from this initial consultation has been discharged. This rule applies only to tariff items 8101 and 8103.

002. Except in those cases where the fee is determined "by arrangement", the fee for the rendering of a service which is not listed in the tariff of fees shall be based on the fee in respect of a comparable service that is listed therein

ALGEMENE KENNISGEWINGS

DEPARTEMENT VAN GESONDHEID

KENNISGEWING 877 VAN 1979

DIE SUID-AFRIKAANSE GENEESKUNDIGE EN TANDHEELKUNDIGE RAAD

KENNISGEWING INSAKE GELDETARIEF TEN OPSIGTE VAN DIENSTE GELEWER DEUR TANDARTSE AAN LEDE VAN GEREGISTREERDE MEDIESE SKEMAS

Kragtens artikel 53A (4) van die Wet op Geneeshere, Tandartse en Aanvullende Gesondheidsdiensberoepe, 1974 (Wet 56 van 1974), soos gewysig, publiseer ek, Willem Hendrik Barnard, Registrateur van die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad, hierby die geldetarief in die Bylae hiervan uiteengesit, vir dienste gelewer deur tandartse aan lede en afhanklikes van lede van geregistreerde mediese skemas, wat die Raad kragtens artikel 53A (1) van genoemde Wet, ter vervanging van die geldetarief gepubliseer by Goewermentskennisgewing R. 313 van 24 Februarie 1978, bepaal het. Die Raad het kragtens artikel 53A (6) (b) van genoemde Wet bepaal dat die genoemde tarief met ingang vanaf datum van publikasie hiervan bindend is vir tandartse wat ingevolge artikel 29 (1) van die Wet op Mediese Skemas, 1967 (Wet 72 van 1967), dienste aan lede en afhanklikes van lede van mediese skemas lewer.

BYLAE

I. ALGEMENE REËLS

001. 'n Konsultasie sluit 'n ondersoek in. Geen verdere konsultasiegeld mag gehef word alvorens die behandelingsplan wat uit hierdie aanvanklike konsultasie voortspruit, afgehandel is nie. Hierdie reël is van toepassing slegs op tariefitems 8101 en 8103.

002. Uitgesonderd in dié gevalle waar die bedrag vasgestel word "volgens ooreenkoms", moet die bedrag vir die lewering van 'n diens wat nie in die tarieflys vermeld word nie, gebaseer word op die bedrag vir 'n vergelykbare diens wat wel daarin vermeld word.

DDR (93) 14/11/79

Medical fee hike defended

EAST LONDON — A local medical spokesman has lashed out against the public outcry that followed in the wake of the 50 per cent increase in medical and dental fees.

The president of the Border Coastal Branch of the Medical Association of South Africa, Dr H. S. Kayser, said in a statement there had been a lot of confusion about the new increase and doctors were blamed for being "greedy".

He said people often confused the Medical Association of South Africa with the South African Medical and Dental Council. The Medical Association was an organisation of doctors and the Medical and Dental Council consisted of 34 members of whom only 10 were doctors elected by medical practitioners.

The rest of the Medical Council consisted of the Secretary for Health plus the 23 others who did not belong to the medical profession.

In the Medical Schemes Act there was provision for a remuneration committee appointed by the Minister of Health. A total of five of these committees had sat over the years but they proved to be unsatisfactory.

In 1974 the fourth committee approved a 20 per cent increase in medical and dental fees and the fifth one approved a 10 per cent increase.

Dr Kayser said in the five years from 1974 to 1979 a total increase of 30 per cent was thus obtained. In the same period the consumer price index had gone up by 75 per cent.

Doctors found themselves in a position where they were not compensated for the rise in practice costs which in some practices was as high as 50 per cent.

In the government's Manifesto against Inflation the private sector was asked to absorb 30 per cent of the rise in costs. Doctors contributed much more to the campaign by absorbing 100 per cent of the rise in costs.

Dr Kayser claimed doctors accepted a lower standard of living in view of the country's economic climate while in the same period, between 1974 and 1978, the average employee's salary went up by an average of 66 per cent and personal income levels went up by 60 per cent.

In 1978 the Minister of Health scrapped the remuneration committees and appointed the Medical and Dental Council of South Africa as a fee setting body.

The 50 per cent increase was granted by this council. If there had not been a backlog in the tariffs the increase could have been phased over a period of time to reduce the shock effect, he said. — DDR.

All-race medical school is new dean's aim

Education Reporter

[illegible] medical school of the [illegible]iversity of the Witwatersrand should be en[illegible]ing equal numbers of [illegible] and white students [illegible] the end of the century, Professor Phillip To[illegible], now dean of the [illegible].

[illegible]ofessor Tobias, the [illegible]-renowned physical [illegible]ropologist and out[illegible] critic of apartheid [illegible] racism, hopes to ini[illegible] long-range planning [illegible] a properly multiracial [illegible]cal school during his [illegible] of office.

[illegible] revealed this in an [illegible]iew on the an[illegible]ement that next [illegible] he will take over from [illegible]sor Robert Charlton [illegible]n of the 60-year-old [illegible]y of medicine at [illegible].

[illegible]essor Charlton will [illegible]me a university [illegible]y. vice-chancellor.

[illegible]essor Tobias (54) [illegible] studying in the faculty in 1944 and has been professor of anatomy and head of the department of anatomy since 1959. He is also honorary professor of palaeo-anthropology.

In his appointment as dean he is again following in the footsteps of Professor Raymond Dart, the veteran physical anthropologist. Professor Dart, one of those who sparked Professor Tobias's interest in fossils, was professor of anatomy before 1959 and served as dean of the school for 18 years.

Increasing

"We expect this school like the rest of the university, to become increasingly multiracial in its composition," said Professor Tobias.

"By the turn of the century there should be a black/white student mix of 50-50. At the moment 90 percent of students in the faculty are white."

Black and brown students entering "white" universities now need Government permission but Wits and other universities expect that university apartheid, in force since 1959, will fall away.

Professor Tobias believes that medical schools currently training only black and brown doctors will not be able to alleviate the "desperate shortage" without help.

"Perhaps the time is nearer than we think when Wits and other medical schools will be free once more to admit students irrespective of race.

"But we may find the effects of more than 20 years of Bantu education to be such that, for a while, we will need 'bridging courses' and special tutorial help for those students whose schooling has been inadequate.

"Last year 14 percent of Wits medical graduates were black or brown. It is a sad reflection that this figure is lower than in the years 1956 to 1958 when nearly a fifth were black or brown. We have much leeway to make up."

Nusas

Professor Tobias, who was president of the National Union of South African Students (Nusas) when the Nationalist Government came to power, believes student thinking has played a part in faculty decisions.

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"Students and staff have long had an interest in the health and welfare of underprivileged communities," said Professor Tobias.

"This is now being translated into concrete modification of the curriculum to put a greater emphasis on this, which is surely one of South Africa's greatest health needs.

"But the changes will make community health an equal partner with branches such as general and specialist practice and research. It will not replace these branches. We turn out a multipurpose product and have no intention of deviating from this.

"But we must find a means to turn out community-minded doctors who would dedicate their lives to promoting the health and welfare of the neediest sections of the community."

Priorities

In the short term Professor Tobias will have three priorities.

One is the organising of the move to the new medical school buildings near Johannesburg Hospital in Parktown. (Some sections of the faculty are moving into the new hospital already.)

He will also oversee two changes which have already started: a new method of selecting students and the introduction of a new curriculum in the faculty.

By interviewing students to judge their suitability instead of relying only on school records, the university hopes to end the practice of admitting only "the cream of the matrics."

"We hope to depart from the elitist image of our student body but without dropping standards," Professor Tobias said.

He expects that his new post will take up 80 percent of his time so he will curtail his teaching and writing. But his research assistants will continue the extensive studies he has been leading into fossil man and into the living peoples of Africa.

All-race medical school is new dean's aim

STAR 26/4/77

Education Reporter

The medical school of the University of the Witwatersrand should be enrolling equal numbers of black and white students by the end of the century, says Professor Phillip Tobias, now dean of the school.

Professor Tobias, the world-renowned physical anthropologist and outspoken critic of apartheid and racism, hopes to initiate long-range planning for a properly multiracial medical school during his term of office.

He revealed this in an interview on the announcement that next year he will take over from Professor Robert Charlton as dean of the 60-year-old faculty of medicine at Wits.

Professor Charlton will become a university deputy vice-chancellor.

Professor Tobias (54) began studying in the faculty in 1944 and has been professor of anatomy and head of the department of anatomy since 1959. He is also honorary professor of palaeo-anthropology.

In his appointment as dean he is again following in the footsteps of Professor Raymond Dart, the veteran physical anthropologist. Professor Dart, one of those who sparked Professor Tobias's interest in fossils, was professor of anatomy before 1959 and served as dean of the school for 18 years.

Increasing

"We expect this school like the rest of the university, to become increasingly multiracial in its composition," said Professor Tobias.

"By the turn of the century there should be a black/white student mix of 50-50. At the moment 90 percent of students in the faculty are white."

Black and brown students entering "white" universities now need Government permission but Wits and other universities expect that university apartheid, in force since 1959, will fall away.

Professor Tobias believes that medical schools currently training only black and brown doctors will not be able to alleviate the "desperate shortage" without help.

"Perhaps the time is nearer than we think when Wits and other medical schools will be free once more to admit students irrespective of race.

"But we may find the effects of more than 20 years of Bantu education to be such that, for a while, we will need 'bridging courses' and special tutorial help for those students whose schooling has been inadequate.

"Last year 14 percent of Wits medical graduates were black or brown. It is a sad reflection that this figure is lower than in the years 1956 to 1958 when nearly a fifth were black or brown. We have much leeway to make up."

Nusas

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① 93. ②

RAND DAILY MAIL, Monday, December 3 1979

'Doctors aim at sole control of health industry'

Medical schemes boss fires salvo at critics

By PAM KLEINOT

THE vice-chairman of the Representative Association of Medical Schemes (Rams), Mr J Ernstzen, charges that doctors are antagonistic towards medical aid societies because they want sole control over the medical "industry".

"They would like to control the industry. They have the mistaken idea that we are making more than a living out of their labours," he said.

His comments follow last week's Consumer Mail report quoting doctors' criticisms of the schemes, which included the following:

- Although ostensibly run on a non-profit basis, some medical aids made large profits. Their administrative allowance amounted to an estimated R40-million a year.
- That entrepreneur schemes were a "high-powered business game" which allowed administrators to "profiteer".
- Concern over more than R200 000 that recently went missing at one medical aid scheme.
- That doctors' earnings should not be dictated by a group of businessmen with vested interests.

The doctors called for medical aids to throw open their books for inspection.

Mr Ernstzen said these criticisms had adversely affected "a very reputable industry".

These are some of the questions Consumer Mail put to him:

Q: Would you care to comment on doctors' accusations?

A: Doctors have not suffered the severe backlog that they have made out. They don't want to have other people involved in the health care industry. Doctors want to control the industry. They have the mistaken idea that we are making more than a living out of their labours.

Q: Why are doctors opting out?

A: They have their own reasons for it. I think it is mainly because the Medical Association said they should, but the reason why some opted out this year was because of dissatisfaction with medical tariffs.

However, I do believe the main reason for opting out is because the doctors feel bitter about late-night calls and the restriction on their charges. This applies particularly to doctors operating in more affluent areas, who are called out sometimes for nothing, and object to charging prescribed fees. Doctors object to being restricted in what they can charge someone who is wasting their time.

Q: Isn't this to the detriment of the consumer?

A: I don't really think so because subscriptions are geared to the tariff so members get benefits at that level. Patients are entitled to shop around for doctors who charge medical aid rates. But we are prohibited in terms of the Medical Schemes Act from issuing lists of doctors and dentists who are contracted in.

There are two ridiculous solutions to this. The one is to force all doctors to contract in, which I don't support, and the other is to increase the tariff to the highest fee charged by the practitioner.

Q: Comment on the estimated R40-million administration costs averaging R1,60 for each member per month.

A: I won't argue with your estimate. The member gets a lot of service for his R1,60 and so does the doctor. Medical aid schemes are not just a debt-collecting agency. Administration must be aimed at seeing the rules of the schemes are

Turn to PAGE 6

88 IV DISEASES OF BLOOD AND BLOOD-FORMING ORGANS

89 VII DISEASES OF THE CIRCULATORY SYSTEM

VIII

Age	1	2	3	4	5	6	7	8
1–4	0,05	0,05	0,02	0,07	0,45	0,26	0,23	0,18
5–24	0,03	0,01	0,05	0,04	0,09	0,06	0,09	0,07
25–44	0,03	0,01	0,04	0,05	0,23	0,09	0,13	0,06
45–64	0,07	0,07	0,21	0,11	0,36	0,13	0,26	0,07
65+	0,18	0,13	0,00	0,15	0,47	0,18	0,44	0,15
ALL	0,06	0,04	0,07	0,06	0,25	0,14	0,17	0,12
NO.	128	85	26	23	289	164	366	187

Age	1	2	3	4	5	6	7	8
0–1	2							
1–4	0,22	0,28	0,90	0,69	5,32	5,45	2,46	2,13
5–24	0,05	0,06	0,17	0,11	0,21	0,23	0,18	0,16
25–44	0,20	0,12	0,37	0,33	0,94	0,72	0,66	0,52
45–64	1,46	0,92	3,33	1,85	4,88	2,14	2,75	1,72
65+	11,52	7,89	16,51	13,42	20,07	10,49	9,32	6,19
ALL	1,12	0,97	1,22	0,79	2,87	2,22	1,37	1,24
NO.	2336	2019	430	282	3270	2588	2858	1951

RDM 3/12/79

Medical aid chief hits back at doctors

strictly adhered to, which involves time, paperwork and money. It includes:

- The calculation of subscriptions and processing of members' particulars and claims.
- Preparing a subscription schedule for employers of their monthly payments.
- Providing members with information, dealing with queries and supplying them with annual tax certificates.

Q: Entrepreneur schemes are said to be competitive. How? Do some offer extra benefits?

A: They are basically competitive in terms of the service they offer. This includes the accuracy and speed with which settlements are made. We have to offer a high range of benefits. Some entrepreneur schemes go beyond the minimum benefits laid down in the Act and offer benefits for

□From PAGE 5

homeopathy, chiropractice and remedial education. Most entrepreneur schemes pay for treatment for infertility, and contraception.

Doctors tend to confuse entrepreneur schemes with exempted schemes, which are not obliged to comply with minimum requirements.

Because of this we all get tarred with the same brush.

Q: Why do some doctors have to wait for up to three months before being paid?

A: Because of the tardiness of members in submitting their accounts.

Q: What are the reasons for the 25% reserve fund?

A: About five years ago, the registrar of medical aid schemes laid down that medical schemes should have a reserve of about 25% of the current year's claims to save them from bankruptcy. However, this is to be attained over several years, not taking a lump sum out of subscription income. We are not carrying a lot of money in our bank account. What we do have in our reserves is to protect us against losses.

According to 1978 figures, 91,6% of subscription money was paid out in benefits to members. Funds can't run on pure income expenditure. We have to budget in advance. There are going to be surpluses and deficits because of under- or over-budgeting.

Q: How many have attained the 25% reserve?

A: Few medical aid schemes have attained the 25% reserve, although at least two have got more than the required 25%. The reason why so few have attained it is because of the heavy run against the schemes in the last few years, particularly due to advances in medicine — for example, the Cat Scan, which is costly.

Q: Comment on the claims that medical aids make large profits, said to be as much as R1-million.

A: When they talk about the R1-million profit, it's the scheme's surplus, which it was fortunate to make in one year. This money will be used only for members' benefits.

Q: What happens to the interest on the 25% reserve?

A: The interest goes into the medical aid funds, which are ultimately used for members' benefits.

Q: How would you feel about a Government-introduced national health plan?

A: I believe this would be an adverse step. It would not be either in the public interest nor in the interest of the medical profession.

My basic objection is that it would turn doctors into public servants. It also doesn't fall in line with the free enterprise philosophy.

'Permit system worsens black doctor shortage'

RDM 4/12/79

93

By MARILYN ELLIOTT

A TOP professor of medicine yesterday cited figures showing South Africa has a critical shortage of black doctors — and put part of the blame on the law restricting the entrance of blacks to white universities.

Professor Phillip Tobias, who takes up his appointment as dean of the faculty of medicine at the University of the Witwatersrand in January, said that last year South Africa produced only two black doctors for every million blacks, in contrast to 142 white doctors per million whites.

He called for the scrapping of the Extension to the University Education Act, which requires blacks, Indians and coloureds to obtain permits to enter predominantly white universities.

Prof Tobias said there were also too few coloureds in SA medical schools.

Over the past 10 years coloureds made up only 3% of the doctors graduating — although coloureds comprised 9% of the population.

"In 1978 there were just under 6 000 registered medical students. Only 306 — about 5% — of these were blacks. Figures for 1979 showed a marginal increase in the number of black students."

In 1978 the Minister of Coloured Affairs had granted 95% of applications, the Minister of Indian Affairs 83%, but only 29% of black applicants were successful.

The statistics will appear in a paper by Prof Tobias titled "Medical Education and Apartheid", to be published in the United States.

Last night, the Minister of Health, Dr L A P A Munnik, said Prof Tobias was "juggling the facts."

"There is a shortage of black doctors, but Prof Tobias has not taken into account the fact that hundreds of white doctors — those employed by both the State and in private practice — treat blacks every day."

The Minister of National Education, Mr Punt Janson, said the shortage was not due to a lack of facilities.

"I would say the problem begins lower down where, in the past, blacks, from primary to secondary schools, have not had the same standard of education as whites".

GENERAL NEWS

Data on black doctors not biased — Prof

RDM 6/12/77

93

By MARILYN ELLIOTT

PROFESSOR Philip Tobias, new dean of the University of the Witwatersrand's medical school, has strongly denied he "juggled the facts" to show up a grave shortage of black doctors in South Africa.

Prof Tobias was reacting to an accusation by the Minister of Health, Dr L A P A Munnik, that he had "arranged the facts" to suit an argument which showed there are very few black doctor graduates in SA compared with whites.

"I strongly deny that I juggled the facts. The facts speak for themselves. In the last decade only 3% of all doctors who graduated in SA were blacks although 70,4% of the total population is black. While the whites comprise only 17,3% of the population, including homelands, 85,4% of the graduate doctors were white.

"Of course, I am well aware that white doctors serve the needs of blacks, but this does not justify the fact only two of South Africa's seven medical schools are freely open to blacks. Nor does it justify the fact that only about 360 of just over 6 000 registered medical students in SA in the last year were blacks.

"I fully agree with the Minister of National Education that much of the blame for the present situation rests with decades of below-standard 'Bantu Education' and that the schooling available to blacks must be vastly improved if there is to be a significant increase in the number of blacks qualified to enter South Africa's medical schools," Prof Tobias said.

Dr Munnik this week stood by his accusation.

"If Prof Tobias can tell me how many blacks presented themselves for medical training at any university and how many were turned away, then I will be interested in his figures. One has to consider the merit selection system of the university which does not take into account whether a student is white or black. There are 23 000 blacks matriculating this year. Every single one of them can apply to enter medicine.

"I find it strange that Prof Tobias wants to publish these figures in America. What is the object of this? His figures and the way he is using them are misleading. I think he is trying to create an anti-South African climate," Dr Munnik said.

Prof Tobias said that while he did not have the figures at hand of the number of blacks who had applied for medicine at one university and were then turned away or accommodated elsewhere, they could be made available.

● A report in Tuesday's Rand Daily Mail and in an editorial yesterday referred to Prof Tobias as noting that only 29% of blacks who applied to Wits received Ministerial approval for entry. In fact, Prof Tobias used this statistic as referring to all universities.

We won't drop doctors' fees, but... says Lapa

Star 12/12/79 (93)

Own Correspondent

Medical fees are not likely to drop under a draft law published today by the Minister of Health, Dr L A P A Munnik.

Dr J Gilleland, acting Secretary for Health, said in Pretoria today the proposed law would enable the Minister to freeze tariffs at their present level.

It was likely he would do this until the commission of inquiry into health services announced yesterday had an opportunity to study the position and make its recommendations.

This follows the controversy surrounding the recent rise of about 50 percent in medical and dental fees.

The SA Medical and Dental Council went ahead with the increase despite pleas from Dr Munnik to revise its decision.

A spokesman for the council declined to comment on the Minister's latest move today. But it is likely the proposed law will receive the full attention of the council at its next meeting.

A draft of the law will be published in Cape Town today and comment from any interested party will be invited before Dr Munnik puts a revised version to the next session of Parliament.

He said when announcing the law yesterday that he had introduced it because it was unlikely the commission would finish its work and make recommendations before the next session was over.

He pointed out that under the present law, he had no jurisdiction in setting fees, but at the same time, was held responsible for any decisions on them.

"NO SETBACK"

The commission "is not a setback for the SA Medical and Dental Council, and probably won't find much that is new," a spokesman for the Representative Association of Medical Schemes.

"It might have been more fruitful for the Minister to have appointed a commission to investigate some fields other than medical schemes," the spokesman said.

"Everything we do is laid down in the regulations and I don't expect the commission will find much that's new.

"There are some members of the Medical and Dental Council who would like to see the medical schemes investigated, but we're prepared to give the commission any information it may need to help its findings.

"We've expected the Minister's announcement for a long time, and have expressed our willingness to co-operate," he said.

● **Page 11: Commission to look into health services.**

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Commission of inquiry into medical schemes

PRETORIA — A commission of inquiry would investigate all aspects of medical aid schemes, as part of a full inquiry into health services, the Minister of Health, Dr L. A. P. A. Munnik, said yesterday.

The Hon Mr J. W. Haak, has been appointed chairman of the commission, which will issue an interim report on medical schemes within three months of its appointment.

As an interim measure, until the commission reported, draft legislation will be gazetted today, concerning the present tariff of fees for services, as the SA Medical and Dental Council has decided to review tariffs.

Dr Munnik said he hoped the commission would be able to remove the unpleasantness that has accompanied the determination of tariffs.

"I hope they will be able to find an acceptable formula to calculate the cost of health services, so that suppliers receive reasonable incomes and patients were assured that they were paying reasonable fees."

The commission will make recommendations regarding the scope and cost structure of health services in both public and private sectors.

"This is with a view to rationalising services and making them more effective, as well placing costs on a sound and firm basis," Dr Munnik said.

He said the tariff of fees for services by medical practitioners and dentists, to members of medical schemes, had made it an appropriate time to appoint such a commission.

Some of the terms of reference of the commission are:

- The rationalisation of medical schemes. An investigation of their administrative costs, assets and reserves, profits and/or compensation of entrepreneurs, use of manpower, the extent of coverage.
- The investigation into the extent to which the recommendations of a previous commission of inquiry into the pharmaceutical industry, have been implemented.
- To determine what influence pharmaceutical manufacturers have had on the cost of medicine.
- To investigate the implementation of the recommendations of a previous commission of inquiry into private hospitals and unattached operating theatres.
- To investigate the provision of medical services by state, provincial and local authorities.
- The incomes and fringe benefits of medical practitioners, dentists and supplementary health service personnel.
- Excessive use by patients of medical services.

The commission will publish an interim report of medical schemes three months after its appointment. It will issue interim reports on various facets of its terms of reference and will appoint committees to investigate these various facets.

Professor J. N. de Klerk, chairman of the Federal Council of the Medical Association of South Africa, MASA, said last night he welcomed the appointment of the commission "with open arms."

"We have stated all along we would support a commission and are only too happy it has been appointed." — DDC.

New bills will bring curbs in medical sectors

C1 13/12/79

(93)

Science Reporter

TWO new draft bills published in the Government Gazette yesterday propose strong curbs in the medical and paramedical sectors, ranging from the scrapping of acceptance of overseas qualifications for psychologists to the nailing of doctors' fees to a prescribed tariff and the assumption by the Minister of Health of the final say in promulgating new tariffs.

The Medical, Dental and Supplementary Health Services Act of 1980 does away with the prescribing of overseas qualifications which entitle any holder to registration as a psychologist.

It also provides for temporary registration for training purposes in the supplementary health services of people not permanently resident in the Republic, and makes new provision for the registration of persons practising these professions.

Further provisions prohibit the use of certain names by unregistered persons, allow no force or effect to tariffs of fees until approved by the Minister of Health and published in the Gazette, define the tariff as the *maximum* fees that may be charged, makes any such tariff binding on all members of the professions covered, and allows the minister to set aside any decision or determination of the Medical and Dental Council if it is considered in the public interest.

The Medical Schemes Amendment Bill among other provisions forbids doctors from recovering fees from a medical scheme member in excess of those laid down by an agreed tariff.

member of the company to whom notice is sent before or after receipt

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ers and Certain Acts

hare capital.—(1) Notwithstanding anything contained in its memorandum or articles, the directors of a company shall not have the power to allot or issue shares of the company without the prior approval of the company in general meeting.

(2) Any such approval may be in the form of a general authority to the directors, whether conditional or unconditional, to allot or issue any shares in their discretion, or in the form of a specific authority in respect of any particular allotment or issue of shares.

(3) If any such approval is given in the form of a general authority to the directors, it shall be valid only until the next annual general meeting of the company but it may be varied or revoked by any general meeting of the company prior to such annual general meeting.

(4) Any director of a company who knowingly takes part in the allotment or issue of any shares in contravention of subsection (1), shall be liable to compensate the company for any loss, damages or costs which the company may have sustained or incurred thereby, but no proceedings to recover any such loss, damages or costs shall be commenced after the expiration of two years from the date of the allotment or issue.

222. Restriction on issue of shares and debentures to directors.—(1) No provision in any memorandum or articles or in any resolution of a company authorizing the directors to allot or issue any shares or debentures convertible into shares of the company at the discretion of the directors, shall authorize the allotment or issue of any such shares or debentures to any director of the company or his nominee, or to any body corporate which is or the directors of which are accustomed to act in accordance with the directions or instructions of such director or nominee, or at a general meeting of which such director or his nominee is entitled to exercise or control the exercise of one fifth or more of the voting power, or to any subsidiary of such body corporate unless—

(*a*) the particular allotment or issue has prior to the allotment or issue been specifically approved by the company in general meeting; or

Biko doctors lose order

By ARNOLD GEYER

THE [illegible] is [illegible] for a possible disciplinary hearing of the State doctors who attended black consciousness leader Mr Steve Biko before he died in detention.

Mr Justice J Coetzee dismissed with costs an application by Dr Benjamin Tucker, chief district surgeon of Port Elizabeth, and Dr Ivor Ralph Lang, principal district surgeon of Port Elizabeth, to block the SA Medical and Dental Council (SAMDC) from proceeding further in its preliminary inquiries into complaints against their conduct.

A copy of the judgment, given in Pretoria's Palace of Justice on December 4, was handed to the Rand Daily Mail yesterday.

The blocking order was opposed by the SAMDC, its president, Professor J H Snyman, and the council's registrar, Mr Willie Barnard.

The SAMDC sent the two doctors complaints levelled against them by Mr Eugene Roelofse, ombudsman of the SA Council of Churches. These were based on deductions he made from reading reports on the inquest of Mr Biko late in 1978.

He wanted the council to establish "whether the conduct of the medical practitioners concerned was in conformity with the its requirements".

Mr F C Kirk-Cohen, SC, for the defence, instructed by the State Attorney, argued that the SAMDC had no inherent powers, the documents furnished by Mr Roelofse did not constitute a complaint, charge or allegation, the complaints did not comply with the requirements of the regulations governing the SAMDC, they were "not concise or specific", and that the complainant had to be prepared to bring evidence to back up his claims.

Mr Justice Coetzee disagreed.

A third doctor named at the Biko inquest, Dr Colin Hirsch, was not mentioned or represented at the hearing.

o In October the State granted the Biko family R65 000 in settlement — made without prejudice or admission of liability by the State — of claims, lodged by Mrs Nontsikelelo Biko, the widow of Mr Biko, her two minor children and Mr Biko's mother, Mrs Alice Bikomade; and arising out of Mr Biko's death.

rural areas or cause of deaths' according to the Bantu Reference Bureau (Personal Communication). At least 50 000 deaths among Africans were not registered. These occur mainly in the rural areas. It is estimated that about 10% of the deaths in the main urban districts are not registered for Africans.

METHODS

The following indices were calculated:

1. Crude Mortality Rates.
2. Standardised Mortality Rates. Two standard populations were used: England and Wales representing a developed population and Mexico 1960 for a developing one.
3. Age and Cause Specific Death Rates. Calculated mainly in five year age groups for the seventeen major divisions of the eighth revision of the International Classification of Diseases (ICD).
4. Proportions of Causes of Death.
5. Infant Mortality Rates.
6. Expectation of Life. Calculated for 1970, the last census year.
7. Competing Mortality Risks.[8] This is the mortality experience of a population under the hypothetical conditions which would exist if a particular cause of death were eliminated. It gives an indication of the relative effect of that cause on the expectation of life.

The calculation of rates involves a knowledge of the base population age specific population. No official estimates of this are available for inter-censual years. For whites, Asians and 'coloureds, the 1970 population has been projected forward using the age specific survival rates from 1970 and taking into account the actual births and deaths in the 0-4 age group. Allowance was made for migration.

For Africans, a different procedure was adopted as a population figure for only part of the country was required. The 1970 age distribution[10] by magisterial district was used, the numbers being adjusted by the 1974 gross population estimates by economic region.[11]

DISCUSSION

The crude death rates and the standardised mortality rates for whites, Asians and 'coloureds' and urban Africans are presented in Fig. 1. The interpretation of these figures is confounded by the differences in the underlying structure of the population. The population pyramids of the various groups were pictured in Part I with the exception of the urban Africans, which appears in Fig. 2. This population shows an excess of healthy working males and lack of elderly persons as a result of the migratory labour situation.

The standardised mortality rate provides a single figure for the mortality

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RDM 15/12/79 (93)

Biko doctors: a fresh approach

By TONY STIRLING
Chief Reporter

THE South African Medical and Dental Council will now ask two State doctors involved in the treatment of former detainee Mr Steve Biko to complete their answers to questions submitted to them as result of complaints from Mr Eugene Roelofse, ombudsman for the SA Council of Churches.

Mr Justice Cotzee has refused an application by the two doctors, Dr Benjamin Tucker, chief district surgeon of Port Elizabeth, and Dr Ivor Lang, principal district surgeon of Port Elizabeth, who tried to block the SAMDC from taking preliminary steps preceeding a possible inquiry by the disciplinary committee of the SAMDC.

Prior to the bringing of this application, the two doctors had been asked if they would answer certain questions arising out of letters submitted to the council by Mr Roelofse.

The doctors can choose whether or not to answer the questions submitted to them.

The matter will then be considered by a sub-committee of the SAMDC which will decide whether or not there are any grounds for a hearing by the disciplinary committee.

A third doctor mentioned at the Biko inquest, Dr Colin Hirsch, was not referred to in the hearing before Mr Justice Coetzee. It could not be ascertained whether, at this stage he has received or answered any questions from the SAMDC as result of the letters of Mr Roelofse.

cities from rural areas. An indication of the situation in the rural areas is given by a sample survey carried out in Cape Town and Transkei among Xhosa-speaking Africans.[12] An increase in infant mortality was observed with decreasing urbanisation, the figure for the completely rural areas being of the same magnitude as those parts of the world devoid of medical services. Fig. 4 summarises the age specific mortality rates of